International Journal of Osteopathic Medicine 30 (2018) 18–24

Contents lists available at ScienceDirect

International Journal of Osteopathic Medicine

journal homepage: www.elsevier.com/locate/ijosm

Original Article

Challenges and opportunities for Australian osteopathy: A qualitative study of the perceptions of registered osteopaths

R. Blaich[a], A. Steel[b,c,*], D. Clark[a], J. Adams[b]

[a] Southern Cross University, School of Health and Human Sciences, Lismore, NSW, Australia
[b] University of Technology Sydney, Faculty of Health, Australian Research Centre in Complementary and Integrative Medicine, Ultimo, NSW, Australia
[c] Endeavour College of Natural Health, Office of Research, Brisbane, QLD, Australia

ARTICLE INFO

Keywords:
Osteopath
Health workforce
Specialism
Integrative medicine
Interprofessional relations

ABSTRACT

Background: The professional landscape of osteopathy in Australia has evolved substantially over recent years including changes in research, education and integration within the wider healthcare system. The challenges and opportunities experienced by members of the Australian osteopathic profession warrant closer examination.
Objective: Explore the perceptions of registered practising osteopaths in Australia regarding challenges and opportunities for the profession.
Design and setting: The study employed a qualitative inductive design and approach through which three focus groups of registered practicing osteopaths were convened across three Australian locations.
Methods: The data were collected through semi-structured thematic guides. Data were analysed from transcripts using framework analysis.
Participants: Registered osteopaths (n = 17) participated in the focus group representing a range of gender, age, education, and years of practice amongst participants.
Results: Thematic descriptive analysis of the osteopaths' accounts identified different perspectives about whether the osteopathic profession was moving in the optimal direction. These included a question about whether osteopaths were best placed as generalists or specialists; the importance of quality education and relevant, rigorous research as pillars for the sustainability of osteopathy; a need for clarity about the place of osteopathy in the healthcare system; and the need to increase public awareness about osteopathy.
Conclusion: This study highlights a number of these challenges and in doing so, provides an opportunity for stakeholders to find appropriate solutions to support the advancement of the profession. To this end there needs to be more effective communication/liaison between the osteopathic profession and education providers, regulators, Government departments, and other healthcare professionals.

Introduction

Osteopathy is defined by the Osteopathy International Alliance – the global peak body for osteopathy – as a manual therapy which follows the principle that structure and function are closely integrated by assessing a person's musculoskeletal, neurological and visceral systems [1]. There is preliminary evidence for the comparative and cost effectiveness of osteopathic treatments for a range of conditions including neck pain and headaches [2]. In Australia, 5.4% of the population consult with an osteopath for their healthcare needs [3], primarily for the management of musculoskeletal disorders such as back pain [4–6].

The international professional identity of osteopathy is influenced by the social, regulatory and political landscape in different countries. Within the US these external factors have seen osteopaths evolve from its founding statements in the early-to-mid 1900s through to its current identity as separate from but equal to the medical profession [7]. UK research describes significant variability in how osteopaths understand their professional identity ranging from very well-defined to somewhat ambivalent descriptions [8]. While there is a growing body of evidence related to manual therapy techniques which may be employed by an osteopath [9,10], the research evidence directly about osteopathic care is limited [11]. This may explain why researchers have also documented friction between the value placed on anecdotal and research-informed knowledge within osteopathic education in Europe [12] despite other research reporting osteopaths as holding positive views towards evidence-based practice [13].

Australian osteopaths have been regulated through statutory registration since inception of the National Registration and Accreditation

* Corresponding author. Level 2, 269 Wickham Street, Fortitude Valley, Qld, 4006, Australia.
E-mail address: amie.steel@uts.edu.au (A. Steel).

https://doi.org/10.1016/j.ijosm.2018.10.004
Received 8 February 2018; Received in revised form 24 October 2018; Accepted 30 October 2018

Scheme in 2010 [14]. Prior to this time, osteopathy was included in state-based statutory registration arrangements from as early as 1978 [15]. Approximately 80% of Australian osteopaths practice in an urban area [16], although more than 50% of osteopaths are based in Victoria [14]. Most osteopaths in Australia practice in multi-practitioner clinical settings and have referral relationships with other health professionals [16]. In addition, registered osteopaths can access publically-funded reimbursements for services through the Medicare Benefits Scheme including Chronic Disease Management plans, previously known as Enhanced Primary Care programs [17,18].

