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NORSK OSTEOPATFORBUND

Svenska Osteopatförbundet

Suomen Osteopaattiliitto ry · Finlands Osteopatförbund rf

Danske Osteopater

OSTEÓPATÍA
OSTEÓPATAFÉLAG ÍSLANDS

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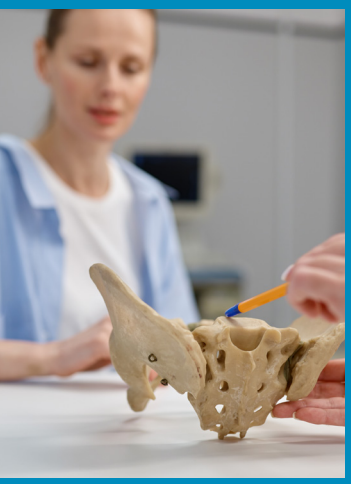

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5th annual congress

Words from the editor

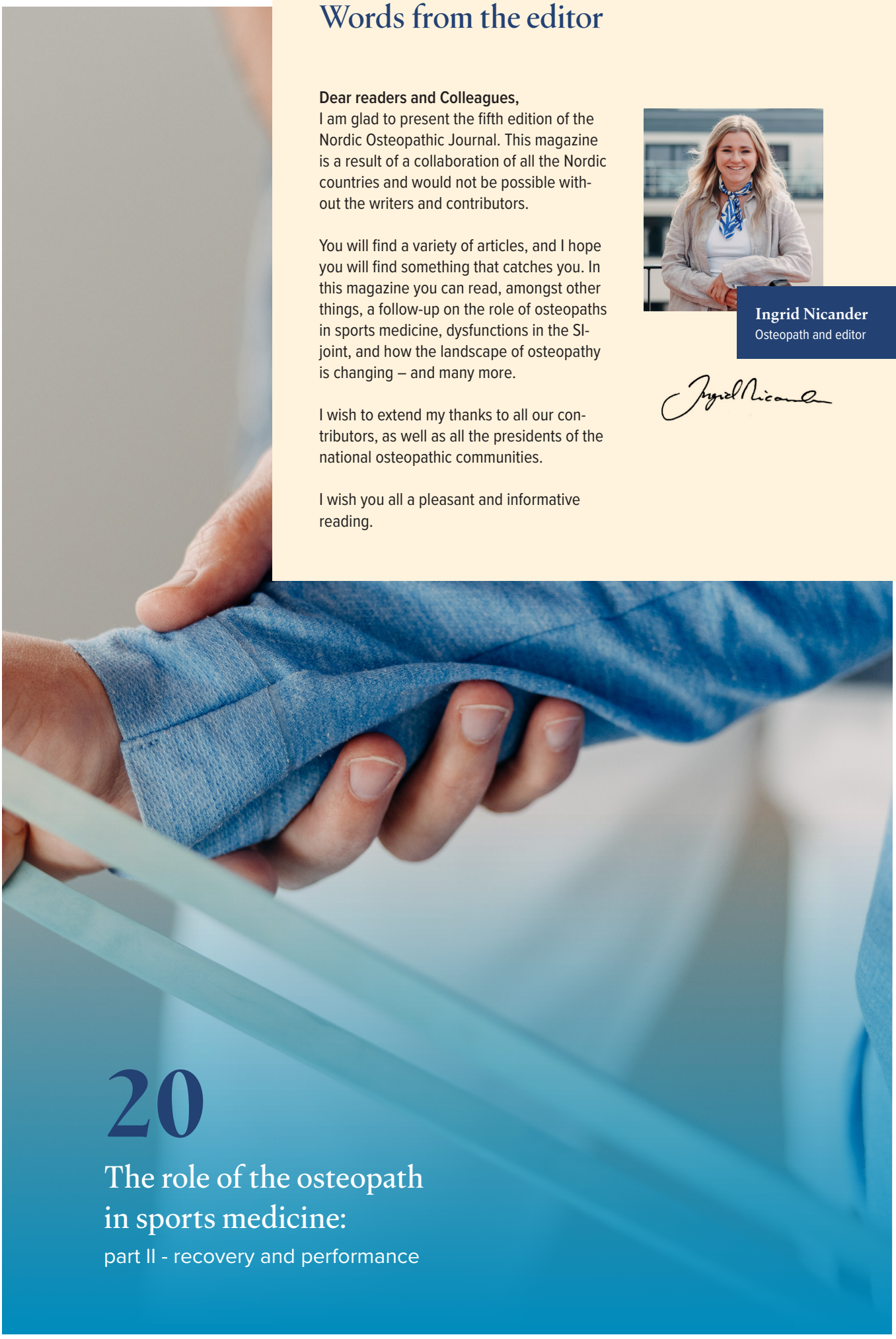
Dear readers and Colleagues,
I am glad to present the fifth edition of the Nordic Osteopathic Journal. This magazine is a result of a collaboration of all the Nordic countries and would not be possible without the writers and contributors.

You will find a variety of articles, and I hope you will find something that catches you. In this magazine you can read, amongst other things, a follow-up on the role of osteopaths in sports medicine, dysfunctions in the SI-joint, and how the landscape of osteopathy is changing – and many more.

I wish to extend my thanks to all our contributors, as well as all the presidents of the national osteopathic communities.

I wish you all a pleasant and informative reading.

Ingrid Nicander
Osteopath and editor



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The role of the osteopath in sports medicine:

part II - recovery and performance

Nordic Osteopathic Alliance

Haraldur Magnússon
President of the Icelandic Osteopathic Association

Regulated since: 2005

Number of members: 3 and a few more pending

Laura Lee Calonius
President of the Finnish Osteopathic Association

puheenjohtaja@osteopaattiliitto.fi
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Regulated since: 1994
Number of members: 205
included students

Tomas Collin
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Regulated since: 2022

Number of members: 447
included students

Emmelie Hansen
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Number of members: 365

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Regulated since: 2018
Number of members: 360
included students

Nordic Osteopathic Alliance

Dear colleagues,

Dear colleagues, times are changing for the osteopathic community and the whole healthcare sector. There is a severe lack of health personnel, especially nurses and general practitioners, and health services struggle to meet the demand.

In several countries worldwide, especially the UK, there is a significant lack of osteopaths to cover open positions, leaving the regulator and association somewhat worried when also seeing declining numbers of new students. The picture is though not all black, as some institutions are in good development and attracting new groups of students.
In the Nordics, we are happy to see a profession that is growing and becoming more and more established, but there are also challenges in our area of the world. We need to continue to work for nationally accredited education to be delivered in all Nordic countries and for a statutory regulation to be installed in Sweden as the last of the five Nordic countries. With this in place, the Nordic would stand out as one of the most well-regulated regions globally, which would align with the vision of regional reciprocity and harmonization presented by the Nordic Ministry. Some critical voices can be heard expressing their worry that regulatory framework and accredited education could limit the profession. For us, it is crystal clear that statutory regulation and accredited education are crucial for setting good standards for osteopathic practice. These measures will ensure the profession's future and valued position within the healthcare services.
Nordic osteopathic healthcare is mainly delivered as a primary service, with osteopaths running private practices. There is a clear demand for osteopathic healthcare from the general public, and many Nordic health insurance provides reimbursement for consultations. At the same time, it takes its toll for new graduates to start a practice and get the ball rolling.

We see a clear and positive trend towards osteopaths running practices in cooperation with colleagues, osteopaths, other healthcare professionals, and fewer sole practitioners. This will improve healthcare provision as working in teams and engaging with competent colleagues are generally good features of any severe service. Teaming up as the Nordic Osteopathic Alliance has proven to be good for our osteopathic community, regionally and nationally. We will continue to draw from our mutual experiences and continue to work to promote osteopathic healthcare in the Nordics and beyond. Finally, we welcome you all to Oslo for the 2024 edition of the Nordic Osteopathic Congress. Hope to see you there!

Kind regards,
The NOA presidents.

Laura Lee Calonius, Finland
Emmelie Hansen, Sweden
Hanna Tómasdóttir, Danmark
Tomas Collin, Norway
Haraldur Magnússon, Iceland

A changing landscape for Osteopathy

Text: David Josefsson

The landscape for osteopathy is changing. Not just in terms of Osteopathic culture, popular theories and tools for practice. The very base for practice is the patients seeking Osteopathic care and our knowledge about that particular group is expanding and demanding new perspectives.

The predominant explanatory models for musculoskeletal pain have been dismantled one after the other in recent years. This is true both in regard to established conceptions within conventional health care as well as classical osteopathic models. The biomedical and biomechanical paradigm has been overthrown. Patoanatomical models of pain have been questioned after a tidal wave of studies showing weak or non-existent correlations between radiological findings and pain (1,2,3).

Kinesiopathological models that have been diligently used within physiotherapy have also been questioned, when the lack of scientific support have become increasingly obvious. Things like lower back rounding, knee valgus and scapular dyskinesis have failed to predict pain, despite being preached as the root cause of common complaints (4,5,6). The same is true for models focusing on motor control like core stability or the ”sleepy butt syndrome” (7,8,9).

The traditional osteopathic models tend to fall somewhere in between, with ingredients of both patoanatomical and kinesiopathological elements, as well as more imaginative attempts of tying static or dynamic examination findings in the movement apparatus to painful states. Many connections like this have been thoroughly tested without any findings of casual relationships (10,11). This challenge to our profession have more recently been brought up by Dr Oliver Thompson with more than a little commotion within the osteopathic society (12).

No matter what one may feel in regards to the criticism of our models and workings, we likely just have to accept that the driving causes of musculoskeletal pain is not mainly going to be found within the body of the patient, but rather in the elements of her life. An increasing number of studies points to correlations between painful states and different types of habits, behaviours, psychological and social factors, external stressors and general determinants of health (13,14,15,16).

This means that we have to consider all of theese factors if we want to help our patients in the best possible way. If we do, then maybe we can actually name Osteopathy an holistic practice for real.

We are not alone in facing this challenge and the argument for expanding the management of musculoskeletal pain have been made elsewhere (17).

There are attempts being made in other areas of healthcare to expand the scope of practice, using concepts such as the biopsychosocial model and personcentred care. In my work as a teacher and tutor I find students and young osteopaths embracing concepts like this in theory, while struggling with its real life applications. How can we in a concrete way, work with the patients cognitive conceptions, behavioural patterns and social structures etc in order to affect somatic symptoms?

There is no obvious answer to this question, however the first step must be posing it in the first place. There is also some solid work being done in this field, where Peter O’Sullivans Cognitive Functional Therapy (CFT) have rendered itself quite some attention more recently (18). Springing from physiotherapy, one of the main tools within CFT is therapeutic exercise. At the same time there is an active struggle within the system to demystify the direct effects of exercise and bring focus to the ways in wich they may support broader goals within a biopsychosocial framework.

