EXPLORING EUROPEAN OSTEOPATHIC IDENTITY: AN ANALYSIS OF THE PROFESSIONAL WEBSITES OF EUROPEAN OSTEOPATHIC ORGANIZATIONS

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Sworn Declaration

I hereby declare that I have written the submitted Master's thesis independently and on my own. All texts either quoted or paraphrased from published or unpublished materials have been designated as such. All sources and aids used for this work have been indicated as such. This work has not been submitted with the same content to any other examination authority.

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Remarks: Quotations appear between quotation marks and are directly followed by the reference, with page number. Shorter quotations in German appear translated in the text itself to facilitate reading. Translated quotations consisting of more than three lines appear in a different print size and are set apart from the rest of the text. They are translated into English with the original appearing in footnotes. Generally we specified the pages for sources such as books, collected papers and theses (and not just for quotations). Pages are not given for other sources, such as articles and letters to the editor.

Abstract

Introduction A sociologically confirmed identity crisis in osteopathy exists in the USA. The crisis lies in the fact that the practical activity of the DOs is no longer sufficiently demarcated from the allopathic activity of the MDs. In Europe we find that differences in terminology and practices exist within the osteopathic professional group, making communication difficult between osteopaths. However, the distinctive identity of European osteopathy is an important precondition for defining a professional profile that would clearly demarcate osteopathy from other medical occupations and that would also set the ultimate goals for a qualitatively protected osteopathic degree program meeting the requirements for state recognition. The result would be improved communication among the osteopaths themselves and with outsiders, to the benefit also of the patient.

Design Systematic, historical and comparative analysis of the literature and of websites

Methods By means of an analysis of the literature we searched for the terms *identity*, *identity crisis* and *professionalization* in reference to osteopathy. To answer our main question: *How do the national professional unions & registers and the international osteopathic organizations in Europe currently present osteopathy?* we systematically analyzed 29 European unions and/or registers (from 19 countries) and 3 international organizations according to a list of questions arranged in 11 categories.

Results *Identity* is a collective term covering personal, collective and professional identity. It refers to a state of unity, continuity and coherence. Identity is inconceivable without the setting of boundaries and the formation of oppositions. There exist identity-constituting features of osteopathy that altogether make up its distinctive identity. Osteopathy is not uniformly characterized by the professional unions and registers and international osteopathic organizations, however. To summarize some of our results: 31% define osteopathy as medicine, and 38% define it as a form of therapeutic method or treatment. Only 21% see the role of osteopathy to lie in first-line medical care. 24% define osteopathy as complementary and 7% as complementary *or* alternative. The *form* of recognition of osteopathy also varies: In some countries osteopathy is an independent profession and in others represents only further training for other health professions (i.e. physiotherapy).

Conclusion Significant intraprofessional differences exist in the presentation of osteopathy among the European professional unions & registers and international osteopathic organizations, and the existence of these differences conflicts with the idea of a collective identity. The criteria for a professionalization of osteopathy as an academic profession are not

fulfilled at present. We may therefore infer that osteopathy is undergoing a crisis of identity in Europe, which can only be resolved creatively, through a *common* orientation of professional values.

Keywords osteopathic medicine, identity, identity crisis, professional identification, professional distinction, professional uniqueness, professional role, professional practice, professional education, allied health occupations, social status

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1 Introduction

> *I have this to say, if osteopathy is dead it is the liveliest corpse I have every seen, and if osteopathy ever dies it will be murdered in the house of its friends. There is not force enough in the organization of the [...] Medical Association, there is not force enough in the Congress, there is not force enough in the Central Powers and Allies combined to kill osteopathy, unless we murder it ourselves.*
>
> *Meacham, 1916*

What is osteopathy?

Does osteopathy as taught in Germany, for example, meet the preconditions for developing a distinct image of itself as an autonomous profession in the future? Do all colleagues apply the concept of osteopathy in the same way? What are the prerequisites for performing the professional role of an "osteopath," and what demands do the "osteopaths" themselves and others place on this professional image? How do these matters stand among our European neighbors – is the available training equivalent? These questions are made pressing by the frequent variations in terminology, in professional beliefs and in the forms of osteopathic practice we encountered in discussions with various osteopaths and in the osteopathic literature (Kuchera, 1991; Allen, 1993; Johnson et al. 1997; Cameron, 1998; Johnson and Bordinat, 1998; Johnson and Kurtz, 2001; Russo et al., 2003; Gevitz 2004, Grundy and Vogel, 2005; Tanguy, 2005; Lucas and Moran, 2007; Abehesera, downloaded 03/2008a, b). We can argue over whether these differences are attributable to the idiosyncrasies of the individual persons, to the differences in content of their basic and advanced training or to the fact that we have no exact definitions of "osteopathy" itself, of what osteopathy is, of the collective goals pursued by osteopaths and of the role they can play in the health care system.

A bachelor's or a master's degree in osteopathic training? "Structural osteopathy," "functional osteopathy," "biodynamic osteopathy," osteopathy as a separate branch of medicine, osteopathy as an alternative and/or complementary practice of medicine, osteopathy as a form of curative treatment or therapeutic method are just some of the indications of the absence of a generally applicable definition of osteopathy as a European occupational profile (Ernst, 1993, 2000; McPartland, 1999; Vogel, 2006; FORE Document, 2007; Abehesera, downloaded 03/2008a, b; AAO, downloaded 04/2008, 05/2009).

How *does* (European) osteopathy define itself today?

This question comes up again and again; it is raised both internally and externally, also and above all by patients and by colleagues from other medical professions in discussing

everyday practice. The question may be conceptual and/or philosophical in content. At the same time, the question concerns a specifically felt professional identity, recognition in professional policy and the perception by society. Clearly this question is too complex for adequate treatment within the confines of a master's thesis. It requires both a critical and a collective discussion of the characteristic osteopathic values and principles (Tyreman, 2008a, b), the formulation of which is rather the future task of the overall profession. According to Korr (1995a, p. 230), the question is no longer "What is osteopathy?" but rather "What do you propose that it become and that it do?"

An identity crisis of the osteopaths (DOs) in the USA is self-evident and has been sociologically studied (Littlejohn, 1901; Hollis, 1910; Anonymous, 1963; Nicholas, 1983; Eckberg, 1987; Cole, 1990; Meyer and Price, 1993; Korr, 1995a, p. 228-230; Fisher and Wilson, 1997; Miller, 1998; Johnson and Bordinat, 1998; Tyreman, 1998; Pogorelec, 2000; Fogel, 2001; Johnson and Kurtz, 2002; Cummings, 2003; Teitelbaum et al., 2003; Gevitz, 1988, 1994, 2004; Licciardone, 2007; Ha, 2008; Campbell, n.d.). One fact responsible for this identity crisis is the practical indistinguishability of the activities of osteopathic physicians (DOs) from those of allopathic physicians (MDs). In the USA, people are now questioning the usefulness of this distinction, despite the DOs' decades-long struggle for professional rights as medical practitioners and despite their present recognition in all 50 states (Garris, 1985; Fisher Wilson, 1997; Miller, 1998; Gevitz, 1998, p. 153; Johnson and Kurtz, 2002). Crisis-ridden discussions have recurred within the profession over the necessary distinguishing features shaping its identity (Littlejohn, 1901; Hruby, 1993; AAO Journal, 1993; Meyer and Price, 1993; Peppin, 1993; Gevitz, 1994, 2004; Tieri, 1999; Siehl, 2001; Fossum, 2002). All this controversy notwithstanding, osteopathic medicine with currently 56,754 active osteopathic physicians (DOs) and 100,000 projected for 2020 is one of the fastest growing professions in the US health care system [AOA, downloaded 2009].

We suspect that osteopathy is undergoing an identity crisis in Europe as well. While many osteopaths understand osteopathy as a distinct profession within the health care system, to date the profession of osteopath (including its professional statutes) has been officially and fully recognized only in a few European countries, like the United Kingdom, France, Switzerland Malta and Cyprus (personal communication Rousseau, 03/2009). The training structure of many osteopathic schools in Europe often has the form of part-time training presupposing another medical or paramedical occupation. In Germany the recognized prior occupation is that of physician, *Heilpraktiker* (complimentary health practitioner), physiotherapist, massage therapist or balneotherapist with manual-therapeutic training [Richtlinien der Bundesarbeitsgemeinschaft Osteopathie (BAO), Guidelines of the German Federal Association of Osteopaths, downloaded 05/2008]. On completion of osteopathic

training some people continue practicing these prior occupations and tend to combine them with osteopathy. In the absence of professional recognition, osteopathic techniques and osteopathic treatment are applied in physiotherapy, medical treatment and complementary health care (the latter case applying only to Germany) [Therapeutenliste des Verbandes der Osteopathen Deutschlands (VOD), List of Therapists of the Association of German Osteopaths, downloaded 05/2008].

In our opinion, recognition of osteopathy as an independent profession in Europe requires in the first place that the professional profile of the osteopaths be formulated on the European level. One purpose of such a profile is the clear demarcation of the profession of osteopath from other medical fields. A professional profile attests a separate professional identity. Before such a professional profile can be created in Europe, however, we think it useful to study, in the form of a master's thesis, the current status of osteopathy regarding its identity in the European countries.

We pose the following research question:

- How do the national professional unions & registers and international osteopathic organizations in Europe currently present osteopathy?

Other issues to be treated in relationship to the research question include:

- How is osteopathy developing in Europe, how is osteopathy defined – does osteopathy enjoy a separate identity?
- Do there exist parallels with the identity crisis in the US?
- Is osteopathy in Europe able to perceive itself as an independent form of medicine?
- What do osteopaths do – how do they define themselves, and are ways of clearly demarcating this profession?
- What sort of political recognition are the professional unions & registers and the international osteopathic organizations endeavoring to achieve in the respective European countries?
- What are the goals of the professional unions and registers regarding the level of training; what sort of degrees (bachelor's or master's) are intended?

This master's thesis accordingly breaks down into the following parts:

- An analysis of the literature in reference to *osteopathic identity*, with a background study of applications of the concepts of *identity*, *identity crisis* and *profession*. In particular, we consider the history of osteopathy in the USA and Europe, and derive

the factors and indications of the identity and identity crisis in osteopathy that have already been and/or are to be (further) investigated.

- We follow with a systematic study of the *osteopathic profession* in Europe on the basis of the websites of national osteopathic unions & registers and international osteopathic organizations. On this level we can obtain information on the current identity of osteopathy in Europe.

2 Methodology of literature research

This thesis represents a systematic historical and comparative study of the literature.
The articles, books and personal documents from the tutor's library provided an initial orientation in the identity crisis of osteopathy in the United States. These consisted mainly of articles from US professional journals, with the oldest article being a special reprint (Littlejohn, 1901) and later articles stemming from recent years (Peppin, 1993; Meyer and Price, 1993; Miller, 1998; etc.). We again searched for these articles in databases in order to identify related articles and obtain cross-references to yet other articles.
A second, very important source was the book *The DOs – Osteopathic Medicine in America* by Gevitz (2004), containing a very precise sociological study of osteopathy in the United States, now updated and expanded with new chapters. The chapters on "A Question of Identity" and "The Challenge of Distinctiveness" specifically treat the identity problem. These additions alone attest the challenging and persistent timeliness of this issue for osteopathy throughout its development up to the present time. The book also contains a useful and comprehensive list of references.
Our third original source was an older book by Gevitz entitled *Other Healers – Unorthodox Medicine in America* (1988), particularly the chapter on "Osteopathic Medicine: From Deviance to Difference," which gave us a considerably briefer, but incisive, history of osteopathy.
Following this introductory survey, we realized that the question of identity in osteopathy is as old as osteopathy itself, and that if we wished to research osteopathic identity in Europe we would be obliged to consider osteopathy in all its different facets and against its contemporary background, to the extent this was possible for us to do.

In addition, it appeared to us necessary in the second introductory phase to study more closely the concepts of *identity, identity crisis, profession* and *professionalization* as applied in the literature. Here we made use of, among other things, references from articles primarily treating *osteopathic identity*, to arrive at articles and books in sociology and, more specifically, in vocational sociology.

2.1 Methodology of literature research in databases, search engines and websites

2.1.1 Research questions

1. What does the concept *identity* mean for a profession?
2. When do we speak of an *identity crisis* of a profession?
3. How is a profession defined, and when do we speak of *professionalization*?
4. What is the *identity* of osteopathy?

2.1.2 Search strategy

For the first three questions we searched through the following databases and websites, and employed the following search engine:

- Google (http://www.google.de)
- Wikipedia (http://www.wikipedia.org)

Entering the search terms *Beruf/profession, Identität/identity* and *Identitätskrise/identity crisis* in Google led us again to Wikipedia (German and English versions) and to the website http://www.thefreedictionary.com/identity, which offered us definitions from various sources. These sources were for the most part dictionaries, along with a link to the website of the Hochschule für Technik, Wirtschaft und Soziale Arbeit in St. Gallen: http://www.ifsa.ch/studienblog/2006/01/24/kriterien-der-profession.
Entering the search term *Beruf* (profession) in the German Wikipedia led to other related search terms, with terms like *Berufsbeschreibung* (profession description), *Professionalisierung* (professionalization) and *Professionsmodelle* (profession models) containing the information and other references of relevance for us.

The search terms *berufliche Identität* (professional identity) and *Beruf* (profession) in Google led exclusively to these websites:

- htttp://www.timunger.de
- htttp://www.neuro24.de/show_glossar.php?id=261
- http://www.edoc.hu-berlin.de/dissertationen/schaemann-astrid
- http://www.andreasjentsch.de:80/berufsoz.htm
- http://www.socialnet.de/rezensionen/3307.php
- http://www.sozialwiss.uni-hamburg.de/lsoz/Eichner/Seminare/VM2/SOZP08/Bie

For the fourth question, we conducted an initial survey of osteopathic and other medical databases starting from the website of the Commission for Osteopathic Research Practice & Promotion (CORPP: http://www.corpp.org/Database/index.jsp), selecting the following:

- Medline (Pubmed) (http://www.ncbi.nlm.nih.gov/pubmed)
- Osteopathic Research Web (http:// www.osteopathic-research.com)
- OstMed.DR® (http:// www.ostmed-dr.com)

To obtain the right search terms, we used the "MeSh" database. Altogether we employed the following search terms, meaningfully combined using the connectives AND and OR: osteopathic medicine, profession, identity, professional identity, uniqueness, professional uniqueness, professional profile, professional values, professional distinction, professional organizations and social status. The searches are summarized in Appendix A.
In case we received no hits for certain terms we used the related terms suggested by "MeSh," again combined by the connectives AND and OR: health occupations, allied health occupations, occupational groups, professional identity crisis, social identification, professional autonomy, professional education, social status, social desirability, social values, professional role, professional practice, professional delegation and societies. The results of our database searches (Pubmed, Osteopathic Research Web and OstMed.DR®) are listed in Appendix B.

We continued searching for "related articles" by directly entering their titles in Pubmed and OstMed.DR®.
Articles not freely available in Pubmed or OstMed.DR® were sought in the Online Catalogue of Kassel University Library (OPAC) and its departmental libraries, or were requested by through interlibrary loan via KARLA, the Kassel Research, Literature and Information portal. Finding that only limited numbers of editions of the US journals were accessible this way, we e-mailed contacts in the USA to request the articles still missing. These contacts were provided by private individuals.

3 What does the concept identity mean for a profession?

3.1 Definitions of the term "identity"

There is no all-inclusive definition of the term *identity.* Associated with the basic theoretical concepts of 20th century psychology and sociology, the expression has spread "epidemically" through our everyday language in recent years, according to Assmann and Friese (1999, p.

11). The cultural sciences treating this concept range from psychology and sociology to history, ethnology and the study of literature; even in mathematics it plays a role. Discussions of the concept *identity* invariably attend to the associated concepts *identification* (Cheney and Tompkins, 1987), *unity* or *oneness* and *uniqueness*, all of which are of interest to us, since they recur as keywords in osteopathic literature (Pugh, 1948; Kuchera, 1991; Allen, 1993; Meyer and Price, 1993; Hruby, 1993; Hruby et al. 1994; AAO, 1994; Johnson and Bordinat, 1998; Miller 1998; Tieri, 1999; Pogorelec, 2000; Fogel 2001; Johnson and Kurtz, 2001; Wagner, 2002; Licciardone, 2007; van Dun, 2008a, b). In the following, we study these individual concepts and their interrelationships in a stepwise fashion. Before continuing our analysis, however, we draw the reader's attention to Straub's warning (1999, p. 78) not to confuse *identity* with *individuality*.

We also emphasize that the literature on the quest for osteopathic *identity* often raises the question of what makes osteopathy unique[1]. According to Drexeler (2009), however, this involves a category mistake, since *uniqueness* does not suffice for *identity*. On the other hand, *uniqueness* is implied by *identity*. The question of *uniqueness* arises from a comparison with others, the necessary presupposition being that a person has an *identity* in the sense of "knowledge about oneself". Not what makes osteopathy *unique*, but what defines osteopathy as osteopathy, is the meaningful question to ask. The answer may involve an aspect of *uniqueness*, but not necessarily.

The dictionaries we consulted define *identity* as follows:

- "The collective aspect of the set of characteristics by which a thing is definitively recognizable or known […]
- The set of behavioral or personal characteristics by which an individual is recognizable as a member of a group.
- The quality or condition of being the same as something else.
- The distinct personality of an individual regarded as a persisting entity; individuality […]."

American Heritage® Dictionary of the English Language, 2003 [downloaded 06/2008]

- "The state of being a specified person or thing […]
- The individual characteristics by which a person or thing is recognized
- The state of being the same […] "

Collins Essential English Dictionary, 2006 [downloaded 06/2008]

We then researched the concept of *identification:*

- "The attribution to yourself (consciously or unconsciously) of the characteristics of another person (or group of persons) […]"

Collins Essential Thesaurus, 2006 [downloaded 06/2008]

[1] See the editor's article in the *AAO* (1994), "The Uniqueness of Osteopathic Medicine: Do We Know What It Is?"

and that of *oneness, unit*y:

- "The quality of being united into one […]"

Collins Essential Thesaurus, 2006 [downloaded 06/2008]

The above definitions of *identity* refer mainly to the individual person. The definitions of *identity*, *identification, unity* and *oneness* also entail a possible and discussed form of *identity* relative to a group, however. Our assumption that there must be something like *group identity* would be buttressed by any references to the *identity of osteopathy* occurring in the literature. Consequently we were interested in all information concerning *identity* relative to a person or to a group, in order to apply this extended notion to the professional group of osteopaths in a second stage of our study.

Concerning the osteopathic literature, Meyer and Price (1993) relate the concept of *identity* to the notions of mission and vision. They write that an *identity* can derive from plans and pursued goals. In their view, a mission constitutes the justification for the purpose of an organization. A vision is the goal that is pursued, and the two together provide a profession with its identity.

Hruby (1993) says that *identity* consists of the beliefs underlying the definition of one's own individuality, with this definition making *something* unique. These beliefs give us certainty as to what we are and how we ourselves set the boundaries within which we want to live. The beliefs are based on the interpretation of past experiences. Hruby speaks of *personal identity*. He also says that it is a human need to strive towards consistency, regardless of whether this perception is accurate or not. Hruby relates this concept of *personal identity* to the concept of osteopathic identity. Osteopathic identity is accordingly based on osteopaths' shared beliefs about osteopathic medicine and on the identification of osteopaths by outsiders in terms of actions and practices.

If we continue looking in the social sciences, we find two basic concepts of *identity* that can yield further information: the concept of *self-identity* or even *personal identity* and the concept of social or *collective identity* (Straub, 1999, pp. 83-104). The first refers to the individual person in his or her self-awareness of personal continuity and coherence through time; the second refers to the *identification* of people among themselves, their idea of similarity or equality with others within the group, including the idea of their distinction from non-members of the group – and thus corresponds to the concept we are seeking.
On the other hand, we find the information on *personal identity* just as relevant and possibly extendable for our understanding of the *identity of osteopathy* (in the collective sense), especially since the two forms of *identity* are interrelated by the process of *identification*. Nor

does the osteopathic literature emphatically distinguish between *personal* and *collective identity*. Talk of the *identity of osteopathy* in general may refer either to the osteopaths as a vocational group or to the individual osteopath, to his or her individual understanding and image of osteopathy.

In his chapter on *personal identity* Straub (1999, pp. 83-95) speaks of *identity* as a construct from so-called basic skills like empathy, role distance, tolerance for ambiguity and the presentation of identity, and says that only those persons able to orient themselves have the sense of being more or less identical with themselves. Straub views all possible verbal and other forms of behavior as the media and means of expression of *identity*. The author regards conditions like unity, continuity and coherence, along with the autonomy of a person in thinking and acting, as constitutive of *identity*. The latter is not innate, but is acquired only in the course of development, and is repeatedly subject to limitations and hazards during its formation and perpetuation. The concept of *identity* presupposes making distinctions and perpetuating differences, as well as synthesizing and integrating those differences. In a later passage Straub writes that there can be no identity without knowledge, reflection and awareness, thereby expressly referring to individual and collective life.

Assmann and Friese (1999, p. 23) write that *identity* is inconceivable without the notion of boundaries. The strength of these boundaries is crucial for the form and character of identity:

> „Identities are the more compact, defensive and possibly also potentially more aggressive the stronger the boundaries they erect as outer protective barriers; and they are the more elastic and differentiated the more they make these boundaries themselves the reflective objects of a constantly open-ended formation of identity." (Assmann and Friese, 1999, p. 23)[2]

Assmann and Friese note that the supposed counterpart to *identity*, namely *difference*, is actually indispensable to *identity*, since *difference* itself becomes the constitutive component of *identity* in drawing boundaries and forming oppositions. When difference becomes internal to *identity*, the latter loses its connotations of homogeneity and totality, and represents no longer the opposition, but a practice, of difference.

If we now wish further to investigate the concept of *collective identity*, we should return to Straub (1999, pp. 96-104), who begins by considering the constitution of the collective: Which persons are counted as members of the collective and by what criteria, and who is authorized to make this selection? Here we make the connection to the professional osteopathic unions

[2] „Identitäten sind um so kompakter, defensiver und gegebenenfalls auch potentiell aggressiver, je stärker sie die Grenze als äußeren Schutzwall aufrichten; und sie sind um so elastischer und differenzierter, je mehr sie diese Grenzen selbst zum reflexiven Gegenstand einer immer offenen Identitätsbildung werden lassen." (Assmann and Friese, 1999, p. 23)

and to their statutes that we have researched. Of special interest to us are the prerequisites for being listed as an osteopath in the directories of these unions. On the basis of Assmann and Kreckel, Straub formulates his own definition of collective identity:

> „By *collective* or *we identity* we mean the image that a group forms of itself and with which the members of that group identify themselves. Collective identity is a question of the *identification* on the part of the participating individuals. Collective identity exists not 'in itself' but always and only to the extent to which certain individuals accept that identity. It is strong or weak depending on its viability in the thinking and actions of the group's members and its capacity to motivate this thinking and acting." (Straub, 1999, pp. 102 -103)[3]

There are two types of collectives: *normalizing* and *reconstructive*. Straub (1999, p. 99) relates both types to normative constructs of meaning. *Normative* in this context probably refers to a directional specification or guideline that the collective imposes on itself, but unfortunately the author leaves out any further details, thus leaving open the questions of concrete examples of the application of the concept and its direct relationship to the formation of *identity*.
Information from Tyreman on the term "normative" provides further clarification, however: Tyreman (2007) treats the terms "fact" and "value" and their significance in medicine in the context of osteopathy. He also sheds light on the related terms "descriptive" and "normative," focusing on their applicability in the clinical practice of the osteopathic profession. In this case the profession would be comparable to a collective. The author possibly deviates from Straub (see above) in equating "normative" with "value judgment". Tyreman describes the relation between the values underlying a given sense of "normative" and the concept of *identity*. The author asks whether the values determine *identity* or whether *identity* arises from the values.

Cheney and Tompkins (1987) have conducted a detailed study of the *identification* by an individual with a particular group. The keywords in their study were *identification* and *commitmen*t, which they found to be expressions regularly used in describing the bonding between an individual and a group or organization. *Identification* and *commitment* are two expressions related to one another that are also associated with *loyalty*, *attachment*, *involvemen*t, *central life interest* and the rather negatively connoting term *alienation*. Following their analysis of the term *identity*, with that of *identification* in the background, the authors propose an integrative definition of *identity* for a collective. *Identity* is then that which a group or a person regards as representative of itself or himself or of a third party.

[3] "Unter einer *kollektiven* oder *Wir-Identität* verstehen wir das Bild, das eine Gruppe von sich aufbaut und mit dem sich deren Mitglieder identifizieren. Kollektive Identität ist eine Frage der *Identifikation* seitens der beteiligten Individuen. Es gibt sie nicht >an sich<, sondern immer nur in dem Maße, wie sich bestimmte Individuen zu ihr bekennen. Sie ist so stark oder so schwach, wie sie im Denken und Handeln der Gruppenmitglieder lebendig ist und deren Denken und Handeln zu motivieren vermag." (Straub, 1999, pp. 102 -103)

In a collective, only the shared pursuit of interests seems to matter for the felt *identity* of the individual member and the we-feeling within the group. The concept of *identification,* relative to the group or even to the individual, includes both the development and preservation of the *common* and the *identical* with respect to changing internal and external influences.
A relationship of tension can then arise between the person's own idea of his or her *identity* and the interpretation by others. It therefore makes sense to consider the connection between the individual and the organization in two ways, from the individual's perspective *and* from the perspective of the collective (Mackenzie in Cheney and Tompkins, 1987).

Concluding, we must note a divergence in the experts' opinions on the existence and character of *collective identity.* Kreckel (in Straub, 1999, p. 99), for example, claims that only individuals can form an *identity*, and that groups and societies cannot. While collectives can emerge only as collective agents or as legal persons, they do not possess anything like a *group mind* or a *collective personality*. The attribution of an identity to a group (in the present context of osteopathy) could only represent an ideological use of language.

For us, the voluminous information on *collective identity* prevails, and we employ this concept along side that of *personal identity* in our analysis. Noting the basic skills (see above) and concepts like unity, continuity, shared pursuit of interests and setting of boundaries at the back of one's mind, our later analysis of the websites will give special attention to the concordance among the European (national) professional unions & registers and international osteopathic organizations in their pursuit of interests in the name of osteopathy and in their practice of the latter. As to the question of *collective identity*, we found it useful to work out the agreements and differences between the different professional organizations regarding the *definition of osteopathy* and that of the *osteopath*, also with respect to:

- goals formulated in professional policies
- the desired role of osteopathy in society and in the health care system
- the acceptance criteria for members.

Our specific consideration of the goals of the osteopathic unions in their professional policies is also based on the study by Meyer and Price (see above), which assesses any osteopathic *identity* in terms of mission and vision.
Having explicated the concept of identity, we must now ask what the literature tells us about *identity crisis*.

3.2 Definitions of the term "identity crisis"

The American Heritage® Dictionary of the English Language defines *identity crisis* as follows:

- "A psychosocial state or condition of disorientation and role confusion occurring especially in adolescents as a result of conflicting internal and external experiences, pressures, and expectations and often producing acute anxiety.
- An analogous state of confusion occurring in a social structure, such as an institution or a corporation."

American Heritage® Dictionary of the English Language, 2003 [downloaded 06/2008]

Note that the definition relates *identity crisis* both to a person *and* to an institution, which would be the same as a collective.

Turning to Straub (1999, pp. 83-86) again, we find definitions based on Erikson and mainly referring to *personal identity crisis*. Talk of an *identity crisis* here primarily refers to an adolescent crisis. Identity crises need not be limited to this phase of life, however, and in principle may have an unrestricted scope. Generally any person is prone at any time to suffer an *identity crisis*. The trigger is the concurrence of certain psychosocial circumstances that "pull the rug out from under someone". Erikson describes the condition of *identity crisis* as a kind of typical ordeal always connected with the formation of *identity*. In other words, the author regards this condition as normal, assuming that the crisis is only of limited duration. When chronic, it is pathological.
People suffer from an *identity crisis* when they lose their orientation in physical, moral or social space, and also lose their corresponding sense of time. The crisis is coupled with the loss of self-determined thought and action and with the sense of no longer being the same, unified person given changing circumstances of life (Erikson in Straub, 1999, p. 85).
The concept of *identity* is therefore irrevocably tied to a certain experience of crisis and to its mental processing by the affected subject. Conversely, a person who never acquired or who lost the ability to react creatively to an *identity crisis* is said to suffer from the *absence of identity.*

The above gives an interesting clue for understanding and assessing the *osteopathic identity crisis* so much discussed in the literature. As we said at the beginning, the definitions from Erikson and Straub seem mainly to concern *personal identity*. In the absence of any further information on the *identity crisis* of a *collective* from these sources, we want again to interrelate *personal identity crisis* and *collective identity crisis* in terms of the process of *identification*, and draw the relevant conclusions for osteopathy. Starting from the typical characteristics of *identity* like coherence and unity, correlated with the *shared pursuit of*

interests and the *we feeling* in the context of *collective identity*, we find that such characteristics no longer pertain to a *collective identity crisis*. On the other hand, the formation of an *identity* inevitably involves passage through an *identity crisis*.

3.3 Definitions of the term "professional identity"

In Germany the choice of a profession falls under the Freedom of Career Choice Act [Grundgesetz für die Bundesrepublik Deutschland, German Basic Law, Art. 12, 2006].
As to the significance of a profession for an individual, basically the economic aspect and the social function of a career are noteworthy.
Pertaining to the economic aspect, we can say that the exercise of work or a profession primarily serves as a financial source for securing one's own existence or that of one's family. In other words: "Professions guarantee the material basis of a lifestyle"[4] (Jentsch 1997, p. 6). Monopolization of work performance then plays a central role in avoiding competition and consequently in securing one's own status in the labor market (Jentsch, 1997).
Still more important for our research on *professional identity* seems the consideration of the social function of a profession. The profession and its career prospects determine an individual's social status within the society and also govern how that person is assessed by outsiders. The chosen profession is determinative of one's own lifestyle and the opportunities for action and self-fulfillment, and consequently directly influences personality formation, thereby closing the circle for forming *personal identity*. A profession can therefore also play a problematic and ambivalent role in the process of self-identification and the development of social *identity* (Jentsch, 1997, in reference to Becker, Brater and Daheim). Generally we can say that a profession has a socializing effect and therefore shapes the personal behavioral patterns of the individual.

As noted by Jentsch, Mayer [downloaded 08/2008] also holds that training and professional activity affects the formation of *personal identity*, and attributes to the *professional identity* a basic share of a person's personality. The author refers to available Anglo-American research and studies ("career-related personality theory") by Holland, which discuss a well developed *professional identity* as indicative of *mental health*, among other things.

Unger [downloaded 08/2008] points out that *professional identity* must be regarded as a learning process, based on identity-related knowledge acquired through social communication.

[4] „Berufe garantieren die materielle Basis der Lebensführung“ (Jentsch 1997, p. 6)

> "We should speak of professional identity when these interfaces involve communication processes and connected self-referential learning processes in which the perception of one's own professional activity and of the interwovenness of one's self with the professional context assume a central place." [Unger, downloaded 08/2008, n.p.][5]

Recalling Straub's statements (1999, p. 93) in section 3.1., we find a few parallels to the definition of *personal identity*, which is also acquired in a process employing all sorts of modes of speech and behavior as media.

3.3.1 The role of values in professional identity

Johnson and Kurtz (2002) describe the relationship of professional values to the development of *professional identity*. They claim that any discussion of unique *professional identity* must refer to professional values. Professional values comprise what an organization considers desirable and preferable. These professional values are instilled through professional training, socialization and acquired professional experience. They represent the underlying attitudes and tenets and their philosophy, which lead to certain forms of conduct and taking of action.

As already noted in section 3.3, Tyreman (2008a, b) in particular discusses the role of values and value judgments in professional practice, and particularly in osteopathic medicine. Tyreman (2008a) speaks of traditional values and principles as characteristic of a profession. The author is convinced that values and value judgments generally guide human behavior. His derived hypothesis is that also professionals base their handling of complex practical situations on values and that these values shape and control professional action (more so than specific professional knowledge). On the other hand, no clear-cut statements are available on whether professional conduct itself is derived from values or whether these are the product of the professional's practical behavior. The author also writes that a profession is judged more by its values than by its products, with these values and principles distinguishing a profession from trades and crafts. Tyreman concludes that values form the foundations for all forms of health practice and that just these values shape the *identity* of a profession.
A consideration of *professional identity* on this basis is provided by the model from Evans employed by Tyreman (in Tyreman, 2007), which in the context of the health care system relates this concept to those of occupational beliefs and clinical behavior. As the figure shows, *professional identity* depends on a comparison with other professions, on traditional principles, values and theories, and on specialized clinical knowledge. *Professional identity* has an indirect influence through occupational beliefs, which in turn are affected by personal

[5] „Von beruflicher Identität sollte dann gesprochen werden, wenn es sich bei diesen Schnittstellen um solche Kommunikationsprozesse und daran anschließende selbstreferenzielle Lernprozesse handelt, in denen die Vergegenwärtigung des eigenen beruflichen Handelns und der Verwobenheit seines Selbst mit dem beruflichen Kontext den zentralen Platz einehmen.“ [Unger, downloaded, 08/2008, s.p.]

beliefs and values. Other influential factors directly or indirectly affecting *professional identity* are cost vs. benefits calculations, the patient population and other external sources not included in the figure.

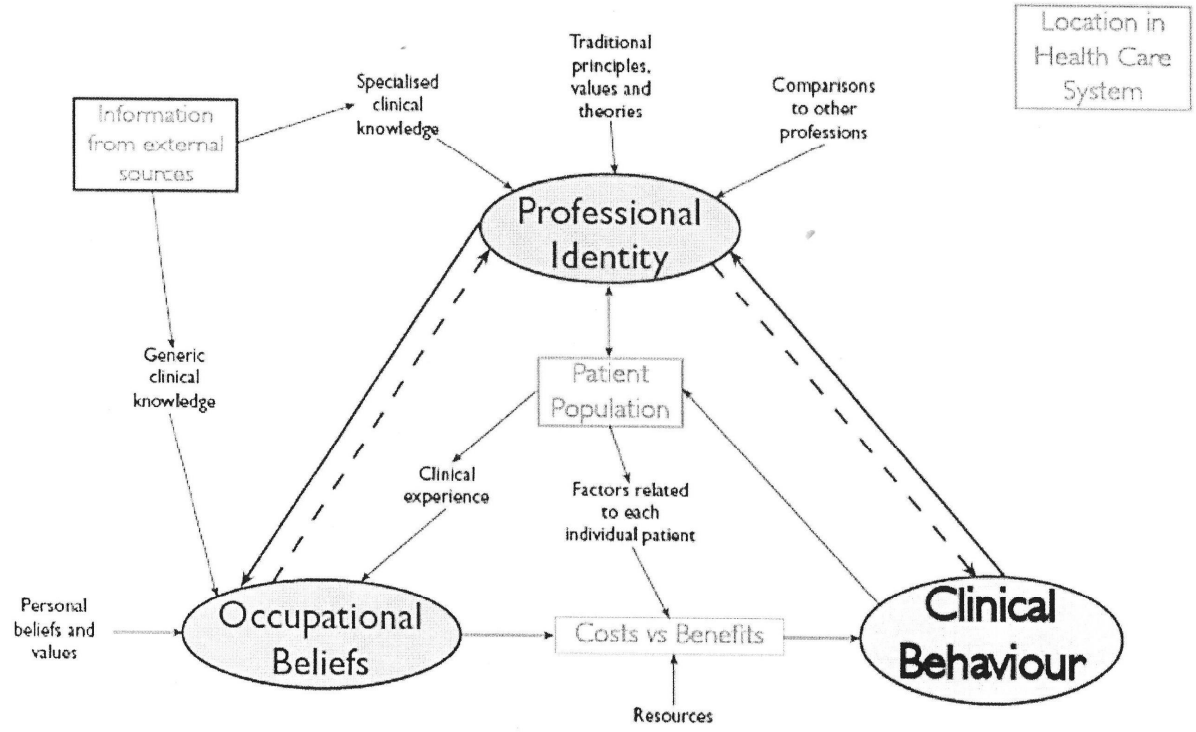

Figure 1: The relationship between themes that influence the clinical behavior of an individual healthcare practitioner (Evans in Tyreman, 2007).

3.3.2 Professional identity from a phenomenological perspective

Another way to consider *professions* and their intrinsic *identity* as *professions* is the phenomenological approach, also known as the *folk approach* (Miller, 1998, p. 1739). Miller employs this phenomenological method in her study on the *professional identity* of osteopathic medicine in the USA. The author regards the concept of a profession as a kind of "folk category" to be employed in studying how the individual members within a vocational group define themselves and their work. To this end she takes a closer look at the available written and oral statements by professionals that are shaped by identification. If we wish to apply the phenomenological approach to our analysis of osteopathy in Europe (in its definitions, for example), among other things, we must be aware of the limitations of this approach:

> " [Within this approach], one does not attempt to determine what profession is in an absolute sense so much as how people in society determine who is a professional and who is not, how they 'make' and 'accomplish' professions by their activities, and what the consequences are for the way in which they see themselves and perform their work". (Freidson in Miller, 1998, p. 1739)

3.3.3 An examination of the concept of professional identity on the basis of a few practical examples

The aforementioned discussion on *professional identity* contrasts with the view of Oser (2003), who regards *professional identity* nowadays only as a sort of luxury item. The author emphasizes that the number of people exercising their profession like a *calling* is vanishing. In support of this claim, Oser notes how the monetary rewards are increasingly playing a predominant role as *identification* recedes into the background.

In his article van Dun (2008b) also gives the example of a master roofer who for reasons of competitive price pressure is forced to save in skilled labor and materials in order to "survive" economically. As a result, the master roofer can no longer maintain the previous level of quality of his shop. Considering then Jentsch (1997) and Mayer [downloaded 08/2008], we find that the quality previously associated with the roofing business is essential to the *professional* and *personal identity* of the roofer himself, in the sense of his *identification* with the work performed. For financial reasons that roofer is now compelled to give this *professional identity* a back seat. Van Dun (2008b) uses this example to broach the issue of quality in current-day (European) osteopathic medicine and the content of training in this field. The US osteopathic literature also contains articles on the subject (cf. Allen, 1990, Teitelbaum et al., 2003).

To Oser (2003) and van Dun (2008b) we can generally add that the trend of increasing consumer-orientation is typical not only of our society, but also of the health care system in particular. This trend poses a challenge to the health professions and necessarily leads to a reformation of their *professional identity*.

Various authors provide still other examples: A general rule in marketing, for example, is that demand determines supply. McClune (2007) describes how the market is becoming increasingly important in the health care system as the power of the health professions declines. He speaks of "deprofessionalization" and of the development of the health industry into a more *patient-centered, evidence-based healthcare system,* with the consequence that the health professions must drop the old paradigms and adapt to the "new" market by acquiring new knowledge and skills.

Ross-Lee et al. (1996) write that the development of the US health care system into a managed-care system (with the claim to cost-effective care and outpatient settings) places practicing physicians before an important problem that we may compare to a *professional identity crisis* according to our present research. The traditional models of medical training no longer correspond to the skills, values and attitudes nowadays required of physicians. Health maintenance organizations, as managers of the new systems, have expressed dissatisfaction with the skill levels of practitioners. On the other hand, many physicians who made the transition to a new practice paradigm by restructuring their practices are dissatisfied and concerned about the quality of care they can deliver.

(The authors' point is that osteopathic medicine has less of a difficulty in changing because of the community-based training.)

Eckberg (1987) described a problem that osteopathic physicians faced and that also was related to changes in the health care system of that time: The new prevailing models suddenly linked prestige and esteem within the industry to specialization on the part of physicians and to the integration of new technologies. This trend was problematic for the osteopaths among physicians, since society regarded them as medically less trained compared with allopaths; the background reason being that, compared with allopathic physicians (MDs), osteopaths (DOs) included relatively few specialists and that their main area of activity originally lay in primary care. Studies show that a large number of DOs themselves began to devalue their own professions, leading them into a *professional identity crisis*.

The descriptions by Eckberg (1987), Ross-Lee (1996), McClune (2007) and van Dun (2008b) point to *one* basic conflict: between tradition (= old professional values constitutive of identity) and innovation (= reconstitution of professional identity on the basis of contemporary values). The changes in society and its systems are the driving force behind the reorientation of the vocational groups in these examples. As already noted by Cheney and Tompkins (1987, in section 3.1), the concept of *identification* includes the development and preservation of what is *common* and *identical* in the face of changing internal and external influences. This applies both to the osteopathic vocational group (see above examples from practice) and to osteopathy *as such*.
Van Dun (2008b) takes up this topic in his essay on the "Wesen der Osteopathie in wechselnden Gestalten" (The Nature of Osteopathy in its Changing Forms), where he makes use of an image of "nature and form" from a book by Kühn. Clearly the concept of osteopathy is being constantly codetermined by its given concrete historical context; in other words: *Osteopathy is never the same, anywhere.* Each age has its own images and realizations of osteopathy, insofar as the latter is conceptually preshaped or reshaped, among other things, by particular contemporary personalities (cf. the changing definitions and terminology in osteopathic medicine observed by Tanguy (2005)). Yet all these variable historical trends and countertrends notwithstanding, *something constant* still prevails through the different, ever-changing historical pictures and lived realizations of osteopathy (such as the basic principles of osteopathy). The nature of osteopathy actually remains the same through its history, but is revealed only in *what is changing*, in other words: The *nature* of osteopathy reveals itself in a constantly variable historical form of appearance or gestalt. Osteopathy thus experiences the same aforementioned basic conflict between tradition and innovations (cf. the history of osteopathy in Europe and USA). The question in Europe is: Will osteopathy succeed in

retaining its essential character despite all the differences and conflicts, all the different directions and schools, and all the struggles between traditionalists and modernists, while also redefining this character for a new generation in Europe?

3.3.4 Conclusions from 3.3 on the concept of professional identity

In summary: The choice and exercise of a profession are first of all performed by the individual. The development of that individual's *professional identity* can be regarded as directly related to his or her *personal identity*. Assuming, as explained in section 3.2, that *personal identity* is connected via the process of *identification* with *collective identity* (in this case in reference to the profession), we are warranted in extending the concept of *professional identity* to *collectives*. In other words, followers of a profession identify themselves with osteopathy and achieve *personal and professional identity* as individuals and as osteopaths; osteopathy in the sense of an osteopathic vocational *group* develops its own *collective professional identity*. The concept of *professional identity* consequently applies both to persons and to collectives.

We were able to observe the influence of a chosen profession on the development of *personal and professional identity* through our own personal impressions of osteopathic training. In reviewing the development we ourselves underwent and that undergone by our fellow-students, we find that osteopathy has indeed impacted both our private and professional lives: We began (even as naive students) osteopathic training with the idea of it as advanced training that would build upon one's prior occupation (in the case of part-time training). Later on, however, we were "forced" to discover that the content taught and the philosophy of osteopathy (as articulated by the school) led to the development of an independent professional concept, which actually necessitated a new career choice. The occupational changes also entailed changes in private life, and new contacts and communities of interest arose.

From the information provided so far by our study, we can also state that changes in the image of the profession caused internally or externally, as well as the social status of the profession, directly shape the *identity* of the members of the profession (with identity as a collective notion). An identity crisis affecting a profession will equally affect the members of that profession themselves. In this regard conflicts may arise in the individual when choosing and exercising a profession, for whereas striving towards the best possible common pursuit of interests by the collective has primary importance for a person, the latter faces the existential question of whether this *professional identity* can outweigh the unavoidable economic aspect.

Given this information on the required changes in professions and professional identity under internally and externally changing circumstances, we can grasp actual existing osteopathy (i.e. the *true identity* of osteopathy) for the purpose of this thesis only if we grasp its nature through its changing historical forms. Besides our analysis of contemporary websites we must therefore devote a section to the history of osteopathy.

3.4 Definitions of and reflections on the term "profession" and "professionalization"

> *Professionals are not new to the world. But in the past, professionals have formed unprogressive castes. The point is that professionalism has now been mated with progress.*
>
> *Alfred North Whitehead*

Professionalization in the broad sense refers to the development of an activity carried out either privately or voluntarily into a profession. In the narrower sense, *professionalization* refers to the development of an occupation into a *profession* as such [German Wikipedia/*Professionalisierung*, downloaded 08/2008]. In this latter sense a *profession* is an academic occupation with a high level of prestige, practiced above all because of the challenge lying in the task. In other words, a *profession* is ascribed the utmost integrity and competence [English Wikipedia/*Professionalization*, downloaded 08/2008].
The broad sense already indicates the elasticity of the concept *professionalization* and the variety of ways it can be brought into consideration.
The distinction between a trade or craft and a *profession* is quickly blurred by the customary generalization of the terms (see also Wilensky, 1964).
Ordinary usage indicates the fusion of the two concepts when we speak of professional work, as when we express our appreciation of person for a job well done by saying, "He certainly handled that *professionally,*" which is to say: "He did that job especially well."