The professional landscape of osteopathy in Australia has evolved substantially over recent years including changes in research, education and integration within the wider health care system [15]. While current osteopathic courses have been delivered through public universities since the mid 1980s, all osteopathic education previous to this time was provided by private colleges [15]. Historically, the osteopathic profession was closely affiliated with the chiropractic profession [15,19]. The professional boundaries between these two professions have developed over time [19] and while osteopathic and chiropractic courses are still delivered within the same faculty in one university, the two professions now have separate registration boards [14,20] and professional associations [21,22]. Alongside these other developments, the place of osteopathy in the health system has also evolved particularly as it relates to the degree to which osteopathy aligns with conventional mainstream health services as compared to its historical position as more marginal or complementary healthcare [15]. This evolution is best demonstrated by some of the features of osteopathy already mentioned such as: inclusion in Australia's National Registration and Accreditation Scheme [14]; access to government-funding for osteopathic services [17,18]; and reported referral relationships between osteopaths and general practitioners [10].

In response to these professional changes, the challenges and opportunities experienced by Australian osteopaths warrant closer examination. The aim of this study is to explore the perceptions of registered practising osteopaths in Australia regarding challenges and opportunities for by the profession.

Materials and methods

The consolidated criteria for reporting qualitative research (COREQ) [23] were used to describe the methods of the study. Approval for this qualitative study was granted by the Human Research Ethics Committee of Southern Cross University (ECN-01-15) and the Endeavour College of Natural Health (#2015035).

Design

This study employed a qualitative inductive design and approach [24,25]. Three focus groups of registered practicing osteopaths were convened across three locations within Australia (Sydney, Melbourne and Lismore) between October and November 2015.

Setting

Focus groups were convened at public neutral environments (e.g. boardroom, restaurant) convenient to the participants.

Recruitment

Recruitment was undertaken by email to registered osteopathic practitioners within the three locations. Purposive sampling was employed in order to ensure a range of gender, age, education, and years of practice amongst participants.

Table 1
Characteristics of focus group participants.

#	Gender	Age	Clinical experience	Qualification	Country of Qualification
1	F	39	13	BM	Aus
2	F	29	4	BM	Aus
3	F	45	1	BM	Aus
4	M	48	13	BM	Aus
5	F	52	30	DO	UK
6	M	54	29	DO	UK
7	M	67	41	DO	Aus
8	M	61	37	DO	Aus
9	M	33	7	BM	NZ
10	M	57	43	DO	UK
11	M	58	16	BM	Aus
12	F	37	4	BM	Aus
13	M	38	10	BM	NZ
14	F	35	6	BM	NZ
15	M	56	21	BM	Aus
16	M	46	4	BM	Aus
17	M	55	33	DO	Aus

BM = Bachelors & Masters degrees.
DO = Diploma of Osteopathy.

Data collection

Participant demographics (age, gender, years in clinical practice, level of qualification, country of clinical training) were documented as part of the focus groups. The data were collected through semi-structured thematic guides which covered topics such as: career choices as an osteopath; characteristics of successful osteopathic practice; challenges facing contemporary osteopathic practice; and the education and scope of osteopathic practice. The research team developed the guide by deconstructing the key domains underpinning the primary research question and formulating open questions designed to elicit detailed responses from participants. The guides were piloted with individuals representing the sample population and refined based on the pilot feedback. The focus groups were recorded using a digital audio recorder and later transcribed by an external professional transcription service. Field notes were also taken by the researchers. The demographics of participants included in the focus group are described in Table 1. [redacted for blinded review] (female) and [redacted for blinding review] (male) conducted the focus groups. [redacted for blinded review] established relationship with participants prior to study commencement through phone and email interaction. [redacted for blinded review] introduced the research team and the study aims of the project to the participants before requesting consent for participation. The duration of the focus groups was between 45 and 60 min. Data saturation was reached after the second focus group but a third focus group was conducted to be certain no additional themes were overlooked.