It should be well within reach for Osteopaths to make use of their toolbox in the same way. Instead of losing our spirit over the fact that our models don’t stand the test of time, we should focus on replacing them with more constructive ones.

In my own experience, manual therapy is an incredible tool for influencing many of those factors that we now know have an actual effect on musculoskeletal pain. Touching the patient is perhaps the most potent tool for therapeutic bonding and confidence-building. Pleasant and soothing touch is also the most intuitive practice among humans for managing distress, be it physical, psychological or emotional. Making use of that hard-earned physical competence by offering a thorough manual examination often means building even more confidence and security, setting the stage for a productive therapeutic conversation and patient adherence when discussing subsequent matters of for example behavioural changes.

The ”scientification” of musculoskeletal health has in some sense brought with it a biproduct of practical paralysis. No model or tool seems to be potent enough to invest in. Lots of studies have been focusing on the way things do not work as well as the effects and values we can not expect. The subsequent result is patients complaining over their care with words like:

> ”I didn’t even take of my clothes”
> or
> ”The doctor didn’t even touch me”

If we want our patients to open up about their everyday practical hardships or emotional lives, let alone be prepared to engage in informed lifestyle changes, then we likely first have to

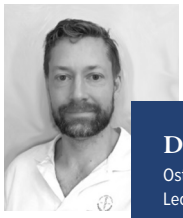
accommodate their expectations and wishes. Osteopaths may have a unique position to do so by just staying with ingrained rituals. Listening (case history taking), looking (inspecting) and feeling (palpating) means validating the person and their suffering. When the patient feels seen and understood, we are most likely in a better position to be heard, if advocating for example increased levels of physical activity or cessation of smoking.

Many of our tools like joint and soft tissue manipulations also have valuable potent short term effects on pain that may be used as a stepping stone for other interventions. A respite from pain may create space and energy for habitual change, as well as demonstrating the adaptability of the human body to instill hope and motivation. Changing the outlook on life and getting more physically and socially active may then be the key to long-term effects on pain and disability.

In the same way that looking at and touching a painful body part is a way of communicating interest and concern in the patients situation there is also something symbolically important about being able to physically adress that body part. It is yet another way of demonstrating an understanding for the problem and initiate the mental process of the patient that hopefully will result in expectations of change. Once that very difficult step is achieved, when the patient actually believes in the process, all other measures becomes more accessible.

We must also remember that while some particular (osteopathic) treatment techniques might fail to show superior results over other treatment options, it is very important to be the one therapist to do something. Offering no treatment at all is guaranteed to also have no effect at all. If we keep listening, examining and physically adressing the patients complaints, we have done half of the work. We can then make use of the process and our position to build more constructive belief systems regarding the body and pain, support better stress management strategies and inspire healthier lifestyle choices, among other things. Such a comprehensive management is lightyears away from some old school approaches, but still very true to osteopathic philosophy and the identity as an holistic and inclusive practice.

We need not throw the baby out with the bathwater but rather apply our tools in a novel way. We should probably also strive to connect more deeply with the patient as an actual person rather than as a mere physical structure. In short, theese new insights brought to us by scientific discoveries need not reduce Osteopathic practice, but rather expand it. The modern Osteopath might not only be targeting joints and muscles, but everything that makes up a person, including factors outside the physical body.



David Josefsson
Osteopath & Physiotherapist
Lecturer & Author

References:

1. Brinjikji W, Luetmer PH, Comstock B, Bresnahan BW, Chen LE, Deyo RA, Halabi S, Turner JA, Avins AL, James K, Wald JT, Kallmes DF, Jarvik JG. Systematic literature review of imaging features of spinal degeneration in asymptomatic populations. AJNR Am J Neuroradiol. 2015 Apr;36(4):811-6.

2. Horga LM, Hirschmann AC, Henckel J, Fotiadou A, Di Laura A, Torlasco C, D'Silva A, Sharma S, Moon JC, Hart AJ. Prevalence of abnormal findings in 230 knees of asymptomatic adults using 3.0 T MRI. Skeletal Radiol. 2020 Jul;49(7):1099-1107.

3 Girish G, Lobo LG, Jacobson JA, Morag Y, Miller B, Jamadar DA. Ultrasound of the shoulder: asymptomatic findings in men. AJR Am J Roentgenol. 2011 Oct;197(4):W713-9.

4. Rabelo NDDA, Lucareli PRG. Do hip muscle weakness and dynamic knee valgus matter for the clinical evaluation and decision-making process in patients with patellofemoral pain? Braz J Phys Ther. 2018 Mar-Apr;22(2):105-109.

5. Villumsen M, Samani A, Jørgensen MB, Gupta N, Madeleine P, Holtermann A. Are forward bending of the trunk and low back pain associated among Danish blue-collar workers? A cross-sectional field study based on objective measures. Ergonomics. 2015;58(2):246-58.

6. Littlewood C, Cools AMJ. Scapular dyskinesis and shoulder pain: the devil is in the detail. Br J Sports Med. 2018 Jan;52(2):72-73.

7. Lederman E. The myth of core stability. J Bodyw Mov Ther. 2010 Jan;14(1):84-98.

8. Lehman GJ, Lennon D, Tresidder B, Rayfield B, Poschar M. Muscle recruitment patterns during the prone leg extension. BMC Musculoskelet Disord. 2004 Feb 10;5:3.

9. Arab AM1, Ghamkhar L, Emami M, Nourbakhsh MR. Altered muscular activation during prone hip extension in women with and without low back pain. Chiropr Man Therap. 2011 Aug 14;19:18.

10. Lederman E. The fall of the postural-structural-biomechanical model in manual and physical therapies: exemplified by lower back pain. J Bodyw Mov Ther. 2011 Apr;15(2):131-8.

11. Nourbakhsh MR, Arab AM. Relationship between mechanical factors and incidence of low back pain. J Orthop Sports Phys Ther. 2002 Sep;32(9):447-60.

12. Thompson O, MacMillan A. What's wrong with Osteopathy? IJOSM. 2023. 48.100659.

13. Ruela GA, Barreto SM, Griep RH, Benseñor IM, Telles RW, Camelo LV. Job stress and chronic and widespread musculoskeletal pain: a cross-sectional analysis from the Brazilian Longitudinal Study of Adult Health Musculoskeletal. Pain. 2022 Oct 1;163(10):2044-2051.

14. Linton SJ. A review of psychological risk factors in back and neck pain. Spine (Phila Pa 1976). 2000 May 1;25(9):1148-56.

15. Guidi J, Lucente M, Sonino N, Fava GA. Allostatic Load and Its Impact on Health: A Systematic Review. Psychother Psychosom. 2021;90(1):11-27.

16. Mills SEE, Nicolson KP, Smith BH. Chronic pain: a review of its epidemiology and associated factors in population-based studies. Br J Anaesth. 2019 Aug;123(2):e273-e283.

17. Lewis J, O'Sullivan P. Is it time to reframe how we care for people with non-traumatic musculoskeletal pain? Br J Sports Med. 2018 Dec;52(24):1543-1544.

18. O'Sullivan PB, Caneiro JP, O'Keeffe M, Smith A, Dankaerts W, Fersum K, O'Sullivan K. Cognitive Functional Therapy: An Integrated Behavioral Approach for the Targeted Management of Disabling Low Back Pain. Phys Ther. 2018 May 1;98(5):408-423.

But my treatment works... - Contextual effects

Text: Lau Saugman Hansen

Osteopaths treat patients primarily via manual techniques to the joints, muscles, viscera and cranial structures. When a given outcome is observed in a patient, the manual treatment is thought to contribute to this outcome. Contemporary research reveals that other factors besides the active osteopathic manual treatment are important to the outcome [1]. These factors are called contextual factors (CF) and the purpose of this article is to make osteopaths more aware of CF in the clinical setting. CF can be defined as

”By definition, CF are physical, psychological and social elements that characterize the therapeutic encounter with the patient” [1].

In the following some of these CF will be reviewed regarding their effect on pain outcomes. The literature around CF is not homogenous so different research will present different factors as CF. The most researched CF will be the discussed in this article.

Natural recovery and regression to the mean

Some CF are not influenced by the clinician. Natural recovery and regression to the mean (RTM) are phenomena whereby patients get better without our intervention and those should be accounted for when a given outcome is observed. We might see a client with acute low back pain (LBP) and use manual therapy as an intervention and after a week the patient reports NRS going from 8 to 2. We might conclude that the treatment worked but it could also be the result of natural recovery and RTM. What would have happened if the clinician had chosen sham treatment, such as detuned ultrasound, simple advice or no treatment? Some research suggests that the patient would report the same outcome [2, 3]. Research also suggest that sham osteopathic interventions equals active treatment for subacute LBP [4]. RTM in our field is that patients seek help when their pain is at the worst. Clinicians see patients with chronic pain or fluctuating pain and these patients come to us when pain levels are high and rarely when pain is low. As in the more acute cases, these patients pain levels also naturally decline to a lower level with or without treatment (5). We cannot conclude that it is solely the osteopathic treatment which helps the individual with pain, acute or chronic. Natural recovery and pain fluctuations are part of this. Voltaire said: “The art of medicine consists of amusing the patient while nature cures the disease”.

CF That are influenced by clinicians are also important. In the next section patient expectations, therapeutic alliance (TA), positive / negative communication and their influence on pain outcomes will be reviewed.

Patient expectations:

Patient expectations, that is, do the patient think they will recover or not, influence their outcome [6]. These expectations influence outcome more for future work participation and less for pain. This can be investigated by asking our patients at first consultation if they think they will recover (e.g. on a NRS scale 0-10). Exploring expectations and asking questions like: “what do you think will help”, “why don’t / do you think your pain can get better” can be very helpful. Having this discussion is important and part of the shared decision-making process. As licensed health care professionals osteopaths have the responsibility to provide evidence-based treatments, and this includes taking patients view on their health issues into account.

Therapeutic alliance (TA)

TA is used in psychology and one of the most cited psychologists regarding TA is Edward S. Bordin. Bordin defined TA as [8]:

“A successful TA as one that establishes an affective bond between the client and the clinician, as well as mutual agreement of goals and interventions”.

Experimentally TA can be manipulated in the clinical setting, an “enhanced” or “limited” TA [7]. The enhanced TA is shown to give better pain outcomes with the same active treatment [8, 9]. That is, with the same osteopathic treatment we can possibly get better pain relief with a good TA – i.e., a “thoracic inlet” focused treatment with enhanced TA will give better pain relief than thoracic inlet with limited TA. TA is a skill, like osteopathic techniques, and can be learned. From the article by Fuentes et al. [7]:

“TA relies on “a complex interplay of technical skill, communicative competence, and the reflective capacity of the therapist to respond to the patient in the moment of therapy.” The TA is more than the communication between the patient and the therapist. For example, the TA involves the sense of collaboration, warmth, and support that are critical aspects of this construct.”