The German Wikipedia (see above) equates *Professionalisierung* with *Verberuflichung,* both ordinarily translated as "professionalization".
Nittel (in Schämann, 2005, p. 25), however, distinguishes these two notions, understanding *Verberuflichung* as an externally controlled process depending on state and industrial purposes, whereas *Professionalisierung*, in the sense of the transformation of an occupation into a *Profession*, undergoes an internal self-directed developmental process.

According to Schämann (2005, p. 26), the initial discussions on *professions* already began in the 1930s. Hesse (in Schämann, 2005, p. 26) has discussed the linguistic history and meanings of the term *Profession* and finds that the term has occurred in German for centuries. According to Hesse, the expression underwent a linguistic development through time to become also the generic term for crafts and trades. Schämann writes that the German debate on professionalization in part inconsistently associates the English term *professional* with *Spezialist*, *Experte* and *Akademiker* noting the problematic transferability of the corresponding terms from the Anglo-American debate.

Merten and Olk (1985, p. 956) attribute the different conceptualizations of *profession* to the concurrence of the scientific, analytic interests of professional sociology and of the professional interests in status and to the variation of their meanings with the social and political climate. In contrast to Schämann, these authors find it appropriate that the German discussion so far has been largely based on the American concepts. They concede, however, that the questions and problems in generalizing such concepts beyond the Anglo-Saxon countries are often neglected.

3.4.1 Models and concepts of professions

There exist different models providing criteria for identifying *professions*. One model is the **attribute model**, also known as the indication-theoretic model or profession-structural model, originating in the period between the 15th and 19th centuries [German Wikipedia/*Professionalisierung*, downloaded 08/2008]. This model contains seven criteria, entailing that for centuries only medicine, jurisprudence and theology could claim to be professions:

1. "Scientifically based special knowledge, special technical terminology
2. Long-lasting, theoretically based courses of training on an academic level (state licensing)
3. Codes of ethics, legal restriction of self-interest (nonprofit)
4. Exclusive monopoly on competence
5. Area of activity consisting of nonprofit functions, duties of basic importance
6. Autonomy in the exercise of the vocation (vocational and technical authority)
7. Self-monitoring through professional unions, special interest groups"

[German Wikipedia/ *Professionsmodelle*, downloaded 08/2008, p. 1][6]

[6] 1.„wissenschaftlich fundiertes Sonderwissen, spezielle Fachterminologie
2. lang andauernde, theoretisch fundierte Ausbildungsgänge auf akademischem Niveau (staatl. Lizenz)
3.berufständische Normen (code of ethics), Eigeninteressen gesetzlich beschränkt (non-profit)
4.exklusives Handlungskompetenzmonopol
5.Tätigkeitsbereich besteht aus gemeinnützigen Funktionen, Aufgaben von grundlegender Bedeutung
6.Autonomie bei der Berufsausübung (Fach- und Sachautorität) cont…

The German Wikipedia adds that newer, more timely models of a profession have arisen that correspond more to the social and structural developments of (post)industrial society and that now allow other occupations to be professions. The later models focus on criteria 1 and 3 of the attribute model,[7] i.e. on the requirement of a scientific basis and on the formulation of a code of ethics. Further details (except for references) are unfortunately lacking here.

Besides the attribute model, Merten and Olk (1985, p. 957) discuss other profession concepts, such as the "functionalist," "power-theoretical," "structure-theoretical" and "semiprofession" concepts. We note that the authors speak of "professional occupations" in addition to "professions".

We briefly summarize the different concepts from Merten and Olk (1985, pp. 957-962): According to the authors, the **functionalist concept of profession** from Parsons basically comprises the question of the social meaning of the profession and its "ideal of service". The special quality of this service ideal rests on a relationship of solidarity between the client and the professional: The client enlists in confidence the professional's aid in dealing with a problem or concern that the client himself cannot resolve because of his inadequate knowledge. The client is the lay person with an interest in competent service on the part of the professional, without the client being able to monitor the quality of this service, hence the need for the cooperative self-monitoring by professional colleagues. The members of a profession guarantee the client and society the utmost competence in accordance with the ideals of the profession as negotiated within the collective. But the authors find that this concept too has its shortcomings.

The **power-theoretical concept of professions** concerns less the internal structure and function of professionalized action than the strategies and power resources leading to the establishment of monopolies (of competence) and state licensing. But the authors find that this model faces the same problems of professionalizability and need of professionalization as the attribute model.

The **structure-theoretical concept of professions** is based on the idea of *professions* as authorities mediating between theory and (life) practice, i.e. between scientific knowledge and ordinary knowledge. Consequently the degree of systematization or scientific foundation of

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7.Selbstkontrolle durch Berufsverbände, Interessenvertretung“ [dt. Wikipedia/ Professionsmodelle, download 08/2008, p.1]

[7] Merten and Olk (1985, p. 957) remark that the attribute model has found widespread acceptance because of its "easy applicability" thanks to the clear listing of the constitutive characteristics for being a *profession*. They criticize, however, that generally any occupation would be *professionalizable* according to this model if the presupposed criteria are met. The authors find that this model stagnates among certain "external insignia of professional occupations". The reason is the particular focus on individual characteristics and the fact that the model, in the authors' view, leaves unconsidered the question whether an occupation *requires professionalization* or is *capable of professionalization* in the first place.

the professional knowledge base is no warrantor for the existence of a profession. The relationship between the professional and his client is therefore not limited to solving a technological problem, which would be equivalent to instrumental action, but also involves communication, the understanding of meanings and the intuitive and situational application of universalized knowledge to the concrete case.

Merten and Olk (1985, pp. 957-962) conclude from the above models and concepts that an assessment of the trends of professionalization in the treatment of central problems in the lay person's life must refer to the establishment of monopolies of competence and the attainment of autonomous rights of control as well as to the development of a certain "internal logic" of the professionalized activity.

The semiprofession concept

According to Merten and Olk (see above) *profession* functions as a demarcation concept, under which only the "classical professions" like medicine, law and theology would fall. The emergence of new occupations led to the concept *semiprofession,* since they were considered as structurally deficient measured by the normative content of the previously present profession concepts. Given the use of the term *profession* for demarcation purposes, *semiprofession* has a negative connotation. *Semiprofessions* lack systematic and theoretical basic knowledge, the training periods are shorter, they have no autonomous control over their members, no sufficient code of ethics, and the corresponding associations are divided among themselves, inefficient and powerless (Toren in Merten and Olk, 1985, p. 961). A *semiprofession* is both organizationally and administratively integrated. The authors conclude that in the meantime the idea of a *semiprofessional occupation* must be rejected as empirically refuted.

According to Wikipedia [German Wikipedia/*Professionalisierung*, downloaded 08/2008], *semiprofessions* are occupations lacking some of the characteristics of the attribute model and therefore qualify as *incomplete professions*. They are generally rated as less demanding. Although their competence contributes to completing important tasks, they do not count as *professions,* since they do not have the appropriate autonomy vis-à-vis delegations outside the field.

Schämann (2005, p. 32) characterizes *semiprofessions* as *professions* surrounding so-called *full professions*. They are *professions* that do not lay down firm rules of admission for members, do not have a clearly defined scope of autonomy of action and do not have any professional conduct boards. The missing autonomy of action consists of the client and organizational autonomy and of the autonomous control over the profession's own status as a

profession. The latter refers to the content and form of the professional training and to the sanctions against disregard of the agreed ethical code. According to the author, *semiprofessions* exhibit no internalized value-based loyalty, have no assertive monopoly of interpretation vis-à-vis competing *professions* as well as the lay public, and involve only limited and in part exclusively technocratic training. *Semiprofessions* generally include a high proportion of women, which according to Schämann is regarded as a reason for the failure of advancement to a *full profession*.

Marginal professions[8]

The term *marginal profession* occurs in Baer (1984b), quoting Wardwell, who applies it to chiropractic (cf. Hassinger et al., 1975) on the grounds that chiropractors see themselves as special doctors and are also so seen by others, but that society as a whole does not award them this status. Bear sees parallels with osteopathy in the United Kingdom at the time, namely 1984. According to the author, osteopathy then was a *marginal profession* because of its lack of autonomy and control over its own profession, and because of its lack of official recognition by the state and of membership in the state-controlled register. A recent essay by Bear (2009, p. 26) examines the evolution of osteopathy in Australia "[…] from a relatively marginal heterodox medical system into a fully legitimized professionalized heterodox medical system." The status of osteopathy here differs from that in the USA, where osteopathy has evolved from a marginal heterodoxy into a fully legitimized and professionalized orthodoxy.

3.4.2 The role of society in the professionalization of occupations

In light of the functionalist concept of profession (see 3.4.1) and Wardwell's argument for chiropractic as a *marginal profession* (see above), it becomes clear how large a role society plays in the *professionalization* of occupations. We find further information on the role of social authority in Schämann and Bear.

Bear (1984b, p. 722) writes: "The professionalization of an occupation depends on its appeal to strategic elites in the larger society." He is supported by Larson (in Bear, 1984b, p. 723), who notes: "Professionalization as a movement for status advancement *must* appeal to general values of the dominant ideology if it is to make its own values acceptable."

Schämann (2005, p. 26) mentions as a crucial factor in the advancement of a vocational group to the level of *profession* the social mandate received by the vocation and the type of license (equivalent in meaning to a social permit) accorded by society. The two are never

[8] The English Wikipedia provides no information on the concept *marginal profession*. Entering the term in Google led to several hits. They include the web link to the Education Resources Information Center (ERIC), and notably to Harrison et al. (1975), who also associate the concept with chiropractic.
The JSTOR link leads to an article by Krause (1965), or rather to the abstract, which although treating the topic would have led us into extensive and detailed vocational sociology without yielding a brief definition of *marginal profession*. For reasons of time we did not pursue this source further.

equivalent and consequently lead to tensions serving the continued development of professions insofar as some "vocations" are associated more with a profession than with an actual vocation. The social license ultimately decides on whether an occupation is elevated to the status of profession, and thus enjoys greater esteem than do other occupations. The divergence[9] between vocational mandate and vocational license has the consequence that occupations not among the classical professions also fall into the domain of profession sociology.

3.4.3 Other characteristics of a profession

Schämann (2005, pp. 27-29) notes still other basic characteristics of professions. They include autonomy of action and organization,[10] universal knowledge and "services related to central values,"[11] which in some points is comparable to "[…] the professional altruism ideal" of Saks (1995, p. 11).

According to Schämann, autonomy of action involves control over one's own activity or over that of the profession. Professions thereby elude control by lay persons, external individuals and organizations (see also criterion 6 of the attribute model, not explicitly mentioned by Schämann, however).
Whether this still applies to professions at present is a matter for discussion, since the evolution of medicine into evidence-based medicine (EBM) necessitates increasing control of the professional by external agents (Drexeler, 2009).
In a foreword to CanMeds, the Framework of Essential Physician Competencies from The Royal College of Physicians and Surgeons of Canada, we read, as in Drexeler, that today's physicians "live in an era with a rising emphasis on accountability and a declining appreciation of professionals [...]" (Frank, 2005, p. 1).

The universal knowledge noted by Schämann (2005, p. 28) basically breaks down into two components: scientific and vocational knowledge. She also characterizes scientific knowledge, which we find addressed by criterion 1 of the attribute model and according to Schämann forms part of the expertise (ascribed to the professions alone), as systematic theoretical and (technical) problem-solving knowledge. Schämann adds that this knowledge is supplemented by the acquired vocational experience and by general ordinary knowledge. Vocational knowledge, which can be derived from the experience acquired in the vocation, contains the cognitive, interactive and normative foundations relevant to exercising the vocation. (The latter reminds us of Tyreman (2001), who also treats vocational knowledge in

[9] Wardwell's example of chiropractic clearly illustrates the divergence between social mandate and social license.
[10] Since we find the information acquired by the author on organizational autonomy less interesting regarding the osteopathic vocational group, we do not pursue this subject in more detail here.
[11] „zentralwertbezogene Dienstleistung“ (Schämann,2005, pp. 27-29)

osteopathy and in his article (Tyreman, 2008a, b) accords professional values a fundamental role in the practical activities of a profession). Schämann writes that this scientific expertise is constituted in specialized and complex research processes and is incorporated together with vocational knowledge in the training that already consolidates the students' orientation as experts. The author regards this process as the students' first step on their way to forming a *professional identity*. According to Schämann, the actual professional *habitus* is consolidated in the later professional practice. In her section on universal knowledge Schämann refers to the dual anchoring in scientific and ordinary practical knowledge, and also (like Merten and Olk, 1985, pp. 957-962) speaks of the pursuit of a certain logic. The members of a profession accordingly play the role of mediators who can interconnect theory and practice on the basis of their universal knowledge. As much at issue, therefore, besides the application of scientific expertise, is the understanding of the individual case from the professionals' side, in the interest of their specific clientele. At issue is the professional resolution of the individual problematic case, something also evident from the functionalist and structure-theoretical concepts of professions discussed above. The author (Schämann, 2005, p. 27) includes under the concept of "service related to central values"[12] the commitment of the profession to nonprofit-oriented maxims and to the preservation of social values like those of right, consensus, truth, health and morality. Truth brings us back to scientific knowledge as the basis of individual action.

Tyreman (2008a) basically reduces the characteristics of a profession to three main criteria. The author claims that it is a general conviction that professions must meet these three criteria: First, they must have a certain value for society; secondly, they must have specialized knowledge proper to the profession; and third, the members of the profession must assume the responsible task of conducting themselves according to the underlying criteria of the profession.

3.4.4 The process of professionalization

Wilensky (1964) generally characterizes the *professionalization* of occupations as a popular generalization in which the necessary criteria are applied too loosely. The author describes the influential factors that play a characteristic role in *professionalization*. He elucidates the process of *professionalization* in the cases of 18 occupations.
The first prerequisite of the process according to Wilensky is that the activity in question be performed on a full-time basis. Secondly, there is the question of training for the performed work. Of six courses of training leading to an established profession, four were closely tied to universities even before "national professional unions" arose. In the less established professions, the reverse pattern was typical. We see the importance given to well cultivated

[12] „zentralwertbezogene Dienstleistung“ (Schämann,2005, pp. 27-29)

knowledge and the strategically innovative role of the universities in combining this knowledge with practice: They form the rational grounds for exclusive jurisdiction. In cases of training institutes not tied to universities at the outset (as in the case of hospital administration), the latter subsequently sought contact with the former. There was a steady development in standard terms of study, academic degrees and research programs to expand the base of knowledge. In cases where the professionalization was the most advanced, it was not the occupational associations that set up training institutes and schools, but rather schools usually promoting effective professional unions.

In the next step, those people advocating professional training and having themselves undergone such training joined together to form a professional union with the aim of distinguishing between *professional* or competent and non-competent practitioners. Besides possibly changing the name of the profession, this step involved the elaboration of further definitions of the professional scope of duties, the so-called "core tasks". This led, according to Wilensky, to internal conflicts between the practitioners owing to their different backgrounds. In some professions (as is evident in classical medicine) there arose a distribution of tasks with a hierarchical character in the sense of delegating duties to "minor professionals" (see 3.4.1, the Semiprofession Concept). It lays in the nature of the matter that internal conflicts between the founding fathers and the newcomers arose within the professional groups: "The newcomers see the old-timers as a block to successful professionalization; the latter see the former as upstarts" (Wilensky, 1964, p. 145). External conflicts were also to be expected in the form of hard competitive struggles against "neighboring" professions. The professions pursued the goal of obtaining legal recognition by the state. They conducted long-term political agitation with the aims of acquiring legal support and consolidating the job territory, their sustaining code of ethics and the legal protection of their titles. Pressure was applied for legal recognition through two possible ways: either through internal debates among the members of the profession themselves, who wanted to effect an elevation of their status, or through social debates on the protection of the public against "dangerous professions"[13].

Wilensky says that in the case of medicine (among others) legal recognition came even before the emergence of a university connection and before the establishment of a national professional union, so that legal protection is evidently not an integral part of "natural professionalization." The formulation of a code of ethics may provide rules and guidelines to eliminate the unqualified and unscrupulous, to reduce internal competition, to protect clients and to emphasize the ideal of service. Among the new and questionable professions there arose codes of ethics at the start of their push for professional status (e.g. hospital administration, city management, etc.). Ten out of thirteen established professions, or groups

[13] Adding to our discussion, in section 3.4.1., on the functionalist concept of professions, we note that the public is again assigned the role of the lay person who cannot judge the competence of the professional and who must rely on the self-controlled quality assurance of the profession.

in the process of professionalization, produced a code of ethics only in the last instance, however (as in the case of medicine, law, etc.).

Wilensky (1964, p. 145) again summarizes the professionalization process usually considered as typical, and adds a few reflective thoughts; the process is depicted again in Figure 2:

> "[…] men begin doing the work full time and stake out a jurisdiction; the early masters of the technique or adherents of the movement become concerned about standards of training and practice and set up a training school, which, if not lodged in universities at the outset, makes academic connection within two or three decades; the teachers and activists then achieve success in promoting more effective organization, first local, then national – through either the transformation of an existing occupational association or the creation of a new one. Toward the end, legal protection of the monopoly of skill appears; at the end, a formal code of ethics is adopted. Power struggles and status strivings common to all occupations help to explain deviations from the sequence. The newer and more marginal professions often adopt new titles, announce elaborate codes of ethics, or set up paper organizations on a national level long before an institutional and technical base has been formed. […] There is a hint, too, that newer professions make contact with universities earlier in their careers […]. Finally, the tactical and strategic situation of an occupation, old *or* new, may demand early licensure or certification whatever the actual development of the technique, training, or association is."
> (Wilensky, 1964, pp. 145-146)

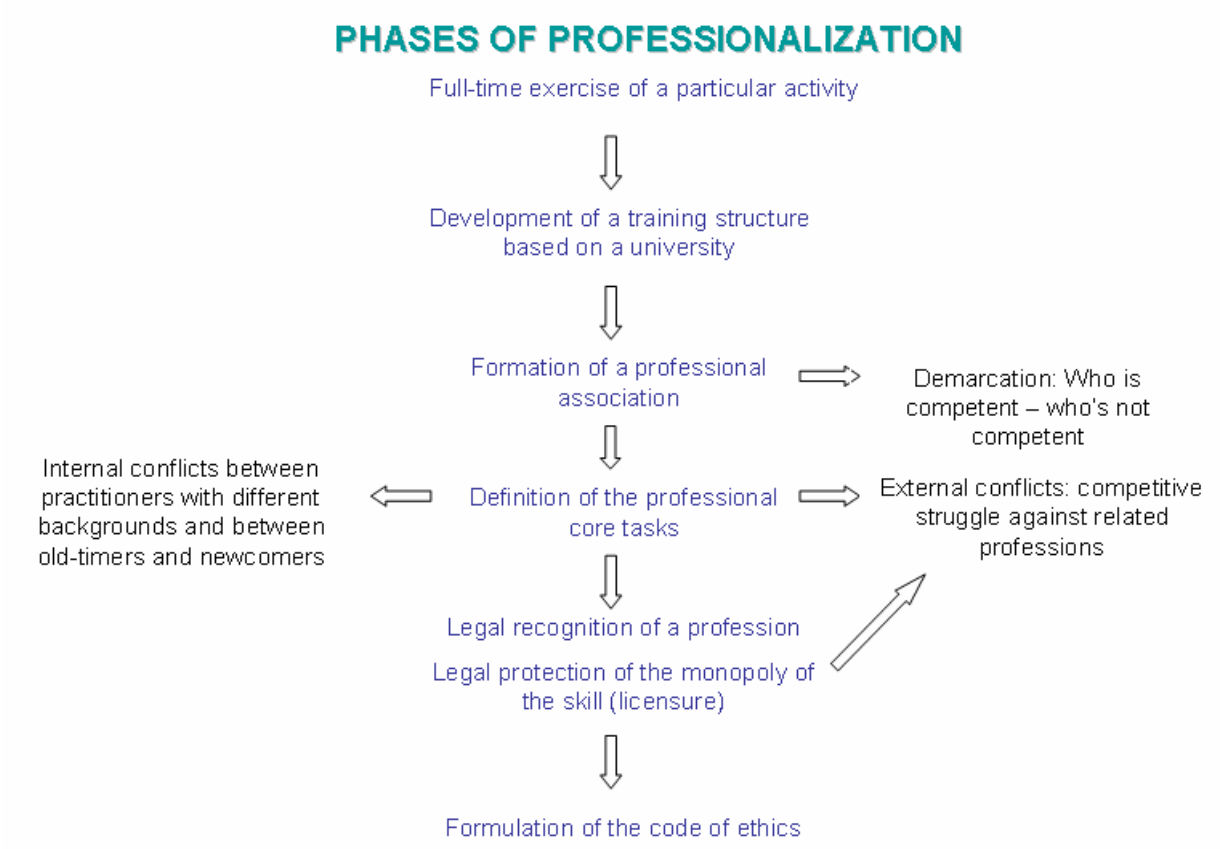

Figure 2: Phases of professionalization according to Wilensky (1964) (blue) and possible conflicts (black).

For a better overview, the following table summarizes the information from section 3.4.1:

Criteria for being a profession	Attribute model	Functionalist concept	Power-theoretic concept	Structure-theoretic concept	Schämann (2005)	Tyreman (2008) and Evans in Tyreman (2007)	Wilensky (1964)
Academic level	+						+
Scientifically specialized knowledge/special expertise	+	+		+	+	+	
Code of ethics	+				+		+
Nonprofit	+				+		
Competence monopoly	+		+				+
Autonomy of action	+	+			+		
Self-control through professional associations	+	+			+		+
Social function	+	+			+	+	
Social recognition					+		
State recognition	+		+				+
Collective value orientation		+			+	+	
Core task / defined scope of practice							+

Table 1: Summary of the discussed criteria for being a profession.

3.4.5 Professions and their collective consciousness

According to Schämann (2005, p. 27), members of professions have succeeded in developing within their professional groups a *collective consciousness* with a shared *professional identity* and value orientation.

We may add that the identification by the profession's members with the values of their *profession* leads to the development of a common *professional identity* (see section 3.3.1). This collective consciousness is then regarded as a guarantor of the relatively stable construction of *professions*, even if Schämann (2005, p. 27) here notes Bucher and Strauss's claim that this assumed homogeneity within the vocational or professional group is an ideal and not always existent, as they could confirm in the case of physicians. For in the view of these authors:

> „Professions are segment-related associations pursuing different goals in different ways and more or less loosely combined under a common occupational heading at a particular period." (Bucher and Strauss in Schämann 2005, p. 27)[14]

According to Nittel (in Schämann, 2005, p. 27), this finding by Bucher and Strauss led to the demystification of the ideas of unity with regard to the medical profession and to the conclusion that within a *classical profession* like medicine different *professional identities* as well as procedures and attitudes are quite possible (Schämann, 2005, p. 7). Nittel (in Schämann, 2005, p. 27) speaks of conflicts existing within the profession and yet not extending to interested lay outsiders.

We may conclude that even a *profession* (in line with the sweeping notion of *identity*) can undergo an *identity crisis*, since the different *professional identities* addressed by Nittel can lead to differences in interests among the members, producing tensions within the collective (see section 3.2). Here we have in mind the division of the US osteopaths into "lesion" and "broad" osteopaths (see section 4.2) and the different terms (i.e. structural, functional, and cranial osteopaths) regarding osteopathy [Abehesera, downloaded 2008a, b].

3.4.6 The role of the professional union

As in criterion 7 of the attribute model (self-control by professional unions and interest groups), Schämann (2005, p. 30), appealing to Schulze-Krüdener, writes that the fragmentation of a

[14] "[Professionen sind Segmentzusammenschlüsse], die verschiedene Ziele auf unterschiedliche Weise verfolgen und die mehr oder weniger lose unter einer gemeinsamen Berufsbezeichnung zu einem bestimmten Zeitabschnitt zusammengefasst werden". (Bucher and Strauss in Schämann 2005, p. 27)

vocational group in different associations indicates different interests within this group and a weakening of the collective and its assertiveness of the intended goals. Schulze-Krüdener sees in the organizational level of the members of a vocation a clear-cut index of the momentary status of a *profession*. A professional union has the task of registering the professional status quo of a vocation or profession and of stipulating the areas of competence of the individual members. The association is responsible for preparing a code of ethics, while another basic goal[15] can lie in establishing a professional autonomy of action (Schämann, 2005, pp. 30-32).

3.4.7 Conclusions from section 3

The literature often speaks of the *identity* and *identity crisis* of osteopathy. We recall that the formation of *identity* inevitably involves an experience of crisis. The concept of *identity* in the context of osteopathy must be understood as a collective notion standing for *personal, collective* and *professional identity* (even if the phrase *professional identity* is often used in professional debates), since these different *identities* may be regarded as interrelated through the process of *identification*. If therefore we speak of the *identity* and *identity crisis* of osteopathy, these concepts apply both to the vocation itself and to the *identities* of the persons "voluntarily" pursuing this vocation.

In choosing a vocation an individual considers two basic aspects: on the one hand the economic aspect and on the other the social function of the vocation, related to its social status. These aspects are constitutive of identity for the individual.

Whether a vocation can claim to be a profession depends on different factors, listed in Table 1. One of these factors is society, which must recognize a vocation for it to become a profession. But as social values can change, so must the professions also adapt to these changes in order to prevail. A sort of communication then occurs between society and its professions, also described by Miller (1998). As she says, *identification* and *professional identity* undergo a process in which a group of communicators negotiate an *identity* for the institution, tied to internal and external conditions (of the larger society). She adds that this *identity* is subject to change, just as the institution may undergo changes through its life cycle (see van Dun (2008b), *Wesen und Gestalt der Osteopathie,* section 3.3.3).

There are different ways to ascribe an *identity* to a vocation. One way is to work with models and concepts of professions and/or to take the phenomenological approach. The models and concepts of a profession were useful to us in preparing our list of questions for the website analysis (see "Methodology," section 5.1.3). Knowledge about the phenomenological approach

[15] The goals and functions of a professional association are treated in Appendix E and are not the subject of this thesis.

was generally helpful in our analysis of the literature on the historical background of osteopathy in the USA and the United Kingdom. This approach seemed also of interest to us for the website analysis, in elaborating the definitions, and goals of the professional unions. Applying the definitions of goals and purposes of the osteopathic professional unions, according to Meyer and Price (1993) (who speak of missions and visions) and Hruby (1993) (who equate *identity* with beliefs) we can also derive a possible *identity* of osteopathy. Equally of interest pertaining to *identity*, according to Tyreman (2008a, b), is the study of the agreed professional values underlying the association's purpose and its goals.

Focusing on the treatment by Straub (1999, pp. 83-95), it is interesting to consider what the acceptance criteria of the collective are and who creates them. The author writes that unity, continuity, coherence, etc. are constitutive of *identity* – that it is useful, therefore, to examine the agreement between the European professional unions in their definitions, goals, acceptance criteria, etc. for determining the actual status of the *identity* of osteopathy in Europe. Straub (1999) also says that autonomy in thought and action is constitutive of *identity*, in line with the profession model and some of the profession concepts treating this form of autonomy as characteristic of a profession.

4 History of osteopathy in relation to its identity

The osteopathic medical profession provides a particularly valuable avenue for the study of the process through which a profession constructs its identity.

Miller, 1998

4.1 Historical development in the USA

Osteopathy was founded in 1874 by Andrew Taylor Still (1828-1917) and has since established itself as a recognized form of medicine within the US health care system, and indeed is still one of the fastest growing professions in that industry generally (Aguwa and Liechty, 1999). If we consider this history, we find that osteopathy has constantly engaged in a struggle with allopathic medicine and other "unorthodox," "alternative" and "manually practiced" forms of medicine. Osteopathy has matured into a functional equivalent to allopathic medicine, which raises the question of the justification of its existence again: If it's the same as allopathy, what is its justification as an independent profession, and if it bears a unique store of knowledge, why should that knowledge be applicably only by osteopaths (Teitelbaum et al., 2003)? Given these questions and facts, it is interesting to see how osteopathy has defined itself in the course of its historical development: How has it adapted itself in order to meet the requirements of the changing US health care system and the social needs related to that industry, and what are the internal and external "risks" to the osteopathic profession past and present? Generally we found it useful to review the literature in order to identify these internal and external "risks" related to the identity crisis and to the professionalization of osteopathy. Statements on and endeavors towards consolidating this specific identity also have direct relevance. Taking up an idea from Miller (1998), we present the results of our research according to the different temporal stages of the evolution of osteopathy.

4.1.1 The early years of osteopathy following its founding in 1874: the seeds of osteopathic identity and the rhetoric of A.T. Still

Clearly, then, A. T. Still's founding vision of osteopathy is one defined by opposition of drugs and by belief in the therapeutic benefits of manipulative treatment (e.g. adjustment of 'the machine')

Miller, 1998

The founder of osteopathy, Andrew Taylor Still, was a physician in early life and adhered to the "orthodox medicine" (also known as regular medicine or allopathy) typical and prevalent at that time. The latter was still in its early stages and was based on a few therapeutic methods

(Gevitz, 2004, pp. 4-8). Still acquired his medical skills at his father's side and from some textbooks on anatomy, physiology, surgery and *materia medica*. His first patients were Shawnee Indians, who served as the most important source for Still's further studies in anatomy and pathology, with Still availing himself of their burial grounds for dissections (Still in Hartmann I, 2005, p. 38). The question whether Still ever completed regular training at a medical college remains unanswered (according to Gevitz, 2004, p. 5), owing to the inadequacy of the records. The College of Physicians and Surgeons in Kansas City has been mentioned as a possibility, also by Lesho (1999), who considers it a likely one.

Following the deaths of two children and his first wife (causes unknown), the loss some years later of three of his children (one being adopted) through cerebrospinal meningitis and of his youngest child through pneumonia within a short period of time, Still began to question the concept of regular medicine and seek new findings from alternative forms of medicine (Still, in Hartmann I, 2005 p. 26). This included the homeopathy of Hahnemann (1755 – 1843), the "eclecticism" of Beach (1794 – 1868), "bone-setting," the forerunner of "manipulative medicine," and "magnetic healing" (Gevitz, 1988, pp. 125-128; Cameron, 1998). Greatly impressed by these alternative forms of medicine, Still initially operated as a self-designated "magnetic healer" and later on as a "lightening bonesetter" in the region surrounding Kirksville, Missouri. Still soon made the important discovery that these methods of treatment were suitable not only for orthopedic problems. He combined a few of the main theories on *magnetic healing* and *bone-setting* into a concept that would later provide the basis for osteopathy under that name in 1874: An illness is the result of an imbalance in the transport of fluids due to an obstruction; the causes are misplaced bones, chiefly those of the spinal column (Gevitz 1988, p. 128; 2004, p. 19).

Still's original intention was not to found a profession separate from allopathic medicine, but rather to enrich the latter with his acquired knowledge and help reorient it towards becoming a holistic form of medicine (Still, 1908, p. 43; Korr, 1997b, p.166; Lesho, 1999). Following the rejection of Still's ideas by the American Medical Association (AMA), the dominant medical organization at that time, he founded his first independent osteopathic school, the American School of Osteopathy (ASO), in Kirksville in 1892.

Its first graduates were awarded a certificate stating they were "diplomats in osteopathy" (DO), with later ones receiving the degree of "Doctor of Osteopathy" (DO) (Gevitz, 2004, p. 22), and encouraged to perceive themselves as doctors, which met with resistance from the allopathic medical profession.

From the outset people questioned the seriousness of Still’s osteopathy, calling it "quackery" and comparing its "laying on of hands" to practices in Christian science, spiritualism and hypnotism. Its identity as a new holistic form of medicine was also questioned: People suspected it of being an amalgam of "bone setting," "massage" and "Swedish movements" (Gevitz, 1988, pp. 2, 13; 2004, pp. 39-40). As a staunch supporter and student of Still,

Littlejohn (1901) responded to these insinuations, emphasizing the independence of osteopathy from massage as another treatment method. Littlejohn identified three specific characteristics of osteopathy that he claimed were not shared by the activities of a masseur: 1. Osteopathy conducts its own diagnosis, leading to specifically adapted and individual treatment. 2. The osteopath has a deeper knowledge of anatomy, physiology and *kindred sciences.* 3. Osteopathy has its own concept based on the idea that each organ functions in combination with the central nervous system.

Within US society the impression spread over decades that DOs treated only disorders of the musculoskeletal system, and that they were not physicians "[…] in the broadest sense of the term" (Gevitz, 1988, p. 130). This impression rested on the fact that Still and his students originally treated patients with chronic, noninfectious illnesses, and on Still's initial curriculum of studies, which only provided for a few months' study of anatomy and instruction in osteopathic principles and practice (OPP).

The DOs also felt that the signal sent by the expression "osteopathy" played a crucial role here, and advocated changing the names later on to "osteopathic medicine" and "osteopathic physician" (Allen,1993; Gevitz, 2004, p. 111).

Noteworthy about Still were his identity-shaping and charismatic statements that attested his refusal to avoid contradiction and dissent. "'How does Osteopathy compare with Allopathy?' Osteopathy cures, Allopathy kills […]" and "[i]f you go out thinking that Osteopathy is a good aid to medicine, you are using the words of incompetency" (Still in Miller, 1998, p. 1742). With his firm belief in the principles of osteopathy Still built up a profession based exclusively on the self-healing powers of the human body and defying all kinds of drug-based therapy. This refusal applied both to allopathy and to homeopathy (Still, 1910; Miller, 1998; Gevitz, 2004, p. 25).

The charismatic speeches of Still and Littlejohn expressly assigned a distinct identity to osteopathy: "Osteopathy is an independent system co-extensive with the science and art of healing" (Littlejohn, 1901, p. 14), and adherents of osteopathy were able to regard a platform authored by Still (1990, pp. 14-15) as a code of ethics. The platform was intended to serve their osteopathic orientation and professional positioning in the public's eye:

> "OUR PLATFORM
>
> It should be known where osteopathy stands and what it stands for. A political party has a platform that all may know its position in regard to matters of public importance, what it stands for and what principles it advocates. The osteopath should make his position just as clear to the public. He should let the public know, in his platform, what he advocates in his campaign against disease. Our position can be tersely stated in the following planks:
>
> - First: We believe in sanitation and hygiene.

- Second: We are opposed to the use of drugs as remedial agencies.
- Third: We are opposed to vaccination.
- Fourth: We are opposed to the use of serums in the treatment of disease. Nature furnishes its own serum [sic] if we know how to deliver them.
- Fifth: We realize that many cases require surgical treatment and therefore advocate it as a last resort. We believe many surgical operations are unnecessarily performed and that many operations can be avoided by osteopathic treatment.
- Sixth: The osteopath does not depend on electricity, Xradiance, hydrotherapy or other adjuncts, but relies on osteopathic measures in the treatment of disease.
- Seventh: We have a friendly feeling for other nondrug, natural methods of healing, but we do not incorporate any other methods into our system. We are all opposed to drugs; in that respect at least, all natural, unharmful methods occupy the same ground. The fundamental principles of osteopathy are different from those of any other system and the cause of disease is considered from one standpoint, viz.: disease is the result of anatomical abnormalities followed by physiological discord. To cure disease the abnormal parts must be adjusted to the normal; therefore other methods that are entirely different in principle have no place in the osteopathic system.
- Eighth: Osteopathy is an independent system and can be applied to all conditions of disease, including purely surgical cases, and in these cases surgery is but a branch of osteopathy.
- Ninth: We believe that our therapeutic house is just large enough for osteopathy and that when other methods are brought in just that much osteopathy must move out."
  (Still, 1910, pp. 14-15)

In 1876, with the discoveries by Robert Koch (1843-1910) and the emergence of germ theory, allopathic medicine made crucial progress in its development, and assumed a new position in the health care system. Koch and other scientists demonstrated that microorganisms played an essential role in the spread of infectious diseases, and both preventive and curative therapies were developed (Gevitz, 1988, p. 131; 2004, p. 37). Still tended to be unimpressed by this development, and remained convinced that structural lesions were the actual cause of disease, weakening the body so as to make infection possible in the first place. He accepted anesthetics and antiseptics in surgical and obstetrical practice, and antidotes in poisoning cases. All other drugs he ruled out, persistently rejecting allopathy's concept of *materia medica* (later known as pharmacology).

These contemporary developments confronted osteopathy with new internal problems. The choice between tradition and innovation – in other words, the decision on whether to integrate pharmaceutical medicine in osteopathy or not – led to a split within the professional group of osteopaths (see sections 3.3.3 and 3.4.5). A prominent agitator was Marcus Ward, DO, who following a dispute with Still also became an MD and founded his own osteopathic school (The Columbian School) teaching the materia medica. He presented himself as a cofounder of

osteopathy and proclaimed that true osteopathy was a combination of materia medica, surgery and manipulative treatment (Gevitz, 2004, pp. 52-53). Ward was an isolated case; although he initially failed, he sparked subsequent struggles, and several voices were raised against Still's strict concept:

> "Being a physician and not a sectarian practitioner I am heir to and privileged to make use of any and all therapeutic measures which the accumulated knowledge of centuries has shown to be of value, or which future learning may place within my reach regardless of its source of character... […]." (Hinckle in Gevitz, 2004, pp. 77-78)

Although at the time Still was disappointed and annoyed over these developments and discord within his own faculty, he did not react energetically enough. Osteopathy subsequently expanded into an intellectual basis that was broader than Still had been able to establish, and the pathways for future development in the direction of allopathy were opened. The first MD DOs came into being, who appended both titles to their names (Gevitz, 2004, p. 77).

Another internal problem was the initially greatly increasing number of osteopathic schools in aggressive competition with one another (Gevitz 2004, pp. 48-53). As early as 1904, only 50 per cent of the estimated 4000 practicing osteopaths were graduates of the American School of Osteopathy in Kirksville (Still's college). Since by that time no general guidelines had yet been formulated for osteopathic education, there were significant differences in content and quality of that training. Often the instructors themselves were not DOs, MDs were taught in half the intended period of study and DO titles were even conferred in exchange for money. One of Still's students saw a market in osteopathy, and announced "[…] that anyone could treat common ailments manipulatively with his text as the only necessary aid" (Gevitz, 2004, p. 51), which only confirmed the bad reputation of osteopathy in the physicians' eyes. Interestingly, this book by Elmer Barber was the *first* publication treating osteopathy. Still other "black sheep" among the DOs sold teach-yourself-at-home textbooks (Gevitz, 2004, pp. 51-52, 65). Some students from Kirksville reacted by forming, in 1901, the American Osteopathic Association (AOA), with the aim of informing members of organized institution, supporting scientific work and eliminating competition between osteopaths by regulating training. In 1904 the AOA adopted a formal code of ethics establishing guidelines for proper professional conduct (Gevitz, 2004, p. 63).
The American Osteopathic Association (AOA) launched the Journal of the American Osteopathic Association (JAOA), which while initially not qualifying as a professional publication, later had its level elevated by the scientific support of the newly established A. T. Still Research Institute.

As the number of DOs striving to duplicate the role and services of MDs increased, attention shifted from osteopathic principles with their philosophical and therapeutic beliefs to the school system (Gevitz, 1988, p. 140). At the focus was whether the standards of the schools were high enough to train qualified physicians and surgeons. The Flexner Report of 1909 found the quality of training to be deficient, resulting in the closing of some osteopathic and allopathic training institutes. The consequence was that the remaining schools had to react by raising their standards, entailing higher admission requirements for training and better equipment with teaching materials. The allopathic institutes responded better than the osteopathic institutes and with significantly more possibilities at their disposal, so that during this period osteopathy trailed behind allopathy. One reason for this disadvantage was the economics of the osteopathic schools, which, despite their nonprofit status, had tuition payments as their sole financial resource, whereas the allopathic schools were supported by the state and by universities. The survival of the osteopathic schools thus depended on their number of registered students, who had to be attracted, so that raising the admission requirements and tuition fees would have a direct impact on enrollment. Nevertheless, even osteopathic schools managed to improve their situation within the limits of what was possible. They invested in teaching materials and built new scientific institutes and hospitals, although usually there were no postdoctoral levels, osteopathic internships or residencies available, and if so, they were not standardized (Gevitz, 1988, pp. 140-141).
These deficiencies would later be brought to bear on the osteopathic professional group.

Another significant external problem for osteopathy was posed by its imitators, such as the chiropractors (Gevitz, 2004, p. 66). Daniel David Palmer (1845-1913) was himself a magnetic healer in Iowa, founded chiropractic in 1895 and began instructing it in 1898.
Palmer declared that 95 per cent of all illnesses were caused by "subluxated" vertebrae. Later on, his son took over the school, which soon greatly expanded thanks to sensational advertising. Students not being able to travel the long distance to Davenport could attend correspondence courses. Early chiropractic very much resembled early osteopathy, resulting in many arrests for practicing osteopathy without a license (Gevitz, 2004, p. 67). In the interest of "survival," chiropractors proclaimed their distinction from osteopaths.[16] The DOs regarded chiropractic manipulation as dangerous and coarse, and buttressed their view of the distinction by serving as witnesses in litigation. In the end they did their own professional group a disservice by giving the chiropractors a competitive edge through the publicity and by aiding their continued existence and legitimization (Gevitz, 2004, pp. 67-68). Later on it turned out that chiropractic schools offered a much briefer course of instruction than did the D.O. colleges. Indeed, every time the DO colleges lengthened their courses for raising the

[16] The argument was that the chiropractors' manipulations differed in execution from those of the osteopaths (see more details in Gevitz, 2004, pp. 67-68).
Other sources reaffirm this distinction still valid today (Bergmann, 1992; Vickers and Zollmann, 1999).

standards requested by the AOA in order to follow the recommendations for licensing, they lost many possible registrants to their rivals, the "osteopathic imitators" (Gevitz, 1988, p. 134).

4.1.2 The rhetoric of 1915 - 1935: expanding the scope of osteopathic identity

> *In the early part of the 20th century, as A.T. Still reached the end of his life, the profession struggled with the tension between maintaining a narrow definition of osteopathy and expanding the profession to meet perceived patient needs and to compete with allopathic physicians.*
>
> *Miller, 1998*

As already mentioned above, two interest groups within osteopathy distinguished themselves from one another in the early 20th century: the "lesion osteopaths," who followed the principles of A.T. Still by excluding materia medica from their manipulative therapy, and the "broad-osteopaths," who combined manipulative therapy with other therapeutics. These two groups disagreed on the scope of their practice, and in particular on the question of which type of diseases and conditions they should treat and which therapeutic modalities they should utilize. At first they disagreed over surgery and obstetrics, but then the dispute extended to materia medica. Endless debates ensued, and "slowly the profession was coming out from under Still's shadow" (Gevitz, 1988, p. 138). In 1915 the Board of Trustees of the AOA, which previously imposed sanctions on members who instructed materia medica at their schools, yielded to the pressure from critics and allowed the schools free choice in this matter (Gevitz, 2004, p. 81).

A. T. Still died in 1917, ending his charismatic influence on his adherents. His last words provided his osteopathic testament: "Tell the boys to keep it pure" (Miller, 1998, p. 1743). Until his death, Still rejected the integration of allopathic medicine and its germ theory, i.e. materia medica, in osteopathy.

Besides the broad osteopaths, who continued their struggle with speeches in favor of materia medica, there were some of the lesion osteopaths who took a more diplomatic stance in order to smooth the troubled waters and discount the basic conflict as "another little canker at work" (Meacham in Miller, 1998, p. 1743):

> "There has been some uneasiness over the trend toward the teaching of materia medica in some of the colleges, due to a misconception of the most vital problem affecting the future of our practice. There is no need for alarm and no danger to the basic principles on which the practice of osteopathy is founded. The problem will work itself out slowly but surely to our advantage." (Upton in Miller, 1998, p. 1743)

Although time would teach them otherwise, the conservatives among the DOs again received a considerable boost during 1918-1919 when swine flu overran the country. In the USA alone

650,000 people succumbed to the virus. The comparison of mortality figures between osteopathically and allopathically treated patients indicated better success on the part of the DOs (Gevitz, 1988, p. 138). The positive word of mouth brought them many new patients and the public came to know that the DOs could treat both acute and chronic illnesses. The consequence was a revival of so-called ten-finger osteopathy as opposed to three-finger osteopathy, which was only required to fill prescriptions and/or operate a syringe.