Data analysis

Data were analysed from transcripts using a Framework approach [26] developed specifically for applied or policy relevant research. The Framework approach to qualitative research starts deductively from the aims and objectives set out for the study but relies heavily on the original accounts and observations of the people studied, and as such is also "grounded" or inductive [26]. Descriptive thematic analysis of the data was undertaken and common themes were noted. The descriptive thematic analysis followed an established process of *familiarisation*, *identifying a thematic framework*, *indexing*, *charting*, and *mapping and interpretation* [27]. Immersion in the raw data was undertaken by [redacted for blinded review] by listening to the audio recordings and reading the transcripts of the focus group discussions. The data were independently coded into themes identified as relevant to the overarching research question by [redacted for blinded review] and [redacted for blinded review]. The independent charting and mapping was

then triangulated via discussions with [redacted for blinded review] and [redacted for blinded review] with any disagreements resolved through discussion until consensus was reached [28]. The researchers had diverse backgrounds: an osteopathy-trained academic; a clinically-trained non-osteopathic health services researcher; and a sociologist. The different perspectives of the researchers allowed for researcher triangulation between the three people in the research team. Direct quotes were identified as supportive evidence indicative of each theme.

Results

Seventeen registered osteopaths participated in the focus groups. Thematic descriptive analysis of the osteopaths' accounts identified several different perspectives about whether the osteopathic profession was moving in the optimal direction. These included a tension between whether osteopaths were best placed as generalists or specialists; the importance of quality education and relevant, rigorous research as pillars for the sustainability of osteopathy; a need for clarity about the place of osteopathy in the healthcare system; and a need to increase public awareness of osteopathy.

The tension between generalist and specialist osteopathic practice

The first major concept expressed by the participants was the issue of specialisation versus generalisation within the osteopathic profession. Differing opinions regarding the definition of 'specialisation' within the context of osteopathy were identified. Some participants considered specialisation to focus on a patient population (e.g. paediatrics), whilst others felt categorising specialties based on the anatomical region or condition being treated was more appropriate (e.g. back pain). Participants also proposed perceived differences between specialist and generalist osteopaths. In this study, participants defined specialists as osteopaths who only treat within a specific area while generalists were described as osteopaths who will treat everyone that presents at their clinic seeking care but may have areas of special interest.

The most dominant opinion expressed by participants was that osteopaths should be generalists who treat holistically but also can have one or more area of special interest.

> *We have to have this general practice capability and we don't want a limiting sort of practice that means that anyone who's just come out of university can't treat children or can't treat old people, can't treat sports injuries. They have to be able to treat everything but they can be able to expand their knowledge in a particular area that they wish to expand it in. (Sydney focus group participant, p28)*

Another dominant, albeit less common, idea expressed by participants was that osteopaths are, or should be, generalists and that specialisation was not necessary and should not be encouraged.

> *[That] Osteopaths are generalists who really are very good at a lot of different things [should] continue and when their particular skill set reaches the limit they have someone they can refer to … (Gold Coast focus group participant, p9)*

Those in support of specialisation argued the importance of this approach based on a concern that the current lack of specialisation within the Australia osteopathic profession could or would lead to a loss of potential clients due to less communication of expertise in a given area compared to other professions.

> *If we can't say we specialise, how would people know where to go? (Melbourne focus group participant, p19)*

> *What's wrong with specialising in an area like paediatrics? You are still treating the body as a whole unit, it is even the osteo philosophy but you are treating the body as a whole unit specific to that body's developmental stage. (Melbourne focus group participant, p20)*

Whereas others felt this argued need for specialisation and its impact on patient retention and overall practice success was fear-based, as described by a Sydney-based osteopath:

> *I think that the whole discussion around specialisation has come from fear. (Sydney focus group participant, p27-8)*

In particular, this participant was referring to the interest in specialisation within the osteopathic profession being driven by fear that absence of osteopathic specialisation would affect the perception among other health professions of osteopaths' competency in treating individuals from specific population groups or with certain health conditions.