Listening to the patient without interruption, reflective questioning (for validation and to be sure we understand), trying to see the situation from the patient’s viewpoint, empathy and shared decision-making are important factors to establish a strong TA. Osteopaths are in a strong position to establish this because we often have more time than other health care professionals.

Positive / negative communication:

“First, do no harm” is part of bioethics in healthcare. That is, partly, why osteopaths are taught about contraindications for treatment. Clinicians do not want to manual treat a fracture, cancer, infection etc.

As our physical treatments, communication can also affect the outcome to the better or worse (“placebo” and “nocebo”) when we deal with subjective outcomes such as pain. Imagine an acute LBP patient at the clinic. The osteopath goes through the assessment and often communicate the findings to the patient. It could be: “you have a rotated SI-joint”, “your thoracic spine is blocked or “your first cervical vertebra is rotated”. We have been taught these diagnostic labels, but to communicate those to the patient can do harm [9]. In radiology communication about MRI findings

affect pain outcome and recovery expectations to the better or worse [10], [11]. Research shows, that how a manipulation technique is presented affects pain outcome (12). If positive communication around the technique is used, a stronger hypoalgesic effect is observed and a negative communication give rise to a hyperalgesic effect, that is patients report more pain. The same is seen for exercise (13). In the clinical setting with the acute LBP patient, after screening for red flags, suggestions for communication could be "I understand, that your situation is very painful, but the prognosis is good and the pain will likely decrease" (14), "There are no concerning findings in the examination", "your back is robust and strong". At the same time, clinicians should validate the experience of pain and the non-verbal communication should be equivalent to the verbal. Manual techniques can still be used, but the technical specificity of those techniques is doubtful (15, 16) so avoiding non-valid examination findings is important.

Conclusion:

When we see patients, we should reflect upon the contextual factors that influence the clinical setting and outcome. A given outcome for a patient is not only due to the osteopathic techniques. Natural recovery, regression to the mean, patient expectations, therapeutic alliance and our way of communication are important factors that influence patient outcome. Research estimate that 50-75% of the effect are due to these factors [17, 18]. It is a hope that more osteopaths will take an interest in these areas, and more post-graduate education will emerge empowering osteopaths competency in the field. For more information on how to tackle the CF of the osteopathic practice the reader could find inspiration in the references of this article.

Lau Saugman Hansen
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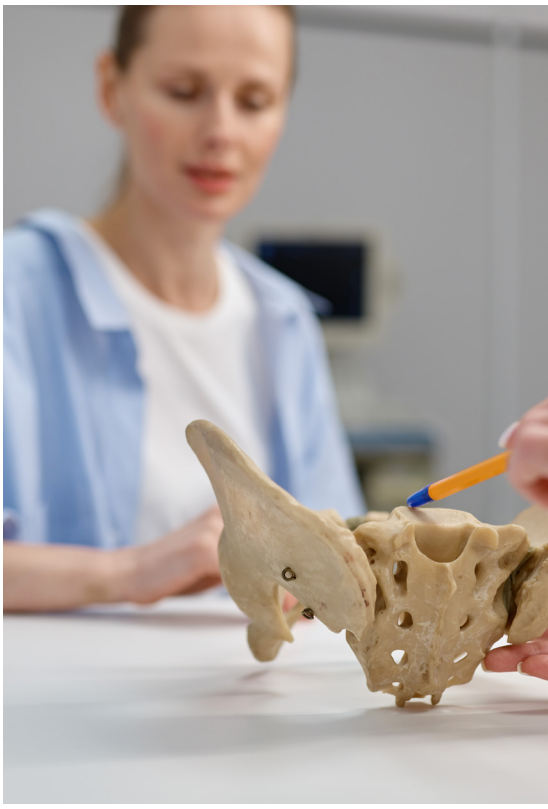
References:

1. Rossettini, G., Carlino, E. & Testa, M. Clinical relevance of contextual factors as triggers of placebo and nocebo effects in musculoskeletal pain. BMC Musculoskelet Disord 19, 27 (2018). https://doi.org/10.1186/s12891-018-1943-8
2. Hancock M.J et al. Assessment of diclofenac or spinal manipulative therapy, or both, in addition to recommended first-line treatment for acute low back pain: a randomised controlled trial. Lancet 2007; 370: 1638–43
3. Artus M, van der Windt DA, Jordan KP, Hay EM. Low back pain symptoms show a similar pattern of improvement following a wide range of primary care treatments: a systematic review of randomized clinical trials. Rheumatology (Oxford). 2010 Dec;49(12):2346-56. doi: 10.1093/rheumatology/keq245. Epub 2010 Aug 16. PMID: 20713495.
4. Effect of Osteopathic Manipulative Treatment vs Sham Treatment on Activity Limitations in Patients With Nonspecific Subacute and Chronic Low Back Pain: A Randomized Clinical Trial. Nguyen C. et al. JAMA Intern Med. 2021 May 1;181(5):620-630
5. Pain in clinical trial for knee osteoarthritis: estimation of regression to the mean. Martin Englund, Aleksandra Turkiewicz. The lancet rheumatology. Vol 5, issue 6, E309-E311. June 2023
6. Hayden j, Et al. Individual recovery expectations and prognosis of outcomes in nonspecific low back pain: prognostic factor review (Review). Cochrane Database of Systematic Reviews 2019, nov25:2019(11)
7. Fuentes J. et al. Enhanced therapeutic alliance modulates pain intensity and muscle pain sensitivity in patients with chronic low back pain: an experimental controlled study. Physical Therapy, Volume 94, Issue 4, 1 April 2014, Pages 477–489.
8. Meredith Kinney, Jasmine Seider, Amanda Floyd Beaty, Kaitlin Coughlin, Maximilian Dyal & Derek Clewley (2018): The impact of therapeutic alliance in physical therapy for chronic musculoskeletal pain: A systematic review of the literature, Physiotherapy Theory and Practice
9. Hohenschurz-Schmidt, D., Thomson, O.P., Rossettini, G., Miciak, M., Newell, D., Roberts, L., Vase, L., Draper-Rodi, J., Avoiding nocebo and other undesirable effects in chiropractic, osteopathy and physiotherapy: An invitation to reflect, Musculoskeletal Science and Practice (2022), doi: https://doi.org/10.1016/j.msksp.2022.102677.
10. Rajasekaran, S., Dilip Chand Raja, S., Pushpa, B.T. et al. The catastrophization effects of an MRI report on the patient and surgeon and the benefits of 'clinical reporting': results from an RCT and blinded trials. Eur Spine J 30, 2069–2081 (2021). https://doi.org/10.1007/s00586-021-06809-0
11. O'Keeffe M, Ferreira GE, Harris IA, Darlow B, Buchbinder R, Traeger AC, Zadro JR, Herbert RD, Thomas R, Belton J, Maher CG. Effect of diagnostic labelling on management intentions for non-specific low back pain: A randomized scenario-based experiment. Eur J Pain. 2022 Aug;26(7):1532-1545. doi: 10.1002/ejp.1981. Epub 2022 Jun 21. PMID: 35616226; PMCID: PMC9545091.
12. The influence of expectation on spinal manipulation induced hypoalgesia: An experimental study in normal subjects Joel E Bialosky, Mark D Bishop1, Michael E Robinson, Josh A Barabas1 and Steven Z George. BMC Musculoskeletal Disorders 2008, 9:19
13. Vaegter HB, Thinggaard P, Madsen CH, Hasenbring M, Thorlund JB. Power of Words: Influence of Preexercise Information on Hypoalgesia after Exercise-Randomized Controlled Trial. Med Sci Sports Exerc. 2020 Nov;52(11):2373-2379. doi: 10.1249/MSS.0000000000002396. PMID: 32366799.
14. Pengel LH, Herbert RD, Maher CG, Refshauge KM. Acute low back pain: systematic review of its prognosis. BMJ. 2003 Aug 9;327(7410):323. doi: 10.1136/bmj.327.7410.323. PMID: 12907487; PMCID: PMC169642.
15. Oliver P. Thomson, Andrew MacMillan,What's wrong with osteopathy?,International Journal of Osteopathic Medicine,Volume 48,2023,100659,ISSN 1746-0689,https://doi.org/10.1016/j.ijosm.2023.100659.(https://www.sciencedirect.com/science/article/pii/S1746068923000032)
16. Nim CG, Downie A, O'Neill S, Kawchuk GN, Perle SM, Leboeuf-Yde C. The importance of selecting the correct site to apply spinal manipulation when treating spinal pain: Myth or reality? A systematic review. Sci Rep. 2021 Dec 3;11(1):23415. doi: 10.1038/s41598-021-02882-z. PMID: 34862434; PMCID: PMC8642385.
17. Hafliðadóttir, S.H., Juhl, C.B., Nielsen, S.M. et al. Placebo response and effect in randomized clinical trials: meta-research with focus on contextual effects. Trials 22, 493 (2021). https://doi.org/10.1186/s13063-021-05454-8
18. Zou K, Wong J, Abdullah N, Chen X, Smith T, Doherty M, Zhang W. Examination of overall treatment effect and the proportion attributable to contextual effect in osteoarthritis: meta-analysis of randomised controlled trials. Ann Rheum Dis. 2016 Nov;75(11):1964-1970. doi: 10.1136/annrheumdis-2015-208387. Epub 2016 Feb 16. PMID: 26882927; PMCID: PMC5099197.

Is it loose, is it fixed...What is it?

Text: Andreas Sønderriis



An update on Sacroiliac joint pain

A common clinical challenge

It's not uncommon for a clinician to deal with clients suffering from pain in the area of the Sacro Iliac joint (SIJ). Up to 50 % of women experience SIJ pain during pregnancy, but the condition isn't isolated to this group of clients alone [1], [2]. A wide range of clients experience this type of pain and the condition is associated with different risk factors such as strenuous workloads, obesity, lower back pain, multidirectional sports and physical trauma [1], [2]. Recently there has been a debate in Denmark regarding the cause of pain related to the SIJ – especially regarding pregnancy related pelvic girdle pain. This article focusses on the clinical reasoning behind understanding and treating clients suffering from SIJ pain.

Movement dysfunctions

Movement dysfunctions such as hypo- or hypermobility in the SIJ has been described as an essential part of the pain mechanism [1], [3] but in light of the evolving understanding of pain science this biomedical understanding of pain is being questioned [4], [5].