As already noted, the times changed in 1920. Legislative changes required that pharmacology (previously known as materia medica) be included in osteopathic training, otherwise osteopathy would be deprived of its legal foundation and there would be no more certifications for the schools and their graduates (Miller, 1998). This in turn lent support to the broad osteopaths among the DOs, and increased the pressure on the American Osteopathic Association (AOA) in 1929. While the latter tried with all means to circumvent the term "pharmacology" by calling the new programs first "comparative therapeutics" and then "supplementary therapeutics," the "official" policy of the AOA ultimately and irreversibly culminated in a truly complete and unlimited scope of practice (Gevitz, 1988, p. 140). The AOA acted diplomatically toward its own members, as evidenced by the AOA Presidential Address of Warren B. Davis in 1931 (in Miller, 1998, p. 1743). In that speech Davis distanced himself from the strict opposition to allopathic drugs by appealing to the DOs learn the materia medica in order to be sufficiently qualified in all ways for general practice. He asked members with whom they would feel better off – with someone who ignored the nature of drugs or with someone who understood them as a DO and could competently assess their risks? In our view, Davis tried to avoid a possible uproar among the conservative DOs by diplomatically stating his belief that the more a physician knew about drugs, the less he would use them and hence the more he would return to osteopathy.

At this early stage, in 1931, osteopathy had already greatly distanced itself from its founder A.T. Still, and the "nature" of osteopathic identity had to reinterpreted. Subsequent speakers among the DOs construed Still's statements so as to confirm their current actions. For example, Riley made use of the following quotation from Still (in Miller, 1998, p. 1743): "I have just charted the bold outlines of osteopathy: you boys and girls will have to go on and fill in the details." The success and progress of osteopathy were prophesied in terms of breadth and distinctiveness, with the consequence that the DOs no longer demonized the MDs as agents spreading drug addition and death through mankind. Some DOs among the conservative lesion osteopaths recognized the dangerous trend in osteopathy towards allopathy, and made not legislation, but their own ranks, responsible for the downfall of Stillian osteopathy in the USA (Miller, 1998, p. 1744).

After the osteopathic schools had adapted their training programs in 1910 in response to the Flexner report and began turning out fully trained physicians and surgeons, the latter still confronted serious problems concerning their state recognition as physicians. DOs on the average faired worse than their allopathic competitors when coming before medical or composite boards. The consequence was that many DOs avoided these examinations and sought refuge in unlimited-license states, where the test procedures were controlled by osteopathic boards (Gevitz, 2004, p. 93). With more than 25 US states denying the DOs full recognition with all rights to practice, new impetus within the osteopathic training programs was inevitable.

In 1940 all osteopathic training institutes agreed on a two-year college requirement. As expected, the schools lost potential new students, although the number of new enrollments increased again in 1947. They also included many students who previously had been accommodated by MD schools and who availed themselves of osteopathic training as a second chance to become physicians (Gevitz, 1988, p. 142).

4.1.3 The rhetoric of 1954 - 1974: a "separate but equal" identity

> *In general, the rhetoric of this time period suggests the "maturing" of the profession. This time period [is] also marked by a larger consideration of the role of osteopathy in public welfare.*
>
> *Miller, 1998*

In 1954 three years of regular college were a prerequisite for registering at an osteopathic college, and in 1960 71% of the new students had a bachelor's or an advanced degree. The higher admission requirements were accompanied by further improvements in the curricula. The osteopathic schools increasingly invested their money in faculty trained in the basic sciences and changed much on the clinical level.

The push towards higher standards between 1935 and 1960 resulted in successes on the legal front. In 1960 38 of the 50 states recognized DOs as fully qualified physicians with all the rights to practice, and by then the osteopathic training institutes were already receiving state aid (Gevitz, 2004, pp. 96-97). At this time the DOs increasingly called themselves "osteopathic physicians" rather than "osteopaths," in order to upgrade the social status of their profession and to shed their reputation as practitioners limited to osteopathic manipulative treatment (OMT) (Allen, 1993; Gevitz, 2004, p. 111).

While the DOs strove to meet the external requirements, internal problems arose again concerning osteopathic training and the DOs' subsequent activities:

In the first place, the previously undertaken improvements in osteopathic education mainly had the goal of qualifying their students for participation in unlimited licensure examinations and affording them a solid degree. The distinctive elements of osteopathic education were of little

relevance in this regard. The emphasis lay on basic science instruction. Many of the full-time instructors at the osteopathic training institutes were therefore not DOs who adhered to the osteopathic theory in their teaching and who would have given their students an osteopathic orientation. The time and space taken up by instruction in pharmacology and surgery overshadowed osteopathic principles and practice (OPP).

Secondly, during the 1940s scientists like Denslow and Korr studied the phenomenon of the osteopathic lesion and published their results. According to Gevitz (1988, p. 145), subsequent clinical studies came to a standstill because they were no longer subsidized from the limited funding for scientific research as controlled by the AOA. At the same time allopathic scientists were developing penicillin, and in 1945 streptomycin, in combination with other drugs like analgesics, anti-inflammatory agents, muscle relaxants and tranquilizers, all of which helped allopathic medicine make great advances. The drug-related scientific studies outweighed those of the osteopathic scientists (Gevitz, 1988, p. 145). As a consequence, the younger DOs who had had a more scientifically oriented schooling with less osteopathic content were more inclined to trust the latest findings of allopathic medicine than those of osteopathy, in contrast to the older and more osteopathically oriented DOs. These younger DOs often relied in practice more on the effects of drugs than on the osteopathic manipulations performed on their patients (see the current study by Kleman, 2009). The overall result was increasing confusion over their own actual professional identity as osteopaths (New in Gevitz, 1988, p. 145).

Thirdly, as allopathy and osteopathy became intertwined, patients also lost sight of the distinction between DOs and MDs,[17] although society still generally tended to regard DOs more as consultants for "back troubles" and joint and muscle injuries, while in the public's view MDs remained the competent authorities on all other illnesses. DOs were even often mistaken for chiropractors (DCs).

Until 1960 the osteopaths constituted only five per cent of the overall medical population (MDs plus DOs) in the USA. Their low number made the DOs practically socially invisible. Again, the DOs drew the conclusion that their titles were to blame for their identity problem. The argument this time for a change in title was that the US public regarded the title of "MD" as universally symbolizing the physician or surgeon. The AOA and other DOs rejected a change in title (Anonymous, 1993), with the consequence that some DOs hung diploma-mill MD degrees in their offices, although these documents were worthless for the purpose of licensing. The diplomas served merely to give patients the impression of visiting "real doctors". Other DOs did not go this far, and "merely" kept silent about the title of DO or their osteopathic background, simply calling themselves physicians or surgeons (Gevitz, 1988, p. 147).

[17] Cf. the study by Johnson and Kurtz (2001), section 4.2.3

Many of the DOs struggling with their professional identity were quite dissatisfied with the policy of the AOA, even if not all DOs shared this view. Gevitz (1988, p. 147) writes that the many changes within the osteopathic profession, given the specific local situations, produced a large spectrum of interpretations and prospects of the osteopathic future, which was nowhere more evident than in California.

In 1962 the DOs and MDs agreed to a merger such that the former would cut all ties to organized osteopathy and in return receive the title of MD, with full rights of practice in the state of California. The existing College of Osteopathic Physicians and Surgeons was accordingly renamed the "California College of Medicine" (Gevitz, 1988, p. 147). The merger made a great impact on the AOA and its adherents from other states who were forced to cope with this development, given the numerical superiority of the Californian DOs over their colleagues in the other states.

Even then California was considered the stronghold of the broad osteopaths. The Los Angeles College (at that time still one of the predecessors of the College of Osteopathic Physicians and Surgeons) was also the first college to introduce materia medica in its curriculum, and generally the first to refuse raising the admission requirements for students. But the college also had a respected reputation as the first and only school to use a large municipal hospital for bedside and outpatient teaching. The Californian DOs had always seen themselves as the country's best-qualified osteopathic physicians and surgeons, but however hard they worked to live up to this ideal, they never achieved the status of MDs, nor were they afforded comparable educational opportunities. The DOs blamed the policy of the AOA and the low educational standards of the other states' osteopathic institutes for this disadvantage.

According to Gevitz (1988, p. 148), many observers considered the developments in California as the first step in the "inevitable absorption" of osteopathy into the regular medical profession. On the other hand, many DOs in the other states who had been frankly undecided about the Californian merger developed an increasingly negative attitude towards the matter over time. The reason was that not everything turned out happily for the Californian DOs, who were now being regarded by the AOA as "little mds". While these DOs had been able to improve their social status slightly through the merger, they were not admitted to the California Medical Association and their AOA board certification credentials were not recognized by the American Medical Association (AMA) and some hospitals (Gevitz, 1988, p. 149).

In other words, they became practically "homeless," no longer genuinely accepted by any organization and having lost their *professional identity* at least on this point.

The Californian merger also benefited the osteopathic profession in at least one way, however: It effected the necessary legislative changes in other states, which fell in suit with California and no longer considered as significant the differences between osteopathic and allopathic training. In 1963 the US Civil Service Commission declared that the MD and DO titles from

now on were to be considered as equal in value. In 1966 the US Secretary of Defense ordered all armed forces to admit for the first time DOs as qualified military physicians and surgeons. The AOA achieved still another great victory when it was designated as the accrediting agency for osteopathic hospitals for participation in the Medicare program (Gevitz, 1988, pp. 149-50).

These "positive" developments in osteopathic medicine would also lead to further attempts at amalgamation on the part of the American Medical Association (AMA) (Gevitz, 1988, p. 150), aimed at weakening their opponents and consolidating their own status. These endeavors by the AMA brought new potential difficulties to the AOA, which promptly reacted by threatening its members with sanctions extending to exclusion if they also maintained membership in the AMA. A large problem was the dependence on AMA residencies, however, since postdoctoral programs had to be maintained. The AOA compromised by permitting DOs admission to allopathic residency programs if they also completed an AOA-approved internship as well as additional residency training in an osteopathic or federal hospital for at least one or two years.

During 1970-72 the figures of the examination licensure boards again increased: The DOs had a pass rate of 89% compared with MDs with their rate of 90%.
By 1973 DOs were eligible for unlimited practice in all 50 states (Gevitz, 1988, p. 153; Lesho, 1999).

During this period, namely between 1954 and 1974, the DOs were as much preoccupied with the role of osteopathy in public welfare as they were with recognition as full-fledged physicians. Previously attention had mainly been given to the effects of osteopathy in the individual cases. Now spokespersons for osteopathic medicine stressed their ability to serve the larger public health needs facing the United States. The osteopathic profession defined itself as the guarantor of "democracy in the field of health care and medicine" (Hayes in Miller, 1998, p. 1745). A possible leadership role for the osteopathic profession was seen in group and industrial medicine, primary care, ecological medicine and holistic medicine, as emerging national trends. As a consequence, the profession redefined itself with a more broadly construed nomenclature. In describing itself it employed terms like "complete," "comprehensive" and "flexible." The roots of osteopathy were thus sought in Hippocrates as much as in A. T. Still (Miller, 1998).

4.1.4 The years from 1974 to the present: distinction or extinction?

> *Clearly, osteopathic identity is still a hotly-contested topic.*
>
> *Miller, 1998*

Owing to the general lack of physicians in the area of general care, new osteopathic schools were established and the number of osteopathic physicians increased. Writers find that these

gaps left open by MDs primary care created the necessary niche for osteopathy and contributed to their relatively large growth (Gevitz, 1988, p. 152; Fisher Wilson, 1997; Glover and Rivers, 2000). While in 1986 there were still only 2,000 registered DOs (Gevitz, 1988, p. 152), today there are 63,747, of which 56,754 are currently active [AOA, downloaded 2009]. The AOA estimates that the number of active DOs will increase to about 100,000 by 2020.

Even in the 1970s the field of family medicine began gradually to replace general practice (Gevitz, 2004, p. 167).

Present-day family medicine comprises a smaller field than general practice insofar as not all practitioners of family medicine deliver babies, or perform surgery or provide care to hospital patients, but they do treat families in pediatrics, women's health care and geriatrics (Tettambel, personal communication, 2008).

Specialization among DOs followed in emergency medicine, internal medicine, general surgery, obstetrics & gynecology and orthopedic surgery. At the same time, a number of the specialized DOs, in particular the family practitioners, moved to allopathic hospitals. Indeed, more and more osteopathic physicians received staff privileges in MD hospitals as the latter actively wooed DOs in order to fill their own beds (Gevitz, 2004, p. 162). But even the subsequently elaborated programs of the AOA did not enable osteopathic hospitals to offer quality of services matching that of their larger and better-equipped allopathic competitors (Gevitz, 2004, p. 162). As a result, the osteopathic hospitals could not prevent the deserting DOs from taking along their patients to the detriment of the abandoned osteopathic hospitals. In addition, they helped the allopathic institutions expand their potential pool of patients (Gevitz, 1988, p. 153).

The subsequent introduction of DRGs[18] (Diagnosis Related Groups) by the US Health Care Finance Administration in 1983 would then result in a further decline in the patient census (Gevitz, 2004, p. 162).

In her section on the history of osteopathy Miller (1998) examined the comments by current medical students, culled from a worldwide web-site, in order to gauge the present and the future of osteopathic identity. She found that the identity of osteopathy was a hotly contested

[18] While we will not be further discussing the DRG system and ICD codes, we can provide some background information (Tettambel, personal communication, 01/2009): "The DRG system was invented by the US Health Care Finance Administration (HCFA) in 1983. It was originally developed to relate types of patients treated to the resources they consumed. The HCFA (see above) has modified its definitions of DRGs. It has evolved into a payment system for hospitals based on the final diagnosis from the hospital. It does not cover fees for physician services and was not originally intended to standardize payments for hospitalized patients. However, many US insurance companies have modified their payment schemes to resemble payments made by the US Center for Medicare and Medicaid services, which relies on DRGs.
ICD codes (international classification of diseases) are used by physicians to bill insurance companies for services (diagnostic and treatment/procedure codes). These codes include osteopathic structural diagnoses for somatic dysfunctions and areas treated by OMT (head, spinal regions, etc.). This represents an attempt to classify manipulation as a procedure billable for reimbursement by 3rd party payers like the government or insurance companies.

issue and that the students had the widest variety of views on the nature of osteopathy, its history, its distinction from allopathy and whether it is a profession with a distinct and independent future.
From her phenomenological approach, Miller concludes that osteopathy has so far survived because it always remained aware of its surroundings and managed to adapt in the presence of these threats. It remained vigilant in its awareness of the other professions and of society in general. But Miller also notes that the practice of osteopathic medicine now hardly differs from allopathy, and she sees problems in the future for the osteopathic profession.

We now return to our examination of osteopathic identity in the USA, and in particular the *present* status of that identity. Such a review being too extensive for the present section, and not really falling under the rubric of the history of osteopathy, we present the information we gathered and our conclusions under a new heading:

4.2 Osteopathic identity in the USA

4.2.1 The professional identity of osteopathy today

4.2.1.1 Changing the profession's name – categorization problems

The name "Osteopathy" was given to the profession by its founder Dr. A. T. Still. and was primarily used for decades. Later on, the term was brought into question by the DOs (see section 4.1.3). As a consequence, since the 1960s *osteopathic medicine* has been the official name instead of *osteopathy*, and *osteopathic physician* and *surgeon* replaced *osteopath* (Gevitz, 1988, p. 147; Allen, 1993; Gevitz, 2004, p. 111). "Osteopathy" and "osteopath" have since served only as historical names in "[…] sentimental and informal discussions" (Fossum, 2002, p. 25).

In recent years there have also been discussions and a lack of clarity on whether osteopathic medicine with its application of osteopathic manipulative treatment (OMT) should be classified as *alternative* or *mainstream* (Cassileth 1999, McPartland 1999).
Fossum (2002) finds that osteopathic medicine is regarded as *mainstream*, but we also find osteopathic manipulative therapy (OMT) and osteopathic manipulative medicine (OMM) categorized as "alternative medicine" (CAM), contributors to which include (US) osteopathic physicians.

We'll return to this nomenclature for osteopathy later in a separate section.

4.2.1.2 Scope of practice

Because osteopathic medical education places a strong emphasis on primary medical care, more than 65% of all DOs practice in such fields as family medicine (general practice), internal medicine, obstetrics & gynecology and pediatrics. While the majority of DOs provide primary care (42.6%), they also specialize in all areas of medicine from psychiatry to cardiology and ophthalmology [AOA, Osteopathic Medical Profession Report, downloaded 03/2009].
The number of DOs actively board-certified by the AOA between 2007-2008 was 22,205 (=100%).
According to the 2008 figures, 42.6% of the actively board-certified DOs engage in family and general practice (see above), 9.5% in general internal medicine, 4.5% in general pediatrics and adolescent medicine and 4.2% in obstetrics. In addition, 1.1% are engaged in pediatric specialties, 1.5% in specialized osteopathic manipulative medicine (OMM) or osteopathic manipulative treatment (OMT) and 36.9% in other specialties. The number of AOA-recognized specialties, subspecialties and added qualifications between 2007-2008 was 67. The final available figures on patient consultations (percentage of all office visits) from 2006 show that DOs were consulted in 6% of the cases [AOA, Osteopathic Medical Profession Report, downloaded 03/2009].

4.2.1.3 Osteopathic medical education

Regarding osteopathic medical education (OME), we find at present 23 osteopathic colleges in 26 locations in the USA. To be considered for admission, applicants typically must have a bachelor's degree. They must also pass the Medical College Admissions Test (MCAT). The training takes altogether four years: The first two years of the osteopathic curriculum focus on the basic sciences. The third and fourth years emphasize clinical work, with much of the teaching occurring in community hospitals, major medical centers and doctors' offices. Osteopathic principles and practices are integrated in the four-year curriculum [AOA, downloaded 03/2009].
The faculties of COMs (colleges of osteopathic medicine) are about evenly divided between doctors of osteopathy and holders of Ph.D. degrees, with a few medical doctors serving at some of the colleges [Barett, downloaded 05/2008].
During the clinical years, students study general medicine and engage in research. They rotate through urban, suburban and rural settings, gaining exposure to all areas of medicine. Following graduation, DOs must complete an approved 12-month internship. Interns rotate through hospital departments including internal medicine, family practice and surgery. They can then opt to complete a residency program in a specialty area, requiring two to six years of additional training [AOA, downloaded 03/2009].

DOs are licensed for the full practice of medicine and surgery in all 50 states. Each state determines the tests and procedures for licensing its physicians. In some states, the same tests are given to DOs and MDs; other states administer separate licensing exams [AOA, downloaded 03/2009].

4.2.2 Why is this identity being questioned? Some examples…

In this section we give several examples and explanations of ways in which the identity of US osteopathy has been contested:

We can gather from its history that the boom of US osteopathy, correlated with a very fast increase in the number of osteopathic colleges, early on presented a problem for the AOA in the provision of sufficient quality postdoctoral programs: The number of new osteopathic hospitals could not alone meet the need for internships and residencies for the larger numbers of students (Korr, 1997b, p. 169; Gevitz, 2004, pp. 164-170). The difficulty was still present in 2005 (Mychaskiw, 2007).
Programs were therefore developed enabling osteopathic students to complete their internships and residencies in allopathic institutions. This policy entailed an intrinsic risk for the osteopathic profession and its practice as far as the necessary autonomy was concerned (Gevitz, 2004, pp. 164-170). The consequences were as follows:
Although 150 AOA-approved osteopathic training programs later came into existence, in time to enough to accommodate most of the osteopathic medical school graduates, a high percentage of osteopaths still favored the allopathic residency programs when finishing their training (Fisher Wilson, 1997; Aguwa and Liechty, 1999), with the consequence that a fair number of these students never returned to the osteopathic profession: They remained in the places where they had completed their training (Fisher Wilson, 1997) and were less likely to identify with their profession (Aguwa and Liechty, 1999).

We may therefore say that a number of the DOs relinquished their *osteopathic identity* at the expense of osteopathy and its (*professional) identity* as a distinct profession. We may also aver that those students who used the osteopathic training programs only as a back door to an affiliated allopathic program later on (Eckberg, 1987) probably never had developed an *osteopathic identity* in the first place.

Another reason for the defection to allopathic residency programs was that the additional revisions undertaken in 1999 and 2002 in the traditional osteopathic internships occurred at the cost of their distinction as a unique osteopathic educational program (Cummings, 2003). Although osteopathic circles continued to speak of an individualistic internship different in kind from that of the allopathic physicians, Cummings considers such talk to have expressed more

a wish than to have reflected reality. Owing to this lack of distinctiveness and to the fact that the ACGME (Accreditation Council for Graduate Medical Education)-approved residencies occurred in a partnership with the AOA, the former had the capacity for absorbing the ever-burgeoning numbers of DOs (Cummings, 2003).

Most likely this is also why the distinctiveness of osteopathy also remained unnoticed by the public for the most part. Indeed, studies by the AOA and the American Association of Colleges of Osteopathic Medicine (AACOM) conducted in 1990 showed that fewer than 15% of the Americans knew the scope of osteopathic medical practice and could significantly distinguish between the DOs and other health care practitioners (Gevitz, 2004, p. 187).

The study by Johnson and Kurtz (2001) stated that 90% of family physicians and 86% of specialists considered themselves osteopathic physicians, whereas only 53% of family physicians and 34% of specialists claimed that their patients also viewed them as osteopathic physicians.
We therefore find a basic difference between the self-perception of DOs and that of their patients, which was also confirmed in a second study by Johnson and Kurtz (2002).

Gevitz (2004, p. 17; 2006) finds that osteopathic medicine today takes up the same professional space as allopathy, the older and much larger profession. Gevitz also states that in the interest of its own independence it no longer makes sense for osteopathy to proclaim its similarity to allopathy. Nor does he see in this professional mimicry a viable way to garner public favor or recognition for osteopathy. The author predicts that lacking a distinctive philosophy the osteopathic profession will have to pass from fashion to fashion in order to justify its existence. From the 1970s to the mid-1980s the fashion was "holistic medicine" and in the 1990s "primary care" (Gevitz, 1994).

Gevitz (2004, p. 187) concludes his sociological study on the DOs in the USA by noting the "social invisibility" of the osteopathic profession.
He gives the following reasons:

- the relatively small number of DOs compared with MDs
- the preeminence of DOs in the field of primary care, which makes them less glamorous
- the fact that osteopathic schools and hospitals are less scientifically oriented
- the similarity of the osteopathic profession with allopathy.

Fogel (2001, p. 330) follows Gevitz (see above) in referring to the "public's ignorance of osteopathic medicine". The reason for this ignorance, according to the author, is the

profession's own inability to promote itself, which could be remedied only if the profession would embody a well-defined *mission* and a secure *identity* (cf. Hruby, 1993 in section 3.1).

Gevitz (2004, p. 187) sees one chance remaining for the osteopathic profession: a return to its osteopathic principles and practices (OPPs), for in the author's view they make osteopathic medicine distinguishable from allopathic medicine (cf. also Johnson and Bordinat, 1998). The OPPs constitute the fundamental tenets of osteopathic medicine (Gevitz, 2006), viz.:

- how a physician approaches patients in health and disease
- how to evaluate the myriad intrinsic and extrinsic factors that bear upon wellness and sickness
- what is to be done by the DOs to keep patients healthy or restore them to health

Gevitz (1994) emphasizes the dependence of the postdoctoral level on the predoctoral level and concludes that in both phases the OPPs must play a basic role in the curriculum in order to bind the DOs to their profession as osteopaths.

Despite the similarity discussed at many levels between US osteopathy and allopathy, prejudices against DOs still seem sufficiently widespread today for us also to include them in this section:

Testimony by Ha (2008) confirms that the specializations and qualifications of the DOs are still not sufficiently known to the large medical institutions like the Mayo Foundation for Medical Education and Research, and that the latter regard DOs exclusively as family practitioners without the potential for specialization. As a consequence, despite his request Ha (a DO) was not given the ordinarily complementary subscription to the *Mayo Clinic Proceedings* on the grounds that as an osteopathic physician she had a claim only to the *Journal of Family Practice*. Ha attributes this incident not primarily to ignorance on the part of this allopathic institution, but to an error in the self-representation of her own osteopathic profession. Ha's view thus concurs with that of Fogel (2001). We also see a connection to Gevitz (1994) here: Whereas osteopathy had expressly highlighted its contributions to primary care in the 1990s, its relegation to this role (in the case of the Mayo Foundation for Medical Education and Research) now seemed no surprise.

As Gevitz (2004, p. 187) had previously spoken of the "social invisibility" of osteopathic medicine to the public, so could one read a letter to the editor by Harper (2002) as indicating a comparable "medical invisibility" among the large medical institutions like the Institute of Medicine (IOM) of the National Academy of Sciences: a private non-governmental organization

providing science-based advice on matters of biomedical science, medicine and health. In its annual report on patient mortality rates related to medical errors, the IOM made no distinction between allopathic and osteopathic medicine. In response to the high mortality rates, 10,000 new studies were conducted and several thousand practice guidelines and consensus recommendations prepared for all practicing physicians. Harper criticized that these practice guidelines were not profession-specific (regarding osteopathic vs. allopathic physicians), but rather related to illnesses, and that only a few to no osteopathic practice-specific guidelines were included. The author appealed to his osteopathic profession to invest more in clinical research in order to underline the uniqueness of osteopathic practice.

A publicly accessible website called "Quackwatch - Your Guide to Quackery, Health Fraud, and Intelligent Decisions" [downloaded 03/2009] lists US osteopathy and its content, clearly indicating the persistence of prejudice against the osteopathic profession. Noteworthy is that the publisher of this website is an MD who generally recommends, if need be, seeking a DO who

- has completed residency training at a medical hospital (meaning an allopathic institute)
- is not of the opinion that osteopaths have a unique philosophy and that manipulation therapy can contribute to general well-being
- does not apply any manipulative therapy (or if so, then only for backaches)
- does not practice any cranial therapy.

This website (revised in 2003) was still available in 2009 and finds some agreement even among the DOs (as evidenced by the readers' comments).
We already noted in our early history of osteopathy (see section 4.1.1) that it was often accused of quackery and that at the time (as now in the case of Quackwatch) its seriousness as medicine was doubted.

We conclude this section with a diagram summarizing the aspects we've so far related to the oft-discussed identity of US osteopathy (Figure 3).

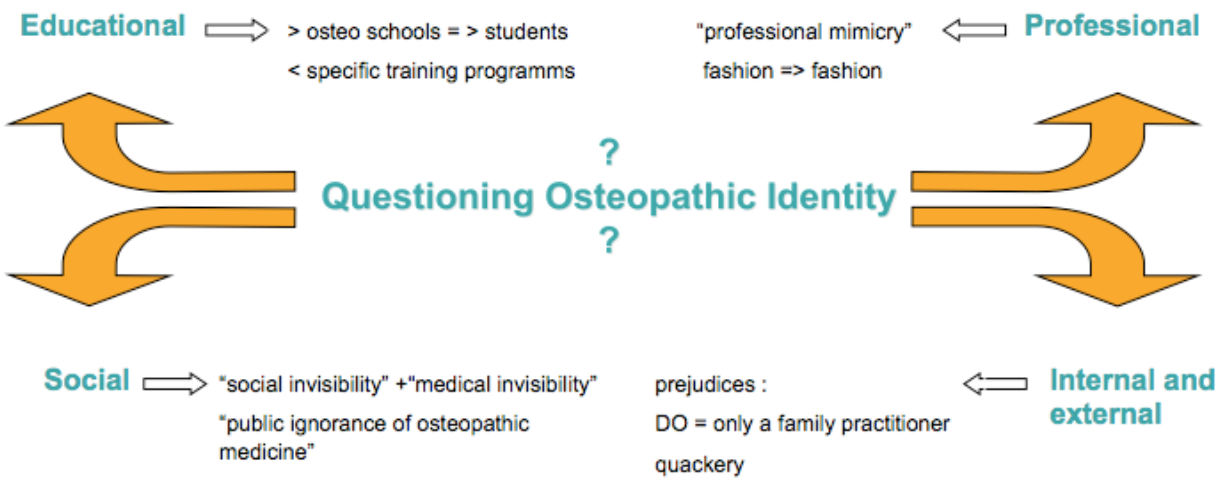

Figure 3: Schematic diagram of the main questions put forward about osteopathic identity.

4.2.3 Factors of the identity crisis in the USA

We now discuss in further detail some of the factors serving as the foundation of US osteopathy and directly related to its identity crisis.

4.2.3.1 OMT - OPP

Osteopathic manipulative treatment (OMT), also referred to by Lesho (1999) as osteopathic manipulative therapy,[19] represents a basic identity-constituting criterion for US osteopathy and is much discussed in the context of osteopathy's distinction from allopathy (Teitelbaum et al., 2003; Licciardone, 2004).

Some writers are of the opinion, however, that OMT does not suffice as the sole criterion for distinctiveness as a profession (Nicholas, 1983; Korr, 1997b, p.167; Johnson and Bordinat, 1998; Siehl; 2001; Hansen, 2006), and that osteopathy must distinguish itself according to other criteria, such as the OPPs (see Gevitz in section 4.2.2).

Northrup's (1972) basic view is that the application of "manipulative therapy" (MT) as an integral part of comprehensive medical practice is justifiable only in combination with osteopathic medical principles.
We note that while Northrup mentions only "manipulative therapy," he presumably means OMT. Generally the terms OMT, (spinal) manipulation, (osteopathic) manipulative therapy and

[19] Osteopathic manipulative therapy comprises over 100 different techniques or procedures, subdivided into 6 main types: high-velocity-low-amplitude, muscle energy, counterstrain, myofascial release, craniosacral, and lymphatic pump techniques (Lesho, 1999).

osteopathic manipulative medicine (OMM) are to be found in the osteopathic literature[20] (e.g. Lesho, 1999; Siehl, 2001, Teitelbaum et al., 2003, Cardarelli, 2006; Hansen, 2006; Davidson, 2008; …).

In this regard we must also clarify the notion of "osteopathic medical principles" (Northrup, 1972; Teitelbaum et al., 2003), also referred to in the literature as "osteopathic principles and practice (OPP)"[21] (Fogel, 2001; Teitelbaum et al., 2003; Gevitz, 2006). According to some writers, the OPPs form an essential part of osteopathic identity and its distinctiveness (Kasovac, 1996; Fogel, 2001; Gevitz, 2004, p.187, 2006).

Russo et al. (2003, p. 429) speak of the integration of OPP as a "[…] hallmark of contemporary osteopathic medicine."

The OPPs are related to the "osteopathic concept" or to the "osteopathic philosophy" (cf. Patterson, 2006).

Gevitz (2006, p. 121) considers the OPPs the "[…] fundamental tenets of osteopathic medicine that guide how a physician approaches patients in health and disease" (see section 4.2.2).

In our view, OMT must be considered a component – or rather a practical medium – of the OPPs.

Decline of OMT among osteopathic physicians

It has been found that OMT is finding less and less application in osteopathic practice (Fry, 1996; Johnson et al., 1997; Gevitz, 1998, p. 154; Aguwa and Liechty, 1999; Johnson and Kurtz, 2001, 2002).

Two surveys were conducted in 1997 and 2001, respectively, to register the status of the practical application of OMT and at the same time to record those factors having an influence on the application:

The study by Johnson et al. (1997) submitted questionnaires to 2000 randomly selected physicians, of whom 1055 responded, yielding a response rate of 54%. The relatively low application of OMT was attributed to practical barriers, such as: lack of time (in 60% of the responses), other professional and practice interests (31%), poor reimbursement for OMT (26%), unsuitable physical facilities (26%), practice environment not supportive of OMT (23%) and lack of patient interest (16%). In addition, 22% of the osteopathic physicians had insufficient confidence in their own OMT skills, and 19% claimed they had had inadequate training (see the similar studies by Gamber et al. and Nemon in Fossum, 2002).

Nevertheless, 95% of the family physicians in the study by Johnson et al. declared OMT to be an effective method of treatment.

[20] The literature is not always clear on this point.
[21] The literature is also not always clear on this point.

In a second study, Johnson and Kurtz (2001) wrote to 3000 randomly selected physicians, who this time had a response rate of 32%. The result was that over 50% of the responding osteopathic physicians used OMT on less than 5% of their patients. The variance in applications of OMT was significantly affected by practice type, graduation date, and the role of family physicians as opposed to specialists. The level of OMT use also depended on the existence of postgraduate training (at osteopathic, allopathic or mixed-staff facilities), especially in the case of osteopathic specialists.

From various sources we have compiled some of the reasons discussed pertaining to the steady decline of OMT:

Osteopathic medical education (OME)

As osteopathy began to achieve political recognition, OMT declined in importance in osteopathic training in favor of pharmacology and surgery (Gevitz, 1998, p. 144; 2006). Later on, OMT was pushed further to the background by allopathically governed postdoctoral training (Gevitz, 1998, p. 154).
It has been noted that those osteopathic residents accommodated by allopathic residency programs were practically insulated from the OPPs. A study by Johnson et al. (1997) found that the more recent the date of graduation from osteopathic medical school, the lower the reported use of OMT.
Aguwa and Liechty (1999)[22] show that OMT finds less application among those DOs who were trained in non-AOA approved programs.

The forms of instruction in osteopathic medicine followed a craft model of training: A master instructed his students in particular tasks, and the students tried as best as possible to imitate him, until they acquired sufficient proficiency (Gevitz, 2006). According to Gevitz, this type of training necessarily required additional demonstrations and exercises that unfortunately did not always take place.
Mann et al. (2000) believe that the lack of individualized performance feedback resulted in the students remaining insecure in the application of OMT techniques in subsequent practice. The authors refer to studies on the positive effectiveness of mastery learning programs for improving osteopathic medical education (OME).

Davidson (2008) writes that the training of osteopathic students in OMM does not reflect the reality of osteopathic practice on patients. He claims this is reason why osteopathic students

[22] In their study the authors surveyed graduates of colleges of osteopathic medicine as to their identification with the osteopathic medical profession.

enjoyed less success in their application of OMM, and therefore lost their confidence in the practice and engaged in it less often. Davidson emphasizes that during instruction students confined themselves too much to the patient's particular symptoms instead of including the entire body in the treatment.

In the assimilation of osteopathic medical education (OME) to allopathic medical education (AME), many students used the osteopathic programs as a backdoor to medicine in the event they were not admitted to allopathic schools (Eckberg, 1987). The primary aim of these students was therefore not to learn osteopathic medicine (OMT), but rather to use this training as an acceptable, alternative way to become allopathic physicians (Gevitz, 2006).

OMT and science

Gevitz (2006) is of the opinion that over the years instruction in osteopathic medicine did not adequately adapt to the intellectual and practical needs of the students. He observed that many students came to osteopathic training with the idea that all phases of that training rest on a scientific basis, an idea not duly accommodated by the COMs, however. According to Gevitz, during the first two years of the curriculum the content of the OMM is based more on the words of a few DO "authorities" than on EBM (evidence-based medicine). Gevitz believes that students seek scientific evidence supporting their activities around patients, and that the students are not satisfied by case reports, anecdotes, testimonials, theories, speculations, reasoning by analogy and by pilot studies.[23] These observations lead him to regard the use of vitalist concepts like "energy flow," "life forces" and "inherent therapeutic potency" in explanation of human physiological processes as problematic for students hungering for science. He also finds that students' confidence in distinctive osteopathic methods becomes problematic on exposure to OMM advocates availing themselves of unorthodox medicine, such as crystals, magnets or chelation, in diagnosis and therapy.

There are also some aspects external to OME in scientific research but regarding OMT that we discuss in further detail in section 4.2.3.2.

[23] Gevitz also notes that many students are not acquainted with the scientific studies by Denslow and Korr, attributing this ignorance to the greater role given to anatomy in historical osteopathic training. According to Gevitz, however, only the subsequently integrated science of physiology has led to the most significant knowledge of somatic and segmental dysfunctions. Years before, Northrup (1972) said that it would be unrealistic to teach structure without function, and in fact equated anatomical structure and physiological function.

Osteopathic faculty

Too few full-time OPP faculty members teach at today's COMs (Colleges of Osteopathic Medicine), so that the programs must rely on part-time and volunteer teaching staff. This has basically two consequences:

- There is a lack of osteopathic teachers for passing osteopathic knowledge on to their students (Gevitz, 1998, p. 144; 2006).
- The relatively low number of OPP faculty members, viewed as table trainers for the larger number of students, do not afford sufficiently dynamic small-group activities for the students to acquire satisfactory practical skills (Gevitz, 2006).

The first point is also supported by Fogel (2001) and Kleman (2009), who generally criticize the lack of emphasis on osteopathic content in contemporary osteopathic education.

The booming business of new COMs

Pandeya (2008) writes that the exponential growth of colleges may be occurring at the cost of the quality of the instruction. While he regards the Des Moines University College of Osteopathic Medicine in Iowa (DMU-COM), for example, as a positive trend towards higher educational standards compared with his own earlier training, he also wonders whether the many new COMs will be able to attract adequate educators:
"I have always wondered about the quantity versus the quality of educators available […]" (Pandeya, 2008, p. 89).
Pandeya refers to a letter to the editor by Mychaskiw (2007) criticizing the situation considerably more sharply and also warning that quality must not be sacrificed for quantity. He sees great problems facing the newly created for-profit institutions: "How interested are these investors going to be in the *principles* and practice of osteopathic medicine, aside from the fact that we are allowing them to enter a new profitable venture?" (Mychaskiw, 2007, p. 247).

Scope of practice

Institutional changes also negatively affected the use of OMT. The shift from a mainly chronic to a broad-based practice meant that DOs had significantly more patients to treat per week, which shortened possible consultation periods and cut the time available for OMT.
Added was the fact that in the DOs' eyes pharmacology provided the faster and more effective solution (Gevitz, 2004, p. 103).

We attribute the latter perception to the aforementioned insecurity in the application of OMT and/or to the remoteness of the students from the OPPs, making OMT seem the less practical and less effective method of treatment.

4.2.3.2 Scientific research

We need not treat this topic in too much detail, since it does not clearly fall within the scope of this thesis. Instead, we give a glimpse of the extent to which scientific research can be burdened with osteopathic identity.

Some writers, like Lesho (1999), Mein et al. (2001) and Licciardone (2004), regard scientific research in the area of manual-medical, clinical studies as methodologically problematic.
Hansen (2006) criticizes rather generally the lack of random control studies that would test the effectiveness of OMT, and Cardarelli (2006) sees a problem in the reproducibility and generalizability of evidence given the frequent small sizes of the groups.

Generally we may assume that the standardization of manual medical treatments and their results is difficult. On the one hand, we must distinguish between potentially effective manual techniques collectively referred to as "manual medicine" but drawn from different fields like osteopathy, chiropractic and physical therapy.[24] On the other hand, we must attend to the practice of "simulated treatments" and their often undesirable physical effects. In contrast to random clinical pharmacological studies, a double-blind methodology is difficult to apply in manual medical studies because the practitioner is always aware of the applied technique (Mein et al., 2001; Licciardone, 2004; Cardarelli 2006). Even the blinding of patients is difficult according to Mein et al. if they've already had experience with manual medical treatment.

Lesho (1999)[25] moreover notes a discrepancy between interexaminer reliability and the self-limited natural histories of many musculoskeletal conditions.
Even long-term results of manipulation, such as for lower back pain (LBP), are problematic, since many of the patients spontaneously recover over a certain period of time without treatment. While Lesho also acknowledges various studies indicating statistically significant benefits from manipulative treatments of LBP, he criticizes many of these studies for not checking for placebo effects.

While these negative factors might indicate an identity crisis in osteopathy, the following writers downplay the "absolute" magnitude of such a crisis:

[24] Cf. Mein et al. (2001), who discuss the errors concerning this necessary differentiation in the publication of studies.
[25] Lesho refers to a Medline literature search between 1966 to 1999 with the terms "manipulation," "osteopathic manipulative therapy," "random," "clinical trials," "diagnosis" and "cohort studies".

Licciardone (2007) does not view the possibilities of osteopathic scientific research so negatively. Although he also notes the insufficient number of basic mechanistic and translational programs that could be regarded as uniquely osteopathic, he also points to the advances in osteopathic clinical trials, particularly those involving OMT for LBP. On the basis of a meta-analysis in the case of LBP, Licciardone et al. (2005) conclude that OMT yields significant relief from complaints in random controlled trials (RCT), having compared OMT with active therapy or with a placebo control group and a control group not receiving treatment.
The author emphasizes the necessity of further studies on OMT for consolidating osteopathic identity, however. They should include (e.g.) large longitudinal studies of the natural history and epidemiology of somatic dysfunctions (including an OMT component).

Positive trends are also to be found in European osteopathic scientific research:
In his *capita selecta* for future physicians van Dun (2007c) writes that new clinical studies are constantly being produced in the field of osteopathy that meet the highest scientific standards. These are solid, scientific studies that confirm a significant improvement in a patient population with dysfunctions and/or pathological conditions. A large-scale study in the United Kingdom showed that (e.g.) manipulations not only provided "best-care" standard treatment, but also saved costs (UK BEAM Trial Team, 2004).
Van Dun also discusses the active participation by the osteopathic community in fundamental and basic-science studies, which he regards a "must" for preserving the separate identity of osteopathy. Van Dun states that knowledge that osteopathy is functioning is not enough – research is also necessary on *why* or *how* it functions.

We also note the increasing number of studies specifically concerning dysfunctions and pathologies and giving attention to osteopathy both as complementary treatment and as standard treatment in cases where conservative treatment offered only slight or even no improvement (Mills et al., 2003).

In her thesis on *The Place of Osteopathy in Today's Health Policy: a Phenomenological Approach*, Drexeler (2009) emphasizes evidence-based medicine (EBM) as the basis of the medical professions. She also notes the narrowing of scope of EBM as scientific knowledge comes to take priority over the patents' desires and the professionals' judgment. The hierarchy within EBM accords RCTs a relatively high importance.
There is also the opposite opinion, however, that instead of narrowing its paradigm the EBM should allow a broad spectrum of investigation methods. The criticism of the hierarchy is that the RCTs can yield answers only to a limited extent (for certain cases), so that their quality is not ensured under all circumstances: In particular, critics have questioned the suitability of

RCTs in complex and dynamic interventions such as those involved in osteopathic examinations and treatments (Danish AKF Report in Drexeler, 2009). The authors of the AKF report are of the opinion that different types of studies are necessary in order to answer different types of questions, and propose replacing an evidence hierarchy with an evidence typology, if the latter is no longer sustainable. As a consequence, the authors are concerned with the development of suitable examination strategies with a better adaptability to certain complex contexts in order to ensure optimal patient care in the future.

Historically speaking, scientific studies never had high priority (Gevitz, 2001);[26] the reasons were, among others, that the main intention of the colleges was to prepare their graduates for practical operations on patients, that before 1960 none of the osteopathic colleges was linked to a university, that tuition fees simply did not suffice for investing in research and that state subsidies also placed greater value on the allopathic institutions.
Over the last decades, however, the focus has clearly lain more on the EBM even in osteopathy, which we may attribute to newly created osteopathic research centers exclusively serving scientific purposes (van Dun 2007c, Licciardone, 2008).
Scientific research has come to be recognized as a *conditio sine qua non* for osteopathic medicine and for its future identity as a profession in the health care arena.

4.2.3.3 Other discussed factors

According to Meyer and Price (1993), the overall US health care system with its exploding costs has contributed to the identity crisis of the DOs (and of the MDs), given the economic impact of the processes of rationalization in the DRG system on medical education and its application in practice. The authors report on financial crises, on the lack of resources among the osteopathic hospitals and schools (see Gevitz in section 4.1.4) and on the trend towards increased ambulant care.
Other factors leading to the crisis according to the authors were the changes in osteopathic graduate medical education (GME) towards more esteemed subspecialization (cf. Korr, 1997b, p. 171) and the existing prejudices against osteopathic training (see sections 4.1.4 and 4.2.2).

Eckberg (1987) conducted a sociological study of the identity crisis, which he characterized as "the dilemma of osteopathic physicians". His hypothesis attributes the image crisis of osteopathy to the conflict between the "classical" lifestyle commitment to one's own profession (e.g. toward general practice, OMT, holism) and the rationalization process of allopathic medicine with its trend toward specialization and scientific elitism. The results of the study generally confirm this hypothesis:

[26] Although we must recall the fundamental work by Korr and Denslow.