Another argument that was presented counter to specialisation was the idea that it may diminish the value of the osteopathic principle of treating holistically, particularly early on in an osteopath's career. One osteopath saw this as a narrowing of the scope of possible treatments and patient populations:

> *I feel like if anyone started specialising in the first few years of graduating, they're closing their minds to what possibilities are out there. (Melbourne focus group participant, p22)*

Whilst a Sydney osteopath described specialisation as a negative attribute for an osteopath because it was considered to represent movement away from the manual practices considered fundamental to osteopathy:

> *It's almost a sign that the practitioner has moved on from manual skills (Sydney focus group participant, p27)*

These views were underpinned by a larger issue for the participants that core osteopathic principals are being lost or may be lost in the future.

> *But it seems osteopaths are straying away from the hands-on and going into postgraduate training and they're actually- I mean the comment I'm hearing is, why would I bother doing soft tissue when I can put a dry needle in and get the same result? (Sydney focus group participant, p17)*

The pillars of sustainability for osteopathy: quality education and relevant, rigorous research

The need for quality education and relevant, rigorous research was consistently raised as an important issue by participants underpinning the sustainability of osteopathy within the Australian health landscape, with many describing a clear interrelationship between both pillars. In the case of education, the issues associated with delivering and sustaining high quality university level education was frequently raised by participants. One such issue was described by some participants to be a concern that the future of osteopathic programs in universities was uncertain. One reason proposed by the participants for this was fiscal pressures from university administration, particularly because of the high cost of a clinical training program such as osteopathy compared with non-clinical university courses that are primarily characterised by didactic delivery methods:

> *If you're not a chalk and talk course you die. (Sydney focus group participant, p25)*

> *Universities are providing a smaller range of courses to a broader range of people …. . So I think it's almost inevitable that we will end up finishing [ending] the training of osteopaths as a profession. (Sydney focus group participant, p14)*

The view presented by participants was that it is simply not possible to teach all that needs to be taught within the constraints of universities was also expressed.

> *So general practitioners do what surgeons of all kinds do, it's what actuaries, accountants, engineers do, the high level part that all the*

university model. None of those professions would ask the university to provide their education. (Sydney focus group participant, p26)

Five years is not enough to learn everything we [osteopaths] need to know about the human body. (Melbourne focus group participant, p22)

Also indicated was the idea that universities are not nurturing the growth of the osteopathic profession in the manner initially anticipated by the profession:

… we've carried it [osteopathy] through to the university systems, which we thought would be a nurturing, growing thing. But we can see plainly, the way its heading is not that way at all. (Sydney focus group participant, p14)

The need for better quality research which targets key health areas of policy and social importance was also proposed by participants as integral to the future of osteopathy and linked to the continued viability of university-based osteopathy programs

We have colleges and universities of education but we can't give them our [osteopathy] research, to show them this is a valid [sic] career we're going to give you because we haven't got the research. (Sydney focus group participant, p15)

However, in contrast the concern was also raised that if osteopathy commits fully to a model of evidence-based practice then this will diminish or undermine the application of osteopathic principles and unique role and value of osteopathy in the healthcare system.

We have cut cranial, [a university] [is] talking about cutting MET [muscle energy testing], talking about cutting counter-strain. If we don't do visceral anymore what are we? (Melbourne focus group participant, p26)

Finding a place in the health system

Another perceived challenge described the participants was a lack of clarity amongst practitioners regarding the place of osteopathy within the healthcare system. This lack of clarity primarily centred on a perception that the value of osteopathy was self-evident and as such difficult to describe in terms of points of difference from other professions. As an example, one participant expressed difficulty describing osteopathy to those outside of the profession as they viewed osteopathy as 'common sense':

I just don't understand what the truth about osteopathy is; it is just the fundamental truth, it is not a political dogma or religious belief, it is just the truth about when we do these things with the body, the body changes for the better. It is more common sense. (Gold Coast focus group participant, p6)

Whilst another participant emphasised the shared characteristics between osteopathy and other conventional medical approaches, and that this similarity presented challenges to those attempting to uniquely position osteopathy amongst other health professions:

If you look at the philosophy of osteopathy there are some key points that are very similar to, for example, other medicine. There are some things that differ to some extent as well but I also agree, I think the role is not entirely clear in terms of how we work; we have the language, we have the shared language but I think we still need to figure out exactly where we fit in. (Gold Coast focus group participant, p3)

However, others expressed a strong view that the principles of osteopathy are entirely unique and are the key point of difference between all other health professions:

I guess what he [another participant] is saying [is that] the principles of [osteopathy is] what we do as well. And our principles are that we're trying to achieve change in the body, then the body can then work with them and continue to change for itself. So from an osteopathic standpoint we don't do this repetitive treatment or want to have people come back time after time. (Sydney focus group participant, p12)

I think we are all potentially primarily healthcare practitioners who work in a holistic paradigm and in that way we are very different to everybody. A lot of professions pay lip service to holistic paradigms because it's a new trendy phase, but when you actually go to the treatment and go through the recipe stuff; that's rubbish and that's what sets us apart. (Gold Coast focus group participant, p4)

A complementary idea that was less commonly expressed is that osteopathic principles and paradigms maintain separation between osteopathy and the other professions within the conventional healthcare system and, in fact, create a barrier to osteopaths finding a common ground with members of other health professions:

As long as we are stuck in our models in essence we will never have a way of meeting. (Gold Coast focus group participantp8).

Contrary to this was an equally expressed perception that the differences between manual therapy health professions are diminishing over time:

The point of differences [between health professions] is changing every year as all the professions in manual therapy change. (Sydney focus group participant, p5)

Some participants viewed this development as a generally positive advancement:

I don't think it necessarily comes down to a battle of professions, I think that we have a lot more unity in terms of training but also recognition in scope of practice. (Gold Coast focus group participant, p4)

Alongside the view that the place of osteopathy was unclear, the importance of collaboration, interprofessional cooperation and being part of the mainstream healthcare system was frequently described by participants. This included the importance of referring on to other health professionals if adjunctive or specialist care was needed:

I think it's really important in osteo practices [to refer] because we aren't the be all and end all. If someone needs psychological care or dietary [advice], we are not trained in that field so we don't let our ego's get in the way and go, 'you know what I can't fix your blah, blah,' if someone else needs to step in and help. (Melbourne focus group participant, p6)

Whilst some raised concerns that this level of involvement with mainstream healthcare presented challenges, the overwhelming view that access to programs such as the Chronic Disease Management (CDM) program were advantageous to the osteopathic profession both because of the increased exposure and the establishment of stronger collaborative relationships with other health providers:

[We benefit from CDM]. It exposes people to osteo[pathy] that would never consider or afford [it]. (Melbourne focus group participant,p14)

If you've got the trust of your GP to send you to an osteopath, you already have that trust there, that is so important. (Melbourne focus group participant, p14)

Being seen: the need to increase public awareness

All participants described an urgent need to increase the awareness of the role, contribution and even existence of osteopathy within the general community and amongst other health professions. The latter group received the most focus by participants. In particular, the need to educate other health professionals about the practice and benefits of osteopathy was highlighted:

There's also the education of other professions. So inter-professional cooperation and being able to educate right from GPs to specialists in

whatever area the osteopath is practising in. (Sydney focus group participant, p15-16)

The theme of educating other professionals but it is also [about] educating osteopaths how to communicate with other professionals as well. (Sydney focus group participant, p19)

However, the participants also acknowledged a number of barriers to increasing the awareness of osteopathy amongst other professions, the most significant barrier being the already described challenge of defining and describing osteopathy:

It is really difficult to explain osteopathy as an experience. When people ask me about osteopathy, I say get on the table and I'll show you, because it doesn't cut it. (Gold Coast focus group participant, p8)

Whilst, less commonly, others felt that it was fear of censure by critics, or fear of creating dissonance between osteopathy and other health professions, that created a barrier to increasing the profile of osteopathy. This particularly related to a view that practitioners did not want to draw attention to less conventional practices in osteopathy:

I think that we need to be careful not to be afraid to talk about the rest of what we do. (Sydney focus group participant, p19)

Another strong theme was a need to educate the general community about osteopathy and thereby enhance its profile. It was perceived that osteopathy was already effective and achieving good outcomes for patients but that lower patient numbers in some areas was linked more to a lack of awareness amongst potential clients:

So I wouldn't necessarily change the treatment or what we do but probably educate people on what it is we do and why we are doing it. (Melbourne focus group participant, p15)

Discussion

This study identifies a number of challenges facing the osteopathic profession in Australia. One significant issue is the ongoing sustainability and viability of osteopathy in terms of its place within the tertiary education system and the need for the profession to make a substantial contribution to advancing osteopathic education and research. This view is supported by existing research which emphasises the importance of strong education and rigorous research for a health profession to be accepted and integrated effectively into available health services [29]. Within Australia, a number of allied health peak bodies acknowledge robust educational standards and the advancement of the body of knowledge underpinning practice through research as a core requirement for the viability of professional practice [30,31]. Despite, this commitment from within the osteopathic profession, as outlined in the results of our study, previous research also highlights a number of challenges facing osteopathic educators as they balance the protection of their professional body of knowledge with the demand for evidence-based education within their institution [32].