The debate on the cause of SIJ pain isn't new, but the biomedical narrative of movement dysfunctions as being the cause of the pain is still firmly integrated in several parts of the Danish healthcare community and the public understanding of the pain mechanism. In manual professions such as osteopathy, chiropractic, and physiotherapy it is often believed, that lower back and SIJ pain is caused by movement dysfunctions, pelvic asymmetry, faulty joint positions, tissue-stretching or other mechanical causes. [5]–[9]

There is little evidence to support this biomechanical pain theory and using this as the analytical foundation for clinical reasoning is problematic [5], [8], [10], [11]. Even though there is a historical tradition for analysing SIJ pain through a mechanical perspective, a problem arise with the causal relationship between the movement dysfunction and the pain [4], [5]. Instead of faulty movement being the cause of the pain, the clinician must ask him or herself if the patient is moving differently because they are in pain [12], [13]. So where does the clinician start the examination if mobility isn't the focus of the clinical approach?

Testing for pain

Safety is the foremost important part of any clinical examination [14]. The SIJ has a rich supply of neural fibres with nociceptive abilities [15], [16] which can be an important part of the subsequent experience of pain [12]. If the osteopath suspects trauma, pathology, or physiological reactions to overloading of intra- and/or extra-articular SIJ tissue and structures, further clinical examination is normally undertaken. Pain provocation tests and mobility tests are often used in the examination of the SIJ [5], [17]. Most clinical SIJ tests have limited reliability and validity on their own, but in combination the provocation tests have shown a good diagnostic validity and are considered a reliable method in discriminating SIJ related pain from pain in the lower back or hip [5], [17], [18]. But increased sensitivity of the joint structures is only a fraction of the multidimensionality of the human pain experience [12] and isn't necessarily related to movement dysfunctions [5].

The problem with testing for SI joint mobility

Testing SI joint mobility is often part of the examination process. It has been suggested that clinicians are able to detect some degrees of SIJ mobility [19], [20], but because of the multiple layers of tissue surrounding the joint and the limited degree of joint movement, validity and reliability of SIJ mobility tests in general has been shown to be poor [5], [21], [22].

If the clinician suspects a decreased SIJ mobility it is often interpreted as the cause of the pain, but this understanding of the pain mechanism is likely to be the result of reversed causality. A decreased lumbo-pelvic movement is just as likely to be the result of the pain and not the other way around. The SIJ mobility is a part of the general lumbo-pelvic movement, but there is little evidence to support the use of SI joint mobility tests as a diagnostic tool [5], [8], [10].

Avoiding Nocebo

Most clinicians are aware of the undesirable effects of Nocebo, which in this context is a term that covers the harmful effects of poor patient communication. This must be avoided in the clinical management of musculoskeletal pain disorders. In situations where there is a strong correlation between pain and structural pathology such as severe degrees of disc herniations or spinal stenosis, a pathoanatomical explanation can be a helpful part of the communication strategy. The problem with explaining pain to a client solely from a pathoanatomical perspective is the possibility of fear avoidance behaviours and negative patient beliefs and emotional responses which can undermine the perception of reversibility of symptoms. [4], [11], [23]

A biopsychosocial approach to analysing the SIJ Pain

After ensuring that there is no underlying pathology or tissue damage the clinical examination can focus on factors that influence the client's perception of threat, physical limitations, and psychological and social barriers [4], [5], [24], [25].

Analysing the SIJ Pain

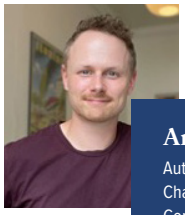
- Which movements, situations or activities are limited because of the pain and in what way?
- What is the clients pain narrative? This could be comments like "I have a loose pelvis" or "my SIJ is out of place".
- Are there social factors that influence the perception of pain or the client's health behaviour?
- Are there psychological issues that influence the perception of pain or the client's degree of empowerment?
- What is the degree of health literacy? And how can the client be supported in his or her understanding of the situation?
- Are there contextual factors that influence the situation?

Management of the SIJ pain

Knowing the pain narrative allows the clinician to better explain how pain works from a biopsychosocial theory. In the communication strategy the clinician can target the fears and unhelpful pain beliefs that influences the client. Understanding the social setting of the client helps the clinician manage cultural, economic, and social boundaries that can act as a barrier in the rehabilitation process. Planning interventions and setting goals can be adapted to the client's needs, so that social challenges are being considered. Analysing the degree of health literacy will make it possible for the clinician to choose the right communication strategy and help the client understand the pain. General activity interventions and specific exercises can be designed to target fear avoidance behaviours and physical limitations from a functional perspective. [4], [5], [24], [25]

Manual therapy as a positive belief reinforcing intervention

The experience of pain is not only a tissue-based stimulus reaction, but can be described as a neural response to the sense of threat [12], [26]. With this in mind the clinician can use manual therapy in combination with positive threat minimalizing communication to reinforce the client's positive health belief. Manual therapy applied to soft tissue might also help the patient relax tensed musculature as well as applying mobilising or manipulative techniques to the joint can result in a positive neurophysiological effect [27]. Avoiding nocebo and undesirable biomedical pain explanations in this process is crucial [11]. With the use of such manual techniques it is possible that the clinician can lower the patient's perception of threat, and thereby influence the pain experience [4], [27]. This therapeutic effect cannot be isolated but is dependent on many other factors such as the therapeutic alliance, pain education and person centred pain management [24], [25].



Andreas Sønderris
Authorised Osteopath and Chair of the Danish Research Committee

References:

[1] S. P. Cohen, Y. Chen, and N. J. Neufeld, "Sacroiliac joint pain: a comprehensive review of epidemiology, diagnosis and treatment," Expert Rev. Neurother., vol. 13, no. 1, pp. 99–116, Jan. 2013, doi: 10.1586/ERN.12.148.
[2] H. Elden, A. Gutke, G. Kjellby-Wendt, M. Fagevik-Olsen, and H. C. Ostgaard, "Predictors and consequences of long-term pregnancy-related pelvic girdle pain: A longitudinal follow-up study," BMC Musculoskelet. Disord., vol. 17, no. 1, pp. 1–13, Jul. 2016, doi: 10.1186/S12891-016-1154-0/FIGURES/2.
[3] A. Kiapour, A. Joukar, H. Elgafy, D. U. Erbulut, A. K. Agarwal, and V. K. Goel, "Biomechanics of the Sacroiliac Joint: Anatomy, Function, Biomechanics, Sexual Dimorphism, and Causes of Pain," Int. J. Spine Surg., vol. 14, pp. 3–13, doi: 10.14444/6077.
[4] T. S. Palsson et al., "Changing the Narrative in Diagnosis and Management of Pain in the Sacroiliac Joint Area," Phys. Ther., vol. 99, no. 11, pp. 1511–1519, Nov. 2019, doi: 10.1093/PTJ/PZZ108.
[5] D. Beales, H. Slater, T. Palsson, and P. O'Sullivan, "Understanding and managing pelvic girdle pain from a person-centred biopsychosocial perspective," Musculoskelet. Sci. Pract., vol. 48, Aug. 2020, doi: 10.1016/J.MSKSP.2020.102152.
[6] Sundhed.dk, "Hvad er bækkensmerter? - Patienthåndbogen," 2022. https://www.sundhed.dk/borger/patienthaandbogen/graviditet/illustrationer/praesentationer/hvad-er-baekkenloesning/ (accessed Aug. 07, 2023).
[7] C. Mikkelsen, "Ny tvivl om bækkenløsning," Fysioterapeuten, vol. 11, 2014, Accessed: Aug. 07, 2023. [Online]. Available: https://www.fysio.dk/fysioterapeuten/arkiv/nr.-11-2014/Ny-tvivl-om-bakkenlosning.
[8] C. Mikkelsen, "Drop bevægetest i sacroiliacaleddene," Fysioterapeuten, vol. 8, 2019, Accessed: Aug. 07, 2023. [Online]. Available: https://www.fysio.dk/fysioterapeuten/arkiv/nr.-8-2019/drop-bevagetest-i-sacroiliacaleddene.
[9] M. Villadsen, "Graviditetsrelaterede bækkensmerter: Hvorledes hjælper vi bedst den gravide med smerter?," Fysioterapeuten, vol. 5, 2022.
[10] D. Miles and M. Bishop, "Use of Manual Therapy for Posterior Pelvic Girdle Pain," PM R, vol. 11 Suppl 1, 2019, doi: 10.1002/PMRJ.12172.
[11] D. Hohenschurz-Schmidt et al., "Avoiding nocebo and other undesirable effects in chiropractic, osteopathy and physiotherapy: An invitation to reflect," Musculoskelet. Sci. Pract., vol. 62, p. 102677, Dec. 2022, doi: 10.1016/J.MSKSP.2022.102677.
[12] David Butler and Lorimer Moseley, Explain Pain , 2nd ed. 2013.
[13] M. Høgh, N.-H. Jensen, and A. P. Pickering, Smertebogen, 1st ed. Munksgaard Danmark, 2015.
[14] M. A. Seffinger, "The safety of osteopathic manipulative treatment (OMT)," J. Am. Osteopath. Assoc., vol. 118, no. 3, pp. 137–138, Mar. 2018, doi: 10.7556/JAOA.2018.031/MACHINEREADABLECITATION/RIS.
[15] K. M. Szadek, P. V. J. M. Hoogland, W. W. A. Zuurmond, J. J. De Lange, and R. S. G. M. Perez, "Possible nociceptive structures in the sacroiliac joint cartilage: An immunohistochemical study," Clin. Anat., vol. 23, no. 2, pp. 192–198, Mar. 2010, doi: 10.1002/CA.20908.
[16] K. M. Szadek, P. V. Hoogland, W. W. Zuurmond, J. J. de Lange, and R. S. Perez, "Nociceptive nerve fibers in the sacroiliac joint in humans," Reg. Anesth. Pain Med., vol. 33, no. 1, pp. 36–43, Jan. 2008, doi: 10.1016/J.RAPM.2007.07.011.
[17] P. Nejati, E. Sartaj, F. Imani, R. Moeineddin, L. Nejati, and M. Safavi, "Accuracy of the Diagnostic Tests of Sacroiliac Joint Dysfunction," J. Chiropr. Med., vol. 19, no. 1, pp. 28–37, Mar. 2020, doi: 10.1016/J.JCM.2019.12.002.
[18] H. Telli, S. Telli, and M. Topal, "The validity and reliability of provocation tests in the diagnosis of sacroiliac joint dysfunction," Pain Physician, vol. 21, no. 4, pp. E367–E376, Jul. 2018, doi: 10.36076/PPJ.2018.4.E367.
[19] B. A. Hungerford, W. Gilleard, M. Moran, and C. Emmerson, "Evaluation of the ability of physical therapists to palpate intrapelvic motion with the Stork test on the support side," Phys. Ther., vol. 87, no. 7, pp. 879–887, Jul. 2007, doi: 10.2522/PTJ.20060014.
[20] R. P. Ribeiro, F. G. Guerrero, E. N. Camargo, L. M. Beraldo, and C. T. Candotti, "Validity and Reliability of Palpatory Clinical Tests of Sacroiliac Joint Mobility: A Systematic Review and Meta-analysis," J. Manipulative Physiol. Ther., vol. 44, no. 4, pp. 307–318, May 2021, doi: 10.1016/J.JMPT.2021.01.001.
[21] M. C. McGrath, "Palpation of the sacroiliac joint: An anatomical and sensory challenge," Int. J. Osteopath. Med., vol. 9, no. 3, pp. 103–107, Sep. 2006, doi: 10.1016/J.IJOSM.2006.03.001.
[22] B. Sturesson, A. Uden, and A. Vleeming, "A radiostereometric analysis of the movements of the sacroiliac joints in the reciprocal straddle position," Spine (Phila. Pa. 1976)., vol. 25, no. 2, pp. 214–217, Jan. 2000, doi: 10.1097/00007632-200001150-00012.
[23] David Butler and Lorimer Moseley, Explain Pain, 2. Noigroup, 2013.
[24] R. Kerry, M. Low, and P. O'Sullivan, "Person-centred clinical reasoning and evidence-based healthcare," Eur. J. Pers. Centered Healthc., vol. 8, no. 2, pp. 215–225, Aug. 2020, doi: 10.5750/EJPCH.V8I2.1845.
[25] N. Hutting, J. P. Caneiro, O. M. Ong'wen, M. Miciak, and L. Roberts, "Person-centered care for musculoskeletal pain: Putting principles into practice," Musculoskelet. Sci. Pract., vol. 62, p. 102663, Dec. 2022, doi: 10.1016/J.MSKSP.2022.102663.
[26] G. L. Moseley and D. S. Butler, "Fifteen Years of Explaining Pain: The Past, Present, and Future," J. pain, vol. 16, no. 9, pp. 807–813, Sep. 2015, doi: 10.1016/J.JPAIN.2015.05.005.
[27] J. E. Bialosky et al., "Unraveling the Mechanisms of Manual Therapy: Modeling an Approach," J. Orthop. Sports Phys. Ther., vol. 48, no. 1, pp. 8–18, Jan. 2018, doi: 10.2519/JOSPT.2018.7476.