> "(1) classical elements of osteopathic commitment are not tied to commitment to the profession in general, (2) there appears to be a waning of commitment to general practice, (3) an increasing number of osteopathic physicians used the DO degree as a 'backdoor' into medicine and are less likely to identify with classical osteopathic norms, and (4) DOs from socially conservative backgrounds are more likely than others to maintain commitment to the classical elements of osteopathic practice.
> (Eckberg, 1987, p. 1111).

On the first and second points we can add that OMT as well as general practice are not strongly linked to general support of the profession. While OMT is still highly esteemed, it may generally be regarded as an *isolated* issue. General practice finds extremely strong support only among general practitioners (GPs). Those who have become most "allopathized" in terms of specialization support the general norms of the profession like others, but they are suspicious of the abilities of GPs.
(In other words: there are conflicts between specialists, residents/interns and GPs: The former consider GPs undertrained, whereas the latter consider the former too specialized and not holistic).
On the third point we can say that with the number of backdoor DOs the potential for a status conflict grows as well, and, regarding the final point, that some aspects of general religiosity and fundamentalist religious affiliation act as variables regarding osteopathic attitudes:

> "Though the effects are not strong, they *seem* to indicate some resistance to elements of rationalization, which fits with the generally fundamentalist'-read 'anti-modern' nature of Bible-belt culture" (Eckberg, 1987, p. 1118).

The aforementioned status concerns can also be related to the social function of a profession and possibly also to the goal of a higher income, which brings us back to the economic aspect of the profession. In section 3.3 we described these two aspects – social and economic – and now we see the importance of both for the choice and exercise of a profession.

4.3 The historical development of osteopathy in Europe (i.e. the United Kingdom) in relation to its identity

In order to compare the European with the US history of osteopathy and ascertain any parallels to the US identity crisis, we next take a closer look at the history of osteopathy in the United Kingdom. We take the UK as representative of Europe in this regard as it has been thoroughly studied by the sociologist Hans A. Bear, among others.

The spread of osteopathy from USA to the United Kingdom

Osteopathy was brought to the United Kingdom by graduates of the American School of Osteopathy (ASO) in Kirksville, Missouri, the very first osteopathic school. Shortly after founding the ASO in 1892 Still met William Smith (1882-1912), a Scottish physician who had studied at the University of Edinburgh. Smith was so impressed by Still's theories that he became the first lecturer for anatomy at the ASO. The most important person to connect US osteopathy with the UK was John Martin Littlejohn (1865-1947), however, who had completed various courses of study in arts, theology, oriental languages, political economy, physiology and anatomy at Glasgow University and Columbia University, obtaining a Ph.D. in political science from Columbia. Later on John Martin Littlejohn decided also to study osteopathy in Kirksville. After a brief period of time he was appointed Dean of the Faculty and Professor of Physiology. He received the title of DO in 1900 and together with his brothers James and John opened his own school, the American College of Osteopathic Medicine and Surgery, the forerunner of the Chicago College of Osteopathic Medicine (Baer, 1984b, Gevitz, 2004, p. 59).

In 1898 he presented osteopathy for the first time in the UK when he gave a lecture at the Society of Science and Arts in London. In 1913 he left the United States to reside in London.
The move had been preceded by disputes with the ASO, but their role in Littlejohn's decision to go to the UK remains unclear according to Bear (1984a): While Still placed anatomy in the forefront in osteopathic training (Gevitz, 2004, p. 31), Littlejohn saw physiology as more important. Whereas Still firmly believed that *structure governs function*, Littlejohn was convinced of the reverse, namely that *function governs structure* [Abehesera, downloaded 03/2008b]. Whereas the DOs followed Still's principles in rejecting the application of drugs, anesthetics and antiseptics, Littlejohn employed these substances in moderate amounts and considered them as an integrative part of osteopathy (Bear 1984a)[27].

Accordingly at this time there occurred the first disagreements over the content of osteopathy between the founding father, A.T. Still, and one of his first followers, J.M. Littlejohn, who himself became the founder of osteopathy in Europe [Abhesera, downloaded 03/2008b]. According to Bear (1984a), the only source of this information, Littlejohn went on to obtain his MD from the Chicago College for Homeopathy even though he had completed his osteopathic training and served as Dean.

The osteopathic practice was already opened in 1902 by F.J. Horn. Other osteopaths trained in the USA followed his example, among them Dr. Willard Walker, who settled in Scotland, and

[27] The sole source we found for this information is Bear (1984a).

Drs. Jay Dunham and Harvey Foote, who went to Ireland [British Osteopathic Association BOA, downloaded 07/2008].

The foundation of schools and associations

Only the most extensive research could list the many individual schools and associations founded in the course of British osteopathic history, and even then one would become lost among the many number of osteopathic institutions that were founded and/or disappeared in part, only to resurface under new names. We do not present this survey of the educational and political development of osteopathy as a complete history; our aim is rather to show that British osteopathy was variously influenced by other health care movements and that these influences led to the division of the osteopathic community into different groups. We'll soon see that the latter trend would hinder the political recognition of osteopathy in the United Kingdom.

The British Osteopathic Society was the first organization to be established, and renamed in 1911 as the British Osteopathic Association (BOA), with John Martin Littlejohn becoming its president in 1925 (The Osteopathic Blue Book in Fossum, 2002). The BOA formed the British counterpart to the American Osteopathic Organization (AOA) for US-trained osteopaths [BOA, downloaded 07/2008].
In 1914 the BOA applied for registration as a scientific society under the Companies' Act, but the application was rejected by the Board of Trade and it was opposed by the General Medical Council (Hall and Wernham, and Littlejohn in Fossum, 2002).
In the following year (1915, with incorporation in 1917) Horn and Littlejohn then founded the British School of Osteopathy (BSO) in London (Bear, 1984a).
At first the BSO and the BOA merged, only to separate later on (Bear, 1984a, b).

The second school, founded in 1921 by the US osteopath William Looker, was located in Manchester and known as the "Looker School". This institution instructed osteopathy and chiropractic in courses of only three to six months in duration. Most of the graduates of this school called themselves osteopaths. Not being recognized by the BOA, however, they founded their own association in 1925, the Incorporated Association of Osteopathy Ltd., which became the Osteopathic Association of Great Britain (OAGB) in 1936 [BOA, downloaded 07/2008].

Here it is interesting to note that an institution like the Looker School initially reacted to its rejection by the BOA by forming its own association and then, after deciding this was not the only fruitful way (out), approaching John Martin Littlejohn and the BSO. Their negotiations

resulted in an agreement between the OAGB and the BSO: Members of the OAGB would have to complete an additional course of studies at the BSO in order to receive a degree from the BSO (The Osteopathic Blue Book in Fossum, 2002). Henceforth the OAGB would practically serve as the "alumni association" of the BSO (Bear, 1984b).
Years later (1991-1992) the OAGB would again merge with the British Naturopathic and Osteopathic Association (BNOA) [BOA, downloaded 07/2008].

While we may assume that the above had something to do with the separation of the BSO and the BOA, the literature does not go into the exact reasons.
Even this brief history of the BSO and its cooperation with the associations BOA, OAGB and later BNOA shows how osteopathy (represented by the BSO) was confronted with chiropractic and later naturopathic influences, with osteopaths from different backgrounds uniting under the label of a single association.

In other European countries, like Belgium and Germany, schools also emerged which founded their own associations or, conversely, associations were created that cooperated only with certain schools. We suppose the reasons lay in the differences between the institutions (schools and associations) regarding their pursued political goals and the content and/or quality of curricula: Consider, for example, the Sutherland College in Germany (Schlangenbad) and the German Association of Osteopaths (Verband der Osteopathen Deutschlands, VOD), both beginning as founding members of the Federal Association for Osteopathy (Bundesarbeitsgemeinschaft für Osteopathie, BAO) in 2004, then withdrawing from the BAO to form the Umbrella Association for Osteopathy (Dachverband Osteopathie, DVO in 2009 [BAO and VOD, downloaded 04/2009]. In Belgium alone there exist five associations that merged under an umbrella association (the Groupement National Représentatif des Professionels de l'Ostéopathie, GNRPO), with one association and one school not belonging to the GNRPO (personal communication, van Dun, 03/2009).

Continuing with the history of the BOA: At the end of the Second World War it founded the London College of Osteopathy, renamed the London College of Osteopathic Medicine (LCOM) in 1978. It served as a postgraduate institution for regular medical practitioners wanting to specialize in OMT. This gave rise to a distinction between "medical osteopaths" or "osteopathic physicians" and so-called "lay osteopaths" (Bear, 1984b), leading to a division within the osteopathic professional group, with the former regarding themselves exclusively as "doctors" ("Drs") and associating themselves more with medical physicians than with the British-trained osteopaths who did not qualify as doctors. Moreover, a large number of patients of osteopathic physicians were referred to the latter by other physicians (Inglis in Bear, 1984a).

The resulting point of contention further increased the divide between the BOA and BSO (Bear, 1984b).

Besides the schools already mentioned, there emerged others that formed their own registers and deserve mention. For example, a group of naturopaths joined some of the osteopaths to form, in 1961, the British Naturopathic and Osteopathic Association (BNOA), with its affiliated British College of Naturopathy renamed as the British College of Naturopathy and Osteopathy (BCNO). This school integrated spinal manipulations and techniques from osteopathy and chiropractic (Bear, 1984a, b). The graduates called themselves either naturopathic osteopaths or maintained their designation as "straight" naturopaths. The degrees awarded were the Diploma of Osteopathy (DO) and the Diploma of Naturopathy (ND), respectively.
The BSO denied these manipulators admission to the former's General Council and Register of Osteopaths (GCRO), so that the latter had to establish their own register, the members of which designated themselves as MBNOAs (Members of the British Naturopathic and Osteopathic Association) (Bear, 1984a).

Bear (1984 a, b) does not provide clear-cut information on the founding of the GCRO. While claiming it was the BSO that refused the BNOA inclusion in the Register, Bear (1984b) says that the Register was established by the BOA, the Incorporated Association of Osteopaths and the National Society of Osteopaths Ltd. in 1936. Members of the Register bore the letters MRO after their DO titles. Perhaps we may assume that at the time of the founding of the GCRO the BOA and the BSO were still cooperating with one another; but the significance of their separation for the continuation of the Register remains unclear.

Owing to internal conflicts within the BNOA, the Society of Osteopaths then developed into a new faction, which in turn gave rise to a subfaction that regarded itself as eclectic in its approach to health care and integrated cranial and visceral manipulation techniques, naturopathy, herbalism, acupuncture and homeopathy (Bear, 1984a).

In the meantime there also emerged an even larger number of "osteopathic factions," as well as a mixed form of osteopathy, already shaped by chiropractic and naturopathy, incorporating herbalism, homeopathy, etc. (see above paragraph). The question thus arises as to the residual essence of osteopathy and its persistence within the mixed form of osteopathy, and it becomes all the more interesting to follow how osteopathy continued to assert itself in the United Kingdom.

Struggles between the BOA and AOA

As already mentioned, the BOA was the only organization to be recognized by the American Osteopathic Association (AOA), although this recognition only referred to the members who had attended AOA-recognized US osteopathic schools. At this point in time, recognition by the AOA did not even extend to the medically qualified graduates of the LCOM, who were accommodated along with their allopathic colleagues by the British Association of Manipulative Medicine. These members of the BOA then taught manipulation to the manual medicine people. As a result, the boundaries between osteopathy and manipulative medicine were no longer sustainable, and the aforementioned mix of osteopathy now also included this (allopathic) sector. The whole issue led to conflicts between the BOA and the AOA. The inevitable result was that the BOA increasingly distanced itself from US osteopathy, as did the rest of British osteopathy (Bear, 1984a, b).

Digression on Belgium and France

Besides giving a brief overview of the situations in Belgium and France, this digression is intended to retrace the influences experienced by British osteopathy in particular from France.

According to Bear (1984a), while the origins of osteopathy in the two countries remain obscure, there did exist French and Belgian physiotherapists who independently practiced and developed themselves into osteopaths. Although spinal manipulation was prohibited in France and Belgium to all except regular medical practitioners, the legal surveillance was lax and sanctions enforced against osteopaths only in the event of incidents involving charges pressed by allopathic physicians.

Opened in 1951, the Ecole Française d'Ostéopathie in Paris (an actually illegal osteopathic school) became "a bit too much" for the French medical establishment and it was ordered to close (Bear, 1984b). In 1965 the school moved to London in a cooperative arrangement with the BCNO (British College of Naturopathy and Osteopathy), from which the Society of Osteopaths broke away after tension developed between the French School and the BCNO. The former Ecole Française d'Ostéopathie reconstituted itself as the Ecole Européene d' Ostéopathie (EEO), which became the European School of Osteopathy (ESO) in 1974. Originally encompassing both French and Belgian physiotherapists, the school later expanded its program to include English-speaking students.

The ESO initially cooperated with a clinic in Maidstone founded by two graduates of the BSO, John Wernham and T. Edward Hall, until differences led the two institutions to separate in 1981. The ESO subsequently developed its own clinic, offering two training programs leading to the European DO. Its graduates were authorized to join the Society of Osteopaths, while the

admission criteria of the school generally excluded regular medical practitioners and medical students, unless they renounced their allopathic background in favor of osteopathic study (Bear 1984a).

The curricula of the schools

Fossum (2002, p. 39) writes that the curriculum of the BSO in 1922 was based on traditional OPPs and that instruction excluded pharmacology and surgery.
According to Bear (1984 a) the curriculum remained conservative, at least until 1984,[28] with cranial manipulations, a French influence (cf. Cazanave, 2003, p. 25 and Abehesera, downloaded 03/2008b), not being taught to beginning undergraduates, but offered to postgraduates at the latter's insistence.
This suggests that the rather conservative attitude of the BSO, among other things[29], was a reason for the reconstitution of osteopathic schools that evidently differed in their view on the scope of practice of osteopathy; for according to Bear (1984b), many students of the ESO, BCNO and also the BSO were also interested in alternative forms of therapy like naturopathy, homeopathy, acupuncture, etc. In contrast to most of the established osteopaths, these students minimized the differences between osteopathy and chiropractic and, as noted above, mixed osteopathy with other therapeutic methods, which in turn was "officially" represented by associations like the BNOA (founded in 1945) and the SO (founded in 1971).
At this point we must note that the subsequent osteopathic institutions saw the potential for a broad scope of practice to lie not in osteopathy *itself*, but rather in the addition of other health care methods.

We found that the BCNO curriculum included instruction in psychology, psychotherapy, ophthalmology, dermatology, gynecology, pediatrics, geriatrics and tropical medicine.
The ESO also provided instruction in cranial manipulation and psychotherapy, in addition to the basic sciences and OPP. It moreover motivated its students and instructors to give presentations on homeopathy, herbalism, acupuncture, Alexander technique and yoga, even if naturopathy *as such* was not part of the planned curriculum.

If we consider the information on the curricula of the osteopathic schools, then we find that it generally reflects the reasons for forming the so-called mixed associations like the BNOA. We must also recognize, however, that the curricula in these years quite varied in content. We've already suggested two likely reasons for the creation of schools other than the originally

[28] While we have no information on the curriculum from subsequent years through the present, we do not find further research on this subject crucial to the present thesis.
[29] Bear also sees the reason to lie in offshoots of the general holistic health movement.

founded BSO, namely the students' interest in alternative forms of medicine and the influence especially of France.
Fossum (2002, p. 39) sees still another reason: In 1922 osteopathy was emphasized as a system of general medicine capable of treating diseases, systemic diseases and musculoskeletal complaints. In the late 1940s the main endeavor to integrate medical diagnosis in osteopathic education and its emphasis as a modality of treatment for various diseases were discontinued and came to be viewed by some osteopaths as even impossible in principle. The narrowing of the scope of osteopathy led to critical voices within the profession, so that new schools formed for the purpose of preserving a broad scope of practice for osteopathy.
Bear (1984b) also writes that despite the broad philosophical basis of osteopathy (as surely propagated by the BOA, among others), most British osteopaths became musculoskeletal specialists. The author quotes Colin Dove, a former Principal of the BSO, who assured that a broad osteopathic concept of disease with an emphasis on fundamental osteopathic lesions was still being taught at the school, but who considered general practice as such impossible to perform.

In sum: If the goal was to be recognition of osteopathy, it was urgent that the organizations and schools agree on the scope of practice and content of training.

We begin with some background information before describing the individual steps towards the political recognition of osteopathy in the United Kingdom.

Early medical politics in the United Kingdom

The practice of alternative forms of medicine originally was a customary right and part of the Common Law in the United Kingdom. The law imposed only a few restrictions with regard to certain diseases, appellations and remedies. This type of health policy differed from that in the USA, which imposed legal sanctions on quackery (Bear, 1984b). By contrast, in the UK many forms of alternative medicine enjoyed full freedom, which also meant a lack of legal controls and quality assurance for the protection of the public. In other words, anyone could call themselves an osteopath (or chiropractor, homeopath, etc.) without having to produce proof of any particular form training (Bear, 1984b).

Organizationally based osteopaths, such as the members of the BOA and BSO, accordingly had a great interest in setting themselves apart from this obscure "health market" and despite their differences and separate ways had a common "enemy": British freelance osteopaths, whom they agreed in regarding as unqualified manipulators. The training of freelance

osteopaths was usually limited to a few courses taught by osteopaths from US schools (who were not AOA-recognized), or to apprenticeships with bone-setters, osteopaths or chiropractors. Some even taught themselves manipulative therapy (Bear, 1984a).

Attempts at regulation

In 1925 the Ministry of Health rejected the first attempt to establish a legally regulated register.
In 1931, 1933, 1934 and 1935 other bills on government-controlled registers were drafted and submitted first to the House of Commons and finally to the Select Committee of the House of Lords. The advocates of such a register were the BOA, the Incorporated Association of Osteopaths, the Osteopathic Defence League and the BSO. The opponents were the British Medical Association, the General Medical Council, the Royal College of Surgeons of England, the Royal College of Physicians of London, the British Chiropractors' Association, the Chartered Society of Massage and Medical Gymnastics, the Nature Cure Association and some other medical schools and universities (Bear, 1984a).
All these attempts at first remained unsuccessful, both because of opposition by organized medicine and because of discord among the osteopathic groups supporting the bills. Instead, the Investigating Committee of the House of Lords proposed the establishment of a separate, voluntary register and the development of a reputable educational system (Bear, 1984b).
The result was the creation in 1936 of the General Council and Register of Osteopaths, Ltd. (GCRO), as an umbrella association uniting the BOA and the OAGB[30]. The purpose of the Council was to transcend interprofessional rivalries and as a unified body to distinguish between osteopaths according to their qualities and types of qualification.
Here we find generally valid parallels with the establishment of umbrella associations in other European countries (like the Groupement National Représentatif des Professionels de l'Ostéopathie (GNRPO) in Belgium, the Bundesarbeitsgemeinschaft Osteopathie (BAO) in Germany and the Osteopathic Council for Ireland) and on the international level (like the European Federation of Osteopaths (EFO) and the European Register of Osteopathic Physicians (EROP)).
The osteopaths listed in the GCRO were allowed to append "MRO" (Members of the Register of Osteopaths) to their DO titles. When the OAGB (an association of the BSO) became larger than the BOA, however, many of the BOA members decided themselves to withdraw from the Register (Bear, 1984a).

A second "official" step towards the unification of the osteopathic profession occurred in 1971 with the founding of the "Guild of Osteopaths". The literature does not describe the formation

[30] Earlier we described the formation of the GCRO in the subsection on *The foundation of schools and associations*; here again we find small discrepancies between Bear (1984a) and Bear (1984b), attributable in our view to the changes in names and to Bear's having considered the associations at different points in time.

and whereabouts of this pact in any detail, but according to the BOA [downloaded 07/2008] it had the purpose "of enhancing, promoting and unifying the profession worldwide […]." This resolution aimed at bringing the older and more experienced osteopaths into contact with the younger "junior" osteopaths.

In 1973 the Committee of the House of Commons then organized a meeting on the status of alternative medicine and invited representatives of the so-called natural therapeutic associations, including the BNOA, the OAGB, the SO and the General Council and Register of Osteopaths, along with other associations, such as the British Chiropractor Organization, Acupuncture Association, etc. (Bear, 1984b). This initiative might be construed as an attempt at unifying the different osteopathic groups under the one cloak of alternative medicine. According to Bear (1984a), however, this unification resulted primarily from the National Health Service's view that recognizing alternative medicine would give it a preventive direction, in the interest of general cost savings in the UK health system.
The General Medical Council followed suit, having at an earlier point stipulated that regular physicians not cooperate with heterodox practitioners and refer patients to the latter. In 1974 the Council relaxed this decree again to allow referrals of patients to other heterodox physicians under the condition that the physicians remain legally responsible for those patients (Bear, 1984b).

In 1976 Health Minister David Owen appointed a working group (the Cochrane Committee) to study the treatment techniques for lower back pain (LBP). The committee investigated whether osteopathic and chiropractic techniques could obtain results for LBP similar to those of allopathic medicine.[31]
The Back Pain Association later came into being, founded by Stanley Grundy, an advocate of chiropractic techniques.
The subsequent Health Minister, Gerald Vaughn, concluded from Grundy's remarkable results that medical manipulators (i.e. osteopaths and chiropractors) meet an important need in health care, and as a consequence released funds for studies on back pain (Bear, 1984b).

In 1981 the BSO[32] and the Polytechnic of Central London agreed on a degree program for osteopaths, the Council for National Academic Awards having suggested to the osteopathic schools that they enter into cooperative arrangements with degree-granting institutions.
The goal was accreditation for awarding a bachelor of science honors degree in osteopathy, which would improve the chances of recognition by the state (Bear, 1984b).[33]

[31] The interest in new forms of treatment responded to cost-benefit calculations for the health system with its spiraling costs.
[32] Bear (1984b) refers here to the School of Osteopathy; we assume he means the BSO.

Recall that Wilensky (see section 3.4.4) stressed the connection to a university as an important step towards the professionalization of an occupational field.

In 1993 the recognition of osteopathy as a separate profession was then formalized by Queen Elizabeth's signing of the "Osteopaths Act" (Maxwell, 1993).
The General Osteopathic Council (GOsC) was chosen as the supervisory body, which immediately assumed the duty of regulating the profession by law and introduced a corresponding register of osteopaths [GOsC, downloaded 09/2008]. The new General Osteopathic Council continued the earlier work by the General Council and Register of Osteopaths (Fossum, 2002, p. 23).
In 1998 the new BOA was formed as an umbrella organization including all formerly existing associations; its first election to the council took place in October, 1998 [BOA, downloaded 07/2008].

As of 2002 six training institutes were listed among the GOsC: the BSO, the BCNO (now the British College of Osteopathic Medicine), the College of Osteopaths, the ESO, the LCOM and the London School of Osteopathy (Cameron in Fossum, 2002, p. 23).

4.4 Comparison of the historical development of osteopathy in Europe (i.e. the United Kingdom) and the USA

4.4.1 Differences between European (i.e. UK) osteopathy and US osteopathy

An initial comparison between UK and US osteopathy reveals a certain irony, as Bear (1984a) and van Dun (2002) also note:
Although Littlejohn's view differed in certain aspects from Still's (see section 4.3), UK osteopathy developed much more according to Still's principles than did US osteopathy, which rather distanced itself from Still through the assimilation to allopathy.

If we now consider the factors leading to the divergent development of osteopathy in the United Kingdom and the USA, our own historical research and Bear (1984a) bring us to two basic issues:

[33] In 1981 negotiations also occurred between the BSO and a Californian university, Columbia Pacific University. They led to a dead-end, however, after it was learned that the University of London had listed this institution as a bogus university.

The existence or non existence of licensing regulations for various types of health care practitioners

Looking back on the beginnings of osteopathy, we find the "medical market" not yet controlled by allopathic medicine in the USA at the end of the 18th century – quite in contrast to the UK market, already fully regulated by the time osteopathy was introduced (Fossum, 2002, p. 58).
In the following decades, however, the regulation and recognition of US osteopathy was to a large part also determined by the allopathic profession, since the AOA had its own boards only in a few states (cf. Gevitz, 2004, p. 93) and in other states the administering boards were dominated by the allopathic medical profession (Bear, 1981).
According to Larson (in Bear, 1984b), the licensing of physicians in USA was a major way in which the allopathic profession restricted competition from osteopaths, chiropractors, and other types of health professionals.

If we look at the situation in the United Kingdom, on the other hand, we find licensing requirements for health practitioners in the decades prior to the Osteopaths Act in 1993 to be minimal, if at all existent. Osteopaths had to deal with competition from other health care practitioners (who also practiced spinal manipulation), as well as with the persistent reputation of osteopathy as a marginal profession (Bear, 1984a). As Bear found in his sociological study, these problems were not satisfactorily resolved by a voluntary register, practically meaningless to both the medical establishment and the National Health Service. The consequence of the voluntary register was rather the formation of different factions within UK osteopathy that for a long time could not reach a consensus with one another. Only after the different associations united, as shown by (e.g.) the formation of the General Council and Register of Osteopaths, did the chances of recognition of the osteopathic profession increase, which then came to pass in 1993.

It is instructive to compare this development of associations in the United Kingdom with that in two other European countries already briefly mentioned in section 3.4. and known well by us personally: In Belgium there are six different osteopathic associations, five of which now belong to the GNRPO as their umbrella association [downloaded 03/2009]. Germany has at least four associations (Verband der Osteopathen Deutschlands (VOD) e.V.; Deutscher Verband für Osteopathische Medizin (DVOM) e.V.; Deutsche Gesellschaft für Osteopathische Medizin (DGOM) e.V.; Deutsches Register für Osteopathische Medizin (DROM)), and two umbrella associations (Bundesarbeitsgemeinschaft für Osteopathie (BAO) and Dachverband für Osteopathie (DVO)) [Google, downloaded 05/2009]. The fact alone of several professional associations existing within a country indicates differences in opinion and objectives on the part of members, and parallels the situation in the United Kingdom (prior to the recognition of

osteopathy in 1993). The establishment of umbrella associations (in these examples) also indicates, however, that the osteopathic profession in Europe is already striving towards a consensus and that this unification on the level of professional policy has intensified the profession's struggle for recognition. The general goal is to reduce the number of associations in the individual countries or to combine them so that in the end *one* strong association for the osteopathic profession can negotiate with the health ministries. Other examples are Ireland and Italy. The Association of Osteopaths in Ireland and the Irish Osteopathic Association combined in January 2009 to form the new Osteopathic Council for Ireland. In Italy five associations combined under the umbrella association Consiglio Superiore di Osteopatia (WOHO News, 03/2009).
The European umbrella association (the European Federation of Osteopaths (EFO)) "encourages" the different countries to organize themselves under respective national umbrella associations (personal communication, Rousseau, 03/2009).

In sum: The larger number of associations in Europe (i.e. the United Kingdom) constitute a significant difference from the USA, where the AOA legally represented the osteopathic profession from the outset.

The allopathic medical presence within osteopathy

Still and some of his early disciples were medical men and the early faculty of the ASO included several individuals with MD degrees.[34] Allopathy was also present in US osteopathy from the outset. Even the State of Missouri would have allowed Still to award the title of Doctor of Medicine (MD) to his graduates at the time (1894), if Still had not rejected the offer in favor of the Diploma of Osteopathy (DO) and, later, the Doctor of Osteopathy (DO) (Still, 1908; Fossum, 2002, p. 16).
Contrary to Still's principles, US osteopathy drew nearer to allopathy in the following decades as part of the struggle for state recognition and equal rights, as already noted. The problem of osteopathic identity thus arose more in reference to osteopathy's similarity to allopathy than in reference to chiropractic, which developed parallel to osteopathy in the USA.
At the time people like the chiropractor David D. Palmer and his followers were considered more as medical outsiders in the USA: they were totally rejected by orthodox medicine as either incompetent quacks or as hopeless cultists – more so than the osteopaths, who in the years following 1894 were regarded by orthodox medicine merely as mavericks and sectarians (Bear, 1984a).

[34] Recall also Marcus Ward (see section 4.1.1), who obtained his MD following his osteopathic studies and founded his own school, which proclaimed materia medica to be part of "true osteopathy" (Gevitz, 2004, pp. 52-53).

It was even thought that this negative stigma of chiropractic may have influenced the osteopaths to a certain extent to give up manipulative therapy for allopathy (Wardwell in Bear, 1984a).
Gevitz (1998, p. 144; 2006) also remarks on the frequent presence of allopathic instructors in osteopathic training as a causal factor in US osteopathy's evolution into allopathic medicine. He also concedes that the instructors' influence on students' development is generally difficult to assess.

In contrast, UK osteopathy for the most part has developed outside the confines of regular medicine. Except for a small number of regular medical practitioners with postgraduate training in OMT and except for recent members of the BOA, there has been almost a total absence of regular (allopathic) physicians in the ranks of UK osteopathy and in its institutions (Bear 1984a). Their striving for recognition rather involved demarcating themselves from other manipulative therapies (like chiropractic and physical therapy).

We conclude this section by noting a study by Fossum (2002), which also points out some differences between the United Kingdom and the USA.
Fossum bases his findings on studies of students' attitudes towards osteopathic philosophy and practice conducted in the United Kingdom (by Fossum himself) and in the USA (by McNamee et al. and Nemon in Fossum, 2002).
As far as we can tell, this study is the only source for the UK and Europe, and surveyed "merely" students from one school, namely the European School of Osteopathy (Maidstone, UK). The students were between their 1st and 4th years of study. The total number of students were 200, and the response rate was 35.5% (*n* =71). Moreover, the study was limited by a reliance on self-reported data.
One result of the UK study was that 90.1% of all students had an osteopathic school as their primary educational choice. In the study by McNamee et al., on the other hand, it was 59%, and in Nemon's study it was 37%. A second result showed that 29% of the students in the United States began their education convinced of the efficacy of osteopathic manipulation (McNamee in Fossum, 2002), while 83.1% of the students in United Kingdom were convinced of its efficacy when they began their studies. Meanwhile, the percentage of students who applied to osteopathic school after rejection from medical school in the United States (McNamee) was similar to that of the United Kingdom (Fossum, 2002, p. 53).
A discussion of further results and comparisons would involve more detail than this thesis requires. We refer merely to the relevant differences: At the end of his study Fossum concludes that the *osteopathic profession* in the United Kingdom does not correspond to *osteopathic medicine* in the USA, except for the adoption by both professions of traditional osteopathic philosophy and OMT. Fossum asks whether the USA, with its assimilation to

allopathy, can serve *at all* as a reference in the worldwide discussion on professional identity and on the practice of osteopathy. Fossum (2002, p. 64) is of the opinion that the history of osteopathy in both the UK and Australia is as long as that in the USA, and that osteopathy also represents a state-recognized profession in these countries, though with the basic difference of having better preserved a more defined identity there. He becomes even more explicit in answering the above question himself, writing that the US osteopathic profession more or less corresponds to conventional medicine and no longer serves as a standard for *osteopathy*. Fossum (2002, pp. 64-65) also notes that most UK students expressly chose osteopathy as their profession, and were more convinced of its medical effectiveness than their US colleagues in McNamee's and Nemon's studies. For Fossum this self-confidence forms the basis of a strong, professional and distinctive identity of osteopathy, stronger indeed than that of US osteopathy among its students.

4.4.2 Parallels between European (i.e. UK) osteopathy and US osteopathy

For the reason given above (see the penultimate paragraph of section 4.4.1), Bear (1984a) considers the *allopathic medical presence within osteopathy* to be one of the salient differences between UK and US osteopathy. The European continent presents a parallel to the USA in this regard, however. The presence of physicians within the European osteopathic profession is growing. There is an increasing number of physicians who themselves have undergone and then present themselves as osteopathic physicians (see Dvorak et al. 2001; Associazione Medici Osteopati Italiani (AMOI), downloaded 05/2009; European Register of Osteopathic Physicians EROP, downloaded 05/2009).

Differences in curricula of osteopathic colleges

Because of the lack of regulation by the state, some colleges in the United Kingdom tried to set themselves apart from other, qualitatively inferior colleges, in order to assure themselves of (at least) a certain degree of legitimacy and respectability: It was the BSO, BCNO and ESO which voluntarily included intensive basic instruction in the sciences, like biology, anatomy, physiology and pathology, in their curriculum (Bear, 1984a).
Here there are parallels with still other European countries, where the level of training continues to vary in part even today (for example, in Belgium, with its higher number of existing schools compared with the lower number of schools recognized by the GNRPO [personal communication, van Dun, 03/2009]. The same applies to Germany; see DVO and VOD, downloaded 05/2009): The reasons probably lie in the differences both in the scope of the curricula of the schools and in their quality. Evidently the curricula are adapted (up to a certain degree) to the students' interests (see section 4.3., i.e. BSO, as well as the reasons

stated for the creation of other osteopathic schools in the UK, and van Dun (2008b)). Abhesera [downloaded 2008a, n.p.] even likens the students' attitude towards osteopathic education to a restaurant menu selection. At the same time, he notes, students generally do not question the purposefulness of allopathic medical study (with its curriculum) in their case.
We may attribute the adaptation of the curricula to the students' desires both to the pressure of competition among the students and to the goal of attracting as many potential students as possible.
Another approach the schools take to acquire respectability is to offer osteopathic training in combination with an academic degree (BSc and/or MSc) [cf. the ESO in the UK and the Wiener Schule für Osteopathie in Austria, downloaded 05/2009].

We find noteworthy parallels to the USA if we recall our remarks in section 4.1.3 on the US colleges and their different curricula.
In the absence of any official regulation of osteopathic education, the US osteopathic colleges varied in their requirements on the students and in the quality these institutions provided. Moreover, those colleges aggressively competing with one another financially relied on tuition fees (see section 4.1.1). The dependence on tuition also limited the schools in their endeavor to set higher admission requirements and quality requirements on the students. But the Flexner Report soon equalized the levels of the schools (even long before the advent of state recognition), with the consequence that many schools had to shut down early because of inferior quality.

The latter situation represented another difference from the United Kingdom (and therefore for Europe), where no sort of Flexner Report existed.
In the case of France, however, the schools also underwent a selection process (first by an independent committee, then by the ministry of health) when there were more than 80 schools applying for accreditation. Following a (quality) test of the schools (which could not correspond to a Flexner Report, however), accreditation was granted only to twelve schools for a period of four years. For reasons unknown to us, the number was then further increased to 47 schools (personal communication, Zegarra-Parodi, 05/2009).

Osteopathic education

In sections 4.2.2 and 4.2.3.1 we described the problems brought on by the booming business of osteopathic colleges in the USA, manifested in, among other ways, too few qualitatively good osteopathic instructor teams and too few postdoctoral programs for osteopathic students. Here again we find a similarity with Europe, namely in the considerable number of schools emerging within the shortest period of time in the trend towards osteopathy. In the case of

Germany, since the initial dissemination of osteopathy at the end of the 1980s (with consequently a very young history of osteopathy), eleven schools have been established, most of which still have branches [Verband der Osteopathen Deutschlands, downloaded 05/2009]. This list does not yet contain the International Academy of Osteopathy (IAO), which alone has 14 locations in Germany [IAO, downloaded 05/2009]. We find this number of institutions quite large, given the 23 osteopathic colleges at 26 locations in the USA, where osteopathy is over 100 years older and the country much larger. As in the case of the USA, the question arises as to where the rapidly increasing number of osteopathic schools are recruiting the many needed instructors. And the second question, also regarding quality, is how high these schools' chances are for developing the tie to a university. The number of universities offering a degree in osteopathy or cooperating with private osteopathic schools is still very small to date.

Professional organizations

The proliferation of professional organizations is related to, among other things, these varying levels of quality of the competing schools. Students of the ASO consequently founded the AOA in 1901. On the other hand, people like Elmer and Helen Barber wanted to spread osteopathy to everyone and assured them that it was possible to become an osteopath even without studying at an osteopathic college, even going so far as to sell DO titles (Gevitz, 2004, pp. 51-52). The Barbers damaged the reputation of osteopathy at the time (quite to the benefit of the allopaths) and catapulted Still and his followers into a defensive stance. The latter had only the one possibility of publicly disassociating themselves from the Barbers and distinguishing themselves through good quality in training at the ASO (see section 4.1.1). This was similar to the notion of freelance osteopaths in the UK and the rest of Europe, where osteopathy was often marketed to other health professions as a set of techniques (cf. Guillaume, 2002) requiring only a quick course of training (Dvorak et al., 2001; brochure of the Lower Saxony Academy for Homeopathy and Naturopathic Treatment (NHAN), 2008, see Appendix F). The charge of *imitation* was also raised, specifically in reference to the chiropractors (Gevitz, 2004, p. 66; cf. section 4.1.1) then proliferating both in the USA and in Europe (i.e. the UK) in parallel with osteopathy.

These freelance osteopaths were a second reason for the emergence of organized associations like the AOA in the USA and (e.g.) the BOA and OAGB in the UK, the Société Belge d'Ostéopathie (SBO-BVO) in Belgium, etc. The common goal was to a certain extent quality assurance and demarcation from the freelance osteopaths. Numerous associations formed in the European countries, and in turn combined under umbrella associations in the interest of a uniform and strong policy vis-à-vis state recognition.

Again we find parallels between osteopaths in the USA, the UK and (e.g.) Belgium when we consider the quarrels and discussions *within* the profession: In the USA part of the osteopathic

physicians (DOs) struggled against holders of the MDDO title and against the "little mds" (see section 4.1.3) who had entered the Californian merger. In the UK there arose a conflict with the naturopathic osteopaths (NDs) and the DOs, while in Belgium the GNRPO quarreled with the Union of the Certificated Physiotherapists and Osteopaths (Unie voor gediplomeerden in de Kinesitherapie en de Osteopathie), an association for osteopathically operating physiotherapists (UKO, downloaded 05/2009, personal communication, van Dun, 05/2009).

Still other parallels exist between European (i.e. UK) and US osteopathy:

The struggle with osteopathic professional identity

Both forms of osteopathy are struggling for their identity: US osteopathy because of its inadequate distinctiveness from allopathy, the UK osteopathy because of its questionable differentiation from other manipulative professions such as chiropractic and physiotherapy (Tyreman in Fossum, 2002, p. 35). In reference to physiotherapy and other manual forms of medicine (manual medicine and chiropractic), we may equally speak of "amalgamation" (as in the US history of osteopathy; cf. the Californian merger discussed in section 4.1.3), since in other European countries, like Austria and Germany, osteopathy is practiced by physiotherapists and allopathically trained physicians, among others (Guillaume, 2002; Krönke, 2006; VOD List of Therapists, downloaded 03/2009; EROP, downloaded 05/2009). Dvorak et al. (2001) are even of the opinion that osteopathy as a distinct profession is not a useful concept and that the field could be integrated in the preexisting structure of medicine.

In his “Investigation of Students’ Attitudes on OPP – a Comparative Study,” Fossum (2002, p. 24) writes that an identity crisis in osteopathy prevails in both countries (the USA and the UK). He is of the opinion that both forms of osteopathy had to struggle with the constantly changing nature of osteopathic education and its practice as well as against external threats to the osteopathic profession from allopathic medicine and other forms of therapy. Although US and UK osteopathy developed differently, both see their professional distinctiveness to lie in their identification with the OPPs and in the application of OMT. Fossum basically attributes the UK identity crisis to political strategies applied by the General Osteopathic Council, among others, as *the* driving force behind the Osteopaths Bill (see also Tyreman, 1998), which limited the scope of practice primarily to musculoskeletal conditions.
Korr (1997b, p.167) also states that a basic part of the AOA's policy led to insufficient distinctiveness, namely when the association began to highlight osteopathic medicine at the expense of allopathy, ultimately leading to the de-emphasis of OMT in US osteopathy (see section 4.2.3.1).

Social invisibility

Both UK and US osteopaths struggled for a certain period of time with their reputation as practitioners limited to musculoskeletal illnesses, and were not known as general practitioners with a broad area of competence (Gevitz, 1998, p. 130; Bear, 1984a). US osteopathy managed more successfully to shed this reputation than did UK osteopathy by developing numerous medical specializations, among other things.

Questions about the scope of practice and the true osteopathic mission

Still another parallel can be drawn between UK and US osteopathy: In recent years UK osteopathy has raised the question whether the osteopathic profession should avail itself of the legally protected privilege of limited prescribing, since the Health and Social Care Act of 2001 authorizes the Under-Secretary of State to grant osteopaths the right to prescribe and administer certain drugs.

A study by the BOA in 2001 showed that the majority of members surveyed supported utilizing the right to prescribe medication (in Grundy and Vogel, 2005). True, the response rate (500 replies = 30%) was very low compared with the number of people surveyed (1600 = approximately 50% of the UK profession), making the representability of this study questionable. Nor was membership in the BOA representative of the *entire* osteopathic profession.

In a second randomized survey of 150 UK osteopaths, Duquemin (in Grundy and Vogel, 2005) found that osteopaths as a professional group were evenly divided on this subject, with 32% in favor, 32% undecided and 36% against. While the study had a higher response rate (52%) than that of the BOA, its sample size was smaller. Nevertheless, the study represented about 5% of the osteopathic profession, and has a certain significance given the randomization and the response rate.

As we know, the same debate began over the scope of practice and the use of adjuncts (in this case: materia medica) very early in the US history of osteopathy (see section 4.1.1).

The UK discussion involved various arguments over the integration of pharmaceutics (cf. Grundy and Vogel, 2005 and Sacral Musings, downloaded 05/2009) that recall the US discussion on "lesion" versus "broad" osteopaths and on "three-finger" versus "ten-finger" osteopathy. The arguments concern the scope of practice, the actual mission of the osteopathic profession and the duty to integrate conventional and standard medical knowledge (see section 4.1.2).

Those members of the osteopathic professional group in Duquemin's study (in Grundy and Vogel, 2005) advocating prescribing rights (28% of the respondents) see therein the possibility of providing more effective pain relief for acute patients. The others, who are against

prescribing rights (29% of the respondents in the survey by Duquemin; see above) fear a departure from osteopathic principles and the loss of the professional identity of osteopathy as an alternative or complementary form of medicine. They also fear that overconfidence in drugs could lead to a loss of manipulative and palpatory skills.

The parallel to US osteopathy becomes even clearer when we recall Gevitz (2004, p. 103), Johnson and Kurtz (2001) and the reasons for the decline of OMT discussed in section 4.2.

Duquemin's study (in Grundy and Vogel, 2005) states further reasons, like the possible misuse of drugs, increases in insurance premiums and more frequent litigation.

Grundy and Vogel (2005) decided on conducting a qualitative study of the attitudes towards prescribing rights in the UK in order to examine the underlying beliefs. They were of the opinion that some of the statements in Duquemin's study and in the public discussions by Cotton and Snelling (in Grundy and Vogel, 2005) may have contained a very central and emotional subject for the osteopaths pertaining to their professional identity, and the qualitative study was intended to register these attitudes and beliefs. The study was also to provide a further basis for discussing prescribing rights. The study concluded by noting the broad spectrum of attitudes manifesting an equally broad range of underlying ideological beliefs and values. The issues emerging in the discussions were partly pragmatic and partly ideological. The pragmatic issues could be subdivided into clinical and professional concerns. The ideological beliefs and values were closely related to the participants' world views and to their perceived roles as health carers. Issues such as those concerning osteopathic principles and the "definition" of the osteopath were closely related to personal (self-) identity, to personal self-esteem and to the self-confidence of the surveyed osteopaths. They reflected the life role that the osteopaths chose with their vocation. The beliefs and values therefore basically governed the osteopaths' attitudes in discussions on prescribing rights. They were equally determinative of the views on other (related) crucial professional issues, like the scope of practice and the role of osteopathy in health care. Grundy and Vogel concluded that a whole range of issues of ideological, professional and clinical nature underlay the decision on prescribing rights, and that the diversity in the osteopathic professional group's attitudes as brought to light by the study could stand in the way of the constitution of a coherent professional identity.

The mixing with other therapeutics

In both US and UK osteopathy osteopathic practice has been "enriched" with other methods of treatment: As we already know, US osteopathy was greatly influenced by allopathic remedies; studies on the practices of UK osteopaths show that only 49% performed strictly osteopathic treatment, while 51% also made use of other methods (Vogel and Herrik, 2008). We will be discussing Vogel and Herrik's study in more detail at a later time. Here we can also mention a

study by Krönke (2006) documenting that Austrian osteopathy is combined with other forms of therapy. We'll also turn to this study later on.