There was a commonly expressed view that increasing osteopathic research will strengthen the position of the profession within the healthcare sector. Indeed, under the influence of the dominant paradigm of evidence-based medicine a more robust evidence-base for health professions may improve the likelihood of referrals from medical doctors and other healthcare professionals [33]. However, the development of evidence for osteopathic practice may not always result in increased referrals if the referring practitioner is not aware of the growing evidence-base of osteopathy. In fact, the existence of evidence may not result in the effective translation of new research into clinical decision-making as has been repeatedly documented as a serious challenge in most primary care settings [34]. As such, osteopaths may need to extend their perspective to not only building the evidence-base of osteopathy but also supporting the translation of new osteopathic research into the clinical awareness of referring practitioners. This idea of knowledge translation is a core aspect of the growing field of implementation science [35,36], which is only beginning to broaden its gaze to encompass the needs of professions such as osteopathy [37]. In some regards, however, the assertion from participants in our study that an increase in the awareness of osteopathy in the general public and among other healthcare providers is important for the sustainability of osteopathy, shows an emerging understanding among osteopaths of the foundational aspirations associated with knowledge translation in healthcare delivery, as defined within implementation science. Additionally, the importance of self-referral and patients' informal networks should not be dismissed [38] and any assumptions regarding the impact of evidence, or lack thereof, in a patients' decision to access osteopathic healthcare warrants closer examination [37].

This study also found that osteopaths perceived both challenges and opportunities with the current osteopathic educational landscape in Australia. The concerns raised by participants about the influence of courses being delivered within a public university setting have some links to existing research. A recent study of the tensions experienced by university-based complementary medicine educators in Australian and the UK, found that osteopathic faculty were critical of the dominant paradigm of evidence-based medicine as it relates to randomised-clinical trials as the gold standard. Instead, osteopathic academics described the need to adopt a broader definition of evidence to inform osteopathic practice [39]. Equally, the clinicians participating in our study appear to concur with this perspective. Our study expands on this view to suggest the osteopathic practitioner community may have concerns that the confines imposed by universities upon osteopathic education may diminish the degree to which core osteopathic principles influence student development and practice. This concern has been raised within the broad scope of health and evidence-based medicine [40] and also more specifically within complementary medicine [41]. Beyond the influence of the evidence-based paradigm in university education, the participants in our study also highlighted possible issues with institutional fiscal policies impacting on the viability of osteopathic programs. This finding aligns with the widely identified financial pressures within Australian tertiary education which are described as affecting the operation of the university sector [42].

Another major theme raised by the participants was the issue of specialist verses generalist osteopathic practitioners. Recent critical discourse regarding medical specialisation describes three key factors influencing the proliferation of specialties, one of which is the economic impact of the size of the general population and the matching diversification of their healthcare needs [43]. Alongside population growth, medical specialisation is also potentially affected by increased practitioner numbers and the corresponding ability for the profession to support niche clinical services [43]. While the Australian population may be sufficient to support specialisation, as evidenced by other professions such as medicine [44], chiropractic [45] and physiotherapy [46], our findings suggest conflict exists in the osteopathic profession regarding the need or appropriateness for specialties in osteopathy. Despite this conflict, there is also evidence that the Australian osteopathic profession is attempting to develop some capacity for recognition of specialised clinical skills through credentialing and other mechanisms [22]. As such, the tensions surrounding specialisation identified through our study may be reflective of the evolutionary stage of the osteopathic profession in Australia. Alternatively, the concerns may stem from a dissonance between the importance of holism within osteopathic philosophy [47,48] and the fragmentation of care that can result from healthcare specialisation [43]. Possibly in response to this philosophical conflict, our study's findings suggest some osteopaths favour specialisation according to patient population rather than patient condition or anatomical-region, thereby enabling application of holistic principles within specialised practice.