The capable human

A personal text revisiting person-centered care in osteopathy

Text: Niklas Sinderholm Sposato

Person-centered care has become a popular mantra in modern healthcare. Sadly, the concept risks dilution if it isn't paired with a genuinely progressive understanding and implementation.

In this personal reflection, I wish to share perspectives that have shaped and aided my comprehension of what person-centered care might entail. Numerous person- and moral-philosophical thoughts have been contextualized within this care model, and it's sometimes difficult to grasp one's own thought processes. To me, perhaps the work of Paul Ricoeur has been more meaningful than that of others in these matters. His perspectives, mediated through my pre-understanding and narrative, have often helped me anchor fleeting ideas and made them more accessible. Perhaps they might also be helpful for you.

Ricoeur emphasizes the idea of the "capable human" and thereby describes every person as a unique individual with their own experiences, needs, resources, and goals. In an osteopathic and person-centered context, this might entail a healthcare encounter that focuses not only on physical symptoms but also on a person's life situation, social and cultural contexts, emotional and mental states, and how these factors can influence their physical and general well-being. These words and thoughts probably sound familiar to many, and most osteopaths would likely agree that this is both crucial and worth striving for. As I see it, however, the real challenge still lies in mutual understanding and implementation.

Our collective work, then, revolves around trying to comprehend and assimilate another person's multifaceted existence through the only filter we possess, our own experiential knowledge and understanding. Ah, that immediately sounds much more challenging and it's therefore easy to see why some might cling to outdated, one-dimensional biomechanical or obscure treatment models. However, if we wish to progress as a profession and as individual caregivers who embrace an honest striving toward person-centered osteopathic practice, we need to put in the effort. At the core of it all, I believe, lies communication. Mutual understanding around concepts requires a dialogue in which parties actively aim to comprehend each other's perspectives. This also is a quality that Ricoeur attributes to "the capable human". For that reason, we need to be individuals who can transcend our limited viewpoint and remain receptive to understanding and being understood. In this context, Ricoeur's ideas about narrative identity might also prove useful. By sharing stories and experiences, we can gain insight into each other's preconceptions, thus more easily achieving mutual understanding.

Extending the scope of person-centeredness in the framework of integrative care, osteopathy may offer a bridging role to multidisciplinary care. At its best, osteopathy not only addresses symptoms in and related to the musculoskeletal system, but also acknowledges the interconnectedness of body systems, incorporating (to appropriate extents) elements of nutrition, mental health, and even spiritual well-being into the treatment strategy. Such approach inherently respects the patient's narrative, welcoming it as a valuable contributor to the diagnosis and treatment process. In a truly integrative setting, the osteopath collaborates with other healthcare professionals to ensure that the care provided aligns with the individual's unique set of needs, goals, abilities, and experiences. This collaborative effort exemplifies the profession's ongoing evolution toward comprehensive, person-centered care.

In conclusion, understanding and implementing person-centered care in osteopathy, or in healthcare at large, is a complex task that requires both intra- and interdisciplinary efforts. This concept cannot be fully reduced to a simple binary scale of being person-centered or not. Rather, it is a continuous process, a sliding scale that relies on a constant pursuit to level out inequalities, include the patient's perspective, and understand the unique circumstances under which each person lives. This pursuit is complicated by the fact that each interaction we have with another person is coloured and limited by our own life experience and preconceived notions. The ability and willingness to scrutinize ourselves and our practices ultimately dictate the level of success we can hope to achieve as inclusive, person-centered clinicians.

References:

1. Paul, R., Homo Capax Texter av Paul Ricoeur i Urval av Bengt Kristensson Uggla. 2011, Göteborg Daidalos. 300.
2. Ricoeur, P., Oneself as another. 1994: University of Chicago Press.

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From EFFO to OE; Osteopathy Europe

Text: Hanna Tómasdóttir

The professional associations of osteopathy across Europe have come together as Osteopathy Europe (OE). Osteopathy Europe is an umbrella association representing professional European osteopathic associations supporting regulation, recognition, and integration of osteopathy as primary healthcare providers within health services and patient care. We are committed to promoting the harmonisation of standards for the osteopathic profession, supporting research initiatives, and advocating for high levels of education within osteopathy.

Osteopathy Europe is responding to the increasing pressures on the health workforce across Europe, as the organisation represents over 28,000 osteopaths across 23 member countries and strives to harmonise the osteopathic profession with the unique requirements of patients and healthcare systems in each country. Through these efforts, we actively address the evolving demands and challenges faced by the healthcare workforce in Europe.

Osteopathy Europe engages members across borders to cooperate, inspire, and support each other in a constantly evolving healthcare landscape. As the profession is not among Europe's largest healthcare professions, the importance of committing to this cooperation cannot be overestimated. By promoting regulation, OE ensures patient safety, fosters trust within the healthcare community and elevates the standing of the osteopathic profession.

As OE continues its resilient efforts, supporting our membership and sharing resources, the vision of advancing osteopathy in Europe remains at the core of its mission, bringing forth a brighter future for osteopathic healthcare in Europe and beyond.

On behalf of Osteopathy Europe, we express our gratitude to our members in the Nordic countries for their outstanding contributions to our profession. It's worth noting that regulation has been achieved in four Nordic countries, marking a remarkable accomplishment that deserves special recognition. Let's continue to work together for the osteopathic community.

The European Federation & Forum for Osteopathy (EFFO) has rebranded as Osteopathy Europe (OE).

Hanna Tómasdóttir
President Osteopathy Europe

Unlock your Power of Knowledge;

Health literacy and empowerment

Text: Pål Andre Amundsen

Have you ever had a patient believing that their pain is caused by their work or a misaligned joint? Have you ever met people that you feel are quick to stigmatise people with chronic (invisible) pain, or a general practitioner (GP) that thinks NSAIDs are the cure for pain? Then you have met people with low 'health literacy' (and a GP with a knowledge gap).

If your patient chooses resting over activity, McDonalds over a healthy meal, pain killers over an active self-management, then you have met a patient with low 'empowerment'. If your patient received a set of exercises or tasks as part of your management plan, but comes back and says "oh, yeah, I haven't been the best at doing that", then your patient has low adherence and compliance. In the centre of these challenges are health literacy [1].

The aim of this short paper is to describe the importance of health literacy and empowerment using a musculoskeletal (MSK) case within the topic of work and health. The choice of topic is not random. Pain is the most frequent cause of sick leave and work disability in Norway [2, 3]. For people who are on sick-leave due to MSK disorders, it seems to be a mismatch between a biomedical legislation for the sick-leave versus the biopsychosocial challenges involved for the person [4]. Loss of work due to MSK problems should be preventable, for example by targeted prevention using educational material for health promotion [5-8]. Known obstacles of successful 'stay-at-work' or 'return to work' include a lack of work-focused health care, challenges in implementing evidence, and communication between stakeholders; the worker, the employer and the health care professionals [5, 9-12].

Jo's downward spiral to ill health

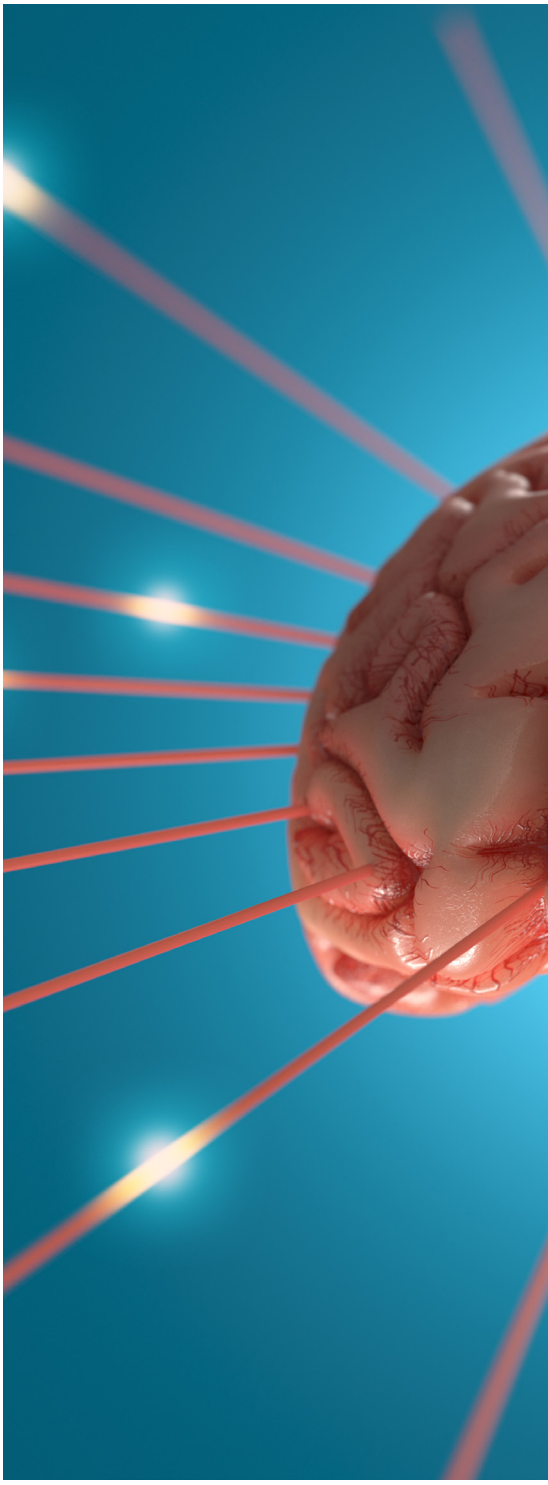
Jo had an incidence of low back pain that made his daily activities a bit difficult. The general practitioner signed him off work for two weeks and gave some pain killers. A friend said that it is probably the work that caused the pain, as he works on a computer sitting down all day. That made sense for Jo. The employer did not contact Jo as they felt it might be intrusive as he was on a sick leave. Jo had some worries as he had read that back pain is a frequent cause of chronicity and disability. He got an extended sick leave and was referred to an MRI scan scheduled two months later. Over time, Jo did not hear from the employer and the MRI scan came back with worrying results, showing a disc bulge and some degeneration.