Osteopathy and osteopathic medicine

As already noted, in the USA osteopathy adopted "osteopathic medicine" as its professional designation. The DOs accordingly no longer called themselves osteopaths, but rather osteopathic physicians. In Europe both designations exist, but unlike in the USA they are used simultaneously. Osteopaths are *sometimes* those practitioners with a prior therapeutic occupation (or in the case of Germany they are *Heilpraktiker* (complimentary health practitioners)), while osteopathic physicians are those with medicine as their prior occupation (cf. Dvorak et al., 2001; EROP Declaration on Osteopathy, 2008); we should add, however, that this separation is not "official", as is evident from (e.g.) the names of some osteopathic schools that train both physicians and physiotherapists (among others). Examples are the "Privat Schule für Klassische Osteopathische Medizin" (Private School of Classical Osteopathic Medicine) [SKOM, downloaded 05/2009] and the German College of Osteopathic Medicine [GCOM, downloaded 05/2009]. Both *osteopathic medicine* and *osteopathy* therefore designate the osteopathic profession in its entirety. The terminological distinction seems primarily to occur in the physicians' own usage (in reference to prior occupations).
Our research also revealed extensive cooperation between (some) European osteopathic physicians, the members of the German Association for Osteopathic Medicine [Deutscher Verband für Osteopathische Medizin (DVOM) e.V., downloaded 05/2009] and some US physicians (members of Nova University, Fort Lauderdale, Florida).

4.5 Osteopathic identity in Europe (i.e. the United Kingdom)

UK osteopathy continues to struggle with identity issues (Fossum, 2002, p. 36). In 1984 it had the status of a marginal profession, similar to that of chiropractic in the USA, the United Kingdom and other countries (Bear, 1984a).
While osteopathy has been officially recognized as a first branch of complementary medicine in the United Kingdom since 1993, and, according to Maxwell (1993), has become a self-sufficient profession independent of medical delegation, it remains a marginal profession, but also a distinct clinical discipline, in the United Kingdom (Bear, 1984a; Tyreman, 1998; Fossum 2002, p. 33).
The literature describes UK osteopathy as having remained a strictly manipulative profession without the opportunity of becoming a full-medical practice (including pharmacology and surgery) (Fossum, 2002, p. 33).

The question, then, is whether osteopathic medicine may be considered a full-medical practice *only if* the former includes pharmacology and surgery. This question ties in with the current discussion in the UK on prescribing rights for osteopaths (Grundy and Vogel, 2005; Sacral Musings, downloaded 05/2009).

Sommerfeld (2009) finds the view of osteopathy as a marginal profession not limited to the UK, but rather common throughout Europe, with the search for (osteopathic) identity being motivated by just this marginality. He adds that an identity generally forms by way of a demarcation from others.
As noted in section 3.1., Assman and Friese also speak of identity as formed through the establishment of boundaries.
Recalling the history of UK osteopathy (and the British Naturopathic and Osteopathic Association (BNOA), for example), we see that these boundaries were "fluid" vis-à-vis other health care professions. The boundaries are perhaps equally fluid in other European countries, where hitherto osteopathy has not been recognized as an independent profession with a clearly defined scope of practice, especially if in these countries osteopathy is practiced by allopathically trained physicians, physiotherapists (and *Heilpraktiker*) who do not apply osteopathy *exclusively* because of their (conceptual) adherence to their previous professions. The question is then how osteopathic identity can develop on this basis.

In asking the “feared” question: "Osteopathy: Physiotherapist with Time or the Practitioner with Healing Hands?" Tyreman (1998, p. 124) begins by noting the identity crisis in UK osteopathy. He describes its 100 + year history as a development "on the fringes of health care provision and in the shadow of conventional medicine [...]", and explains:

> "[...] it has found itself suddenly accepted by an establishment previously sceptical about its claims and even hostile to its right to practice. The rapidity of the turnabout, I contend, has left the osteopathic community in a dilemma about whether it is a branch of modern medicine drawing sustenance from scientific medical research and focusing on disease as the explanation of illness, or an autonomous profession rooted in its own unique traditions."
> (Tyreman, 1998, p. 124)

Several studies and facts give an impression of the activities of the European osteopaths and of the identity[35] expressed by these activities.

[35] Recall that all possible modes of linguistic and other behavior (including the field of activity) serve as the media and means of expression of identity.

4.5.1 Scope of practice as an expression of identity

Scope of practice in the UK

As already mentioned, UK osteopathy defined itself as conventional modern practice mainly through the General Council and Register of Osteopaths (GCRO), and primarily focused on the treatment of musculoskeletal complaints. In this way it hoped to improve its chances for statutory regulation (cf. Bear 1984a, Tyreman in Fossum, 2002, p. 33).

A few years later, however, osteopaths had the opportunity to lobby for limited prescribing rights. Since the aforementioned quantitative studies by the BAO and by Duquemin (in Grundy and Vogel, 2005) alone did not suffice (see section 4.4.2), in a further study Grundy and Vogel examined the attitudes and beliefs of UK osteopaths on the role of prescriptions in osteopathy. But the authors conceded that even this study had its limits, given its preliminary character. The models used had not been previously tested, while the study had a non-representative bias and was therefore not generalizable. Grundy and Vogel consequently proposed further studies as *necessary,* to serve as the basis for a decision on a professional and regulatory level. As we can see from the homepage of Sacral Musings [downloaded 05/2009], however, a decision on this matter has evidently not occurred to date.

If we look at the study by Vogel and Herrik (2008), "Service Delivery Characteristics of UK Osteopaths – a Cross Sectional Survey," we get an idea of what a practicing osteopath offers his or her patients: Besides osteopathy, an additional 16% / 10% of the surveyed osteopaths provide dry needling or acupuncture, 22% electrotherapy, 19% nutritional therapy and 7% homeopathy.
Altogether nearly 51% of the surveyed osteopaths combine osteopathy with another form of therapy. Only 49%, therefore, pursue a strictly osteopathic practice.
We must add that the results of this study have only limited validity due to the bias in the collection of data. Nevertheless, 791 osteopaths participated in the survey, providing 652 responses for the study – enough to indicate definite trends. The average professional experience was 15.4 years.

Having acquainted ourselves with the history of osteopathy in the UK, we can now put together the pieces of our puzzle. As we know, many interactions and mergers occurred between osteopaths, chiropractors and naturopaths, so that it comes as no surprise when Fossum (2002, p. 33) writes that for the last 50 years UK osteopathy has been struggling to define its scope and limits of practice, as well as its distinctiveness from other manipulative professions like physiotherapy and chiropractic. The history also explains why many osteopaths today are

extending their scope of practice to other forms of therapy, as is also reflected by the curricula of the colleges.
Naturally we must then raise the question of the identity of osteopathy today (as already mentioned so often above).

Scope of practice and the qualification of osteopaths in Belgium and the UK

Noteworthy among the results of Vandenberghe's (2008) study on "The Practice of Osteopathy – a Comparison between Belgium and UK" is that 42% of the osteopaths surveyed in the UK have the DO title and 58% a Bachelor of Science (BSc). In Belgium, on the other hand, 93% of the respondents had DOs and 7% BSc degrees.
91% of Belgian osteopaths and 45% of UK osteopaths had other healthcare qualifications, with most coming from physiotherapy (0% in the UK, 87% in Belgium), acupuncture (17% in the UK, 13% in Belgium), massage (15% in the UK, 11% in Belgium) and naturopathy (15% in the UK, 7% in Belgium). The remaining percentages were taken up by other therapeutic methods, such as reflexology, Reiki, meditation, aromatherapy, psychotherapy, homeopathy, shiatsu, medicine and chiropractic.
The survey yielded 376 usable responses (202 for the UK and 174 for Belgium) from 700 contacted osteopaths, and had limited generalizability. The study moreover neglected to examine whether the osteopaths were still exercising their specified healthcare qualifications at the time of the survey and combining them with the practice of osteopathy.
The survey of the osteopaths' specializations (for all types of osteopathy) in the UK and Belgium yielded the following results: cranial (47% in the UK, 36% in Belgium), obstetrics/pregnancy (30% in the UK, 16% in Belgium), pediatrics/children (43% in the UK, 39% in Belgium), somato-emotional (14% in the UK, 24% in Belgium), sport injuries (42% in the UK, 21% in Belgium) and visceral (14% in the UK, 35% in Belgium).
Unclear is why Vandenberghe speaks of "specializations" with respect to these osteopathic subfields, which in our view form part of basic osteopathic training.

Scope of practice in Austria

Krönke's (2006) questionnaire for evaluating the professional field of osteopathy in Austria yielded interesting results regarding "additional therapeutics" and "primary profession". While this small study is hardly generalizable, it does suggest some trends. It is also the sole source of information for Austria.
192 Austrian osteopaths were contacted, 107 of whom responded, corresponding to a response rate of 56%. Ultimately only 70 responses could be evaluated, however (owing to errors). Of the 70 people surveyed, all had passed their final exams in osteopathy: 66 were

graduates of the School of Osteopathy in Vienna and four had graduated from other schools. Altogether 26 of the 70 participants had a diploma in osteopathy.
The primary professions included nine general practitioners (13%), five specialists (7%), 54 physiotherapists (77%), one "medical technician" and one medical doctor in education (together, 3%).
The results showed that 14% worked only as fulltime-osteopaths while 86% were still practicing their primary profession, with an average of 20.5% of their work time devoted to their primary profession and 79.5% to osteopathy.
Methods applied in addition to osteopathy (all less than 20%) were Bach flower remedies, aromatherapy, TCM, kinesiology, acupuncture, homeopathy, neural therapy, orthomolecular medicine and other methods (like manual lymph drainage, reflex zone treatment, yoga, magnetic therapy, Feldenkrais, etc.). Unfortunately more precise percentages are not provided, and we are left with only a rough graph.
The largest number of osteopaths (61% of the people surveyed) also practiced physiotherapy.
The study provided still other noteworthy information: 93% of the active osteopaths were self-employed, while 7% were working as employees. Six per cent responded to the question: "Do you specialize in a medical field in your osteopathic work?" with "pediatrics".

Remarkably, few of the Austrian osteopaths actually worked in their offices as "osteopaths" (i.e. full-time), and very often offered mixed therapies. Here we see parallels to the United Kingdom, since some of the therapists overlapped in the supplemental treatments they offered (acupuncture, homeopathy, aromatherapy). Both groups of osteopaths also exhibited a trend towards *alternative therapies* (Reiki, meditation, Bach flower remedies, etc.). Here again the question of osteopathic identity and its distinctiveness from other health care methods arises.

Altogether, only few qualitative studies in Europe reflect the practices of osteopaths, while such studies are actually needed in every European country.

4.5.2 Factions within European osteopathy

As already mentioned in section 4.4.2, a conceptual distinction is sometimes made between "osteopath" and "osteopathic physician" that is open to discussion given the common training institutes and the existence of associations all representing osteopaths (osteopathic "factions") in common, irrespective of their prior professions. Three possible examples of such associations are the Deutsche Gesellschaft für Osteopathische Medizin e.V., (German Society for Osteopathic Medicine), the Verband der Osteopathen Deutschlands (Association of German Osteopaths) [DGOM and VOD, respectively, downloaded 05/2009] and the Österreichische Gesellschaft für Osteopathie (Austrian Society for Osteopathy) [ÖGO,

downloaded 03/2009]. A possible reason for the conceptual distinction is the availability of part-time training in osteopathy for medically pretrained professional groups (such as physicians, physiotherapists, *Heilpraktiker* (in the case of Germany), etc.) [Bundesarbeitsgemeinschaft Osteopathie (Federal Association of Osteopaths), downloaded 05/2009], while in those countries (e.g. Germany and Austria) where osteopathy is (still) not recognized as an independent profession it is a mandatory requirement that the titles from the prior professions be still displayed. Evidently for this reason the designations of the prior professions are appended to that of osteopathy in Europe (see the lists of osteopaths of the VOD and ÖGO [downloaded 05/2009]). On the other hand, in France and Belgium, for example, osteopaths publicly identified themselves "merely" as osteopaths from the outset (personal communication, van Dun, 05/2009).

Regarding the division of the osteopathic professional group into factions it is also noteworthy that the European Register of Osteopathic Physicians (see the EROP Declaration on Osteopathy in 2008) distinguishes the *osteopath's* field of activity from that of the *osteopathic physician* insofar as the *osteopaths* are excluded from gynecology, pharmacotherapy and surgery. This fact raises questions at least in the case of *Heilpraktiker*, however, who are allowed to perform services in gynecology apart from the treatment of infectious diseases (see the *Heilpraktikergesetz* [German Non-Medical Practitioners Act], downloaded 05/2009]. The role pharmacology should play in osteopathy *generally* is also an issue (we refer here to the UK discussion, see section 4.4.2). The meaningfulness and the content of this conceptual distinction within the osteopathic profession must be critically examined. We do not further discuss the different definitions (of the osteopaths, the osteopathic physician, etc.) of the EROP, as the numerous definitions from other associations would extend beyond the confines of this thesis.

But Abhesera discusses still other trends towards divisions within the profession [a and b downloaded 03/2008, n.d.]. He even speaks of a *split* of the osteopathic professional group into structural osteopaths and functional or even cranial osteopaths, noting that they've lost their common language. He also claims that differing in their techniques and principles each group does not believe in the *value of the other group's osteopathy*. According to Abhesera, structural osteopaths believe that cranial osteopathy involves no more than a "very light scalp massage," while cranial osteopaths regard high-velocity, low-amplitude impulses (thrusts) "as gross, violent assaults on the tissues". He also includes a third faction, the "US osteopathic physicians," as distinct from the other two groups.
Finally, Abhesera draws a connection between the old and new concepts: Still's "healing" became cranio-sacral osteopathy and "bone-setting" became "structural osteopathy". Abhesera sometimes refers to his own type of osteopathy as "connective osteopathy" and

sometimes as "connective therapy". The models of medicine, healing and bone-setting have "cross-fertilized" in his mind, yielding his own terminology.
We have, then, yet another designation for osteopathy (this time from Abhesera), and we must ask how the profession is to reach a consensus on these tags.

Summary

While these conceptual distinctions and the different self-characterizations indicate the existence of “factions” within the osteopathic professional group, the bearing of such factions on the struggle for a common professional identity of osteopathy in Europe remains an open question.

4.5.3 Osteopathy as an independent profession? – Pros and cons

In their (previously mentioned) article, Dvorak et al. (2001) compare three manual forms of medicine (osteopathy, chiropractic and manual medicine *per se*) in terms of their training programs, self-definitions and their diagnostic and therapeutic measures. Interestingly, the European Board of Osteopathic Medicine (EBOM) commissioned the writers with evaluating the situation of osteopathic medicine in Europe. The writers conclude from their comparison of the three professional groups (Dr. med., DO and DC) "that both physicians trained in manual medicine and chiropractors have comprehensive basic training and competence in osteopathic techniques and procedures […],"so that "the establishment of new health professions [like osteopathy] and the founding of new institutions and schools are not necessary or useful" (Dvorak et al., 2001, p. 71)[36]. We should add that the literature search for this comparison was rather modest and limited to three "pertinent glossaries" (textbooks in chiropractic, osteopathy and manual medicine). Diagnostic as well as therapeutic content was compared on the basis of this literature. Studies from practice were not considered.

The conclusions by Dvorak et al. contrast with Tyreman's treatment of "The Concept of Function in Osteopathy and Conventional Medicine: A Comparative Study" (Tyreman, 2001) and with studies by Carey et al. (2003) and Pincus et al. (2006).

Tyreman's (2001) case studies examined the concept of function as applied by osteopathic medicine and conventional medicine in their clinical theories and in practice. He compared responses to case vignettes (by an osteopath, general practitioner and orthopedic surgeon) as

[36] Original: „dass sowohl manualmedizinisch ausgebildetete Ärzte als auch Chiropraktoren eine umfassende Grundausbildung und Kompetenz in den osteopathischen Techniken und Verfahren haben […]“ und somit “die Etablierung neuer Gesundheitsberufe, [wie die Osteopathie] und die Gründung von neuen Institutionen und Lehrstätten nicht notwendig und nicht sinnvoll [sei]” (Dvorak et al., 2001, p. 71).

well as responses to a patient study (by an osteopath, physiotherapist and orthopedic surgeon).

The study is an example of how the investigation of different forms of medicine and their concepts presupposes a detailed and exact study such as Tyreman's, for just such an exact analysis brings the differences to light. We mention only some of the writer's results, to avoid unnecessary detail: Tyreman writes (in section 3.4. of Part 2 of his study) that he found significant differences in the diagnoses as performed by the osteopath on the one hand and the orthopedic surgeon on the other. In the case vignettes the interpretation of psychosocial factors also varied between the professions studied.

One of Tyreman's other results (p. 115) is the *prima facie* differences between the ways osteopathy and conventional medicine (as exemplified by the orthopedics studied) understand musculoskeletal problems (at least in his examples). The writer also finds two different concepts of function being applied in practice, with both concepts applied by all practitioners, though to different degrees (p. 248).

The study therefore indicates that differences may very well exist in the activities of osteopaths compared with those of "related" professional groups (like orthopedic surgeons).

Still other studies indicate distinctiveness: Carey et al. (2003, p. 313) examined whether osteopathic primary care physicians' interactions with patients reflected the principles of osteopathic medicine compared with allopathic physicians' interactions. The osteopathic principles were correlated with recordable speech patterns: 54 patient visits to 7 allopathic and 11 osteopathic primary care physicians in Maine (for screening, physicals, headache, low back pain, and hypertension) were recorded on audiotape and dual-abstracted.

The writers found that the "osteopathic physicians were easily distinguishable from allopathic physicians by their verbal interactions with patients."

Pincus et al. (2006) compared attitudes to back pain among musculoskeletal practitioners: chiropractors (CPs), osteopaths (OPs) and physiotherapists (PTs) within the UK. The writers used a validated questionnaire on "The Attitudes to Back Pain Scale in Musculoskeletal Practitioners (ABS-mp)". The cross-sectional survey covered 300 persons from each professional group (n = 900). Responses from 465 practitioners were analyzed, consisting of 132 chiropractors (28%), 159 osteopaths (34%) and 174% physiotherapists (37%). The results concerned only attitudes and not actual behavior, however.

The study identified attitudinal similarities and differences between the main musculoskeletal practitioners who treat LBP, namely CPs, OPs and PTs. All three groups manifested a psychosocial approach to their patients, and regarded reactivation as the primary goal of treatment. On the other hand, the PTs tended to endorse limited treatment sessions more than the osteopaths, who in turn endorsed such limitations more than the CPs. The writers

conclude that professional grouping seems to explain only some of the differences in the practitioners' attitudes and beliefs. While the professions' attitudes are similar to a certain degree, the study again clearly indicates the need for further studies to include practical activities for the purpose of a "complete" comparison of the professions.

We can add a personal communication by Tyreman (2007) made during an international MSc course at the Osteopathic School in Vienna. Tyreman reported (unpublished remark) that an MSc course of the BSO also made the comparison between CPs, OPs and PTs. In fact, the three groups were quite similar in their theoretical concepts, while differing considerably in practice. In other words, significant differences existed in how the spoken word was put into practice among all three professions, but especially among the CPs.
This discrepancy must be kept in mind when seeking to determine the nature of osteopathy on the basis of uttered or written definitions and professional profiles. As Tyreman says, "practical knowledge needs practical language" (personal communication, 2007).

4.5.4 The professional profile of osteopathy – a possible picture for Europe?

So far there has been no official professional profile defining the scope of practice of osteopathy in Europe. At present the European Federation of Osteopaths (EFO) and the Forum for Osteopathic Regulation in Europe (FORE) are jointly working on such a profile. Initial proposals (guidelines) of the EFO, such as the European Charter of Ethics of the Professional Associations, the Deontological Code of European Osteopaths and the Framework of Professional Activity of the European Osteopath, are already available (personal communication, Rousseau 03/2009). FORE has elaborated proposals (guidelines) in the form of the European Framework for Standards of Osteopathic Practice (EFSOP), European Framework for Codes of Osteopathic Practice (EFCOP), and the European Framework for Standards of Osteopathic Education and Training (EFSOET) [FORE, downloaded 03/2009].

If we want to sketch a *possible* image of osteopathy as a "profession," however, then van Dun's (2008c) description in his "Reflecties over CAMs" (Reflections on CAMs) is *one* possible basis: The osteopath's field lies within primary health care, so that no referral by a physician is required and the osteopath performs a function akin to that of the family doctor. The osteopath works together as much as possible with other specialists and disciplines in health care to the extent agreed to by the patient and to the extent necessary for the patient. The autonomy of the osteopathic profession pertains to the individual osteopath in his or her actions (expertise, diagnostics, safety, due diligence), attitude (respect, handling of patient information, sense of responsibility, professional discretion and confidentiality) and organization (expediency, insurance protection, right of action) (van Dun, 2008c).

Osteopaths are either self-employed, exercising their profession in their own practices or in joint practices, or they are employed by other practices or they are civil servants or agents in public institutions (Deontological Code of European Osteopaths (EFO), 2008, unpublished).
Osteopaths do not make a claim to *full* authority in all areas of health and illness. Osteopaths are *nevertheless* active in the overall field of health and illness. That is to say, osteopaths do not limit themselves to a certain area of health care. Osteopaths are autonomous in the practice of their profession. They are able to exercise and evaluate their profession both diagnostically and therapeutically. They know both the possibilities and the limits of their profession, and conduct themselves accordingly (van Dun, 2008c).

4.5.5 Problems in the search of a definition for osteopathy

There are numerous possible definitions of osteopathy (Abhesera, 1986; Tanguy, 2005; Tyreman, teaching material, 2007; Corriat, n.d.). The definitions vary in content, length and terminology.

In the case of the United Kingdom, for example, Tanguy (2005, p. 23) writes in his review of the literature that no definition of osteopathy has been *declared as such* by the General Osteopathic Council (GOsC) (in other words, the word "definition" is not used). We have instead a description of osteopathy under the heading "About Osteopathy". Regarding the content of this *description*, Tanguy writes: "the GOsC can be described as both vague and old-fashioned, with no innovative concepts, or discouraged from establishing a proper definition for osteopathy" (Tanguy, 2005, p. 24).[37] The writer adds, however, that the task of producing a definition in not incumbent on the GOsC alone, but rather falls to the entire osteopathic profession.
We may add Fossum (2002, p. 40), who also takes a critical stance: “[...] the osteopathic profession in the United Kingdom has done a bad job in defining themselves as a profession."
But why has a profession like osteopathy had so much difficulty in coming up with a definition of itself? And why does the GOsC's "definition" count as a description? We now pursue these two questions in further detail, beginning with a letter from Edna Lay to Madeline Rathjen, Secretary of the Cranial Academy (in Corriat, n.d., p. 110). This letter contains Lay's reply to Rathjen's request for help in producing a definition of "cranial" osteopathy. While conceding that the previously published definition[38] is adequate for satisfying the majority of the osteopathic profession, Lay claims that it is less suitable for science, society and orthodox medicine. To quote: "My reason for this is that the terminology is strictly osteopathic and would

[37] The *description* of osteopathy Tanguy has in mind is still (as of March, 2009) that of the GOsC, and can be found in our website analysis in Appendix C.
[38] Lay is speaking here of a particular definition, which unfortunately we cannot specifically identify. Presumably she has in mind a pre-existing definition of "cranial".

not be understood by the other groups" (Lay in Corriat, n.d., p. 110). Lay is also of the opinion that instead of defining "cranial" it would be more reasonable to explain that "cranial" refers to the application of osteopathic principles to the craniosacral system.
Lay's further statements apply not only to the definition of "cranial," but to the definition of osteopathy *as such* as well. These statements make it clear that the attempts undertaken to define osteopathy over many years have failed because, as Lay says, it is not possible to encompass osteopathy in one or two paragraphs (equivalent in length to a definition). According to Lay, such definitions should therefore not even be *attempted*. Lay argues for this last point by pointing to her own experience as an instructor. She explains that in each course of instruction lasting over two academic years it costs her three hours a week to convey an understanding of the bare essentials of osteopathic principles to students.
She ends her letter with the following words:

> "If the person asking the question does not know what osteopathy is, or does not understand what osteopathic principles are, I suggest that they either enter an osteopathic college or give me about seventy hours of their time for a period of several months to explain these subjects."
> (Edna Lay in Corriat, n.d., p. 110).

Tanguy (2005), who conducted a study of the literature on the development of terminology in osteopathy, opens the discussion on whether it is meaningful *at all* to attempt a definition if one of the factors enabling osteopathy to survive over time lies not in its definition but in the description of *what osteopathy is*. He regards descriptions as conceptually flexible and elastic, allowing adaptation within the language of modern science and doing greater justice to the holistic concept of osteopathy.
Tanguy believes that a *description* of osteopathy based on the following points would be useful:

- "The values of A.T. Still
- distinguished from medical practice and definition
- acceptable to the general public and other health professions."
  (Tanguy, 2005, p.28)

As values from A.T. Still, osteopathic principles could be integrated in the definition and description of osteopathy (Tanguy, 2005, p. 30). While these principles would still characterize the original, distinctive osteopathic concept, they would no longer have to be regarded as specific to osteopathy, since they are already shared with other health professions like physiotherapy and regular medicine.
Following Tanguy, we conclude that the presence of the principles in a description of osteopathy can resolve neither the issue of the distinction from medicine and other health

professions nor the problem of a potential definition. In other words, osteopathic principles afford no solution to the osteopathic identity crisis.
Tanguy (2005, p. 17) also makes the critical observation on behalf of osteopathy that expressions like "system of medical practice" and "structural integrity" stand rather for a holistic concept in contrast to the etymology of the term "osteo-pathy". These expressions are used, however, to define osteopathy, among other purposes. Tanguy sees the antagonism to exist on two levels: "health (system of medical practice) versus disease (-pathy) and holistic (structural integrity) versus reductionism (osteo-)" (Tanguy, 2005, p.17). He also sees in this antagonism the reason for a permanent conflict between the etymology of the word "osteo-pathy" and "any random practical definition".

Abhesera [downloaded 03/2008a] also describes problems related to the name "osteopathy". He believes that the term limits education and practice as well as their definition, and that the term does not reflect the true resources of osteopathy. According to Abhesera, the name "osteopathy" cannot bring out a change in the paradigm, and this lack of change is leading the profession to its demise. He also [downloaded 03/2009a, b] brings up a second important point: The grouping into functional and structural osteopaths within the osteopathic profession (and later the concept of functional osteopaths will be superseded by that of cranial osteopaths) renders finding a definition additionally difficult: Who is now the true osteopath – one who lays on hands or one who "thrusts"?

We conclude this section by returning to some of the conclusions drawn by Tanguy (2005, pp. 84-85):

- Osteopathy does not have a clearly stated "body of knowledge" which delineates itself from other professions.
- A consensus on the definition of osteopathy in Europe is not well accepted and it is suggested that a benchmark statement for osteopathy might resolve the issue between the necessity to define osteopathy or to describe what osteopathy is. It would also provide a description that is identifiable to the osteopathic community but also to other health profession and to the general public.
- A definition of osteopathy in the USA appears to be medically orientated and osteopathy seems to drift towards a dominant practice of allopathy. The distinction between allopathy and osteopathy is consequently questioned.
- Medicalisation of the osteopathic terminology has contributed to a dysfunctional communication within the osteopathic community but also with other health professionals.
- Non medicalised terminology in the osteopathic language appears also to be misinterpreted.
- The switch of terminology between the osteopathic lesion concept and the somatic dysfunction does not appear to have resolved the problem of osteopathic communication.

- […]
- It could be suggested that the language of osteopathy has today not resolved the issue of osteopathic identity and the profession "osteopath" could be in danger of disappearance in the machinery of allopathic practice. […].
- The identity of osteopathy is therefore at stake not only in the USA but also in the UK.
  (Tanguy, 2005, pp. 84-85)

4.5.6 Possible definitions of osteopathy – three examples

In line with the general construction of our thesis, we begin with a definition of "US" osteopathy. Our second example is the definition of "UK" osteopathy currently formulated (March 2009) in the Osteopathic Practice Framework of the General Osteopathic Council (GOsC) and offered as an alternative to the definition by the GOsC (see Tanguy, 2005, p. 23 and also Appendix C). The third definition arose from the Convention Européene d'Osteopathie held in 1987 in Brussels, and to date might be regarded as a representative definition of osteopathy for Europe.

"What is osteopathic medicine?
Osteopathic medicine is a complete system of health care with the underlying philosophy of treating the whole person. Rather than just ameliorating symptoms Osteopathic Physicians use their special training to find the cause of a patient's suffering and restore health. Osteopathic Medicine emphasizes the interrelationship of structure and function, and honors the body's ability to heal itself."
(American Academy of Osteopathy, downloaded 05/2009)

"Osteopathy is an independent system of primary contact health care that focuses on the diagnosis, management treatment and prevention of musculoskeletal and other related disorders without the use of drugs or surgery. It is a patient-focused, rather than a condition / disease-centred approach to healthcare."
(General Osteopathic Council, 2009)

"Osteopathic medicine is a science, an art and a philosophy derived of [sic] health care supported by expanding scientific knowledge. Its philosophy embraces the concept of the unity of the living organism as structure and function. Its art is the application of its concepts to the medical practice in all its branches and specialties. Its science includes among others the behavioral, chemical, physical and biological knowledge, related to the establishment and maintenance of health as well as the prevention and alleviation of disease. Osteopathic concepts emphasize the following principles:

- The human body through a complex equilibrial system tends to be self-regulatory and self-healing in the face of disease processes.

- The human body is a unit in which structure and function are mutually and reciprocally interdependent.
- A rational treatment regimen is based on this philosophy and these principles. It favours a diagnosis approach and a manual therapy."

(Convention Européene d'Osteopathie, Brussels 1987 in Corriat, n.d., p. 79)

4.5.7 The identity-constituting features of osteopathy

The features of osteopathy constitutive of its identity include at first four main characteristics that we wish to discuss in turn (cf. van Dun, 2008b):

- The application of particular osteopathic concepts

The *four principles* (Kirksville Consensus Declaration, in Seffinger et al., 1997) are meant here. The principle of "the rule of the artery" may be added. We must add, however, that all these principles can no longer be exclusively evaluated for osteopathy, since (e.g.) allopathic medicine also rests on them (Peppin, 1993; van Dun, 2008b). Noteworthy differences may exist in the role played by the musculoskeletal system in the concept of health (among the different professions), however, as well as in the depth of application of these principles in daily practice (Tyreman, personal communication, 2007; van Dun, 2008b).

Another concept underlying osteopathy is that of *holistic medicine,* reflected in the aforementioned principles, among others. Peppin (1993) finds that this concept also offers no effective demarcation from other professions that equally embody holistic approaches.

The *hygiogenetic model* according to Heine (1997, p. 3) as well as the *salutogenetic model* of Antonovsky [English Wikipedia, *salutogenesis*, downloaded 05/2009] also share the concept of osteopathy. Both models, not identical despite the shared details, are related to the capacity of the body for autoregulation and self-healing, and are therefore characteristic of, but *not* specific to, osteopathy.

Tyreman (2001) also examined another important concept in osteopathy, namely the *concept of function*. He writes that functions on all levels (from the local functions of bodily parts to the functioning of a person in his physical and social surroundings) are contextual and that clinical decision making depends on how this context is understood and structured.
The function of an item is determinable not from its properties alone, but only relative to its ontological context. Tyreman gives the example of the human heart: It performs its function in the overall cardio-vascular system, even though its functional properties can be viewed in

isolation. That is to say, while the isolated functional properties of certain local bodily parts and organs play an important role in our knowledge of their capacities, these properties have clinical relevance only if they are understood *globally* (relative to the entire system of the body).

We therefore understand local functions, as well as possible *dys*functions, only if we consider the local functional activities in relationship to the person's agency ("the intention to act in a particular context," Tyreman, 2001, p. 297). Tyreman mentions as one example that of an injured knee, which can result in a person's immobility and consequently directly affect that person's ordinary intentions and abilities to act.

Activity is enabled in particular by the musculoskeletal system as its basis, which is also significant for understanding function (Tyreman, 2001, p. 297). A distinctive feature of osteopathy is its focus on dysfunctions in the individual human body and its attention to the contextual significance in the explanation of local functions. Osteopathy can here provide deeper insights because its diagnosis and treatment rest on a holistic concept that considers the body as a whole, from which osteopathy infers the significance of the body's parts. (The musculoskeletal system moreover constitutes one of the main areas of activity in osteopathy).

Tyreman adds that especially the primary care practitioners (including complementary or conventional medicine) regard illness (as interpreted and anamnestically reported by the patients *themselves*) in a larger context, which makes the work of primary care practitioners technically, psychologically and conceptually complex. He concludes:

> "Osteopathy has a special contribution to make from its explicit recognition of context in defining function all the way down from the global functioning of the person to the function of constitutive local parts. By identifying agency as the key to linking the rôle of context in the meaning of function statements to patients' intentions and self-perception, three elements that are important for (all) practitioners are made explicit: the context in which people and body parts act plus the structures formed by systemic relationships; the mental intentions of the agent and the way intentions provide a focus for action; finally, the extent to which the ability/capacity to act in ways that are taken-for-granted defines a person's perception of themselves as an agent, and informs judgements of whether or not they are ill." (Tyreman, 2001, p. 294)

- The manual form of diagnostics and therapy

Osteopathy as manual medicine primarily makes use of the sense of touch in its diagnostic and therapeutic approach to patients in the context of close physical contact. Drexeler (2009) notes that the manual approach has a certain effect on the patient-practitioner relationship, and that this effect must be considered essential from a phenomenological perspective.

The manual approach (with the osteopathic touch) forms a basis for the distinction from regular medicine, which primarily employs visual and equipment-supported diagnostics (Peppin, 1993; Drexeler, 2009). While the manual form of diagnostics and therapy is hardly any longer the sole area of activity in osteopathy, and is also applied in manual medicine, chiropractic, physiotherapy, etc., it does remain an essential feature of osteopathy. According to Peppin (1993) the only aspect discussed as possibly *specific* to osteopathy, is the "osteopathic touch". He further states that touch may have effects that we have only begun to understand.

Sommerfeld (2009), on the other hand, claims that the search for a specific characteristic like that of the "osteopathic touch" is a predictable consequence of the struggle for identity in the osteopathic professional group. In other words, the osteopathic professional group must seek a way to demarcate itself, and this way supposedly lies, in the "especially pronounced meticulousness, devotion and occasionally virtuosity concerning the handicraft of palpation" (Sommerfeld, 2009, p. 33)[39]. Seeking to demystify the concept of "osteopathic touch," the writer proposes its rationality (neutrality) for critical discussion.

In sum, while the osteopathic touch is a characteristic feature of osteopathy, whether it is *specific* to osteopathy and can therefore serve as a strong argument in the issue of osteopathy's distinction as a profession from other manual forms of medicine remains an open question.

- The performance of certain manual techniques in diagnosis and therapy

Some writers, like Mein et al. (2001), are convinced of a diversity in the performance of the manual techniques and advocate manifesting this diversity with devotion in manual-therapeutic studies. Van Dun (2008c) describes the diversity in performance more precisely, appealing to Bergmann (1992) and Vickers (1999): Most HVLA techniques in osteopathy employ long levers and apply little force to the affected anatomical structures. In contrast, chiropractic works with short levers.
Van Dun (personal communication 05/2009) recalls from the history of osteopathy (cf. Gevitz, 2004 and section 4.1.1 of this thesis) that many manual techniques *originally* came from osteopathy (and its forerunners), and only afterwards were adopted by the professions (like chiropractic, manual medicine and physiotherapy). Van Dun (2008c, p. 15) writes of a sort of "technical Darwinism" in which the more efficient techniques naturally come to prevail over

[39] "[…] besonders ausgeprägte Akribie, Hingabe und bisweilen auch Virtuosität, was das Handwerk der Palpation betrifft" (Sommerfeld, 2009, p. 33).

time and are then adopted and practiced by different professions as a result of increased interprofessional exchanges.[40]

- Primary care

We already gathered from different articles on American osteopathy that the latter initially asserted itself through its primary care activities in the US health industry (Meyer and Price, 1993; Gevitz, 1994; Cameron, 1998). This aspect no longer suffices for the distinction from the allopathic profession, however (Korr, 1997c, p. 184), since the latter itself has begun to fill the niche it left open in primary care; nevertheless primary care activities are constitutive of the identity of osteopathy.
Van Dun (2008b) also writes that in view of the historical development of the osteopathic profession in Europe and of its function, most European osteopathic professional associations, as well as the European Federation of Osteopaths, are of the opinion that the position of osteopathy lies in first-line medical care. According to these organizations, first-line medical care is all-encompassing, lifelong continuous health care (including emergency medical aid) embodying a humanistic orientation.

- The preventive character of osteopathy

Osteopathy is both preventive and curative (van Dun, 2008b; Drexeler, 2009). If, however, we assume that somatic dysfunction (as *the* field of activity of osteopathy) can be prodromal for a pathological change and that osteopathy as both adjuvant therapy and standard therapy already finds application in this early stage of illness (see the pertinent clinical studies in van Dun, 2007), then the decidedly preventive role of osteopathy becomes clear.

Summary:
All the above features (with the possible exception of the osteopathic touch) are no longer unique to osteopathy, and yet each serves as a characteristic constitutive of identity.
It is rather the *combination* of these characteristics within osteopathy that make it distinctive from other professions (van Dun, 2008b).
In a master's course at the Osteopathic School in Vienna Tyreman (personal communication, 2007) also mentioned three distinctive, but not unique, aspects of osteopathy: the wholeness of the body, the value of function and the value of touch. In other words, Tyreman is also of the opinion that only the combination of the characteristics *as such* provides the identity-constituting component for osteopathy.

[40] "Technical Darwinism" does not refer only to osteopathic techniques.

We add that the application *alone* of osteopathic techniques and concepts does not define the *essence* of osteopathy, since they can be equally learned in other manual professions (see above). It is rather the underlying "osteopathic thought process" that leads to the distinction according to the principle that the whole is greater than the sum of its parts, as when one and the same cooking recipe leads to differently tasting results when employed by *different* cooks.

4.5.8 Is osteopathic medicine alternative or complementary?

To answer this question, we should first survey the terminology:
The phrase *alternative medicine* is used throughout the modern Western world. It encompasses any healing practice "[…] that does not fall within the realm of conventional medicine" [Engl. Wikipedia, downloaded 04/2009] and its practices are as diverse in their foundations as in their methodologies. The term is frequently grouped with complementary medicine, which generally refers to the same interventions when used in conjunction with mainstream techniques, under the umbrella term *complementary and alternative medicine* (CAM) - although some significant researchers in alternative medicine oppose this grouping, preferring to emphasize differences of approach. The term *alternative* medicine is generally used to describe practices used independently or instead of conventional medicine and vice versa practices / therapies are termed as *complementary,* when used in conjunction with or to complement conventional treatments [English Wikipedia and The Alternative Medicine Home Page, downloaded 04/2009].
It is also said that *complementary medicine* may lack biomedical explanations, but as they become better researched some (such as physical therapy, diet, and acupuncture) become widely accepted [The Alternative Homepage, downloaded 2009].
On the other hand, the Merriam Webster Medical Dictionary [downloaded 04/2009] defines *complementary medicine* as "any of the parts of alternative medicine accepted and practiced by mainstream medical practitioners".

We see, generally speaking, that there is no clear and consistent definition as to the exact nature of alternative or complementary medicines. Various definitions and distinguishing characteristics have been offered by groups and individuals [English Wikipedia, downloaded 04/2009].
One of these is "The Panel on Definition and Description, CAM Research Methodology Conference" (Office of Alternative Medicine, National Institutes of Health, Bethesda, Maryland) which in April 1995 defined complementary and alternative medicine as:

> "a broad domain of healing resources that encompasses all health systems, modalities, and practices and their accompanying theories and beliefs, other than those intrinsic to the politically dominant health system of a particular society or culture in a given historical period. CAM

> includes all such practices and ideas self-defined by their users as preventing or treating illness or promoting health and well being. Boundaries within CAM and between CAM domain and the domain of the dominant system are not always sharp or fixed."
> [The Alternative Medicine Home Page, downloaded 04/2009]

Reviewing the literature on CAMs, we repeatedly find the terms *unconventional, unorthodox, extramural, parallel, traditional* and *unproven* being used.[41]
Conventional medicine is associated with the terms *regular, orthodox* and *mainstream*.

What does this mean for osteopathy?

While a search for the definitions of *alternative medicine* in Wikipedia yielded "naturopathy," "homeopathy" and "chiropractic" among the commonly cited examples, osteopathy was not expressly mentioned.

In 2008 The American Academy of Osteopathy (AAO) still defined osteopathic medicine as "not alternative at all" [downloaded 09/2008]. Its arguments were that osteopathy has a 125-year old history and represents a complete system of holistic medical care. According to the AAO, the DOs, like the MDs, are fully trained and licensed medical physicians who provide comprehensive health care.
One year later the AAO's position on the question of whether osteopathy is to be regarded as alternative medicine is already less clear:

> "Since OMT is a treatment modality that is not universally known, many people consider it alternative. However, Osteopathic Medicine is *part* of mainstream medicine and has a 125-year-old history. In fact, it is the only complete system of medical care originated in the United States."
> [AAO, downloaded 05/2009, our italics]

In this regard it is noteworthy that Saxon et al. (2004) showed in their study that eighteen out of a total of nineteen osteopathic colleges surveyed in the USA integrate CAM in their curricula (even if with less than 20 contact hours). The topics receiving the most instruction were acupuncture (68%), herbs and botanicals (68%), spirituality (56%), dietary therapy (52%), and homeopathy (48%). Few (12%) of the instructors taught CAM from an evidence-based perspective, while most (72%) CAM instructors were also practitioners of CAM modes of

[41] *Parallel* means "extending in the same direction, everywhere equidistant, and not meeting [...]", *extramural* "existing or functioning outside or beyond the walls, boundaries, or precincts of an organized unit (as a school or hospital)" and *traditional* "an inherited, established, or customary pattern of thought, action, or behaviour (as a religious practice or social custom)" [Merriam Webster Medical Dictionnary, downloaded 04/2009].

therapy. The writers found that instruction in CAM resembled in form and content that also occurring in allopathic educational institutions.
The study by Saxon et al. evidences the integration of unconventional modes of therapy in osteopathic and allopathic education. In addition, we recall Korr's (1997b, p.167) earlier criticism of the osteopathic profession's tendency to conduct itself as parallel as possible to allopathic medicine in all the latter's endeavors. One might suppose that this parallelism also contributed to American osteopathy (like allopathy) integrating CAM in its concept. One might also suppose that the classification of American osteopathic medicine either as *mainstream* or *alternative* has lately become the subject of discussion for the aforementioned reason (see section 4.2.1.1). We must nevertheless ask whether logically the same discussion ought not to be conducted with regard to allopathy.
Another reason for the integration of CAM in the osteopathic curriculum is probably the public's regular and indeed increasing demand for complementary and alternative modes of therapy (Ernst, 2000).

The European literature often (at least in the United Kingdom) accords osteopathy the status of complementary medicine (Maxwell, 1993; Ernst, 1993; Tyreman, 1998; Wilson et al. in Tyreman, 1998).
Maxwell (1993) offers three basic criteria for complementary medicine: a solid foundation in science, clinical effectiveness, and public demand.
An article by Budd et al. (1990) regards British osteopathy as both complementary and alternative.
On the other hand, in their study on "Attitudes towards Prescribing Rights of UK Osteopaths" Grundy and Vogel (2005) employ a scientific model containing certain core values in their survey. Given this model, "British" osteopathy is accorded the role of a specialization within orthodox medicine.

Writing on osteopathy in Belgium in his "Reflections about CAM: Osteopathy" van Dun (2008c) notes that recent socio-professional and academic trends (in Belgium) have rendered questionable the classification of osteopathy as alternative medicine, and suggest that it may be more properly regarded as regular medicine. The academic and socio-professional trends mentioned by van Dun are related to the present possibility of pursuing an "osteopathic" course of studies at a university in Brussels (Université Libre de Bruxelles, ULB) and to the "Law Providing Guidelines for CAM from Colla" governing the statutory regulation of osteopathy as an independent profession (among other things).

If we add the definitions of the EROP's 2008 "Declaration on Osteopathy," we find that Mayer and Adler-Michaelson regard osteopathic medicine with its "salutogenetic model" (Antonovsky) as complementary to standard medicine. According to these writers, osteopathy is

interdisciplinarily associated with the different health professions and all medical disciplines in Europe, and (in the case of "osteopathic physicians") is applied in combination with the "usual medical diagnostics and therapy [...]" (Mayer and Adler-Michaelson, 2008, p. 35).