The results of our study also suggest perceived ambiguity exists regarding the position of osteopathy within the contemporary Australian healthcare system. Like both physiotherapists and

chiropractors, Australian osteopaths have access to Medicare provider numbers [18] which allow Medicare rebates for axial skeleton plain film radiography and to the Chronic Disease Management plan (previously known as the Enhanced Primary Care plan [17]). Despite this recognised place in the publically-funded healthcare system our study participants expressed difficulty when attempting to differentiate their services within the community from similar health professions. Research does suggest that patients with back pain may discern between different manual therapy professions based on factors such as the condition requiring treatment and the patient's personal views towards health [49]. Another study indicates patient choice of practitioner for back pain may be influenced by external factors such as geographical location, qualification of practitioner, previous experience of the treatment, and recommendations from social networks [50]. Given that more than half of osteopathic practitioners are based in Victoria, the impact of poor geographical spread may have wider professional implications which, to date, are unexplored. As a result, osteopaths may be limited in their ability to consolidate their place in the broader healthcare landscape in concert with other available health services until the motivations for patients choosing, or health professionals referring to, specific manual therapists in preference to others are more clearly understood.

Our study has some limitations. This study was limited to three locations nationally and as such may not have captured the nuances of perspectives for osteopaths practising in other regions and restricts the study transferability. The results are also largely specific to the Australian context and may not be transferable to other jurisdictions. The qualitative nature of the study can also be seen as a limitation for those seeking to generalise the findings across the osteopathic workforce due to data having been obtained from a small sample. However, qualitative research has been recognised as a good study design when exploring perceptions and attitudes in health [51]. More research is necessary to provide additional context and a broader understanding of our findings. Despite these limitations, this study offers unique insights into the challenges faced by an evolving health profession in the Australian healthcare landscape.

Conclusion

Australian osteopaths are currently facing a range of challenges affecting their professional practice and the long-term sustainability of their profession. While some of these challenges are shared with other health professions additional challenges are unique to the osteopathic profession. This study highlights a number of these challenges and in doing so, provides an opportunity for practitioners, professional leaders, regulators and policy makers to find appropriate solutions to support the advancement of the profession. There needs to be greater cohesion and consensus within the osteopathic profession on how to best tackle these issues. To this end there needs to be more effective communication/liaison between the osteopathic profession and osteopathic education providers, osteopathic regulators, Government departments, and other healthcare professionals.

Ethical approval details

Approval for this qualitative study was granted by the Human Research Ethics Committee of Southern Cross University (ECN-01-15) and the Endeavour College of Natural Health (#2015035).

Funding sources

None.

Author contribution

AS conceived of and coordinated the study. AS and RB conducted the field work. JA provided methodological supervision. DC, RB and AS analysed the data. RB and DC wrote the first draft of the manuscript. All authors edited and approved the final version of the manuscript.

Conflicts of interest

AS was a board member of Osteopathy Australia during the data collection phase of this project. No other authors have conflicts of interest to declare.

Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.ijosm.2018.10.004.