The obstacles related to Jo's recovery process are:
Health: Ineffective treatment, inappropriate referral, waiting lists for investigations, unnecessary sick leave, and unhelpful advice.
Psychological/Personal: Negative beliefs, uncertainty about what is wrong (and subsequently what to do, and the future holds) and anxiety.
Social/work: No contact with workplace, thus no 'absence management'; no discussion on temporary modified work, lack of support, less social and working relationships.

What is health literacy?

A systematic review identifying definitions and conceptual frameworks for health literacy, suggested the following definition [13] :
"Health literacy is linked to literacy and entails people's knowledge, motivation and competences to access, understand, appraise, and apply health information in order to make judgments and take decisions in everyday life concerning healthcare, disease prevention and health promotion to maintain or improve quality of life during the life course."

The definition refers to competence, which can be explained as having 'enough' skill or knowledge to do something well. The definition entails skills and knowledge to access, understand, appraise, and apply health information well. Taking the definition literally, doesn't it seem unrealistic to achieve



"Health literacy implies the achievement of a level of knowledge, personal skills and confidence to take action to improve personal and community health by changing personal lifestyles and living conditions".

health literacy? In other definitions of health literacy, the word adequate is used, which seems more realistic [14]. Adequate health literacy is proposed to being able to read and comprehend essential health-related material such as prescriptions. Additionally, people with adequate health literacy can take responsibility for his/her own health [13].

Jo displayed low health literacy.
I would argue that it is 'enough' to increase the health literacy of Jo, to also affect indirectly what happened at the GP office, and the relationship/communication with his workplace. Jo would be better equipped to be involved in co-decision making, e.g., usefulness of a sick-leave and purpose of an MRI, as well understanding the role the employer should have on helping him stay at work or return to work early.

Choice of words is important!
What the GP or other health care professional say can be a powerful intervention[15]; either for good or harm. Saying the wrong words about the pain, health, and its relationship to work, can create or reinforce myths (see box). Myths are probably existing due to low health literacy, and these are worth debunking [16-21]!

Common myths, debunked!
"Pain is caused by work."
• Work is just one factor of a multifactorial issue.

"Pain means underlying disease/damage."
• Often not any an underlying disease or any permanent damage involved.

"With pain you would need sick leave."
• Often not necessary with sick leave (sometimes for a very short period, or to a certain degree (e.g., 50%) for a limited time). Most manage to remain at work or return quickly.

"You shouldn't return to work unless you are 100% pain-free."
• There are so many benefits of being involved in work, that work is seen as an intervention on its own; minor adjustments to the work can be agreed for a limited time.

"Pain is cured with a biomedical approach."
• Well, it may provide some symptom relief, but you cannot cure a multifactorial problem with a unifactorial approach.

"If you got a sick-leave, you need to complete the period of the sick-leave."
• You have been advised to be temporarily unfit for work; meaning you can arrange to get back at any point (even just in a small percentage).

"As an employer, don't contact the employee as its intrusive."
• Maintaining contact is important; being proactive, caring and supporting is appreciated and valued.

Explanations given should reflect the up-to-date knowledge that's available. In addition to providing good manual care to restore some function and provide symptom relief, an osteopath could help to make sense of pain and aid the dialogue with other stakeholders by providing accurate information and advice.

What about empowerment?
Empowerment is defined as: "an educational process designed to help patients develop the knowledge, skills, attitudes, and degree of self-awareness necessary to effectively assume responsibility

for their health-related decisions" [22]. According to Schulz and Nakamoto, four elements must be addressed to empower patients; 1) self-efficacy, including coping skills, 2) motivation to be self-determined, 3) to be able to feel a meaningfulness in activities, and 4) the experience of impact on daily life [23]. Empowered or not, many people with a chronic pain remain at work without seeking care [24]. We need to be careful to assume that this is the best solution for everyone; meaning that people can just live with the pain without proper support from health care professionals [25]. In relation to the example of work, empowerment can also be seen as the ability to predict how and when work affects the pain and the changes needed in lifestyle or pain management to cope better [26].

The connection between health literacy and empowerment

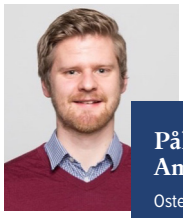
There is a debate on whether empowerment and health literacy are or can be separated. Patients might be empowered without being health literate, although this may arguably lead to inappropriate behaviour, such as a "dangerous self-manager" [23, 27]. The World Health Organisation states [28]: "Health literacy implies the achievement of a level of knowledge, personal skills and confidence to take action to improve personal and community health by changing personal lifestyles and living conditions". Does 'take action' and 'changing' require empowerment? Arguably, as shown in Jo's alternative story (below), the capacity to use health information effectively means that health literacy is a tool for empowerment; a view shared by many authors [29]. According to Sykes et. al., (2013), health literacy resembles empowerment, and include health knowledge as well as advanced personal skills such as confidence, self-efficacy and, no surprise; empowerment [30].

In a parallel universe

When Jo experienced pain he managed to critically assess the information he googled about low back pain. He stayed in work and had a dialog with his employer about the situation, which led to a minor temporary adjustment to his work. The employer made sure to have an ongoing dialog about the situation. When the pain flared up to a new level, he consulted his GP. The GP reassured Jo, and they talked about taking an MRI scan with the conclusion that it was not necessary as there was no sign of neurological or malignant involvement. Jo consulted with an osteopath: they talked about his pain within a person-centred approach, acknowledging the multifactorial nature. Jo was explained potential contributing factors, importance of gradually increasing activity, and the osteopath provided symptom relief and worked on Jo's function through movements and hands-on treatment. The osteopath made a note about a "stay at work" plan, which Jo and his employer discussed and tweaked. Gradually, Jo got better and has now learned how to manage any new incidences of pain, and when to use health care professionals as guides and support.

Sharing is caring

In summary, health literacy and empowerment are essential components of promoting the well-being of individuals. By empowering individuals with knowledge and fostering health literacy, we can help them make informed decisions, actively manage their condition, and work towards a healthier and more productive life.



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References:

1. Miller, T.A., Health literacy and adherence to medical treatment in chronic and acute illness: A meta-analysis. Patient Educ Couns, 2016. 99(7): p. 1079-1086.
2. NAV. Disability benefit - Quarterly statistics. 2020 Aug 11]; Available from: https://www.nav.no/no/nav-og-samfunn/statistikk/aap-nedsatt-arbeidsevne-og-uforetrygd-statistikk/uforetrygd.
3. NAV. Legemeldt sykefravær etter diagnose. Kvartal. 2023; Available from: https://www.nav.no/_/attachment/inline/7b020c51-eb64-485e-9218-60fc674b225c:aa3f31cf7c8d10682e0679b1faf248af-f54a7346/SYFRA560_Legemeldt_sykefrav%C3%A6r_etter_diagnose_202204.pdf.
4. Tingulstad, A., et al., Effectiveness of work-related interventions for return to work in people on sick leave: a systematic review and meta-analysis of randomized controlled trials. Systematic Reviews, 2022. 11(1): p. 192.
5. Frank, J., et al., Preventing disability from work-related low-back pain. New evidence gives new hope--if we can just get all the players onside. Cmaj, 1998. 158(12): p. 1625-31.
6. Costello, E.J., Early Detection and Prevention of Mental Health Problems: Developmental Epidemiology and Systems of Support. Journal of Clinical Child & Adolescent Psychology, 2016. 45(6): p. 710-717.
7. McDaid, D., A.L. Park, and K. Wahlbeck, The Economic Case for the Prevention of Mental Illness. Annual Review of Public Health, 2019. 40(1): p. 373-389.
8. Kendall, N.A.S., Psychosocial approaches to the prevention of chronic pain: the low back paradigm. Best Practice & Research Clinical Rheumatology, 1999. 13(3): p. 545-554.
9. Bartys, S., et al., System influences on work disability due to low back pain: An international evidence synthesis. Health Policy, 2017. 121(8): p. 903-912.
10. Lin, I., et al., What does best practice care for musculoskeletal pain look like? Eleven consistent recommendations from high-quality clinical practice guidelines: systematic review. Br J Sports Med, 2020. 54(2): p. 79-86.
11. Loisel, P., et al., Prevention of work disability due to musculoskeletal disorders: the challenge of implementing evidence. J Occup Rehabil, 2005. 15(4): p. 507-24.
12. Christian, J., et al., Preventing Needless Work Disability by Helping People Stay Employed. Journal of Occupational and Environmental Medicine, 2006. 48(9).
13. Sørensen, K., et al., Health literacy and public health: A systematic review and integration of definitions and models. BMC Public Health, 2012. 12(1): p. 80.
14. Baker, D.W., The meaning and the measure of health literacy. J Gen Intern Med, 2006. 21(8): p. 878-83.
15. Anon.(compiled by G Waddell and K Burton) (2007). Advising Patients About Work, London, The Stationary Office. ISBN: 9 780 -11-703772-4.
16. Burton, A.K. and G. Waddell, Health and Work - Employee's booklet. 2007: The Stationary Office.
17. Burton, A.K. and G. Waddell, Advising Patients About Work: An Evidence-based Approach for General Practitioners and Other Healthcare Professionals. 2008: The Stationary Office.
18. Burton, A.K., et al., Patient educational material in the management of low back pain in primary care. Bull Hosp Jt Dis, 1996. 55(3): p. 138-41.
19. Waddell, G. and A.K. Burton, Is work good for your health and well-being? 2006, Department for Work and Pensions.
20. Waddell, G. and A.K. Burton, Work and Health: Changing How We Think About Common Health Problems. 2007: The Stationary Office.
21. Waddell, G., K. Burton, and N. Kendall, Vocational rehabilitation – what works, for whom, and when? . 2013, Vocational Rehabilitation Task Group.
22. Feste, C. and R.M. Anderson, Empowerment: from philosophy to practice. Patient Educ Couns, 1995. 26(1-3): p. 139-44.
23. Schulz, P.J. and K. Nakamoto, Health literacy and patient empowerment in health communication: the importance of separating conjoined twins. Patient Educ Couns, 2013. 90(1): p. 4-11.
24. Mose, S., et al., Trajectories of Musculoskeletal Healthcare Utilization of People with Chronic Musculoskeletal Pain - A Population-Based Cohort Study. Clin Epidemiol, 2021. 13: p. 825-843.
25. Lennox Thompson, B., J. Gage, and R. Kirk, Living well with chronic pain: a classical grounded theory. Disabil Rehabil, 2020. 42(8): p. 1141-1152.
26. Hoegh, M. and D. Gulseren, Work is therapy, not a goal in itself, for people with chronic pain. 2023. 2023.
27. Kayser, L., et al., A new understanding of health related empowerment in the context of an active and healthy ageing. BMC Health Services Research, 2019. 19(1): p. 242.
28. Nutbeam, D., Health Promotion Glossary. Health Promotion International, 1998. 13(4): p. 349-364.
29. Crondahl, K. and L. Eklund Karlsson, The Nexus Between Health Literacy and Empowerment:A Scoping Review. SAGE Open, 2016. 6(2): p. 2158244016646410.
30. Sykes, S., et al., Understanding critical health literacy: a concept analysis. BMC Public Health, 2013. 13: p. 150.