Summing up the literature researched so far, we find a certain trend towards classifying osteopathy as CAM. On the other hand, we must ask whether osteopathy is not rather a regular form of medicine (see van Dun above). A reasonable conclusion is that there is yet no "official" and/or uniform specification of osteopathy as alternative, complementary or orthodox (mainstream) *on the part of the osteopaths*. We must also keep in mind the insufficient distinction in the literature between the terms *alternative* and *complementary*, and the possible inaccuracies in osteopathic professional policy that may ensue. Additional confusion over CAM arises when the literature interchangeably speaks of medicine and of a mode of therapy, whereas on closer view we may find these concepts being applied in different contexts (such as a delegation-free or delegation-required sense, or regarding primary or secondary practice). We trust that our website analysis reflects the attitude of the other European countries and professional unions and registers, including those of the umbrella European professional organizations, and hope that it shows how they undertake the classification of osteopathy as *alternative*, *complementary* or *mainstream* and whether an *osteopathic* consensus can be derived from this information.

4.5.9 The role of osteopathy in society

> *A profession justifies its existence only by meeting the societal needs not met by any other profession.*
>
> *Irvin Korr, 1987*

Still's original idea was not to create a new profession with osteopathy, but rather that osteopathy would reform the medical system existing at the end of the 19th century, in order to set that system on a more rational and scientific basis. Osteopathy therefore emerged in response not to a *general* social need, but to the needs of a *single* man and his small group of adherents (Korr, 1997b, p. 166). Still saw a necessity in creating osteopathy in order to demonstrate to society what *medicine could also mean*. He had a different concept to offer than that of allopathy, which derived its interpretation of disease from the perspective of germ theory. The function of osteopathy in society envisaged by Still was to offer a drugless, natural and complete medical approach to health and disease, in contrast to allopathic medicine.

In her thesis on "The Place of Osteopathy in Current Health Policy," Drexeler (2009) writes that Still's philosophy of health and illness can be viewed as a phenomenological approach. The phenomenological approach to illness and health presents a possible way to circumstantiate the relevance of osteopathy for society. We may say that osteopathy (from the

time of its creation) combined both the classical medical definition of illness and the phenomenological approach to illness and health. With its concepts of health and illness, osteopathy offers society an alternative to classical medicine. Herein the (osteopathic) view of the body and its capacity for auto-regulation and self-healing play an essential role, which were emphasized by, among others, Korr (1997a, pp. 164-165) in speaking of "the physician within" and "the body's own medicines" and which justified the existence of the osteopathic approach to the patient.

According to Korr (1997a, p. 165), the preventive and therapeutic character of osteopathy, as an "approach to health, quality, length of life, and the economy of our nation", is based on an exceptionally humanistic form of service that so far no other profession has been able to offer to society (see also Lister in Glover and Asubonteng Rivers, 2000). Osteopathy moreover fulfills its preventive role with respect to chronic diseases, in contrast to allopathy, whose germ theory offers only meager explanations of these types of illness (as opposed to acute and infectious diseases). Korr is convinced that "the chronic diseases are largely the products of neglect, abuse, and impairment of the inherent resources, and are therefore largely preventable" (Korr, 1997a, p. 165).

Drexeler (2009) also sees among all forms of medicine (curative, preventive, palliative, transformative and predictive) the role of osteopathy to lie mainly in preventive[42] and curative medicine, which two areas she regards as literally "reserved" for osteopathy.
According to Drexeler, if osteopathy succeeds in convincing society of this role, than it will make an essential contribution both in the social sector and in the economic sector towards solving the problems of today's health care system, namely by presenting a low-cost alternative to the use of technology, for example. The real social task of osteopathy today is to bring its main philosophical tenets from a micro level to the macro level of health care policy. But then we must ask if this is still a real option for osteopathy, for up till now our increasingly scientifically and technologically oriented health care system has had only little place for forms of alternative medicine. The use of technology is still uncontroversial in medicine at present, and (on the contrary) is even "demanded" by society today (Drexeler, 2009).

On the other hand, basing their discussion on Ernst, Glover and Asubonteng Rivers (2000) note increasing dissatisfaction with orthodox medicine among consumers, leading to a greater

[42] Drexeler writes that osteopathic prevention fundamentally differs from the primary form of allopathic prevention, which is based on certain vaccination programs for a group of diseases (such as carcinoma of the cervix) that may arise in healthy people or on preventive measures during certain periods of time (such as flu vaccinations during winter). This type of prevention is based on the view that a healthy organism is not alone capable of sufficiently protecting itself against disease-causing influences and needs something added (from the outside) in order to ensure its healthy functioning. Another type of allopathic prevention, secondary prevention, consists of the screening programs (such as mammography for women) that serve the early detection of illness and are intended to prevent an illness from (further) developing and possibly becoming fatal. These screening programs basically declare a "healthy" person to be a potentially "ill" person.

acceptance of "alternative" forms of treatment. Glover and Asubonteng Rivers see osteopathy, with its over 100 year old philosophical concept, as the spearhead in today's health care system, as society's need for holistic medicine continues to grow (see also Ernst, 2000).

Like Drexeler (see above), Korr (1997c, p. 184) also writes that the justification of osteopathy and of its continued existence lies behind the endeavor to convince society that osteopathy's health care strategy is a way to meet the increasing (crucial) health care problems and costs. Korr accordingly finds the role of osteopathy to lie in primary care.

What remains according to Drexeler (2009) is a lack of clarity in the manner in which osteopathy presents itself in its curative role. This lack of clarity has three causes: the differences in the *nature of practice* between European and US osteopathy, the way in which European osteopathy defines itself and the obvious difficulties in clearly defining the concept of *illness*.

Drexeler (2009) concludes that osteopathy with its underlying philosophical theses can be incorporated in a contemporary phenomenological interpretation of health and illness, to yield added value for health care. To be sure, it remains incumbent on the profession to become clear on which segment in the health care system it covers, what possibilities and in particular what limits it offers and how to explain these possibilities and limits to society.

5 Methods of website analysis

5.1 Search and literature analysis methods for the websites of national professional unions & registers and international osteopathic organizations

5.1.1 Search strategy

To access the websites of the professional unions and registers of the different European countries, we went to the website of the European umbrella organization, the European Federation of Osteopaths [EFO, http://www.e-f-o.org, downloaded 04/2008, updated 03/2009]. From this website we received a list of those countries and professional unions and registers that are members of the EFO. We found that not all European countries were included.

To complete our list, we also consulted the website of the Forum for Osteopathic Regulation in Europe [FORE a, http://www.forewards.eu, downloaded 04/2008, updated 03/2009]. We found that the osteopathic organizations for Portugal and Spain listed on the websites of FORE and EFO partly varied in name and spelling, so that only with the aid of Google could we arrive at the pages relevant to our search (in red in Table 2). Moreover, the websites did not always list associations with their own homepages, but sometimes only with personal representatives or e-mail addresses. The latter we omitted from the analysis, and show them in red in Table 2 under "Web address not available". Exceptions are the three Belgian professional unions BAKO-ABOC, SBO-BVO and ROB (out of altogether five members of the GNRPO), whose Web addresses were not available through the website of the EFO, but which we easily found out through Google, the GNRPO and/or personal contacts, and listed in Appendix C.

We studied exclusively the websites of the professional unions and registers available from FORE and EFO; we omitted related schools and/or other organizations, except for Poland and the Netherlands. We made Poland an exception because here the Web address of the association TOP was also that of the SCOM school. The Dutch association NVO is also linked through its website to its register (NRO). The European osteopathic professional unions and registers and international osteopathic organizations thus gathered are listed in Table 2. Altogether we identified 29 professional unions and registers and three international expert organizations.

5.1.2 Research question

How do the national professional unions & registers and the international osteopathic organizations in Europe currently present osteopathy?

5.1.3 Presentation of the website analysis

To answer our research question, we prepared a list of subsidiary questions. Using this list, we systematically examined the websites of the EFO and FORE as European umbrella organizations and the websites of the individual European professional unions and registers. We also studied the website of the World Osteopathic Health Organisation [WOHO, http://www.woho.org, downloaded 04/2008, updated 03/2009]. The researched information is given in Appendix C.
All quantitative data concern exclusively the 29 professional unions and registers. We treat the three international organizations separately in this regard.

5.1.3.1 List of questions for the website analysis:

1. What is the definition of osteopathy?
2. What do osteopaths do – how do they define themselves?
3. What is the role of osteopathy in health care?
4. What is the role of osteopathy in society?
5. What is the current status of the legal recognition of osteopathy as a profession?
6. What forms of training and academic degrees currently exist for osteopathy or are goals set for the future?
7. Are there any special features of the content or presentation of the website?
8. Is there a defined professional profile or code of practice?
9. Is there a formulated ethical or deontological code?
10. Is there a public list of osteopaths?
11. What is stated in the statutes of the professional union or register and of the expert organization – what are the admission criteria for members and what goals are being pursued?

All 11 questions form a separate category in Appendix C, under which we initially grouped the information available from the website. In the next step (for a better overview), we created further tables either presenting the information from Appendix C in condensed form or listing the professional unions and registers (or PUR for short) and the international organizations (abbreviated as IO) corresponding to the search keywords of the respective categories (see Appendix D). We numbered them in the same way as in the tables below, and differentiate between them by the letters (a = table in analysis and b = table in Appendix D). For the analysis we used the usual abbreviations of the PURs (see Table 2). In the analysis we often grouped the PURs according to their countries for the sake of a better overview, however. In the analysis of the individual categories of the questions list we also (subsequently) added specific information from other categories if they corresponded in content to the sought

category or represented an additional and useful contribution to the latter (for example, the information from the "definition of osteopathy" also contained information on the role of osteopathy in the health industry, while much useful information appeared "at second glance" in the special features & content category). We decided on this approach in order not to have to duplicate all of the information (which was to be grouped in multiple categories) in Appendix C.

5.1.3.2 Relevant information for the list of questions:

Re 1: What is the definition of osteopathy?
Here we included all recognizable information on the definition and description of osteopathy. We distinguished between two types of definition: DEF_{def} (for "DEFINITION defined"), which characterized osteopathy in *one* incisive sentence and DEF_{des} (for "DEFINITION described"), which owing to its detailed and lengthy character presented a description of osteopathy. We used red for labeling in Appendix C. Both types could simultaneously occur in one of the professional unions or registers or international organizations. As regards content we looked for the following sort of information:

Characterizations of osteopathy:

- System of health care, medicine, therapy, discipline, concept, philosophy, science, art, manual or manipulative in practice, global or holistic in approach, autonomous or independent, drugless, no-surgery, causative or non-symptomatic treatment or vice versa osteopathy as symptomatic treatment
- Osteopathy as a system offering independent diagnoses and treatment
- Osteopathy as a pure treatment system (without diagnosis)

The osteopathic principles:

- The four osteopathic principles (according to the Kirksville Consensus Declaration): 1. The body as a functional dynamic unit (body and mind), 2. The interaction between structure and function, 3. Ability of self-regulation / restoration of health, and 4. Responsible treatment based on the first three principles
- Other principles than the four above (life is movement, "rule of the artery," etc.)

Information on further points of definition:

- Specific palpation / touch
- Individual / patient-oriented treatment
- Information on somatic / osteopathic dysfunctions or lesions
- Indications and contraindications of osteopathy (and/or its techniques)
- Division into structural (parietal), visceral and craniosacral systems

We also included other designations and circumlocutions when they evidently corresponded in meaning to the above concepts.

Re 2: What do osteopaths do – how do they define themselves?
We include all recognizable information embodying a definition and/or description of either the osteopath as a person (possible criteria related to professional policy or associations) or of the osteopath's activity (descriptions of a course of treatment). We distinguished as above between definitions (DEF_{def}) and descriptions (DEF_{des}). We gave particular attention to the following content:

- Characterizations of the osteopath (as therapist, osteopath, physician, practitioner, primary health care practitioner).
- Linkage of the term *osteopath* to the DO title or to an academic title

Re 3: What is the role of osteopathy in health care?
We looked for:

- Osteopathy as a primary contact health profession / osteopathy as first-line-medical care (with autonomous diagnoses and therapy, without delegation)
- Mentioned specializations
- Information on the practice of osteopathy by other professions
- Preventive and/or curative role (possibly overlapping in content with the definitions of osteopathy)
- Cooperative arrangements with hospitals or other institutions
- Treatment costs, treatment periods, reimbursement
- Statistics on osteopathic consultations

Re 4: What is the role of osteopathy in society?
We looked for the following information:

- Facilities like emergency services and foundations
- (Competitive) sports
- Information for patients, references to science, the media

Re 5: What is the current status of the legal recognition of osteopathy as a profession?
We looked for the main information. Any legal texts and their content were not (owing to their length) included in the analysis.

Re 6: What forms of training and academic degrees currently exist for osteopathy or are goals set for the future?

We collected information on the duration and numbers of hours of osteopathic training, on the type of training (fulltime or part-time training) and on the possibilities of obtaining an academic degree (Bachelor (BS), Master (MS) or Doctor (PhD)).

Re 7: Are there any special features of the content or form of the website?
Here we included all information and personal impressions that we deemed additionally noteworthy as regards the *identity of osteopathy*. This information in question is "special" insofar as it "deviates" from that of other websites or pertains to website presentations like video links, photos, etc., or does not fall under any of the categories in the list of questions (1-11).

Re 8: Is there a defined professional profile or code of practice?
Here we looked for an official professional profile or code of practice available from the website or downloadable as a PDF file. Mere mention of the possible existence of such a profile or code, of the intention to elaborate on one, did not suffice and was designated in Appendix C as "information not available". Otherwise we noted down "available."
We were interested only in the existence of detailed and written professional profiles and codes of practice: Our analysis excluded content and its exact assessment.

Re 9: Is there a formulated ethical or deontological code?
We looked for an official ethical code available from the website or as a PDF file. Mere mention of the possible existence of such a profile or code, or of the intention to elaborate on one, did not suffice and was noted down in Appendix C as "information not available". Otherwise we noted availability simply with the remark "available."
Our interest extended only to the existence of detailed and written ethical codes: Our analysis excluded content and its exact assessment.

Re 10: Is there a public list of osteopaths?
We mean a list of osteopaths maintained by the given professional union or corresponding expert organizations. We employed the following criteria: students, graduates, DO title or academic degrees, designation of prior or auxiliary occupations, locations of activity, advertisements for one's own practice, etc.

Re 11: What is stated in the statutes of the particular professional unions or expert organizations – what are the admission criteria for members and what goals are being pursued?
We copied the stated goals to Appendix C in order to compare them with the other professional unions. We gathered only the most important information on the admission

criteria, however. We gave special attention to the educational level required for membership, to the endeavors of the particular PURs and IOs to have as members exclusively osteopaths with a DO or an academic degree, and to the condition possibly imposed on members of documenting their exclusive activity as osteopaths.

In the event of linguistic difficulties, we availed ourselves of Google's translation program (http://www.google.de), Yahoo Babel Fish (http://babelfish.yahoo.com) and/or "ePals" (http://www.epals.com/translation/translation.e)
[downloaded 08/2008-03/2009] and noted such in Appendix C. The texts were mostly translated by Google into German, and by ePals and Babel Fish into English. We highlighted the original texts in blue, while the translations appear in black and between quotation marks (" "). Our summaries of the websites and their information appear in blue-green. Content changed by updating appears in red in Appendix C. The analysis used only the currently available information (updated as of 03/2009) as well as the previously available but unchanged website information from 2008.
Since the translation programs available through the Internet are not very reliable, deviations in meaning from the original texts cannot be ruled out. We also made use of our own knowledge of German, English, French and Dutch. We excluded from the analysis any content that was fully unclear. The biggest problem concerned the Polish website of the professional union TOP, since its Polish texts could not be copied into the translation programs. We printed them out and submitted them to an acquaintance of Polish origin.
Information from the websites on recognition in professional policy that was unclear or capable of being misunderstood we compared and completed with information from personal contact with Dimitri Boulenger (Treasurer of the EFO) in the form of e-mails (02 and 03/2009) and with information from Claude Rousseau (Secretary of the EFO), whom we personally interviewed (03/2009) and with whom we exchanged e-mails (04/2009 – 06/2009). This information appears in violet to contrast with the website-sourced information.

5.1.3.3 Background information:[43]

The EFO represents 16 of 27 European countries (numbers of members in parentheses):

Austria (60); Belgium (709); Cyprus (13); France (1300); Germany (226); Greece (21); Ireland (129); Italy (878); Luxembourg (17); Netherlands (420); Poland (1); Portugal (28); Spain (95); Sweden (120); Switzerland (650); United Kingdom (2928)

(Boulenger, personal communication, 02/2009)

[43] Only those professional unions may apply for membership in the EFO that are officially recognized as professional associations in their respective countries. These professional unions must submit their statutes and educational structures to the EFO and are only accepted for membership if they meet the EFO's criteria. The statutes of the EFO accept only osteopaths with a DO and/or academic title (BS, MS), who cannot enter the organization as individuals but only as represented by their professional unions (numbers in parentheses, see above). According to Rousseau (personal communication, 03/2009) the statutes of professional unions generally contain a code of conduct or deontological code, a code of ethics and a code of professional competence, professional profile or code of practice. While these codes are often not available in written form from the existing professional association, at the latest all three codes are required in time for complete legal recognition (Rousseau, personal communication, 03/2009). The EFO is represented in the European Council of the Liberal Professions (CEPLIS), a registered international organization under Belgian law (Rousseau, personal communication, 03/2009). CEPLIS represents the liberal professionals at the community level. “As such, it is an agreed organization of the European Economic and Social Committee (EESC) and maintains close contacts with the European Commission Parliament and Council” [CEPLIS, downloaded 03/2009].
“The Forum for Osteopathic Regulation in Europe (FORE) seeks to bring together national registers and competent authorities for osteopathy across Europe” [FORE a, downloaded 03/2009], which may also be private persons. There exist no admission criteria comparable to those of the EFO (Rousseau, personal communication, 03/2009). FORE was established in the United Kingdom and is therefore of purely British origin. A basic reason for its establishment was the immanent cross-board health care regulations that went into effect in 2010. (Rousseau, personal communication, 03/2009; FORE a, downloaded 03/2009).
Denmark, Finland, Russia and Norway also belong to FORE, but are not represented in EFO.
We also received the information that EFO and FORE had hitherto negotiated with one another on their respectively demarcated areas of activity. At the last general meeting of the EFO in February 2009, however, the desire for closer cooperation in the form of a future merger between the two organizations was expressed, in the interest of presenting osteopathy as a united front (Rousseau, personal communication, 03/2009).

Country	Organisations	Abkürzung	Website or Contacts	Mitgliedschaft
Austria	Österreichische Gesellschaft für Osteopathie	ÖGO	http://www.oego.org	EFO, FORE
Belgium	Belgische Associatie van Klassieke Osteopaten	BAKO-ABOC	http://www.aboc-bako.be/nl	EFO
	Société Belge d'Ostéopathie	SBO-BVO	http://www.osteopathie.be	EFO
	Groupement National Représentatif des Professionels de l'Ostéopathie	GNRPO	http://www.gnrpo.be	EFO
	Register voor de Osteopaten van België	ROB	http://www.osteo-rob.be	EFO
	Union Belge des Ostéopathes	UBO-BUO	webaddress not available	EFO
	Unie van Osteopaten	UVO	webaddress not available	EFO
Cyprus	Clement Rhein		webaddress not available	EFO
Danmark	Danske Osteopater	-	http://www.danskeosteopater.dk	FORE
Finland	Suomen Osteopatiayhdistys = Finnish Osteopathic Association	FOA	http://www.osteopatiayhdistys.fi/	FORE
France	Union Fédérale des Ostéopathes de France	UFOF	http://www.osteofrance.org	EFO
	Registre des Ostéopathes de France	ROF	http://www.osteopathie.org	FORE
	Syndicat Français des Ostéopathes	SFDO	http://www.sfdo.info	FORE
Germany	Verband der Osteopathen Deutschlands	VOD	http://www.osteopathie.de	EFO , FORE
Greece	Greek Register of Osteopaths DO Europe	-	http://www.osteopathy.gr	EFO
Ireland	Osteopathic Council for Ireland			EFO
	Association of Osteopaths in Ireland	AOI	http://www.osteopathyinireland.ie	FORE
	Irish Osteopathic Association	IOA	http://www.osteopathy.ie	EFO, FORE
Italy	Consiglio Superiore di Osteopatia	CSdO	webaddress not available	FORE
	Associazione Diffusione Osteopatia	ADO	http://www.adoitalia.it	EFO
	Registro degli Osteopati d'Italia	ROI	http://www.roi.it	EFO, FORE
	Federazione Sindicale Italiana Osteopati	FeSIOs	http://www.fesios.it	FORE
Luxembourg	Association Luxembourgeoise des Osteopathes	ALDO	http://www.osteopathie.lu	EFO
Netherlands	Nederlandse Vereniging voor Osteopathie	NVO	http://www.osteopathie.nl	FORE, EFO

Country	Organizations	Abkürzung	Website or Contacts	Mitgliedschaft
Norway	Norsk Osteopat Forbund	NOF	http://www.osteopati.org	FORE
Poland	Osteopatia.Pl	TOP-SCOM	http://www.osteopatia.pl	EFO
Portugal	Associação e Registo dos Osteopatas de Portugal	AROP	webaddress not available	EFO
	Associação de Profissionais de Osteopatia	APO	webaddress not available	FORE
	Federação Portuguesa de Osteopatatas = Registo	FPO	http://www.osteopatiaemportugal.com.pt/registo.html	FORE
	Federação Portuguesa de Osteopatia		http://www.fposteopatas.pt	FORE
Russia	Register of Osteopaths of Russia	RRDO	http://www.osteopathy.ru	FORE
Spain	Associação de Profissionais de Osteopatia		webaddress not available	FORE
	Associação e Registo dos Osteopatas de Portugal		webaddress not available	FORE
	Registro de los Osteopatas de Espana	ROE	http://www.osteopatas.org	EFO , FORE
Sweden	Svenska Osteopatförbundet	SOF	http://www.osteopatforbundet.se	EFO, FORE
Switzerland	Federation Suisse des Osteopathes	SVO-FSO	http://osteopathes-suisses.ch/	EFO
United Kingdom	British Osteopathic Association	BOA	http://www.osteopathy.org	EFO
	General Osteopathic Council	GOsC	http://www.osteopathy.org.uk	EFO, FORE
	International Organizations	**Abkürzung**	**Website or Contacts**	
	World Osteopathic Health Organization	WOHO	http://www.woho.org	-
	Forum for Osteopathic Regulation in Europe	FORE	http://www.forewards.eu	-
	European Federation of Osteopaths	EFO	http://www.e-f-o.org	-

Table 2: List of European osteopathic professional unions/registers and international osteopathic organizations [downloaded 06-09/2008, updated 03/2009]

Key: Blue = websites of professional unions and registers directly available from FORE and EFO. Red = no website addresses available from FORE and EFO.

6 Results of the website analysis

6.1 The definition of osteopathy

Our analysis of the literature revealed the existence of both definitions and descriptions of osteopathy. The latter are expedient insofar as it is hardly possible to capture osteopathy in a brief definition, while descriptions are conceptually more elastic and flexible (see section 4.5.5). We examined the definitions and assessed them either as definitions in the strict sense (DEF_{def}) or as descriptions (DEF_{des}).

Our results are as follows: 97% of the professional unions and registers (PURs) provide a definition (DEF_{def} and/or DEF_{des}). The exception is the Belgian umbrella association GNRPO, which provides no such information. Our close examination of the definitions (n = 28) showed that in *all* cases a description (DEF_{des}) is given, with four PURs *additionally* offering a short and incisive definition (DEF_{def}) (see Table 3a). Belgium, France and Germany provide a DEF_{def}.

Definition of osteopathy	PUR		EFO	FORE	WOHO
	%	n			
Definition available	97	28		x	x
No definition available	3	1	x		
Type of definition					
DEFdef	14	4			
DEFdes	97	28		x	x

Table 3a: Number and type of definition of osteopathy by European osteopathic professional unions/registers and international osteopathic organizations (rounded up to whole per cent).
Key: PUR = professional unions and registers (n = 29), DEFdef = definitions (concise sentences), DEFdes = descriptions (considered such because of their detailed and lengthy character), EFO = European Federation of Osteopaths, FORE = Forum for Osteopathic Regulation in Europe, WOHO = World Osteopathic Health Organization.

Among the international organizations we recorded no results for the website of the EFO. The website searches of FORE and WOHO each yielded descriptions of osteopathy (DEF_{des}) (see Table 3a).

If we now consider the content of the definitions (DEF_{def} and/or DEF_{des}) in terms of the characterization of osteopathy, we do not find 100% agreement between the PURs (see Table 4a).

The greatest agreement concerns *manual in practice* with 69% and *system of diagnosis and treatment* with 66%. There is also noteworthy agreement on osteopathy as *causative, not*

symptomatic treatment (55%), as a *science with (scientific) knowledge* (52%), as a *form of therapeutic method or treatment* (38%) as *holistic medicine* (34%) and as a *philosophy* (34%). There follow the descriptions of osteopathy as a *form of medicine or medical in character* (31%), as a *system of treatment (no diagnosis mentioned)* (31%) and as an *art* (28%).

Note that 66% view osteopathy as a *system of diagnosis and treatment*, so that diagnosis is expressly addressed in the definitions, whereas 31% of the definitions describe osteopathy as a *system of treatment (no diagnosis mentioned)*. Moreover, the first 66% include PURs that do not *expressly* mention diagnosis and therapy, but rather use differently worded descriptions, such as "to study the individual in its complex" (FeSIOs, p. 44 in Appendix C), "to identify problem areas" (BOA, p. 68) in Appendix C) or "a way of detecting and treating damaged parts" (GOsC, p. 68 in Appendix C), all of which we interpreted as *system of diagnosis and treatment*, however.

Characterization of osteopathy	PUR		EFO	FORE	WOHO
	%	n			
Manual / by hand (in practice)	69	20			x
System of diagnosis and treatment	66	19			
Causative / non-symptomatic treatment	55	16		x	x
Science / knowledge of sciences	52	15			
Form of therapeutic method / treatment	38	11			
Holism / global approach	34	10			
Philosophy	34	10		x	
Form of medicine / medical	31	9			
System of treatment (no diagnosis mentioned)	31	9		x	x
Art	28	8			
System of health care / caring approach / system of healing	21	6		x	x
Manipulative (in practice)	17	5		x	
Drugless / no surgery	17	5		x	
Concept	14	4			
Autonomous / independent	14	4		x	
Discipline	7	2			
Osteopathy as symptomatic treatment	7	2			

Table 4a: Number of European osteopathic professional unions/registers and international osteopathic organizations mentioning specific labels and characteristics in their definitions of osteopathy (rounded up to whole per cent and ordered according to magnitude of the percentage).
Key: PUR = professional unions and registers (n = 29), EFO = European Federation of Osteopaths, FORE = Forum for Osteopathic Regulation in Europe, WOHO = World Osteopathic Health Organization.

21% define osteopathy as a *system of health care, caring approach or system of healing.* 17% employ the term *manipulative* and 17% include the characteristic of *drugless and no-surgery*

osteopathic practice in their definitions. 14% define osteopathy as a *concept*, and again 14% define it as an *autonomous or independent* profession, while 7% view osteopathy as a *discipline* and another 7% claim it to be *symptomatic treatment.* Interestingly, for the last item 7% view *osteopathy as symptomatic treatment,* as opposed to 55% who define osteopathy quite oppositely, as a *causative or no(n)-symptomatic treatment*. This (latter) 7% concerns Switzerland with its association, the SVO-FSO, and the UK with its GOsC (see Table 4b, in Appendix D).

FORE's description of osteopathy includes the terms *causative / non-symptomatic treatment, system of treatment, philosophy, system of health care, manipulative in practice, drugless / no surgery, autonomous / independent.*
WOHO mentions *manual / by hand, causative / non-symptomatic treatment, system of treatment, system of health care* (see Table 4a).

We see that a clear majority of the definitions of the PURs vary in their listing of osteopathic principles (compared with the listing in the Kirksville Consensus Declaration) (see Table 5a): Of altogether 83% (of the PURs stating variants of osteopathic principles), 69% specify the *relationship of structure and function,* 66% the *self-regulatory processes or restoration of homeostasis,* 55% the *body as unit* and 31% *life is movement*. They are followed by 17% which specify *the rule of the artery*. 7% avow other principles and only 3 % (n = 1) of the definitions contain the principles of the Kirksville Consensus Declaration. 17% of the PURs state no principles in their definitions.

Osteopathic principles in the definition of osteopathy	PUR		EFO	FORE	WOHO
	%	n			
Principles mentioned	83	24		x	x
Relationship of structure and function	69	20			x
Self-regulatory process / restoration of homeostasis	66	19		x	x
Body as unit	55	16			x
Life is movement	31	9			
Rule of the artery	17	5			
Others	7	2			
4 principles of the Kirksville Consensus Declaration	3	1			
No principles mentioned	17	5			

Table 5a: Number of European osteopathic professional unions/registers and international osteopathic organizations mentioning specific osteopathic principles in their definition of osteopathy (rounded up to whole per cent and ordered according to magnitude of the percentage).
Key: PUR = professional unions and registers (n = 29), EFO = European Federation of Osteopaths, FORE = Forum for Osteopathic Regulation in Europe, WOHO = World Osteopathic Health Organization.

The definitions of FORE contain no other principles than *self-regulatory processes or restoration of homeostasis*.
WOHO mentions the three principles of *relationship of structure and function, self-regulatory process / restoration of homeostasis* and *body as unit* (see Table 5a).

In the case of the "other points in the definition of osteopathy," 52% of the definitions of the PURs referred to *indications and/or contraindications* of osteopathy (sometimes only one of the two). Often entire lists of illnesses are given that exhibit either indications or contraindications, or the PURs go so far into detail as to explain these indications and contraindications in connection with the individual osteopathic techniques and their effects. The second largest group in this category employs the keywords *individual / patient-orientated* with 45%, whereas only 21% emphasize *specific palpation or osteopathic touch*. The phrases *somatic or osteopathic dysfunction or lesion* follow at 17%, and 10% of the definitions divide osteopathy into the three areas *structural (parietal), visceral* and *cranial*.
FORE's definition emphasizes the *individual/patient-orientated* character of osteopathy, whereas WOHO places value on *indications and contraindications* (see Table 6a).

Other points in the definition of osteopathy	PUR		EFO	FORE	WOHO
	%	n			
Indications / contraindications	52	15			x
Individual / patient-oriented	45	13		x	
Specific palpation / touch	21	6			
Somatic / osteopathic dysfunction or lesion	17	5			
Differentiation between structural, visceral, cranial	10	3			

Table 6a: Number of European osteopathic professional unions/registers and international osteopathic organizations mentioning other characteristics in their definition of osteopathy (rounded up to whole per cent and ordered according to magnitude of the percentage).
Key: PUR = professional unions and registers (n = 29), EFO = European Federation of Osteopaths, FORE = Forum for Osteopathic Regulation in Europe, WOHO = World Osteopathic Health Organization.

Summary of findings

Compiling the terminology employed at a rate over 50% and thus constituting the predominant terminology (related to PURs only), we arrive at the following European *description* of osteopathy: Osteopathy is a *system of manual diagnosis and treatment*, *causative* in character, including the three basic *principles* (body as a unit, the reciprocal relationship between structure and function, self-regulatory processes / restoration of health) and containing *indications* and, in particular, *contraindications*.

FORE describes osteopathy as a system of health care which is *patient-centered / patient-oriented*, as a *philosophy*, as *manipulative* in diagnosis and treatment, as *autonomous, drugless / no-surgery,* and emphasizes as a principle *self-regulatory processes / the restoration of homeostasis*.
WOHO defines osteopathy as a *system of health care*, as *manual* in diagnosis and treatment, and mentions in this regard the three principles of *body as unit, relationship of structure and function* and *self-regulatory processes or restoration of homeostasis (health).*

Comparison of the PURs with the IOs shows the greatest agreement in content to exist between WOHO's definition and the definitions by the PURs.

If we wish next to consider a *single* country that is represented by multiple PURs and determine the agreement between the definitions from these PURs, Belgium suggests itself as a country with three representative PURs, united in the umbrella association GNRPO. We chose this country because it has the most PURs that we investigated (four including GNRPO) and because in the case of SBO-BVO we have an overriding definition (of the sort DEF_{def}) from the "Academy of Osteopathy in Belgium". None of the other PURs, including the umbrella association, reproduce this definition. Each of the PURs provides either a different definition or none at all (see above). The results show no agreement between the PURs on a "definition of osteopathy".
Further analysis revealed agreement in *one* case, namely two French PURs (ROF and SFDO) both of which give the definition (besides other definitions) from the "Reference Frame of the Profession of Osteopathy ®" on their websites.

6.2 The definition of the osteopath

We examined the definitions and assessed them either as definitions in the strict sense (DEF_{def}) or as descriptions (DEF_{des}).
The results: 86% of the PURs provide definitions (DEF_{def} and/or DEF_{des}) of the osteopath *all* of which (of this 86%) give a *description* (DEF_{des}). Altogether 14% of the PURs give no definition (DEF_{des} and/or DEF_{def}) on their websites (see Table 7a).
In the case of international organizations, FORE and WOHO give definitions of the osteopaths, with both having the character of a *description* (DEF_{des}). EFO yielded no results.

We obtained the following results regarding the content of the definitions (see Table 8a):
69% of the PURs employ the term *osteopath* in their definitions, and never write *osteopathic physician*. 17% of the PURs relate the term *osteopath* to a *diploma* and/or the *"DO" title.* The first group three of n = 5 cases concern the same PURs (the Belgian association ROB, the Luxembourgian association ALDO and the Dutch association NVO), which also refer to the

osteopath as a *holder of a diploma*. 14% speak of a *professional* or *health professional*. 7% of the PURs employ the term *practitioner,* and one PUR (3%) writes of the *therapist*. Accordingly a clear majority identify themselves with the term *osteopath*.

Definition of osteopath	PUR		EFO	FORE	WOHO
	%	n			
Definition available	86	25		x	x
No definition available	14	4			
Type of definition					
DEFdef	-	-			
DEFdes	86	25		x	x

Table 7a: Number and type of definition of an osteopath by European osteopathic professional unions/registers and international osteopathic organizations (rounded up to whole per cent).
Key: PUR = professional unions and registers (n = 29), DEFdef = definitions (concise sentences), DEFdes = descriptions (considered such because of their detailed and lengthy character), EFO = European Federation of Osteopaths, FORE = Forum for Osteopathic Regulation in Europe, WOHO = World Osteopathic Health Organization.

Noteworthy is that in contrast to *osteopathic medicine,* used as a term in the "definitions of osteopathy" in 31% of the cases (see above), *none* of the PURs mention *osteopathic physicians* in the "definition of the osteopath". Nor do they speak of the *primary health care practitioner*. Four PURs (ROB in Belgium, UFOF in France, GOsC in the UK and ADO in Italy) use the word *professional* in speaking of the osteopath.

The definition from FORE is significantly more comprehensive in content compared with that of WOHO. FORE defines the *osteopath* both as a *primary health care practitioner (practitioner)* and as a health care *professional.* The definition by FORE also serves as a code of standard and practice.
In contrast to FORE, WOHO exclusively uses the term *osteopath* (see Table 8a).

With a clear majority (69%) over the other designations, *osteopath* is the "term of choice" among the PURs. Its definition is not a definition in the narrow sense (DEF_{def}), but rather a *description* (DEF_{des}). In most of the cases the osteopath is defined in terms of his or her activity with the patient, with (e.g.) a course of treatment being described. Some of the PURs, such as GNRPO and SBO-BVO, tie certain of their professional policy criteria to the professional designation "osteopath" (see Appendix C, pp. 8-11 and 11-15). These criteria mostly involve documented membership in a recognized osteopathic professional association, completed osteopathic study, holder of a diploma, a professional liability insurance, agreement with the code of ethics, etc.

Again, others, like the ADO (Appendix C, pp. 36-39) emphasize the characteristics of the osteopaths, such as knowledge of basic sciences and the ability to perform specific palpation.

Content of the definition of osteopath	PUR		EFO	FORE	WOHO
	%	n			
Osteopath	69	20		x	x
Holder of diploma	17	5			
Holder of the DO title	17	5			
Professional / health professional	14	4		x	
Practitioner	7	2		x	
Therapist	3	1			
Primary health care practitioner	-	-		x	
Osteopathic physician	-	-			

Table 8a: Number of European osteopathic professional unions/registers and international osteopathic organizations with specific content in their definition of an osteopath (rounded up to whole per cent and ordered according to magnitude of the percentage).
Key: PUR = professional unions and registers (n = 29), EFO = European Federation of Osteopaths
FORE = Forum for Osteopathic Regulation in Europe, WOHO = World Osteopathic Health Organization.

WOHO agrees with the PURs in its DEF_{des} and its exclusive use of the term *osteopath*. WOHO's definition is basically intended as information for patients as to what to expect from osteopathic treatment (treatment on a therapeutic table, possible disrobing, etc.). On the other hand, other PURs are more precise than WOHO and describe an overall course of treatment (e.g. ÖGO and Danske Osteopater, Appendix C, p. 7 and pp. 19-21).
In contrast to the case with WOHO, FORE's definition provides detailed information directly pertaining to the professional profile of the osteopath. FORE associates still other terms with *osteopath* and in this terminology agrees with a minority of the PURs (see Table 8a). FORE's definition is a *description* concerning detailed practice guidelines containing the following points: The osteopath is basically a *primary health care practitioner* and consequently a health *professional*: The professionalism is confirmed by this designation of the osteopath and at the same time determines the latter's area of activity. FORE's description (see Appendix C, pp. 70-76) gives the impression of an independent and full-fledged picture of the profession of the osteopath.

6.3 The role of osteopathy in health care

We decided on compiling part of the results according to country because we consider comparison between countries more useful than a comparison between the PURs themselves (the PURs are listed in Tables 9b and c in Appendix D. On the information below see Table 9a).

In seven European countries (Belgium, France, Ireland, Luxembourg, Norway, Switzerland and the UK) osteopathy is described as *first-line-medical care* by the corresponding PURs. As first-line medical care osteopathy is practiced without a referral from the patient's physician.
FORE is the only international organization characterizing osteopathy as *first-line medical care* or as primary care provision.
EFO provides no information on the role of osteopathy in health care.
WOHO speaks of osteopathy as an "established recognized system of health care of diagnosis and treatment," without clearly referring to its role in primary contact care.

We obtained the following results regarding the characterization by the PURs and IOs of osteopathy as a form of medicine belonging to CAM or conventional medicine: Two PURs (in Greece and Italy) describe osteopathy as *complementary* or *alternative*, using these terms. The Italian association ADO, for example, writes that osteopathic treatment consists of a "complete therapeutic arsenal," and therefore represents an alternative *or* complementary form of therapy (see Appendix C, p. 39). In other words, a distinction is not made between the two terms (or no decision on such a distinction is made), so that we may assume these PURs regard osteopathy as *complementary and alternative* medicine, i.e. CAM.
In seven European countries (France, Germany, Italy, Norway, Poland, Spain, Switzerland) osteopathy is classified as *complementary* to regular medicine. None of the PURs directly speak of osteopathy as *alternative* medicine (using this term). The PURs from Belgium, Italy and Portugal, respectively, refer to osteopathy as *non-conventional* medicine.
In the actual wording, the terms "medicine" and "therapy" are both used in reference to osteopathy, viz.: alternative / complementary *medicine* and alternative / complementary *therapy* (see, for example, VOD, p. 31 and ADO, p. 39 in Appendix C).
Poland (TOP-SCOM) speaks of osteopathy as integrative medicine, with the classification as CAM, alternative or complementary remaining unclear. The other PURs (n = 16) provide no information on such a classification.
Nor do any of the international organizations (EFO, FORE, WOHO) provide information on a classification of osteopathy as *complementary* and/or *alternative*.
Austria (ÖGO) and Germany (VOD) also note that osteopathy is practiced by physicians and/or physiotherapists. Germany adds the profession of *Heilpraktiker*.

Specializations in osteopathy are child osteopathy (in Austria, the Netherlands and Greece) and sport osteopathy (described by the Greek professional union and the international organization FORE). The Greek association adds cranial & visceral osteopathy as well as applications for pregnant women to its list of specializations. It is also the only association mentioning (with a website link) osteopathy for animals, in particular, horses.

While the other PURs and IOs provide no information on specializations, their descriptions of osteopathy often refer to applications in sports (but *not* in the sense of a specialization) and to the suitability of osteopathy for all age groups (including children and infants).

Criteria of osteopathic role in health care	European countries which give information	International organization
Osteopathy as first-line-medical care (no referral needed)	Belgium, France, Ireland, Luxembourg, Norway, Switzerland, UK	FORE
CAM	Greece, Italy	
Complementary	France, Germany, Italy, Norway, Poland, Spain, Switzerland	
Alternative	-	
Non-conventional medicine	Belgium, Italy, Portugal	
Integrative medicine	Poland	
Practiced by other professions (physicians, physiotherapists, etc.)	Austria, Germany	
Preventive and curative role	Austria, Belgium, Denmark, France, Germany, Italy, Norway, Poland, Portugal	FORE
Information on curative role	Belgium, Finland, France, Ireland, Portugal, Luxembourg, Netherlands, Spain, Sweden, Switzerland, UK	WOHO
Specializations	Austria, Greece, Netherlands	FORE
Treatment of all age groups	France, Poland, UK	
Cooperation with hospitals and/or other institutions	UK	FORE
Information on treatment periods	Austria, Germany, Ireland, Spain	
Information on treatment costs	Austria, Germany, Luxembourg, Norway, Spain, UK	
Information on reimbursement	Austria, Belgium, France, Germany, Ireland, Luxembourg, Netherlands, Switzerland	
Statistics on osteopathic consultations	Belgium, UK	

Table 9a: List of criteria for role of osteopathy in health care with European countries and international organizations subscribing to those criteria.
Key: FORE = Forum for Osteopathic Regulation in Europe, WOHO = World Osteopathic Health Organization.

The *preventive and curative* role of osteopathy is mentioned as such by 13 PURs (45%) from a total of nine countries. In contrast, the *curative* role of osteopathy can be derived from the information provided by 14 PURs (48%) from 11 countries (e.g. from the definition of

osteopathy and based on the indications described therein). The *preventive* character is *not* evident to the website visitor in the latter cases.
FORE emphasizes the *preventive and curative* role of osteopathy, while WOHO speaks only of the *curative* role. The website of EFO provides no information in this regard.

Information is hardly available on the cooperation with *hospitals and other institutions*. The only professional union providing information is the UK's General Osteopathic Council (GOsC), which states that while most osteopaths are self-employed in independent practices, there is a growing trend towards multi-disciplinary environments and integration with the National Health Service (NHS). Occupational health within private and public companies is also a key growth area for the practice of osteopathy. Indirectly (in going through the individual lists of osteopaths) we now and then found osteopaths who gave a clinic as their place of work, but they were rather the exception among the many osteopaths working in an independent practice.
FORE writes: "Osteopaths work predominantly in independent private practice, but also in collaboration with other healthcare professionals. They also provide advice on health issues to the public and to industry."
WOHO and EFO provide no such information.

The treatment periods vary: 30 - 40 minutes in the UK (GOsC), 30 - 60 minutes in Austria and France (ÖGO and SFDO) and an average of 50 minutes in Germany (VOD). In one case, Ireland (IOA), a distinction is made between an initial treatment of 60 minutes and follow-up treatments of 20 - 30 minutes each.

The costs of treatment also vary: EUR 40 - 60 in France (SFDO), EUR 60 -100 in Germany (VOD), EUR 50 - 100 in Luxembourg (ALDO) and EUR 50 - 120 in Austria (ÖGO). The United Kingdom stated £25 - 50 (approx. EUR 28 - 48 at the current conversion rate). Noteworthy is that the variance in costs sometimes exceeds 50%.

Austria, Belgium, Germany, France, Luxembourg and Switzerland provide reimbursement in case of private supplementary insurance. The amount varies with the insurance institution. Germany is an exception, since as a private additional service osteopathy costs are reimbursed according to the fee structures of the *Heilpraktiker*.
In Ireland all large health insurers reimburse the costs. Most of the insurance institutions (whether private or state is not clear) companies in the Netherlands provide reimbursement. In Spain reimbursement varies. The available information in this case also does not make clear whether the insurance is private or state-run.
We did not obtain more detailed information from other countries and their PURs. The international organizations also did not provide any information.