Growth through collaboration and commitment

Text: Tiana Newell & Lex Flisijn

A group photo of the congress attendees at the ROE congress in April 2023

Dr Francesco Cerritelli presenting his research.

A throwback to ROE osteopathic congress and an interview with Lluís Horta DO MSc

It is a sunny Saturday afternoon, on April 15th in 2023, and the second day of the international osteopathic congress in Mallorca, organized by the Spanish register of osteopaths, Registro de Osteópatas de Espana ROE. All participants from 23 countries have gathered for a group photo. They have just enjoyed a refreshing coffee break in the company of fellow osteopaths on the terrace admiring the sea view.

The theme of this congress was “Osteopathy building bridges: towards the future of healthcare”. It delivers the intention to have collaborative dialogues and the flow of the congress was carefully considered in advance.

Firstly, the casual pre-event served as a kick-start for networking. The speakers and the congress attendees were introduced to local flavors at a local vineyard. The following three-day program of the actual congress offered a wide selection of relevant topics from a top line-up of osteopathic researchers and teachers such as Dr Francesco Cerritelli PhD, Dr Gerard Alvarez PhD, Dr Gary Fryer PhD, Dr Jerry Draper-Rodi PhD, and Dr Robert Shaw PhD. The topics ranged from osteopathic care of neonates to the hormonal issues underlying polycystic ovary syndrome to osteopathic clinical reasoning and many more.

The lectures were intermitted by lunch and coffee breaks that offered plenty of time for more networking. Each day ended with a panel discussion where key topics such as osteopathic identity, and interprofessional communication and collaboration were addressed. Both lectures and panel discussions included QA sessions engaging the audience in the conversation.
The second day provided an added chance to continue conversations while enjoying a delicious meal at the gala dinner. After the meal, the dance music inspired every osteopath to bring out some flashy moves at sunset as they embodied the first tenant of osteopathy, sensing and moving their body as a unit.

Organizing an international congress with all the technology involving the signing up, logistics, recording, broad-

Metropolia's master's degree students: Robert Grech, Hakim Mhadhbi, Morten Vind-Visby, Tiana Newell, Bruno Mendes and Lluís Horta.

Congress attendees enjoying music and dancing together.

Metropolia's master's degree students and faculty: Julian Ims, Lluís Horta, Tiana Newell,Robert Grech, Hakim Mhadhbi, Laura Lee Calonius, Bruno Mendes, Morten Vind-Visby and Lex Flisijn.

casting, and presenting takes two years, easily. "Details matter", says Lluís Horta, one of the organizers of the Spanish Register of Osteopaths (ROE) congress. Lluís was partly in charge of creating the flow of the congress by planning and hosting the event. "You need to think about who you are organizing the event for and why you do it. Every event must have a purpose." he says. "You have to think of where and with who" – selecting the venue and the line-up of speakers as well as forming partnerships are crucial steps in the success of an event.

Organizing a congress is always a learning process and every event serves as a steppingstone for the next one. For this congress there were some new tools available as Lluís is a graduate from the first master's degree program in osteopathy at Metropolia University of Applied Sciences. "I learned a lot about service design, innovation, and health business management. I used some of the knowledge and tools to organize the congress."

Lluís highly values participating in osteopathic congresses. "Meeting international colleagues in congresses, chatting with them, and learning from them is priceless. We need that to grow personally and professionally, but also to help the development of osteopathy."

The congress also served as a meeting place for the members of Metropolia master's degree class to see each other live for the first time since the program was entirely based online. A fellow classmate, Hakim Mhadhbi, MSc, presented his master thesis research to the congress audience adding an extra special flavor to the occasion.

The theoretical approach of the congress was a good match for the master's degree students since in addition

> “I love my profession and I think it deserves a better place in the healthcare arena.”
>
> - Lluís Horta

Dr Robert Shaw, Hazel Mansfield, Dr Paul Vaucher and Dr Jerry Draper-Rodi.

to health business management, the content of the program highlights the scientific methodologies and research methods. “Osteopathic research is important. Probably all development steps are somehow related to research because research is about asking questions and trying to answer them.”, Lluís says.

Research is needed for the recognition and the regulation of the profession. Despite having been on the European committee of the CEN standard for osteopathy, Lluis thinks that there is still a lot to do in terms of improving the position of osteopathy. “I love my profession and I think it deserves a better place in the healthcare arena.” To gain a better stance there is a need for more education in research, he says.
While conducting the master’s thesis every student gets to apply the methods in practice. “In my view, one of our biggest problems lie within the research methodologies.”

Patient-centered care
Lluís Horta started his Master in Osteopathy at Metropolia in Helsinki, Finland not just for the title. After practicing osteopathy for 18 years, he wanted to develop something new and innovative to support future research. As a member of the Research Committee of Osteopathy Europe he is, like many of us, often confronted with remarks from the outside world about the low and moderate quality of our research. Lluís asked himself “Why do we have low quality research and how can we improve this?” In his opinion we might have been measuring some of the results of our treatments with the wrong tools. This motivated him to work on a model to meet two important requirements.
First, it should take into account that in osteopathy we do not treat patients but persons. In the words of Lluís “Patient centered care is at the core of our profession. Evaluating the effectiveness of person-centered care should take into account the person-centeredness”. The tool should enable us to measure if we really practice person-centered care in our clinics.

Second, can this person-centered approach in osteopathy be proved in a scientifically convincing way? Lluís: “We can’t evaluate osteopathic practice and the effectiveness of pharmaceuticals in the same way”. A practical tool was developed as part of this research.

In the end, this two-year studying period was a real transformational process for him. As mentioned at Niklas Sinderholm Sposato’s lecture the purpose of a master’s program is to initiate this transition from a consumer of knowledge to a producer of research! Since Lluís really resonates with every opportunity he has to promote osteopathy, he was very delighted when invited to speak at osteopathic conventions in London and Paris. He will be presenting his thesis and the tool to do research in person-centered care.

As authors, ROE 2023 congress attendees and fellow Metropolia classmates, we would like to wish Lluís well on his journey with new endeavors. He is an inspirational spokesperson on behalf of the whole professional body of osteopathy. We look forward to more opportunities at future conferences to meet, connect, and learn from new colleagues across the world. Dear reader and fellow osteopath: please, consider this an open invitation to join!

roe. Registro de Osteópatas de España

The Spanish Register of Osteopaths (ROE) is a non profit organization that attempts to group together those professionals in Osteopathy of Spain who, according to their academic level, are up to the European Standards established by the European Federation of Osteopaths (EFO) and the Forum for Osteopathic Regulation in Europe (FORE)

Tiana Newell
Osteopath, Master’s Degree in Osteopathy student, Metropolia UAS

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The role of the osteopath in sports medicine:

part II - recovery and performance

Text: Martin Stav Engedahl

Osteopaths have an important role in sports medicine, where as part of rehabilitation after injury is the most important.

As discussed in a previous editorial (1), osteopaths as healthcare professionals have a more comprehensive role than just manual therapy and should be part of the multidisciplinary team when it comes to injury prevention and rehabilitation. In this editorial I will discuss whether osteopaths can contribute to recovery and performance as well.

Recovery

Recovery has always been an important part of exercise planning and effective recovery can optimize training effects, enhance performance, and maybe prevent injury and burnout (2). Recovery is a multifaceted process, and as with many aspects of sports medicine the optimal recovery strategies and methods depends on the sports, the athlete and part of the season. The different recovery strategies are often illustrated as a pyramid where the strategies regarded as the most important, and having potential for the greatest impact on performance, forms the foundation of the pyramid (fig. 1). Typical manual therapy osteopaths do, as soft tissue work, stretching and joint mobilization are higher up the pyramid and can have an important role if executed correctly.

The most studied manual treatment for recovery is massage therapy. However, the effect of massage therapy on recovery is unclear (3). Several mechanisms are postulated, among them increased blood flow, reduced muscle tone, and reduced delayed onset muscle soreness (ref). However, the evidence to support these effects are scarce (3, 4). There are some evidence for physiological changes important for recovery that might be able to influence mechanotransduction and the chemical environment in the muscle (4-6). However, based on current evidence, we cannot be sure of these effects. Massage is a highly valued post-training and post-competition treatment for athletes, and they experience better recovery after such treatment. The most important effect of massage therapy is probably a combination of increased rest time and a psychological effect. Massage has the ability to modify both the perception of recovery and soreness from exercise. It is suggested that massage stimulates the autonomic nervous system through its effects on the parasympathetic nervous system (7). This can improve relaxation and sleep quality, and result in better recovery.