Concerning the statistics on osteopathic consultations, the information from two associations (SBO-BVO and GOsC) is meager given the total number of PURs.
Statistics for Belgium from 1997 revealed that 42% of Belgians had already resorted to non-conventional medicine. 41% of the consultations conducted with 8% of the population in 1996 were with either a homeopath or an osteopath.
According to UK statistics "in the United Kingdom osteopaths currently carry out an estimated seven million consultations every year. This is a 25% increase in demand since the introduction of statutory self-regulation for osteopaths in the 1990s" (GOsC).

6.4 The role of osteopathy in society

We researched the following information on facilities like emergency services and institutions performing a function in society. Altogether only a few websites provided such information.
Two countries, Belgium and France, report on charitable osteopathic facilities: in Belgium a social dispensary of the SBO-BVO, set up with the administration of the City of Brussels in order to offer osteopathic treatment to people (and their children and newborns) with financial difficulties.
In France there are several such organizations, such as the EHEO, providing the treatment of handicapped children, the "Voie Osteopathique Infantile Espoir V.O.I.E.," operating in Vietnam, the "Association Mandarine Océan," which osteopathically treats children in a Jerusalem hospital, and the "Péniche du Cœur", an osteopathic facility for socially disadvantaged people.
Belgium also has an emergency call service on weekends and public holidays, at a number listed in the Yellow Pages of Truvo, for information on on-duty osteopaths located nearest to the caller (see SBO-BVO, p. 78 in Appendix C).
In the UK there is a hotline called COSSET (Confidential Osteopathic Support for Emotional Trauma) for patients to discuss their problems with experienced osteopaths after office hours (see BAO, p. 99, Appendix C).
The French professional union UFOF reports on an "Alliance Santé Ostéopathie" (ASO), an association for consumers that advocates the right to free choice in methods of treatment. This includes osteopathy with the organizations LIBERO and AREDOE: the one a consumer association for the independent application of osteopathy and the other an association specially established for research and development in osteopathy in Europe. There is also a patient organization called "Aujourd'hui Santé Ostéopathie".

Osteopathy and its function in sports, and particularly in competitive sports, is mentioned by several PURs from different countries.

The French association UFOF reports on the involvement of osteopathy in French competitive sports enjoying high levels of popularity, such as the "Tour de France à la Voile", the "Trophée Clairefontaine," the Evian Masters (in golf), the "Coupe du Monde d'escalade" and others.
Other professional unions not so much mention competitive sports as generally explain the preventive and curative function of osteopathy for sports injuries (BOA in the UK, ROE in Spain, ADO in Italy and the Greek association).

Generally we can ascertain among a large number of the associations an effort to provide in-depth and detailed information to patients. This information sometimes consists of a concrete description of the scope of osteopathy (partly with video clips), with possible indications (i.e. illness-related complaints), answers to frequently asked questions about osteopathy, and financial information (costs of treatment, reimbursements, etc.). Some PURs have links to medical and osteopathic databases in their websites, or directly refer in their websites to relevant osteopathic studies (see, for example, the websites of ÖGO, FOA, ROF and SVO-FSO).
Among others, the VOD (Germany) gives very much attention to public relations by frequently representing osteopathy at trade fairs and by maintaining a notably detailed list to links containing press releases, TV reports, etc. On the other hand, some associations (such as the AOI und IOA (Ireland)) present no press releases on their websites.
Some of the professional unions (e.g. ÖGO, VOD, FOA, NVO) refer to their own periodicals.
Only in the case of the VOD do we find an *express* reference to a an arbitration board for handling patients' complaints.
Some of the associations emphasize their insurance services for members in the form of *collective* professional indemnity insurance also serving the protection of patients (see, for example, the SBO-BVO, SFDO and BOA), or they advise members to purchase such insurance for themselves (see the VOD).

Summary:
Of altogether 12 PURs (41%) not providing any information in their websites on the role of osteopathy in society, a total of 17 PURs (59%) provided us with the aforementioned content.
An examination of the websites of the three international organizations, EFO, FORE and WOHO, yielded no results (see Table 12 in Appendix D).

6.5 The political recognition of osteopathy

The websites of the professional unions and registers yielded the following results (see Table 10a, and 10b, c in Appendix D): France and the United Kingdom have recognized osteopathy as a profession and the professional designation (the title) is protected.

Belgium has recognized osteopathy as a non-conventional medical profession, but the title is not protected. From Switzerland we have the information that the profession is recognized, but no information on the protection of the title. In Italy osteopathy is recognized as a form of non-conventional medicine, and the title is not protected. No information is available on whether Italy recognizes osteopathy as a profession.
In Portugal osteopathy is recognized as non-conventional medicine, but the question as to its recognition as a profession and the protection of the title remains open. In Germany one state (Hesse) recognizes osteopathy as a specialization among other health professionals. The title is also protected in that same state. Osteopathy is not recognized as an independent profession in Germany.
In Spain osteopathy is recognized as a specialization for physiotherapists, but not as a profession. No information is available on protection of the professional designation (title).
In Finland osteopathy is recognized not as a profession, but as a specialization among other health professionals (in delegation); the title is officially recognized and protected.
In Austria, Greece, Ireland, the Netherlands, Norway and Sweden osteopathy is not recognized as a profession. (No further information is available on protection of the title or on recognition as a specialization).
No information is available on Denmark, Finland, Luxembourg, Poland or Russia.

The websites of the international organizations provide no further information on the individual countries.

Additional information from personal communications with the EFO (Rousseau, 03/2009):

According to Rousseau, General Secretary of the EFO, so far it has been France, Malta, the United Kingdom, Switzerland and Cyprus where osteopathy is "fully recognized," i.e. osteopathy is established in these countries as a primary health care profession with a protected professional designation and established professional statutes. A restriction in the case of Cyprus should be noted: the recognition of osteopathy as a profession applies only to the Greek part of the island.
We add that this "full recognition" is not recognition as the practice of *medicine*, but rather concerns the political recognition of the profession; the professional designation is consequently *osteopath* (= professional practitioner) and *not "*osteopathic physician".
Ireland and Sweden are expected to recognize osteopathy as a profession very soon.
In Belgium the professional statutes are in progress, so that the osteopathic profession has moved a bit closer towards achieving full recognition (including a protected professional designation).
In Portugal the situation is the same as in Belgium: The profession is recognized, but the title is not protected – the professional statutes are in progress.

Denmark, Luxembourg, Poland and the Netherlands have no state recognition of osteopathy. The Netherlands does accord the freedom to practice osteopathy, however. The organization of the profession is regulated through a (voluntary) register (NRO). Professional statutes have been formulated.

The EFO has no information on professional policy towards osteopathy in Norway and Russia.

Information from PUR websites	European countries (information from PURs)	Additional information from EFO (personal communication)	TOTAL
Full recognition of the osteopathic profession with protection of title	France, United Kingdom	Switzerland, Malta, Cyprus	5
Recognition of the osteopathic profession without protection of title	Belgium	Portugal	2
Recognition of the osteopathic profession – no information about protection of title	Switzerland	-	1
Recognition as non-conventional medicine without protection of title	Italy	-	1
Recognition as non-conventional medicine – no information on title protection	Belgium, Italy, Portugal	-	3
No recognition of profession but protection of title	Germany (one German state)	Finland	2
Recognition as a specialization for other health professionals	Germany, Spain	Finland	3
No recognition at all	Austria, Germany, Greece, Ireland, Netherlands, Norway, Sweden	Denmark, Luxembourg, Poland	10
No information available	Denmark, Finland, Luxembourg, Poland, Russia	Norway, Russia	7

Table 10a: Status of political recognition in Europe.
Key: PUR = Professional Unions and Registers (n = 29), EFO = European Federation of Osteopaths.

6.6 Scholarship and academic level within osteopathic medical education

Osteopathic education occurs in the various European countries in the form of part-time and full-time training, with the number of part-time schools predominating over the full-time colleges (see, for example, the ADO for Italy, with altogether three accredited full-time colleges and six accredited part-time schools, Appendix C, pp. 164-165). The requirements of the two forms of training vary, with the osteopathic part-time training as continuing education for people from prior medical and paramedical occupations requiring a low number of hours compared with full-time programs (see the ROI: part-time at least 1635 hours (167.2 credits)

and full-time at least 3600 hours (300 credits), Appendix C, pp. 166-167). The type of prior occupation also plays a role in some of the osteopathic part-time educational institutions: The training period for physicians is therefore sometimes set shorter compared with people from other prior occupations (see, for example, TOP-SCOM, Poland: the part-time training for physicians is 1000 hours and for non-physicians 1300 hours, Appendix C, pp. 174-177).

The variation in requirements on the two forms of training in the different European countries warrants presenting them in more detail.
The length of study for the *part-time training* required for possible recognition of the representative professional unions and registers in the different European countries is as follows: The longest period for part-time training is 6 years in France (UFOF), the Netherlands (NVO) and Austria (ÖGO), followed by Belgium (ROB), Denmark (Danske Osteopater) and the UK (GOsC) with 5 years. Germany (VOD) follows with 4 years and Russia (RRDO) with 3 - 4 years' training time.
No information was available for the other countries and PURs.

Full-time training is completed in Russia (RRDO) in 6 - 7 years, in France (UFOF) in 6 years, in Germany (VOD) in 5 years, in Austria (ÖGO), Switzerland (SVO-FSO) and the UK (GOsC) in 4 - 5 years, and Belgium's professional union, the ROB, stipulates 3 - 4 years. In the last case, ROB (like TOP-SCOM in Poland) further distinguishes between physicians or physiotherapists and other participants, but only in reference to full-time training. Physicians and physiotherapists can complete training in three years, while students with only secondary school education require four years. The Belgian association SBO-BVO mentions the possibility of a 6-year full-time course of study at the Université Libre de Bruxelles (ULB), comprising 5000 hours (or 360 ECTS) (personal communication, Rousseau, 03/2009). No information on full-time training was available (as above) for the other countries and PURs.
While the three PURs – the French SFDO, the Luxembourgian association ALDO and the Norwegian association (NOF) – do provide some information on the years of training (6 years and twice 5 years, respectively), these periods do not clearly refer to full-time as opposed to part-time training, so we cannot include them in our statistics.

It is interesting to look at the above training periods in combination with the numbers of credits required in the part-time versus full-time programs, and with the respective numbers of hours.
For the *part-time training* we have, in order of size, a minimum number of 2000 hours for France (UFOF), 1800 hours for Switzerland (SVO-FSO), 1635 hours (or 167.2 credits) for Italy (ROI) and 1350 hours for Germany (VOD).

In the case of *full-time training* France (UFOF) requires 5000 hours, Italy (ROI) 3600 hours (or 300 credits) and Switzerland (SVO-FSO) 3600 hours. The German association (VOD) gives no details on this point.

Some non-specific information is available from the Greek association with 5000 hours, the Spanish register (ROE) with 4500 hours, the Portuguese association (FOA) with 240 credits, the Norwegian association (NOF) with 2310 hours and the Polish association (TOP-SCOM) with 1300 hours for physicians and 1000 hours for non-physicians. Finally, the Luxembourgian association (ALDO) specified 1500 hours.
This information must be regarded as non-specific because it does not clearly refer to either full-time or part-time training (as stated by the PURs).
We may suppose, however, that the first two cases do indeed refer to full-time training. Accordingly the other data, with the lower numbers of hours, probably concerns part-time training. Note, however, that some of the prospective students with previous professional backgrounds can decide in favor of a full-time program, which they may be able to complete in a shorter period of study if need be. Consequently the latter data does not *necessarily* refer to part-time training (see the example of the ROB above).

The approved prior occupations for osteopathic part-time training are nearly always that of physician and physiotherapist (e.g. ROB). Other PURs, such as the ÖGO (Austria), expand their lists to include the occupations of ergotherapist and midwife, the VOD (Germany) accepts the occupations of *Heilpraktiker*, masseur and balneotherapist, the Danish association (Danske Osteopater) adds the occupation of chiropractor and the Polish association (TOP-SCOM) accepts medical students and people with master's degrees in other health professions. Finally, the Swiss association (SVO-FSO) adds hospital nurses and midwifes to its list.
Exceptions: The Italian association (ROI) admits only physiotherapists with the BSc degree for part-time training, the Russian association (RRDO) admits only physicians and the Luxembourgian association (ALDO) requires a degree in a paramedical or medical field or a minimum of four years of higher education.

Some of the PURs provide information on titles or on the awarding of academic titles, but it is not always clear whether these possibilities definitely exist in the respective countries or exist only through cooperative arrangements with institutions outside the given country or are merely noted as desired goals.
Award of DO: The degree of DO is stated (in these words) as the goal of altogether six PURs (ÖGO in Austria, ALDO in Luxembourg, NOF in Norway, RRDO in Russia, SOF in Sweden, SVO-FSO in Switzerland (intercantonal)).

Bachelor's degree: We have information from the four PURs (ÖGO, ROB for Belgium, Greece, SOF). The Swedish association (SOF) mentions the Bachelor's degree as an option of the school in Göteborg and refers to the cooperation with the British University of Wales.
Master's degree: The PURs ÖGO, SBO-BVO (Belgium), Greece, IOA (Ireland) and NOF mention the Master's degree as the goal. Belgium refers specifically to a "complementary Master," available from the Université Libre de Bruxelles (ULB) in a 6-year course of study. The Norwegian association NOF and the Belgian association (BAKO-ABOC) refer to a cooperative arrangement with the European School of Osteopathy (ESO) in Maidstone, UK.

Of course, other PURs stipulate *one* of the possible titles as a goal in training, but not all websites *expressly* provide information on this matter, and therefore cannot be included in this category. Altogether 21 PURs (72%) provided usable information (varying in volume), while the websites of 8 PURs (28%) contained no information.
Interestingly, Ireland seems to tie osteopathic training closely to the UK schools, for the AOI writes: "At present, neither of the Irish Colleges which trained Osteopaths in the past is accepting students, so the nearest alternative choice is in Britain."

Turning next to the information from the international organizations, we find the EFO taking up the Bologna proposals and writing that for each type of first-line-medical care a BAC/A level plus a training period of at least five years is *essential*. The EFO also notes, however, that the EFO by itself as well as in combination with Belgium and Switzerland currently offers osteopathic training equivalent to the BAC/A level plus six years (EFO, Appendix C, pp. 187).
The EFO sets as a goal full-time training with at least 4500 hours, as preparation for a Master's degree. The part-time training should comprise a minimum of 1500 hours (personal communication, Rousseau, 03/2009).
The document (EFSOET) available from FORE's website states that the number of contact hours should lie between 4000 and 4800, with a minimum of 1000 hours in osteopathic clinical training. The course duration for both full-time and part-time training should lie between 4 and 6 years. The Bachelor's degree is a minimum prerequisite for a final degree, but the Master's degree is considered more appropriate.
Both organizations (EFO and FORE) no longer expressly refer to the DO as the final degree. WOHO provides no information (see the information above in Table 13 in Appendix D).

6.7 Special features of content

Of the extensive information we collected in Appendix C, we give here only the most important regarding osteopathic identity: The websites sometimes differ considerably in their form of presentation. There are simple and neutral websites that sometimes place very much value on

clarifying the situation in professional policy in relation to the role of osteopathy in the current health care system. On the other hand, websites from other PURs serve more as advertisements for osteopathy, containing video links, colorful graphics and headings like "Osteopathy and you" (BOA, Appendix C, pp. 182-184). At the website of the Portuguese association (FPO), for example, we find video clips announcing: “Osteopathy…with you day-by-day to provide your tranquility, balance, health…the best professionals near you to regain your wellness." The Greek website contains a video with pleasant background music documenting the (in part quite private) life of a French osteopath and also showing some actual treatments of patients (in which the patients are not rendered unrecognizable). On the other hand, some PURs place special value on a serious Web presentation and include photos from medical practice (for example, FeSIOs in Italy). X-ray photos or spinal column diagrams are shown, or, as in the case of the Finnish association (FOA), photos of treatment showing osteopaths in white lab coats. The PURs having photos and/or video presentations on their websites mostly show hands being laid on a part of the body (such as the cranium). Some photos and video clips indicate techniques from the cranial, parietal or visceral fields of osteopathy.

A few PURs use their websites to explain the distinctiveness of osteopathy from other health professions. The explanations are very brief, as in the case of the Russian association RRDO (Appendix C, pp. 59-60), which simply notes that osteopathy is not to be compared to manual therapy or chirotherapy, or the explanations are very detailed, as in the cases of the two Belgian associations, the SBO-BVO and the ROB. We give the most important statements of the PURs regarding osteopathy and its distinctiveness.
Statements by the Belgian association SBO-BVO include the following:

> "Nonetheless compared to the other trends of Manual Medicine, osteopathy certainly acknowledges a bigger influence from the a-specific characteristics of its action, by the fact that its practitioners attach great importance to the value of 'touch,' even in its most symbolic connotation. It is an implicit recognition of the psychosomatic approach of osteopathy which is one of its special features.
>
> We would like to draw the attention of physical therapists to the fact that osteopathy is not a specialisation in physical therapy. The acts performed by osteopaths make in no way part of the domain of physical therapy. It is thus with full knowledge of the facts and after mature consideration that one must decide to begin studies of osteopathy and choose the path of a new profession." (SBO-BVO, Appendix C, pp. 124-125)

The underlying theme of this association is to develop among junior osteopaths an awareness of the distinctiveness of osteopathy. It gives the following reasons why such differentiation is useful:

- "The personal reason is to be proud to have achieved one's purpose, to have succeeded on a difficult path, to see one's efforts rewarded and to have reached a new therapeutic dimension.
- The professional reason is to help our patients find their way in the jungle of pseudo-osteopaths by offering them responsible and well-trained professionals. This differentiation comforts the patients in their initiative to consult and favours the "multiplication" of new patients. It is also a way to place ourselves among the other medical professions, to assert our professionalism as health practitioners and to encourage inter-professional relationships.
- The political reason is for administrative and political authorities to recognise osteopathy as a medical profession in its own right with a high level of responsibility and not to misconceive osteopathy as a sort of recycled physical therapy. Our profession is thus part of the health field at these different levels." (SBO-BVO, Appendix C, pp. 126-127).

The Belgian association ROB also offers information on distinguishing osteopathy, giving examples of manual medicine (called "manual medicine" or "manual therapy" by the ROB), physiotherapy and chiropractic.

Osteopathy *versus* "manual medicine (therapy)"

This heading makes clear that the term "manual medicine*"* is being equated with the concept of *manual medicine* and with that of *therapy* in the ROB's register. We emphasize, however, that the concepts differ insofar as osteopathy, chiropractic and manual medicine *in themselves* are (forms of) *manual medicine*, while the concept of *therapy* may also involve the delegation to therapeutic professions.

ROB writes that "manual" medicine rests on (consciously controlled) motions (in reference alone to the apparatuses of motion) as they are evaluated and treated both quantitatively and qualitatively. In contrast, osteopathy additionally includes the visceral and craniosacral systems (as two autonomously controlled systems), and establishes therein a difference from "manual" medicine (ROB, Appendix C, pp. 133-134).

Osteopathy *versus* physiotherapy

According to the ROB, osteopathic treatment attends more to underlying causes and stimulates the body's self-healing processes. It has less the task of treating individual painful or motion-impaired parts of the body. In contrast to physiotherapy, osteopathy has only little use for local, pain-relieving techniques or for relaxation and muscle training. Osteopathy is exclusively manual and, unlike physiotherapy, does not employ equipment (as used in electrotherapy, for example). According to the ROB, rehabilitation programs occur in physiotherapy but not in osteopathy. Another difference is the autogenous and self-learning relaxation and anti-stress techniques commonly used in physiotherapy but not in osteopathy (ROB, Appendix C, pp. 134-135).

Osteopathy *versus* chiropractic

We recall that chiropractic arose parallel to osteopathy and indeed from the roots of osteopathy. A large part of chiropractic techniques stem from the basic principles of osteopathic medicine. But the therapies also differ in that chiropractic mainly treats the apparatuses of motion and, compared with osteopathy, includes less the visceral and craniosacral systems. Consequently it is osteopathy that the ROB describes as holistic (ROB, Appendix C, pp. 132-133).

Looking at the websites of the international expert organizations, we find that FORE has a section in its "European Framework for Standards of Osteopathic Education and Training (EFSOET)" that also treats the "Distinctiveness of Osteopathic Practice" (p. 11). The forum describes the following distinctive principles and practical features:

> • "[…] Emphasis is on the patient and not just on their [sic] condition. This has been a longstanding tenet for osteopathy, and it is a conceptual principle that informs the whole of the osteopathic approach to care of the patient. It is about seeing a person not as someone with a disorder, but as someone who is seeking the facilitation of optimum health. It involves viewing the person as having an integrated blend of influences that combine to effect health. Osteopathy seeks to identify and address the key influences that will lead to restored health and well-being.
> • The intention to enhance the intrinsic health-maintaining and health-restoring capabilities of the individual person. This involves the consideration of a broad range of factors to identify and resolve the causes of impaired health.
> • Individually tailored intervention and advice encompassing a range of specific technical treatment modalities and approaches. These may include specific osteopathic manipulation techniques, exercise advice, lifestyle advice, dietary advice, coping strategies, and other advice to enable the patient to understand the cause and contributing factors of their [sic] impaired well-being.
> • An approach that emphasises the integration of the musculoskeletal system with other body systems, the reciprocal influences that impairment of function of each may have, and the adverse effects such impairment may have on the health of an individual.
> • Close collaboration between the patient and osteopath to identify the factors contributing to the patient's impaired well-being, and to determine the clinical and other changes needed to restore optimum health.
> • Enabling the patient to understand and implement measures to take responsibility for assisting their own recovery and enhancing their health.
> • Using critical reasoning to apply knowledge and skills in an integrated and informed manner."
> (FORE, Appendix C, pp. 191-193)

The website of the EFO provides only little information on this point. Links for definition, deontology, etc., do not appear with texts. The EFO's link on "History of Osteopathy" describes

the development of osteopathy in Europe in the case of England and France, and refers to a few differences from US osteopathy:

> "In contrast to the USA, highly qualified osteopaths, such as Littlejohn in England or Gény in France, were forbidden to perform surgery, prescribe drugs or to assist in child birth. This inevitably led to osteopathy developing in two directions. While the non-medically qualified osteopaths in Europe were compelled to concentrate on their manual techniques and improve these techniques continuously, the osteopaths in America undertook scientific research over a broad area, particularly in increasing the precision of surgical methods. If the origins of visceral techniques are in Europe (Barral and Weisschenk), minimally invasive and tissue sparing surgical techniques and important neurophysiological results are due to American initiatives (Korr, Denslow). Still's traditional holistic osteopathy with the central concept of the triune represents a symbiosis of these two approaches. The situation became even more complicated when European doctors arbitrarily mixed manual therapeutic and chiropractic elements and reduced their complexity to make them more suitable for every day work. The osteopath as intermediary was replaced by a local manipulator, working in a one dimensional manner, tending to restore the old hierarchy in which the therapist was simply "a pair of hands." In the context of the historical quarrel between doctors and non-doctors, all this has led to osteopathy becoming a plaything between the lobbies. Reconciliation may appear utopian at the moment, but is the only way and the most important challenge for all participants to develop osteopathy's full potential - for the good of the patient."
> (EFO, Appendix C, pp. 187-188)

Notable in WOHO's description of osteopathy is the reference twice to differences in the manner of osteopathic treatment and to the dependence of the success of osteopathic manipulative treatment (OMT) on the skills of the individual practitioner and also on the patient's type of complaints (in contrast to a holistic and non-symptomatic concept of treatment as described above FORE):

> "The application of osteopathic principles in clinical practice varies with the training, interest and license of the individual practitioner. A partial list of complaints in which osteopathic treatment would commonly be applied would include: back pain, headache, neck pain, shoulder pain, non-anginal chest pain, athletic or overuse strain injuries.
> Depending on individual practitioner expertise, osteopathic manipulative treatment may make a significant contribution to the health care management in the following diagnoses: muscle or ligament strains, ankle, elbow, knee, traumatic injuries without laceration or fracture, pregnancy and childbirth, gestation, labor and post-partum, muscle tension headache independent or associated with migraine sinusitis, allergic rhinitis, otitis media, infant colic, plagiocephaly, osteoarthritis, pneumonia, bronchitis, congestive heart failure, hypertension, gastric reflux, non acute cholecystitis, anxiety and depression, vertigo." (WOHO, Appendix C, pp. 188-190)

6.8 The formulation of a professional profile / code of practice

Altogether only three PURs (10%) state a professional profile or code of practice on their websites: the French register ROF, the Italian register ROI and the UK association GOsC (see Appendix C).
Of the international organizations only FORE provides information in the form of the following documents for downloading: the European Framework for Standards of Osteopathic Practice (EFSOP), the European Framework for Codes of Osteopathic Practice (EFCOP), and the European Framework for Standards of Osteopathic Education and Training (EFSOET).
In a new update of the EFO website (downloaded 06/2009, in addition to personal communication with Rousseau, 03/2009) we learn that a "scope of practice" (SOP) for Europe is in progress in cooperation with FORE. For the Netherlands a professional profile has already been elaborated by the professional union NVO and the register NRO (personal communication, van Dun, 05/2009).

6.9 The formulation of a code of ethics and code of deontology

Altogether five PURs (17%) allow free downloading of either a code of ethics or a code of deontology from their websites (see Appendix C). In the case of the Austrian association ÖGO, the French register ROF and the Swiss association SFO-SVO we have a code of deontology. The Polish association TOP-SCOM and the Russian RRDO speak of a code of ethics. The members' section of the Belgian SBO-BVO's website contains a code of deontology (personal communication, van Dun, 06/2009).
None of the websites of the international organizations EFO, FORE and WOHO yielded information on a code of ethics or code of deontology.
We do know, however, that a European code of ethics and a European code of deontology, as well as a European charter of ethics of the professional unions (developed by the EFO), already exist (personal communication, Rousseau, 03/2009).

6.10 The formulation of goals and admission criteria

Altogether 34% of the PURs (n = 10) out of altogether 29 PURs provide statutes through their websites, and these statutes generally also include a formulation of the purpose of the association in connection with the association's goals and the criteria for membership. In cases where no statutes were available, we searched the websites themselves. Altogether 59% PURs (n =17) offered no statutes, but at least expressed their goals. Only in two cases did we find nothing: the UK's BOA and the Portuguese register FPO. Altogether, therefore, we analyzed the goals of 93% of the PURs (n = 27), but these goals sometimes varied greatly in

scope (see Tables 13b and 13c in Appendix D). We can offer only an impression of the most frequently formulated goals and admission criteria that seemed interesting to us in our research on osteopathic identity (see Table 11a below and 11b, c in Appendix D).

Association goals

52% (n= 15) of the PURs set the *promotion and awareness of osteopathy among the public* as a goal. 48% (n = 14) pursue the goal of *political recognition of osteopathy as an independent profession in health care*. The same number of PURs (48%, n = 14) are working on the *specification and monitoring of osteopathic basic and advanced training* and another 48% of the PURs set *promotion and monitoring of members* as a goal. 31% (n = 9) promote the *DO title* or osteopathic training at a university with an *academic degree*. "Promotion of the title (or academic degree)" means, for example, that in some associations only the osteopaths with a DO title qualify as active members with full voting rights (see, for example, the Belgian association SBO-BVO and the Belgian umbrella association GNRPO), or that the stated goals refer only to osteopaths as DOs (see the French association UFOF, Appendix C, pp. 205-208), or that (in the case of the Russian association RRDO) a professional criterion for the protection of patients is that the trained physician have a diploma for this practice, among other things (Appendix C, pp. 237-239).

28% of the PURs (n = 8) formulate the *creation of documents*, like a *code of ethics,* a *code of deontology* and a *code of practice*. 21% (n = 6) speak of the *protection of the osteopathic patent clientele* by, for example, setting a high standard of training, sufficiently protecting osteopaths with professional liability insurance, binding the osteopaths to a code of practice, etc.. 17% of the PURs (n = 5) include the *promotion of scientific aspects* or *research in osteopathy* as an extra item in their list of goals. 14 % (n = 4) again expressly mention their efforts towards *solidarity between the different osteopathic groups* and 7% (n = 2) want to promote the *integration of osteopathy in hospitals* or *cooperation* with the latter.

The Belgian association BAKO-ABOC appears in the analysis as an exception among the associations, since its single clearly formulated goal is the *promotion of the osteopathic tradition*: "BAKO-ABOC wishes to promulgate and maintain this osteopathic tradition, received directly from the Maidstone college of Osteopathy (UK) of Mr. John Wernham."

Consider the goals of the international expert organizations in comparison: The EFO has set the goal "[...] to coordinate all efforts by professional unions of D.O. to gain legal recognition of osteopathy in each EU member country. [The EFO] will propose draft criteria for professional practice, a professional code of ethics and minimal training standards for all EU countries". A further goal is "[…] to stimulate consultation among all EU countries in order to promote the creation of a European Academy of Osteopathy, which would be autonomous and independent of the EFO." It will serve as the representative of the European osteopaths (DOs)

with the Commission of the European Communities and the European Parliament and "will avoid undue interference into national policies concerning the profession" (see EFO, Appendix C, p. 248)

The aim of FORE is *organized* cross-border health care by 2010, when the European borders will be opened for osteopaths (and other medical professions) and increased mobility of professionals and patients across Europe will become possible. "For these reasons FORE is working to improve information exchange and develop a consensus on standards of osteopathic education, training and practice across Europe." Its aim is to ensure that European citizens receive safe and effective osteopathic care. In this way FORE hopes to encourage the regulation of osteopathy as an autonomous health care profession where this does not yet exist (see Appendix C, pp. 253-256).

WOHO's goals are "to promote, develop, protect and establish throughout the world, the study, knowledge, philosophy and practice of osteopathy, its application and research for the benefit of the peoples of all nations […]". The organization wants to ensure the worldwide availability of the practice of osteopathy at the highest possible standards and wants to promote the integration of osteopathic philosophy and practice with related clinical and health care subjects (see Appendix C, pp. 248-250).

Admission criteria

In analyzing the admission criteria for members of the PURs, we must consider these criteria in relationship to the aforementioned goals. In most cases a distinction is made between active and passive or between ordinary and extraordinary members. The former generally have full voting rights, the latter restricted or no voting rights.

The results are as follows: In 69% (n = 20) of the altogether 29 PURs we were able to ascertain the criteria for membership. 31 % (n = 9) yielded no results. 59% (n = 17) require the DO title or an academic degree in osteopathy for full membership. 38% of the PURs (n = 11) expressly presuppose the completion of osteopathic training at one of the schools they recognize, but we may infer that all the PURs requiring a title (DO or academic degree) as a prerequisite for full membership also presuppose the corresponding training. In 7% of the cases (n = 2), namely the German association (VOD) and the UK association GOsC, completed osteopathic training according to the criteria of the particular professional union suffices for full membership.

17% (n = 5) of the PURs additionally require *exclusive* activity as an osteopath for full membership: the SBO-BVO and ROB in line with their umbrella association, the GNRPO (Belgium), the French register ROF, the Italian association ADO, the Polish association TOP-SCOM and the Switzerland association SVO-FSO. The SBO-BVO moreover distinguishes so-called "graduated aspirant members" already having a DO but still working part-time in their prior occupations.

To become a registered member in the Swiss umbrella association, the SVO-FSO, one must submit proof of having completed two years of (exclusively) osteopathic practice, among other requirements. This is one of several prerequisites for participating in an intercantonal examination leading to an intercantonal diploma in osteopathy.
An extraordinary membership is generally related to the status of the student in osteopathic training. Two PURs (the Austrian ÖGO and the Swiss SOF) accept students from the fourth year of training, 28% of the PURs (n = 8) stipulate no such particular training level as a criterion for membership.

As to the criteria of the international organizations, we find that the EFO requires membership in a professional union politically recognized (registered) in the given European country. Membership is restricted exclusively to those DOs registered with such organizations.
FORE's website contains no specific acceptance criteria except for the note that "national registers and competent authorities for osteopathy across Europe" are in question.
WOHO differentiates between types of membership (full registered membership, full membership of the organization, student membership, etc). One basic prerequisite for full membership at WOHO is proof of clinical, academic or scientific activities or practice "devoted to the promotion, application or development of […] osteopathic medicine […] including the minimum standards of education and clinical competence established by the Organisation" (WOHO, Appendix C, pp. 248-253). For registered (full) membership the following additional criteria must be fulfilled: "[…] a governmental recognized license as an osteopath or osteopathic physician in his or her country of practice" (WOHO, Appendix C, pp. 248-253), as well as a practice within those guidelines and the graduation from an "[…] osteopathic academic institution recognized by a governmental accredited licensing body".
For full (non-registered) membership the applicant must, in addition to completing the appropriate training (see above), submit proof that osteopathy in the given country is on its way towards achieving state recognition, state-recognized training and/or a license to practice.
Membership for students requires osteopathic training (undergraduate or postgraduate level) recognized by the Executive Committee, and this training must provide the foundation for full (or fully registered) membership.

Formulation of goals in osteopathy	PUR		EFO	FORE	WOHO
	%	N			
Promotion of osteopathy (among the public)	52	15			x
Promotion of the political recognition of osteopathy as a profession in health care	48	14	x	x	
Specification and monitoring of osteopathic basic and advanced training	48	14			
Promotion and monitoring of members	48	14			
Promotion of members with the DO or academic degree	31	9	x		
Set of standards in practice and conduct (ethics, deontology)	28	8	x	x	x
Protection of patients	21	6		x	
Promotion of scientific aspects & research	17	5			x
Solidarity between the different osteopathic groups	14	4	x		
Integration of osteopathy in hospitals/ cooperation with clinics	7	2			
Promotion and monitoring of the osteopathic tradition	3	1			
Formulation of membership criteria: full membership					
DO title or academic degree	59	17	x		
Graduate of recognized osteopathic school with a DO or academic degree	38	11			
Exclusively osteopathic practice	17	5			
Graduate of recognized osteopathic school (no title or degree required)	7	2			x
Student membership					
No mention of the completed year of education	28	8			x
After fourth year of education	7	2			

Table 11a: Number and formulation of goals and membership criteria of European osteopathic professional unions/registers and international osteopathic organizations (rounded up to whole per cent).
Key: PUR = professional unions and registers (n = 29), EFO = European Federation of Osteopaths, FORE = Forum for Osteopathic Regulation in Europe, WOHO = World Osteopathic Health Organization.

6.11 Osteopath lists

Nearly each of the PURs maintains a list of osteopaths on its website. Searching is usually possible by directly entering a name or by entering the region and/or postal code. The names of the list vary. A list of osteopaths (see (e.g.) GNRPO, Belgium) or a list of therapists (VOD, Germany) are mentioned, and sometimes there is even an extra list of students (see VOD (Germany), ADO (Italy)). Depending on the admission criteria imposed by the association on

its members, sometimes they consist only of osteopaths with a DO, osteopaths with an additional academic title and/or osteopaths without a title. The Austrian and German associations (ÖGO and VOD, respectively) distinguish in their lists between the prior occupations of the listed members and thereby constitute an exception among the PURs. For example, the register of the ÖGO contains the titles PT for physiotherapist, Dr. for medical doctor, MSc for Master of Science in Osteopathy, DO for Diploma in Osteopathy and "i. A." for *in Ausbildung* (in training). The association also lists members with a DPO (Diploma in Pediatric Osteopathy), in contrast to the other PURs, which do not make this distinction. The VOD divides its list into a category for physicians, *Heilpraktiker* and physiotherapists (the DO title is not necessarily, but possibly, listed). The other PURs sometimes list only names without any titles, and in the case of registers add the letters "MRO" after the DO title (plus an additional letter to distinguish the list from other registers). The Portuguese association (FeSIOs) seems to list exclusively osteopaths with an academic title (BSc). The list of the Greek association contains many (but not only) BScs.

Now and then we encountered unfamiliar titles, as in the case of the French association UFOF, with the titles T.O.M., D.O.M. and C.O. The Irish association AOI lists titles like M.A.O.I., M.B.O.A., R.N.(Dip), BSc (Clin.Sc.) and M.H.Sc.(Ost)).

Some professional unions (such as the French register ROF) keep their lists of osteopaths very neutral and brief with only names, addresses and phone numbers, while others (for example, ÖGO for Austria, VOD for Germany) include links to websites where individual members present their practices and/or osteopathy on their own homepages.

Looking more closely at the address data and names of the practices of individual members in the different lists of the PURs, we find them to include some non-osteopathic practices (such as physiotherapy practices, medical health centers, etc.) (see the ÖGO for Austria, VOD for Germany, FOA for Finland and ROI for Italy). The British association GOsC's list includes work places associated with "Ambition Fitness Healthcare," "Musculoskeletal Medicine," "Posture Dynamics – Healing Bodyline Fitness," as well as a few hospitals.

The EFO maintains a list of osteopaths arranged by name and region and containing exclusively osteopaths with a DO and/or academic degree.

FORE lists the PURs (private individuals are not listed).

The membership list of WOHO does not consist only of osteopaths, and does not further specify the names, regions or types of members. It contains osteopaths with and without a title or academic degree.

7 Discussion

The literature characterizes *identity* as a state of unity, coherence and continuity, connected with autonomy in thought and action (Straub, 1999, pp. 83-95). Nor is *identity* conceivable without the setting of boundaries and formation of oppositions (Assmann and Friese, 1999, p. 23). Setting these boundaries and forming these oppositions first require knowledge of *oneself*: What constitutes osteopathy *as such*, what is its *essence*, its *nature* (van Dun, 2008b)? We've learned that *identity* is not to be confused with the concept of *individuality* (Straub, 1999, p. 78), just as *identity* cannot be derived from uniqueness (Drexeler, 2009). It would therefore be incorrect to ask what makes osteopathy unique; rather, to determine its identity we must examine the nature of its mission (or purpose) and visions (goals and plans) (Meyer and Price, 1993). To this end we must also consider its professional beliefs (Hruby, 1993) and values (Tyreman, 2007). Drexeler's (2009) claim that identity cannot be derived from uniqueness contrasts with much of the osteopathic literature, which employs the identity-related concept of *unity/oneness* almost interchangeably with *uniqueness* (cf. Pugh, 1948; Kuchera, 1991; Allen, 1993; Meyer and Price, 1993; Hruby, 1993, 1994; AAOJ, 1994; Johnson and Bordinat, 1998; Miller 1998; Tieri, 1999; Pogorelec, 2000; Fogel 2001; Wagner, 2002; Licciardone, 2007; van Dun, 2006, 2008a, b). The osteopathic literature also speaks of *distinctiveness*, a concept to which the sociologist Norman Gevitz (2004) devotes an entire chapter in his book on US osteopathic medicine. Korr (1997a, p. 164), on the other hand, always reacts dismissively to the concepts of distinctiveness and uniqueness when applied to osteopathy:

> "I am sure that somewhere, in one of my earlier polemics, I must have explained my antipathy to the preoccupation with distinction as the reason for separatism from the majority medical profession.[…] First, it reflects a defensive, even apologetic posture. […]. Second, it is virtually impossible to distinguish oneself from something as ill-defined as orthodox medicine.[…]. Third […] there is no merit in just being different." (Korr, 1997a, p. 164)

Korr (1997a, p. 164) is of the opinion that the profession should ask itself what it can offer society that's new, in order to justify its existence as a *profession*. Here Korr (1997b, p. 172) has in mind something not in addition to regular medicine, but rather independent, which hitherto no other profession has provided to society in order to meet the latter's needs.

Now and then the websites we analyzed bring up the *distinctiveness* of osteopathy. Sometimes this distinctiveness was only hinted at in passing, however, as in the case of the Russian association RRDO and the Luxembourgian association ALDO: RRDO states only that osteopathy is not the same as manual therapy or chiropractic, while ALDO claims that osteopathy focuses on the forces of self-healing in the human organism and, unlike allopathy, does not pursue the battle against illnesses and their symptoms by appealing to external means (ALDO, Appendix C, pp. 168-170). The Belgian PURs, SBO-BVO and ROB, on the

other hand, discuss distinctiveness in deeper detail by explaining the differences from other forms of manual medicine (see section 6.7). Nevertheless, we can say that the PURs as a whole give very little attention to *distinctiveness* of osteopathy in relation to professional policy. One conceivable reason for this reticence would be that most of the PURs use their websites to inform potential patients and therefore omit content relating to professional policy. (Possibly policy matters are considered of interest only to the particular professional group and to other health professions).

According to Evans's model (in Tyreman, 2007), on the other hand, *professional identity* exists as much in the comparison with other professions as it does in direct reference to traditional principles, values and theories and to specialized clinical knowledge. In particular, Tyreman (2008a) views values as determinants of the *identity* of a profession, and claims that they influence professional behavior. It remains to be discussed whether professional behavior derives from the values or whether the values are the product of the professionals' behavior (Tyreman, 2008a). We consider this issue to have minor importance; rather, we find interesting Hruby's (1993) statement that we osteopaths are identified by outsiders as *osteopaths* on the basis of our thought and especially action.

It is also interesting to recall that there are two possible perspectives on osteopathic *identity* (as *a* profession): On the one hand, the *osteopath* can be defined in terms of certain distinctive, osteopathic qualities or in terms of professional values. This sense of *identity* lies on the theoretical level (i.e. in terms of a definition of osteopathy). Here the osteopathic principles could serve as an example of professional values. On the other hand, there is also a second perspective on *identity* at the practical level: namely, that (e.g.) the manner of treatment indicates the practitioner must be an osteopath because he or she embodies the defined distinctive qualities of osteopathy and, as in the aforementioned example, applies the osteopathic principles in the treatment. In other words, if the identity in question is "genuine," then it should be possible to infer from professional behavior to the profession of the practitioner.

Recalling "technical Darwinism" (van Dun, 2008c, p. 15), according to which the more efficient techniques naturally come to prevail over time, and are applied as a result of the interprofessional exchanges between the different professions, we have greater difficulty in identifying the profession of the given practitioner. We then realize that a profession cannot be characterized by its techniques alone. We need a separate concept with an underlying philosophy in order to construct an *identity* (in the sense of setting boundaries and forming oppositions as discussed in Assmann and Friese, 1999, p. 23). Because A. T. Still proceeded in this way from the outset and brought osteopathy into being with its own concept, Guillaume's statement (2002, p. 51) seems more than justified: "People are not osteopaths because they apply 'osteopathic' techniques". We can add Tyreman (personal communication,

2007) as support, who despite this "technical Darwinism" was able to observe significant differences between the practical activities of the osteopaths, the chiropractors and the physiotherapists (mentioned in an MSc course at the BSO).

On the other hand, if we consider the attributes of identity, namely unity, coherence and continuity, by themselves (and neglect the important points of setting boundaries and forming oppositions), then it could appear reasonable to unify the manual forms of medicine, namely osteopathy, chiropractic and manual medicine, by reference to their techniques (cf. Dvorak et al., 2001). Here again the remarks by Korr (1997a, p. 164) are important, who had previously emphasized that it is essential to a profession's justification of its existence to assert itself by performing a *specific* function for society. A profession like osteopathy must offer something to society that other professions cannot. The difference lies not (as mentioned above) in the techniques, but, according to Korr (1997b, p. 172), in the concept of health and disease (see also Drexeler, 2009). It does not suffice for osteopaths to distinguish themselves from the allopaths by opposing a pathogenetically oriented concept of health and disease, but rather osteopathy must clarify that a concept based in particular on *health* means *something more* than allopathy:

> "While continuing to be 'against' disease, the osteopathic medical profession must remember and proclaim that opposition to disease is not the same as the affirmation of health, any more than opposing war is enough to bring peace" (Korr, 1997b, p. 172).

Our analysis of the literature shows that the formation of *identity* is always correlated with a critical process that is to be regarded as "normal" if it does not become chronic. This view is interesting if we look back on the history of osteopathy in the USA and the United Kingdom, where the literature describes an identity crisis of osteopathy (Littlejohn, 1901; Hollis, 1910; Anonymous, 1963; Nicholas, 1983; Eckberg, 1987; Cole, 1990; Meyer and Price, 1993; Korr, 1995a, p. 228-230; Fisher Wilson, 1997; Miller, 1998; Johnson and Bordinat, 1998; Tyreman, 1998; Pogorelec, 2000; Fogel, 2001; Johnson and Kurtz, 2002; Cummings, 2003; Teitelbaum et al., 2003; Gevitz, 1988, 1994, 2004; Licciardone, 2007; Ha, 2008; Campbell, n.d., *for the USA*, *as well as* Tyreman, 1998*;* Fossum, 2002, p. 36 *for the UK*). In the case of US and UK osteopathy we suspect that the identity crisis has already become chronic, given the existence of osteopathy in these two countries for over 100 year as well as their histories. On the other hand, Erikson (in Straub, 1999, p. 85) writes that anyone never having acquired the ability (or having lost it) of creatively responding to such a crisis will suffer from *identitylessness*. For a counterargument we can cite Miller (1998), who concludes from her phenomenological approach to US osteopathy that the latter has succeeded in surviving to the present day because it always remained aware of its environment and, in view of the risks (both internal and external), managed to adapt. A similar vigilance regarding both the other professions and society can also be noted in the case of the United Kingdom, if we recall the continuous efforts

of British osteopathy to organize itself professionally and to distinguish itself from osteopathic "imitators (so-called freelance osteopaths) and other professions (such as naturopathy and chiropractic) by reference to the quality of osteopathy, combined with various adaptations in osteopathic education. Their struggle for a distinctive identity notwithstanding, ultimately both US osteopathy and British osteopathy succeeded in effecting state recognition as an independent profession. In these cases, given the historical changes, while we can speak of an *identity crisis,* we cannot *truly* speak of the *identitylessness* of osteopathy (see above).

A more detailed discussion of osteopathic *identity* (for Europe) is possible on the basis of its definitions, its characterized role in the health care system and in society, and its status in terms of professional policy. As to its *nature*, it is especially crucial to discuss its concept, the underlying osteopathic principles (= the professional and collectively agreed values) and the characteristics of osteopathy that are constitutive of its identity. In our website analysis the osteopathic collective we studied is represented by the selected professional unions and registers and by the umbrella (international) expert organizations.

The literature reports that osteopathy has so far failed to define itself: Fossum refers in this regard to the United Kingdom (Fossum, 2002, p. 40). Edna Lay (in Corriat, n.d., p. 110) is generally of the opinion that it is not possible to define osteopathy in one or two paragraphs, and Tanguy (2005) concludes that rather a *description of what osteopathy is*, as more flexible and extendable conceptually, has helped osteopathy survive to the present day. Our website analysis confirms the statements by Lay and Tanguy in that it indicates a clear trend towards *describing* osteopathy (97% DEF_{des} compared with 14% DEF_{def}). The same trend also reveals itself in the "definition of the osteopath" (86% DEF_{des} compared with 0% DEF_{def}). Deriving *identity* from unity and coherence, we do find some deviations in content among the PURs: While a still relatively large majority (69%) of the osteopaths are in agreement in defining themselves as "osteopaths" and in defining their actions performed on the patient as "manual" ("by hand"), the percentage of agreement for the other definitional criteria we analyzed is rather low. Only 55% define osteopathy as a *causative, non-symptomatic treatment* and 52% relate osteopathy to *science or scientific knowledge*. Particularly the last criterion is a crucial one for the possible status of osteopathy as a *profession* (see Table 2 in section 3.4.1)[44]. The website analysis revealed 52% of the PURs and WOHO to describe the indications and contraindications of osteopathy, whereas 48% of the PURs (and FORE) do not speak of indications and contraindications. Moreover, 55% of the PURs (and FORE) define *osteopathy as non-symptomatic treatment*, as opposed to 7% of the PURs which view osteopathy as *symptomatic treatment*.

Since indications (and contraindications) are offered for osteopathy *as such* on the basis of certain clinical characteristics and complaints, we might say of osteopathy that it bases itself

[44] We discuss this criterion in more detail below.

on a pathogenetic (or allopathic) concept. It is an open question whether such a characterization would not conflict with the osteopathic concept given that the latter is geared primarily to human health (and to the human capacity for autoregulation and self-healing) and that this emphasis on human health is a reason given by the osteopaths *themselves* for the distinction from allopathy with its emphasis on pathogenesis (Korr, 1997a, p. 164; Drexeler, 2009). We suppose, however, that these lists of indications (and contraindications) are intended to give the website visitor as a lay person a picture of the comprehensiveness of the osteopathic practice as something not limited to musculoskeletal complaints.

Of interest would be a differentiation within the list of indications and contraindications by reference, not to osteopathy *as such*, but to its techniques. This would both make the list of contraindications for some of the PURs shorter and confirm the criterion of the *individual, patient-oriented* character of osteopathy. As we know, we osteopaths have a whole arsenal of techniques at our disposal that allow us to fall back on a "gentler" technique (such as a counterstrain technique) in the event of a contraindication for a particular other technique (such as an HVLA technique) (Lesho, 1999).

Our website analysis showed that the PURs vary in their listing of indications and contraindications: the spectrum ranges from a long list to no list at all, and from indications and contraindications related to techniques to those not related to techniques.

Regarding osteopathic identity in terms of unity, continuity and coherence, our website analysis shows that the content of the definitions of osteopathy and of the osteopath also deviate with respect to other criteria. Moreover, some of the results even appear inconsistent: for example, a relatively large percentage (66%) of the PURs describe osteopathy *as a system of diagnosis and treatment* in their "definition of osteopathy," whereas 31% of the PURs give the impression in their "definition of osteopathy" that the latter is *exclusively* a *system of treatment*.

It is interesting to contrast this criterion with that of *autonomy/independence*, which only 14% of the PURs put forth. One might conclude that a system containing its own diagnosis and treatment would underpin a self-sufficient and independent profession (cf. van Dun 2008c, section 4.5.4), but evidently only a minority of 14% of the PURs (see above) are of this opinion. Evidently we have here two levels of consideration: an "internal" attitude towards osteopathy that conceives it as an autonomous system, and the external observation that hitherto osteopathy has been *fully recognized* only in five countries and in the other countries, such as Austria and Germany (in Germany in the case of the "non-*Heilpraktiker*"), still partly depends on delegation by the physician. This would be another explanation of why none of the PURs in the website analysis describe the osteopath as a *primary health care practitioner* (in contrast to FORE's policy) or as an *osteopathic physician*. This could also be related to the fact that 38% of the PURs define osteopathy as a *form of therapeutic method* or *treatment*. In

contrast, 31% describe it as a *form of medicine or medical in character*. The remaining PURs avoid (consciously or unconsciously) the polarization expressed by the terms *therapy* versus *medicine* by opting for the descriptions like *system of health care / caring approach / system of healing*, or by speaking of osteopathy as an *art*, *philosophy* or *discipline*. We do not know (since we did not research this question) how large the possible percentage of physicians and physiotherapists within the PURs is that could have an influence on the last criterion.

It was interesting to examine a possible correlation between the political recognition of osteopathy as an independent profession and its characterization as a *form of medicine* or as *medical*. We find, however, that no such correlation exists: Looking at the three countries of France, the United Kingdom and Switzerland (besides Malta and Cyprus that we did not analyze through their websites)[45], where osteopathy enjoys "full" political recognition (as confirmed by Rousseau, personal communication, 03/2009), our website analysis found that none of these countries categorized osteopathy as a *form of medicine or medical in character*. On the contrary, it is France and Switzerland, among others, which describe osteopathy as a *form of therapy* or *treatment* in their "definition of osteopathy". The United Kingdom (represented by the GOsC and the BOA) does not enter into either category.

While explaining this by our chosen inclusion criterion of *terminological occurrence*, we also have the impression that the PURs do not consciously distinguish between the concepts of *medicine* and *therapy*. Possibly some PURs have adopted "osteopathic medicine" *as such* simply as a *customary* descriptive phrase (for no particular reason). We also think that the concept *therapy* is not always (i.e. necessarily) brought into relationship with a delegation process, but rather that it is used in the sense of the curative character of osteopathy. The concept of (osteopathic) *treatment* is possibly associated with the concept *therapy*.

Concerning osteopathic principles, we note Tanguy's (2005, p. 28) remark that they should be integrated in a *description* of osteopathy since they characterize the original and distinctive osteopathic concept (even if these principles no longer apply specifically to osteopathy). We also find that the osteopathic principles form a part of the characteristics constitutive of osteopathic identity (see section 4.5.7, based on Peppin, 1993; van Dun 2008b; Tyreman, personal communication, 2007).

In contrast, Korr (1997c, p. 184) emphasizes that while the osteopathic concept (which he describes as the "osteopathic strategy of health care") is inherent to the osteopathic principles, "[…] the strategy is not implemented through the pious repetition of such inarguable clichés as 'the body is a unit', 'structure and function are interrelated,' and 'the body is endowed with healing powers'." He sees the task of osteopaths to be rather in-depth research of the implications of osteopathic principles for practical action in medicine and for the development

[45] We excluded Malta and Cyprus because their website addresses were not available from EFO and FORE at the time of the analysis.

of a health care system. In other words, according to Korr (1997c, p. 184), we osteopaths should demonstrate the relevance of these principles for the "disease burdens" both at present and in the future.

Our website analysis showed that a clear majority of the PURs (83%) mentioned at least one of the osteopathic principles (17% mentioned none). On closer consideration, however, this majority presents us with no such agreement as the Kirksville Consensus Declaration would indicate. Only 3% make use of the Declaration. A clear majority use their own compilation of the principles which, however, in most cases reflect the first three principles of the Kirksville Consensus Declaration in a different order of sequence (*relationship of structure and function* (69%), *self-regulatory processes / restoration of homeostasis* (66%), *body as unit* (55%)). The detailed character of the presentations of the principles varies, nevertheless we can claim that a large number of the PURs are inclined to explain these principles very precisely and understandably to the website visitor.

80% of the PURs do not reproduce the fourth point of the Consensus Declaration: *Responsible treatment is based on the first three principles*. As we already noted, however, the identification of osteopaths by outsiders (in this case including the patients) becomes possible only when osteopaths integrate the defined qualities of their activities in their treatment instead of merely having recourse to individual techniques (or principles). The fourth point of the Kirksville Consensus Declaration could also be viewed as an abbreviated code of practice wherein an osteopath officially avows the first three principles. We also refer back to the result of our analysis of the literature that only the *combination* of the identity-forming features (characteristics) *as such* (including the osteopathic principles, see section 4.5.7) takes us to the distinctiveness of osteopathy (cf. Tyreman, personal communication, 2007; van Dun, 2008b).

We also researched in the literature, as a further key characteristic of osteopathy, the *manual form of diagnostics and therapy*, which was also confirmed by the website analysis of 69% (for manual character) and 66% (for diagnosis and therapy) of the PURs.

Peppin (1993) discusses *specific palpation* or the *osteopathic touch* as perhaps the only characteristic *specific* to osteopathy. The number of PURs referring to this distinctive characteristic in their definitions is rather low, however (21%).

Our website analysis revealed the drugless concept of osteopathy so much propagated by A.T. Still (Still, 1910, p. 14-15) to be reflected by the *drugless / no-surgery* criterion, employed only by 17% of the PURs. Only 17% of the PURs stress the criterion of *somatic dysfunction or osteopathic lesion*, which plays a prodromal role in the emergence of pathologies, thereby forming an important basis of the preventive character of osteopathy (van Dun, 2007). The "definition of osteopathy" by the international organizations (EFO, FORE and WOHO) does *not* contain these two last key characteristics.

We remain with the preventive character of osteopathy as a further identity-forming characteristic (see van Dun, 2008b and Drexeler, 2009): Our website analysis found that 45% of the PURs mention or describe the preventive role of osteopathy alongside that of the curative (using these terms). From descriptions of illnesses and their symptoms, in connection with their treatment through the restoration of homoeostasis, only the curative role of osteopathy becomes evident to the lay person in 48% of the PURs. As already noted above, only 17% of the PURs employ the concept of *somatic dysfunction or osteopathic lesion* when explaining the function of osteopathy as preventive medicine. Nor do the international organizations present a unified picture in this regard: FORE emphasizes the preventive and curative roles, while WOHO brings up only the curative character of osteopathy.

In our survey of the literature we explained the role of osteopathy in primary care, which on the one hand constituted an important development niche for US osteopathy (Meyer and Price, 1993; Gevitz, 1994; Cameron, 1998) and on the other hand, according to van Dun (2008b), is aspired to as a position of osteopathy in the present health care system by most of the European osteopathic unions, including the European umbrella organization EFO, (see the Staten-Generaal Osteopathie der GNRPO, 2007; and the Osteopathic Practice Framework of GOsC, Consultation Document, 2009, p. 3). In contrast, our website analysis found only seven European countries where the PURs stressed the role of osteopathy in primary care (referred to in the analysis as first-line medical care), namely Belgium, France, Ireland, Luxembourg, Norway, Switzerland and the UK.

As we know, in the above remark van Dun (2008b) is referring to documents such as the Staten-Generaal of the Belgian umbrella association GNRPO (see above). These documents are not themselves available through the websites of the PURs (including that of the GNRPO), however. We find that this partly also applies to the information of the Staten-Generaal in terms of *content*: Although this information is subject to agreement by the Belgium PURs we analyzed, it does not appear on every website. An example of such a gap in information is the characterization of osteopathy as *first-line medical care*, which, according to the document, found 100% agreement by the PURs. The phrase *first-line medical care* does not specifically occur on three of the four Belgium websites, however (in contrast to the websites of six other countries and the European umbrella organization FORE).

We know from our study of their websites (and from personal communication with Rousseau, 03/2009) that France, Switzerland and the UK politically also recognize osteopathy as first-line medical care. We suspect that the political role has an influence on this characterization as primary care by the PURs. In other words, we again seem to have two ways of treating *identity*: either characterizing it in terms of external (definitive) qualities only (such as apparent political recognition), or, following Hruby (1993), deriving identity from beliefs or (in the case of

Meyer and Price (1993)) from visions. Consequently we must ask why the PURs do not seek to exemplify more their vision (= aspired goal) of osteopathy as a profession in first-line medical care. This last point can actually be extended to all aspired goals of the osteopathic profession that are still to be fulfilled in the future.

An important basis for discussion that presents itself regarding the role of osteopathy as an independent profession in the health care system is its classification as *regular*, non-*conventional*, c*omplementary* and/or *alternative* medicine. From the literature we know that this classification is still pending in part: While osteopathy is politically recognized as *complementary medicine* in the United Kingdom (Maxwell, 1993; Ernst, 1993; Wilson et al. in Tyreman, 1998)[46], in the USA discussion continues on whether perhaps osteopathy is "not alternative at all" [AAO, downloaded 09/2008] but rather *mainstream*, or ultimately *alternative* (Cassileth, 1999, Mc Partland, 1999) or alternative *and* complementary (CAM) (Fossum, 2002, p. 30).

Nor did our website analysis provide any clear-cut classification in this regard: Two PURs (from Greece and Italy) describe osteopathy as *either* complementary *or* alternative (CAM). In seven countries (France, Germany, Italy, Norway, Poland, Spain and Switzerland) the PURs classify osteopathy as *complementary*. In the cases of Belgium, Italy and Portugal we know that osteopathy is legally recognized there as non-conventional medicine (Colla Bill, Lucchese Bill, Lei 45/2003), without further details being provided on the classification as *alternative* and/or *complementary*. Our website analysis found that Germany, Spain and Finland recognize osteopathy as a specialization for other health professionals. We may infer that a classification as *complementary* medicine or therapy therefore also comes into question. If osteopathy has become a specialization in physiotherapy, we might also regard it in the future as *mainstream* (since physiotherapy falls under the delegation by regular medicine).

The lack of clarity notwithstanding, our website analysis indicates a trend towards assigning osteopathy to the group of complementary forms of medicine. We note that the classification as *medicine* or *therapy* is also not clear-cut.

In our research of the concept *alternative* in the literature we found, among other things, that the concept of *alternative medicine* is usually applied to the practice of medicine exercised independently or instead of conventional medicine. Conversely, the c*omplementary* treatments represent a form of medicine or therapy applied in combination with or in addition to conventional treatment [English Wikipedia and The Alternative Medicine Home Page, downloaded 04/2009].

If we consider this last point from different perspectives, we can basically extend our discussion to the division into *alternative, complementary, non-conventional, regular,*

[46] In an article by Budd et al. (1990) we found both concepts, *complementary* and *alternative*, applied to osteopathy in the UK.

mainstream, and conventional and question the practicality of this classification. For example, according to Maxwell (1993), given the criteria (a solid foundation in science, clinical effectiveness, and public demand) for complementary medicine one can regard osteopathy as *complementary*. From another perspective, however, one can equally consider osteopathy as *mainstream* at the point where it becomes standard therapy for certain dysfunctions and pathologies for which regular medicine can achieve either little or no amelioration (van Dun, 2008c). Conversely, we can ask ourselves whether a *conventional* treatment (as in the case of low back pain (LBP)) doesn't itself become *complementary* when it is additionally combined with a manual form of medicine (osteopathy, chiropractic or physiotherapy), perhaps performed or delegated by the physicians themselves. We recall van Dun (2008c)'s point that in view of its progressive academization and political recognition osteopathy might also be regarded as a *regular (form of)* medicine sometime in the future.

The Panel on Definition and Description, *CAM Research Methodology Conference (1995)* includes the statement that the "boundaries within CAM and between the CAM domain and the domain of the dominant system are not always sharp or fixed" [The Alternative Medicine Home Page, downloaded 04/ 2009]. The same panel stated that the decision on the classification of other forms of medicine as CAM basically depends on the current, politically dominant health care system (relative to an individual society and its culture). The panel refers to the statement by Freidson quoted by Bear (1981) that every other form of medicine deviating from the norm (of organized medicine "as pre-eminence") enters into a direct conflict with the latter. According to Bear (in Glover and Asuboteng Rivers, 2000, p. 158) Freidson sees the main criteria fulfilled for the leading status of regular (organized) medicine to be "its professional dominance, prestige, esoteric knowledge, autonomy and humanitarian service ethic of legitimacy." Glover and Asuboteng Rivers (2000) add that the historical interaction between the allopaths and the osteopaths can be characterized as a struggle over power and domination on the part of the allopaths and as a struggle for self-determination and autonomy on the part of the osteopaths.

But we can equally gather that the aforementioned panel is speaking of a *currently* dominant (that is to say, *temporally limited*) health care system related to a particular society and its culture. Consequently it is also society that can have an influence on health policy and the composition of its health care system. All the more important it then seems to inform society on the "osteopathic offer".

As we've learned, interest is growing among consumers in other "alternative" possibilities of treatment (Ernst, 2000): Osteopathy has come to be regarded by society as more effective and humanistic than the regular medicine (Ernst in Glover and Asuboteng Rivers, 2000). Korr (1997a, p. 165) describes the humanistic type of service inherent to osteopathy as extraordinary. He sees in it a function that hitherto no other profession has been able to offer to society.

Altogether our website analysis yielded little information on a possible interest of society in alternatives to regular medicine: For example, only two PURs provided statistics on osteopathic consultations. The website analysis did reveal a second aspect of the social function of osteopathy that we did not find described in the literature, however, namely its function in sports, in animal care and in the establishment of charitable osteopathic facilities. Our analysis found that osteopaths are also active in these areas, even if only a few PURs actually provide information on this score. Generally we can say, however, that the osteopathic profession as characterized by the PURs and the international organizations has recognized the importance of informing society as much as possible. This is evident from a few highly detailed websites of the PURs as well as from the publicity activities of the PURs in the form of their presence at trade fairs, newspaper articles, TV appearances, video clips, etc. (see, for example, Greece and VOD, Germany).

Another point for discussion is the seriousness of osteopathy as a form of medicine, often doubted especially by allopathic medicine. As we learned from the literature, this seriousness was already brought into question in the early days of A. T. Still (Gevitz, 2004, p. 51). Even later, the literature still notes this doubt (cf. Quackwatch – Your Guide to Quackery, Health Fraud, and Intelligent Decisions, downloaded 03/2009, which, to be sure, was started as a website by an MD). Nevertheless, even our website analysis contains a few indications as to how the seriousness of osteopathy as medicine could be put up for discussion. Some of the websites advertise osteopathy as a form of "wellness," for example (see the Portuguese register FPO in section 6.7). They contain banners like "Osteopathy and you" (see the BOA website). We must concede, however, that we've based our assessment here a bit on regular medicine and its standards. We can only give a subjective impression: It seems odd to us that a branch of medicine like osteopathy should present itself so colorfully on some websites, with video clips, banners (like the above), musical background, etc. We are rather inclined to associate seriousness with a neutral and technically informative presentation of osteopathy. No small number of the PURs seem to share this inclination, as their websites show (e.g. FeSIOs in Italy, SBO-BVO in Belgium and ROE in Spain).

The literature tells us that the importance of a profession for an individual lies in its economic aspect (as a material basis) and in its social function (Jentsch, 1997). Contrary to Korr (1997b, p. 172) and Drexeler (2009), who define the role of osteopathy in terms of its function *for* society, Jentsch (1997) relates the *social* function to the status of a profession and to its carrier prospects regarding the individual. Both (status and carrier prospects) are crucial for the opportunities of self-realization and lifestyle for a member of the profession, and influence that person's bond (identification) with his or her profession. This interesting aspect also underpins Eckberg's (1987) hypothesis: An image crisis of osteopathy is the consequence of a conflict

between the "classical" life style commitment to one's own profession and the rationalization process of allopathic medicine with its trend towards specialization and scientific elitism. One result is the phenomenon of so-called "backdoor students" who use the osteopathic training programs in order later to get a foot in the door of allopathy.

Of interest is a consideration of the roles of professional status, a profession's prestige and its economic aspect in the case of European osteopathy. As we found in our analyses of both the literature and the websites (and fully confirmed at least for Austria and Germany; see the lists of osteopaths of the VOD and ÖGO), factionalization occurs within osteopathy with respect to prior occupations. In particular, we ascertain a difference in status concerning the prior occupations of physician and physiotherapist: Regular medicine is a recognized *profession* and physiotherapy is a recognized *semiprofession* because the latter falls under medical delegation (Schämann, 2005, p. 32).

A distinction between the *osteopathic physician* and the *osteopath* has also been declared on the international level (EROP's Declaration on Osteopathy, 2008; WOHO Guidelines; and documents of the International Osteopathic Alliance; personal communication from van Dun, 05/2009), although the professional designation of *osteopath* has attained legitimacy in five European countries in line with a full recognition of osteopathy (personal communication, Rousseau, 03/2009), and the designation has also existed independently of such a recognition from the outset in Europe (see the history of British osteopathy given in section 4.3 above and EFO/History, downloaded 05/2009).

The question therefore arises why this distinction is upheld: In reviewing the studies by Eckberg (1987) and the information by Jentsch (1997), the thought suggests itself that the same status concerns underlie the aforementioned division into factions: As long as osteopathy does not enjoy the prestige (due to a medical profession) as a *profession* (of medicine), in particular the physicians among the osteopaths will stick with the status of their prior occupations. For the profession of physician this would mean a loss of image, prestige and a loss in material terms as well. For people with the prior occupation of physiotherapy, on the other hand, the problem would be less serious, since osteopathy is generally considered a high-quality form of training (as attested by, among other things, its recognition as a *specialization* for physiotherapists in Spain, Finland and in the German State of Hesse). The latter may even have the prospects of a better income (see the results of the survey on treatment costs in section 6.3). On the other hand, it is certainly no simple matter to relinquish an established physiotherapeutic or medical practice for an osteopathic practice as long as osteopathy is not recognized by the state and accordingly protected as a profession. In particular we also have in mind the economic aspect, given the important role played by the health insurance companies in reimbursements: As our website analysis showed, these reimbursements vary greatly because of the absence to date of the corresponding state regulation in most of the countries (see the results reported in section 6.3).

If a future goal of the osteopathic professional group is to form (or preserve?) a *collective* professional identity, then it must counteract the progressing division into factions, in line with pursuing the goal of creating a uniform osteopathic status as a *profession*. In the future this status should also extend to the present osteopathic physicians, in order to integrate them in a satisfactory way. For activity in the area of first-line medical care, which is connected with the delegation-free, autonomous activity as an osteopath (cf. van Dun, 2008c in section 4.5.4), appropriately high-powered training must be ensured as a prerequisite (see the EFSOET by FORE, downloaded 04/2009). One possible step towards standardizing osteopathic education would be to set full-time instead of part-time training in osteopathy as a goal. Our website analysis showed that besides the part-time schools some full-time schools exist as well in the different countries, although the part-time institutions outweigh the full-time ones (see the ADO for Italy, for example). There also exist a few universities offering studies in osteopathy (such as the ULB in Brussels with its Complementary Master's degree).

We note that the number of osteopathic schools generally plays an important role in the quality of the education. Pandeya (2008) writes that too large a number of schools could be related to lower quality, since not enough high-quality instructors can be recruited for the training programs. In view of the relatively short history of osteopathy, as is the case of most European countries [see, for example, Germany, VOD, downloaded 05/2009], one can well imagine that the number of experienced osteopaths who are potential instructors is limited. Moreover, the excessively large and fast increase in the number of osteopathic schools leads us to suspect that for-profit institutions may be involved (Mychaskiw, 2007).

We recall the case of France, which we know originally had more than 80 schools requesting accreditation. Initially only 12 and then later on 47 schools received accreditation, after the quality of all the schools had been checked (personal communication, Zegarra-Parodi, 05/2009). Our analysis of the literature showed 11 schools existing in Germany, with an unclear number of branches. We did find, however, that the International Academy of Osteopathy (IAO) *alone* listed 14 locations in Germany [IAO, downloaded 05/2009].

Given this excessive number of schools, the question arises as to the *seriousness* of osteopathic education. In the latter case, we would return to the aforementioned status concerns of the physicians in the event of a standardization of the professional image of osteopathy.

In our analysis of the literature we examined, among other things, the concept of *professionalization*, which can have two meanings: The concept applies both to the development of an activity exercised in an occupation and to the elevation of an occupation to the higher status of a profession [German Wikipedia on "*Professionalisierung*," downloaded 08/2008]. According to the latter sense, a *profession* is an academic occupation with a high level of prestige [English Wikipedia on "Professionalization," downloaded 08/2008].

Consequently, one goal of the osteopathic profession could be *professionalization* by means of the steps described by Wilensky (1964) and by fulfillment of the criteria listed in Table 1. Osteopathy should be aware, however, of the aforementioned different senses of "professionalization," namely as an *occupation* and as a *profession*, respectively. If osteopathy understands itself as medicine, its goal must then be to bring about its status as a *profession*. In presenting itself as a method of treatment, osteopathy at best acquires the status of a *vocation*, or it remains a recognized *specialization* of the prior occupations.
It is also interesting to observe that the steps of professionalization as described by Wilensky (1964) in part occur in Europe in the reverse order. Following the establishment of osteopathy in Germany, for example, we find that the German Association of Osteopaths (Verband der Osteopathen Deutschlands) achieved recognition as a specialization in the state of Hesse even before the educational structure became established on the basis of a university [see WPO-Osteo in 2008, VOD, downloaded 12/2008].

In the literature we came across the following criteria for being a *profession* (see Table 1: *academic level, scientifically specialized knowledge/special expertise, code of ethics, nonprofit, competence monopoly, autonomy of action, self-control through professional associations, social function, social recognition, collective value orientation* and *core task/defined scope of practice.*
Comparing these criteria with the information gathered from the website analysis, we find that 52% of the PURs ascribe *scientifically specialized knowledge* to osteopathy in their "definitions". There are also indications that osteopathy has aspired to an *academic level* in recent years: In osteopathic education we find the aspired degrees of DO (six PURs), the Bachelor (4 PURs) and Master (5 PURs). Some individual universities (such as ULB in Belgium) also offer an osteopathic degree program, and others [such as Danube University Krems, WSO, downloaded 05/2009] cooperate with a (private) school for osteopathy. The title of DO introduced in Europe, equivalent to a diploma in osteopathy, is awarded for a successfully defended scientific thesis. Some research centers have emerged with an interest in advancing scientific work in osteopathy [for example, the National Council for Osteopathic Research (NCOR - University of Brighton) and the Centre Européen d' Enseignement Supérieur de l'Ostéopathie/Département Recherche (CEESO) Paris & Lyon – France, in CORPP/Databases, downloaded 05/2009]. All in all, therefore, the first serious steps have been taken in Europe towards the academization of the osteopathic profession.
Our website analysis found that 5 PURs provided a *code of ethics* and/or a code of deontology on their websites for free downloading. Moreover, the EFO and the Belgian umbrella association GNRPO provide a code of ethics and a code of deontology (Rousseau and van Dun, personal communication, 03/2009). As far as this criterion is concerned, we may therefore say that European osteopathy is on the way towards becoming a *profession*.

Certainly there are some countries forming the vanguard and others forming the rear guard in this endeavor.

We now turn to the criteria of *competence monopoly*, *autonomy of action* and *core task/defined scope of practice* together with the results of the literature search and the website analysis: The literature reveals a trend towards mixing osteopathy with other therapies and forms of medicine (Grundy and Vogel, 2005; Krönke, 2006; Vogel and Herrick, 2008; Vandenberghe, 2008). It remains to be discussed whether in this way osteopaths can expect to expand their scope of practice or whether this might not be counterproductive for the dissemination of a code of practice, and whether setting boundaries and forming oppositions in the interest of osteopathic identity (as explained by Assmann and Friese (1999, p. 23)) would still be possible with this approach.

Osteopathy is fully recognized in five of the altogether 29 countries we researched; that is to say, osteopathy is recognized in these countries as an independent profession in the field of first-line medical care, its professional designation is protected, and professional statutes (containing a code of practice, among other things) have been formulated. In two other European countries the statutory regulation of osteopathy is expected in the near future (Rousseau, personal communication, 03/2009). Statutory regulation alone as a profession (*without* protection of the title), as has been the case so far in Belgium and Portugal, does *not* lead to monopoly of competence. This is evidenced by the Belgian professional union "Unie voor gediplomeerden in de kinesitherapie en de osteopathie (UKO)" [downloaded 05/2009] and attested by personal remarks by people (personal communication, van Dun, 05/2009).

Pertaining to the criterion *core task/defined scope of practice* only 3 PURs provide a professional profile or code of practice on their websites. As we know, however, the Netherlands (as an additional PUR) also has a professional profile available (van Dun, personal communication, 05/2009). This time we also find that the websites do not reflect all information. Moreover, EFO and FORE are currently working on a scope of practice (SOP) [EFO, downloaded 06/2009].

In sum, European osteopathy is also on the way to meeting these three criteria (*competence monopoly, autonomy of action and core task/defined scope of practice*) for being a *profession*.

The criterion of *self-control through professional associations* is obviously fulfilled: Except for Malta and Cyprus (the latter hitherto represented by an individual person) we were able to find among 29 countries at least one, if not several, professional unions that generally also maintain a list of osteopaths. As we found in our analysis of the literature, however, a large number of professional associations indicates a splintering of the overall professional group, leading to the weakening of the collective and to achievement of the goals set (Schulze-Krüdener in Schämann, 2005, p. 30). The history of British osteopathy confirms Schulze-Krüdener in her remarks. This is probably the reason why the EFO and the WOHO as

international umbrella organizations also advocate a merger of the European unions into national umbrella associations. Italy and Ireland accommodated this "wish" only recently (Rousseau, personal communication, 03/2009; WOHO News, 03/2009). A trend in the opposite direction is currently occurring in Germany [see VOD, with the goal of founding a second umbrella association, DVO, in addition to the existing umbrella association BAO, downloaded 05/2009].

We will not separately discuss the criteria of *social function*, *social recognition*, *collective value orientation* and *nonprofit* again, since they were treated above. Pertaining to the criteria of *social recognition* our research yielded altogether few results, but we refer to the statistics on patient consultations on the websites of the Belgian association SBO-BVO and the British GOsC, and to the information in the literature, which shows an increasing trend in the consumption of alternative forms of medicine (Ernst, 2000, Glover and Asuboteng Rivers, 2000).

7.1 Limitations of the study

The professional unions and registers we researched concern only those organizations maintaining a membership in EFO and FORE. In other words, our website analysis did *not* consider other European unions and umbrella organizations, as well as and in particular, the medical osteopathic associations (except for EROP in the literature part of this study and the Russian association RRDO).

We discovered that not all the information known to us from other sources was to be found on the websites of the PURs, so that the actual status has possibly changed here. In addition, linguistic difficulties and the low quality of the automatic translation programs we used are possible sources of error.

Our own understanding of languages, as well as our own nationality, had an unavoidable influence on the number of articles we could research from the different European countries (with preference given to the countries where English, German, Dutch or (in part) French is spoken).

In our analysis of the websites with respect to the concepts we searched we partly relied on specific word searches to minimize error. In some other cases we added closely related terms. Viewed as a whole, the website analysis was susceptible to a certain degree of subjectivity, which we tried to exclude as much as possible (by searching for specific terms, for example, which we did not imposes on ourselves as a strict rule, however, since it did not seem practical for each of the categories in our list of questions).

7.2 Suggestion for future research

Only few qualitative studies, such as the cross-sectional survey by Vogel and Herrick (2008), reflect the practical activities of osteopaths as they occur in real life. It would be interesting to conduct this sort of study in the other European countries in order to assess the actual status of osteopathy there. Such a study could give an overview on the extent of agreement between the level of theory and professional policy of osteopathy on the one hand and the actual practice as an osteopath on the other. The study could then serve as the basis for creating a professional profile.

8 Conclusions

The aim of this thesis is to explore the identity of osteopathy in Europe and to arrive at a picture of the current status of this identity. The issue took form as we noticed the differences in osteopathic terminology and in the practical application of this terminology within the osteopathic professional group.

The literature reveals that identity generally is a state of unity, coherence and continuity, and that it underlies autonomy in thought and action and as well as the setting of boundaries and the formation of oppositions. To ensure the formation of such boundaries and oppositions, the osteopathic professional group must recognize and clearly define the *nature* of osteopathy. Consequently, the professional group of osteopaths must pose the question of the distinctiveness of osteopathy, *not* in order to define osteopathy relative to the other manual forms of medicine, but to present *what* osteopathy is *inherently*, what is *essential* to it.

We conclude that the *identity* of osteopathy is to be understood as a collective term encompassing both the *personal* identity of the osteopath and the *collective* identity of the osteopathic professional group. The collective sense can be related to *professional identity.* In other words, the osteopath *and* the professional group commonly form a professional identity through the identification with *osteopathic professional values*.

We conclude that the *state* of osteopathic identity depends on the ability of the professional group to characterize osteopathy in a *uniform* way, in line with shared osteopathic values and goals. In particular, it is the professional values that exercise an influence on the behavior of the professional osteopath (Tyreman, 2008a).

We conclude that osteopaths are identifiable to the outside world by their professional activities given the integration of the identity-constituting features of osteopathy, elaborated in section 4.5.7. We emphasize that only the *combination* of such characteristics constitutes the

distinctive identity of osteopathy. A presentation of individual characteristics does *not* suffice since they are not specific to osteopathy.

We have empirically established that the osteopathic professional group in Europe, as represented by the national professional associations and registers and international osteopathic organizations, at present does not have the ability to present osteopathy *uniformly* enough for meeting the stated criteria of identity (unity and coherence).
We can consequently claim that European osteopathy is undergoing an identity crisis. According to the literature, this condition must be assessed as "normal," since it is associated with the formation of an identity, unless the condition becomes chronic.
We also conclude that osteopathy is not identity*less*, since its history in the USA and Europe (i.e. UK) proves that it has hitherto been able to react creatively to its identity crisis, for otherwise it would not have advanced to statutory regulation in these countries and would probably have been absorbed into other forms of medicine and therapy, namely by allopathy in the USA and by (e.g.) naturopathy and chiropractic in the UK.

We also conclude from our research of the term *professionalization* that certain steps must be completed before osteopathy can become a recognized vocation or a profession (Figure 2). A profession is an academic vocation enjoying a high level of prestige and fulfilling several criteria (Table 1).
If we consider the criteria of *academic level* and *scientifically specialized knowledge/special expertise*, we can infer a trend towards the academization of osteopathy, related to the goal of establishing a Master's degree in osteopathic education. Nevertheless, at present the DO degree predominates, with the Bachelor's degree taking second place. The DO title is of “limited value” insofar as the corresponding degree is awarded not by accredited universities, but by the professional unions. We conclude that the number of universities currently offering full-time study in osteopathy or part-time study in cooperation with an osteopathic school is still too small for fulfilling the *academic level* criterion.
The fulfillment of the criterion *academic level* is also dubious given the excessive number of osteopathic schools. As the cases of France and, given the Flexner Report, of the USA show, we may assume that a high number of schools include a certain number that would not pass a quality inspection. We conclude that in those European countries where so far there has been no statutory regulation of osteopathic education and which also have a large number of schools the probability is high that *some* of these schools are of low quality and moreover are for-profit organizations (Mychaskiw, 2007).
We think that the educational structure of these schools still varies partly because EFO and FORE as European umbrella organizations can only make recommendations in the form of guidelines to the national professional unions and registers. Checking the implementation of

the guidelines by the national professional unions and registers does not lie in the purview of EFO and FORE.

We conclude from the documents of EFO and FORE (which themselves slightly differ in the specifications of length of training and numbers of hours) that osteopathic training on the average should consist of five years and nearly 4500 hours in the case of full-time training. Part-time training should involve a minimum of 1500 hours.

In reference to the criterion of *scientifically specialized knowledge/special expertise*, we can conclude that European osteopathy is indeed on the right path (we have in mind the new research centers), but also that the professional associations and registers altogether incorporate *scientifically specialized osteopathic knowledge* to an inadequate extent (52%) in their definitions of osteopathy.

In sum, concerning the aforementioned criteria of *academic level* and *scientifically specialized knowledge/special expertise* we conclude that while the osteopathic professional group manifestly aspires to meet these criteria in the future, it is still far from reaching this goal.

Other criteria that European osteopathy is *beginning* to fulfill are *self-control through professional associations*, *creation of a code of ethics* and *core tasks*. While osteopathy in Europe is represented in the majority of the countries by the corresponding professional unions and registers that we researched in our website analysis, differences do exist in the level of organization in terms of professional policy, this level being determined by the total number of professional associations. Too large a number of professional unions and registers indicates a low level of organization and a weakening of the collective (Schulze-Krüdener, in Schämann, 2005, p. 30), from which we infer a present threat to the identity of European osteopathy.

We therefore deem appropriate the endeavors by the international organizations, WOHO, EFO and FORE, to unite the professional unions and registers and to bind them to a *code of ethics,* a *code of deontology* and a *code of practice (core task).* A few such documents are available from EFO and FORE as guidelines, and some professional unions and registers have elaborated documents like these, but by far not all of these professional associations highlight them on their Websites.

We can therefore infer that the criteria of *code of ethics* and *core task* are not sufficiently met. Given the differences in emphasis of these criteria for being a profession, we may say that the professional unions and registers do not uniformly apply these criteria to the extent required by a collective with its *common* orientation and as would be appropriate to osteopathic identity.

The fulfillment of the criteria *competence monopoly/defined scope of practice/core task and autonomy of action* depends on, among other factors, the status of the political recognition of osteopathy. As we found, the level of recognition of osteopathy varies considerably in the

individual countries. It ranges from full recognition as a profession to recognition as a specialization for other prior occupations or no recognition at all. We may assume that if the title is not protected then the scope of practice is also not legally protected or defined. Nor is there a monopoly of competence without full recognition.
Accordingly, since these professional criteria are also not *uniformly* fulfilled, we cannot speak of a collective identity of European osteopathy as an occupation with the status of a *profession*.

We can conclude that *social function*, as manifested by the preventive and curative character of osteopathy (Drexeler, 2009), among other things, is also not *uniformly* asserted as a criterion (as far as the importance of the preventive character is concerned). Regarding the criterion of *social recognition*, the two sets of statistics available from the Belgian and UK websites do not provide enough evidence for inferring a protected identity of osteopathy in Europe. We may conclude, however, that sports, including competitive athletics, is considered a potential area of activity for osteopathy.

An attempt to draw further conclusions on the clinical level of osteopathy ends in a dilemma between characterizing osteopathy as a field of *medicine* and / or characterizing it as a form of *therapy*.
We find that while osteopathy is spoken of as a field of *medicine*, the chosen designation of the professional is *mainly* that of the osteopath. Other designations, such as *primary health care practitioner* and *osteopathic physician*, are rarely used.
Moreover, a simple majority of seven professional unions and registers describe osteopathy as complementary, two refer to it as complementary *or* alternative, and the rest of the associations abstain from this classification. This variance is due in our opinion to uncertainty on the part of the osteopathic professional group regarding the classification as *CAM* or *mainstream*.
We conclude that the osteopathic professional group characterizing osteopathy as *complementary* wants to preserve for itself *both* the status of a field of *medicine* as practiced by the physician *and* the status of a form of *therapy* as practiced by other health practitioners.
The presentation of osteopathy as medicine *and* as therapy is attributable to, *among other things*, *an* existing factionalization of the osteopathic professional group into the *osteopathic physician* and the *osteopath*. This factionalization of the osteopathic collective results in a difference in status not consonant with *unity*, *continuity* and *coherence* in reference to an osteopathic *identity*. Status is additionally tied to the economic aspect and the cost-benefit relation. The latter is an important factor in the osteopath's identification with his or her vocation (Jentsch, 1997).

We conclude that as long as osteopathy does not have the status of an independent profession and *moreover* its establishment in the health care system is not coupled with the assurance of reimbursement for osteopathic services, the probability is high that the economic aspect will predominate and consequently militate against giving up the well-established practice of a physician, physiotherapist or other practitioners. The *safer* option economically would therefore seem to be the combination of osteopathy in the existing practice with the prior occupation. We conclude, however, that a loss of identity would ensue for osteopathy, in giving up its boundaries and oppositions. The identification with osteopathic values by adherents of the profession *must* consequently be very high if this identification is to outweigh the economic aspect and lead to a re-opening of an osteopathic practice following relinquishment of the prior occupation.

Finally, comparing again the history of US osteopathy with that in Europe (i.e. the UK), we find some parallels and differences from which we may draw the following conclusions.

Parallels

- The absence of statutory regulation of osteopathic education has a negative impact on the quality of the schools.
- A large total number of schools often includes those with lesser quality.
- Organization of the profession through the formation of professional unions serves quality assurance and the distinction from osteopathic "imitators".
- Professional and standardized organizations increase the chances for recognition.
- Both US and European osteopathy are discussing the issue of the identity of osteopathy.
- Both forms of osteopathy pose the question of their scope of practice and their application of additional means.

Differences

- In the USA osteopathy is recognized as a field of *medicine*, and consequently one speaks there only of the *osteopathic physician.* In Europe there is a factionalization according to the prior occupations, and one refers both to *osteopathic physicians* and to *osteopaths.*
- In the USA *DO* stands for "Doctor of Osteopathy," and designates the status of a physician. In Europe the DO stands for "Diploma of Osteopathy," and is not an academic degree.

- In the USA osteopathy is represented to date by only one association: the AOA. Europe has numerous associations, resulting in a weakening of the collective.
- In the USA osteopathy is evidently greatly influenced by allopathy. In Europe it is rather influenced by other forms of CAM.

In concluding our discussion of osteopathic identity, we suggest that the inhomogeneity of our professional group might be explained by reference to Bucher and Strauss's view of professions as segment-related associations "[…] pursuing different goals in different ways and more or less loosely combined under a common occupational heading at a particular period" (Bucher and Strauss, in Schämann, 2005, p. 27; see also section 3.4.5).
It is accordingly a challenge for the osteopathic professional group to defy this view of Bucher and Strauss by *collectively* aligning themselves with their professional values and working through their identity crisis with creativity.

We end by returning to the question we raised at the beginning of this thesis: Will osteopathy succeed in retaining its essential character despite all the differences and conflicts, all the different directions and schools, and all the struggles between traditionalists and modernists, while also redefining this character for a new generation in Europe?

Epilog

Osteopathic Identity: Finding the Pony

„There were once two brothers, one of whom was an incurable pessimist and the other an incurable optimist. One year, on Christmas day, the pessimist was given a room full of shiny new toys and the optimist, a room full of horse manure. The pessimist opened the door to his room full of toys, sighed and lamented, "A lot of these are motor driven and their batteries will run down; and I suppose I'll have to show them to my cousins, who'll break some and steal others; and their paint will chip; and they'll wear out. All in all, I really wish I hadn't gotten this room full of toys!" The optimist opened the door to his room full of horse manure and, with a shout of glee, threw himself into the muck and began burrowing about in it. When his horrified parents extricated him from the excrement and asked him why on earth he was trashing about in it, he joyfully cried, "With all this horse manure, there's got to be a pony in here somewhere!"

(Adapted from the story told in Sackett et. al: Clinical Epideminology: A Basic Science for Clinical Med., second edition, Boston: Little, Brown and Company, 1991, in Hruby, 1993)

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