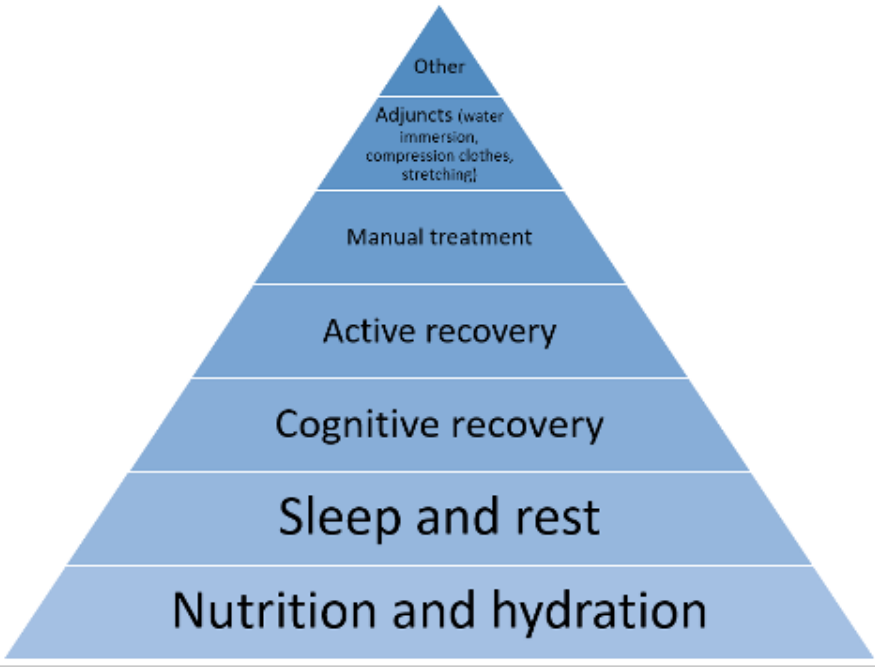


Figure 1: The recovery pyramid. The strategies regarded as the most important, and having potential for the greatest impact on performance, forms the foundation of the pyramid.

Osteopaths do other soft tissue treatment than massage only, but the effects are probably similar. As an osteopath you offer a relaxing situation with personalised care and full focus on recovery. In addition to relaxation, it provides an opportunity for the athlete to talk about their sporting performance and how they are feeling, but also to talk about other everyday things they are concerned with. This will provide a cognitive and mental recovery as well. Manual therapy makes the athlete relax, down-regulate stress, and can contribute to improved cognitive recovery and sleep, and through these mechanisms have an important role in recovery.

In-depth knowledge of various strategies and methods for recovery in combination with a detailed understanding of the sport and the athlete is the most important when choosing recovery strategies.

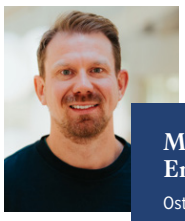
Performance

Manual therapy as a method to enhance performance is highly questionable. For manual therapy to enhance performance the prerequisite is that what is being treated must contribute to poorer performance and when it is treated, it leads to improved performance. This assumption rises several challenges. First,

segmental motion palpation to identify somatic dysfunctions have poor reliability (8). We cannot rely on movement palpation to identify somatic dysfunction or whether there is palpatory pareidolia. And if we could reliably find segmental dysfunctions we do not know if or how they influence performance. We cannot know whether treating certain dysfunctions will improve performance if we do not know whether it reduces performance in the first place. If we treat something that does not need to be treated, it is likely that nothing will happen, but in the worst case, it may lead to an adverse event that can negatively affect the athlete's performance.

An examination of the musculoskeletal system will always identify some motion restrictions, increased soft tissue tension and tenderness in an asymptomatic population. The clinical significance of these palpatory findings is uncertain (9). This is equal to diagnostic imaging like MRI and ultrasound where examination identifies degenerative changes, ruptured labrum and even prolapsed discs with nerve root compression in asymptomatic populations (10-12). If motion restrictions or dysfunctions could reliable be identified, it is still impossible to decide which dysfunction to treat or not. Somatic dysfunction is part of a functional body and a way for the body to compensate and adapt to different kinds of load and stress.

Another perspective is the ethical questions it raises. Is it ethical to claim that manual therapy can improve the performance of an athlete who is not injured or has a problem that affects performance? The evidence for manual therapy for musculoskeletal pain and injuries is sparse, as a method to increase performance the evidence is lacking and will be based solely on experience and anecdotes. There is also a risk that the athlete becomes "addicted" to pre-competition treatment to feel ready. If this is the result of the treatment, it is only a mental effect and it would be better for the athlete to learn and practice mental training techniques to achieve readiness. If you are treating athletes to improve performance, be aware that the athlete may, for better or for worse, share some responsibility for their performance with you. I argue that teaching athletes that they need manual therapy to perform at their best is a bad idea.



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References:

1. Engedahl M. The Role of Osteopathy in Sports Medicine - injury prevention and rehabilitation. Nordic Osteopathic Journal. 2022;4(1):18-9.
2. Kellmann M, Bertollo M, Bosquet L, Brink M, Coutts AJ, Duffield R, et al. Recovery and Performance in Sport: Consensus Statement. Int J Sports Physiol Perform. 2018;13(2):240-5.
3. Poppendieck W, Wegmann M, Ferrauti A, Kellmann M, Pfeiffer M, Meyer T. Massage and Performance Recovery: A Meta-Analytical Review. Sports Med. 2016;46(2):183-204.
4. Dupuy O, Douzi W, Theurot D, Bosquet L, Dugué B. An Evidence-Based Approach for Choosing Post-exercise Recovery Techniques to Reduce Markers of Muscle Damage, Soreness, Fatigue, and Inflammation: A Systematic Review With Meta-Analysis. Front Physiol. 2018;9:403.
5. Rapaport MH, Schettler P, Bresee C. A preliminary study of the effects of repeated massage on hypothalamic-pituitary-adrenal and immune function in healthy individuals: a study of mechanisms of action and dosage. J Altern Complement Med. 2012;18(8):789-97.
6. Crane JD, Ogborn DI, Cupido C, Melov S, Hubbard A, Bourgeois JM, et al. Massage therapy attenuates inflammatory signaling after exercise-induced muscle damage. Sci Transl Med. 2012;4(119):119ra13.
7. Arroyo-Morales M, Olea N, Martínez MM, Hidalgo-Lozano A, Ruiz-Rodríguez C, Díaz-Rodríguez L. Psychophysiological effects of massage-myofascial release after exercise: a randomized sham-control study. J Altern Complement Med. 2008;14(10):1223-9.
8. Stolz M, von Piekartz H, Hall T, Schindler A, Ballenberger N. Evidence and recommendations for the use of segmental motion testing for patients with LBP - A systematic review. Musculoskelet Sci Pract. 2020;45:102076.
9. Walker BF, Koppenhaver SL, Stomski NJ, Hebert JJ. Interrater Reliability of Motion Palpation in the Thoracic Spine. Evid Based Complement Alternat Med. 2015;2015:815407.
10. Brinjikji W, Luetmer PH, Comstock B, Bresnahan BW, Chen LE, Deyo RA, et al. Systematic literature review of imaging features of spinal degeneration in asymptomatic populations. AJNR Am J Neuroradiol. 2015;36(4):811-6.
11. Girish G, Lobo LG, Jacobson JA, Morag Y, Miller B, Jamadar DA. Ultrasound of the shoulder: asymptomatic findings in men. AJR Am J Roentgenol. 2011;197(4):W713-9.
12. Heerey JJ, Kemp JL, Mosler AB, Jones DM, Pizzari T, Souza RB, et al. What is the prevalence of imaging-defined intra-articular hip pathologies in people with and without pain? A systematic review and meta-analysis. Br J Sports Med. 2018;52(9):581-93.

iO Convention 2023

Text: Nora Lona Hansen and Frederik Jahr

Frederik Jahr &
Nora Lona Hansen
Osteopathy students

Dear readers,
This is a letter from two Norwegian fourth year students, Nora Lona Hansen and Frederik Jahr, who were selected to participate at Convention Osteopathy 2023 by the Norwegian federation of osteopathy (NOF).

Celebrating 30 years of regulation in the United Kingdom with passionate peers from around the globe was an inspiring experience for both of us. Our motivation to apply for the two spots NOF had announced was to gain as much new knowledge in varying topics of osteopathy, to meet likeminded passionate osteopaths from around the globe and to discover the diversity of practice and education around the world. Another goal was to network with future leaders in osteopathy.

Since Norway has become a full member of the Osteopathic International Alliance, we were invited to participate in their annual meeting. We learned a lot about their work to unite osteopathy worldwide. The need for a common osteopathic language, for regulation in non-regulated countries, as well as common standards for education were addressed specifically. Presentations were given on these topics, and we are excited to see the results moving forward.

The lineup of key speakers at the convention was, without exaggeration, outstanding. Topics varied from regulation to women's health, to cranial osteopathy to sports medicine to cancer patients. The diversity of topics and knowledge strengthened our pride in osteopathy and highly motivated us to dive deeper into all the topics. We were reminded that using the principles of the early osteopaths, we can help so many people to better health. It also underlined the fact that we will always be students of osteopathy. As a very experienced and humble osteopath said: I've tried to become a good osteopath for the past 45 years... We can always learn something new, and that makes our profession so amazing.

Meeting with students and practitioners from various countries gave us insight to the large potential osteopathy has in the health care system. We spoke with osteopathic physicians from the United States who incorporated osteopathic care into emergency medicine and who achieved better patient outcomes than their peers. It was valuable to learn from students and osteopaths with other backgrounds. One of the students we spoke to stated that
"I have gained a lot of new knowledge that I will bring with me. I will also take with me the contacts I have made with clinicians and osteopathy students internationally. The conference has made me consider pursuing further education in other countries."

We highly agree! Furthermore, the most memorable experience she stated was *"making contact with other clinicians and osteopathy students. I have experienced that we have a lot to learn from each other and I find that everyone I have met is very helpful."*

One of the American students added that she wanted to explore osteopathy in Europe. She is going into pediatrics and gaining insight from abroad was valuable to her.

To us it was fun to deepen our knowledge in certain topics. A few of the lectures stood out and gave us practical tools to bring back to our patient encounter. For instance, a lecture from an osteopath from Australia, Amanda Hannaford, who works solely with breast cancer patients at a hospital, gave us valuable tools on how to work on scar tissue with induration and seroma after surgery and radiation, as well as work on cording. Another lecture that stood out was Renzo Molinari's case presentation on women's health where a patient with cervical cancer, hysteria and pelvic congestion syndrome received osteopathic care with great results. A lecture by Clivey Lathey on an integrative approach to runner's knee was very valuable, as the presenter had extensive experience working with Olympians and professional runners. Equally fascinating was Susan Turner's presentation on the role of ligaments in articular healing and the application of BLT. Further, a takeaway was the fact that the education we receive in Norway is very strong. Our education gives us a great foundation for becoming authorized health personnel, and for continuous learning when we leave school.
The convention increased our hunger to learn more and to stay humble entering our careers as future osteopaths.

Nordic Osteopathic Congress: Oslo 2024

5th annual congress

Save the dates: 14.-15. september

Norsk Osteopatforbund is exited to welcome you all to the 5th annual Nordic Osteopathic Congress.

The details are still in the making, but mark your calendars today.

Best regards,
The Conference Commitiee

osteopati.org/noa-nordic-osteopathic-congress-oslo-2024

We're looking forward to seeing you!

Get ready for a professionally rewarding and exciting weekend in Oslo.

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