References

[1] Osteopathic International Alliance. Osteopathy and osteopathic medicine. 2013.
[2] Steel A, Sundberg T, Reid R, Ward L, Bishop FL, Leach M, Cramer H, Wardle J, Adams J. Osteopathic manipulative treatment: a systematic review and critical appraisal of comparative effectiveness and health economics research. Musculoskeletal Sci Pract 2017;27(Supplement C):165–75.
[3] Steel A, McIntyre E, Harnett J, Foley H, Adams J, Sibbritt D, Wardle J, Frawley J. Complementary medicine use in the Australian population: results of a nationally-representative cross-sectional survey. Sci Rep 2018. In Press.
[4] Frawley J, Sundberg T, Steel A, Sibbritt D, Broom A, Adams J. Prevalence and characteristics of women who consult with osteopathic practitioners during pregnancy; a report from the Australian Longitudinal Study on Women's Health (ALSWH). J Bodyw Mov Ther 2016;20(1):168–72.
[5] Murthy V, Sibbritt D, Adams J, Broom A, Kirby E, Refshauge KM. Consultations with complementary and alternative medicine practitioners amongst wider care options for back pain: a study of a nationally representative sample of 1,310 Australian women aged 60–65 years. Clin Rheumatol 2014;33(2):253–62.
[6] Murthy V, Sibbritt DW, Adams J. An integrative review of complementary and alternative medicine use for back pain: a focus on prevalence, reasons for use, influential factors, self-perceived effectiveness, and communication. Spine J 2015;15(8):1870–83.
[7] Miller K. The evolution of professional identity: the case of osteopathic medicine. Soc Sci Med 1998;47(11):1739–48.
[8] Thomson OP, Petty NJ, Moore AP. Osteopaths' professional views, identities and conceptions – a qualitative grounded theory study. Int J Osteopath Med 2014;17(3):146–59.
[9] Hidalgo B, Detrembleur C, Hall T, Mahaudens P, Nielens H. The efficacy of manual therapy and exercise for different stages of non-specific low back pain: an update of systematic reviews. J Man Manip Ther 2014;22(2):59–74.
[10] Adams J, Sibbritt D, Steel A, Peng W. A workforce survey of Australian osteopathy: analysis of a nationally-representative sample of osteopaths from the Osteopathy Research and Innovation Network (ORION) project. BMC Health Serv Res 2018;18(1):352.
[11] Steel A, Sundberg T, Reid R, Ward L, Bishop FL, Leach M, Cramer H, Wardle J, Adams J. Osteopathic manipulative treatment: a systematic review and critical appraisal of comparative effectiveness and health economics research. Musculoskeletal Sci Pract 2017;27:165–75.
[12] Sposato N, Shaw R, Bjerså K. Addressing the ongoing friction between anecdotal and evidence-based teachings in osteopathic education in Europe. J Bodyw Mov Ther 2018;22(3):553–5.
[13] Weber V, Rajendran D. UK trained osteopaths' relationship to evidence based practice - an analysis of influencing factors. Int J Osteopath Med 2018;29:15–25.
[14] Osteopathy Board of Australia, [http://www.osteopathyboard.gov.au/].
[15] Baer HA. Osteopathy in Australasia: from marginality to a fully professionalised system of health care. Int J Osteopath Med 2009;12(1):25–31.
[16] Adams J, Sibbritt D, Steel A, Peng W. A workforce survey of Australian osteopathy: analysis of a nationally-representative sample of osteopaths from the Osteopathy Research and Innovation Network (ORION) project. BMC Health Serv Res 2018;18.1:352.
[17] Chronic Disease Management (formerly Enhanced Primary Care or EPC) — GP services, [http://www.health.gov.au/internet/main/publishing.nsf/Content/mbsprimarycare-chronicdiseasemanagement].
[18] Medicare provider number for health professionals, [https://www.humanservices.gov.au/organisations/health-professionals/services/medicare/medicare-provider-number-health-professionals].
[19] Cameron M. An international study of osteopathic practice. Victoria University of Technology; 1999.
[20] Accreditation, [http://www.chiropracticboard.gov.au/Accreditation.aspx].
[21] What is Chiropractic?, [http://chiropractors.asn.au/AM/Template.cfm?Section=What_is_Chiropractic].
[22] Clinical Practice Groups, [http://www.osteopathy.org.au/pages/clinical-practice-groups.html].
[23] Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. Int J Qual

Health Care 2007;19(6):349–57.
[24] Magin P, Adams J, Heading G, Pond D. 'Perfect skin', the media and patients with skin disease: a qualitative study of patients with acne, psoriasis and atopic eczema %. J Australian J Prim Health 2011;17(2):181–5.
[25] Magin P, Adams J, Heading G, Pond D, Smith W, Psychological sequelae of acne vulgaris: results of a qualitative study. 2006, 52(8):978-979.
[26] Pope C, Mays N. Qualitative research in health care. John Wiley & Sons; 2013.
[27] Bradshaw C, Atkinson S, Doody O. Employing a qualitative description approach in health care research. Global Qual Nurs Res 2017;4. 2333393617742282.
[28] Carter N, Bryant-Lukosius D, DiCenso A, Blythe J, Neville AJ. The use of triangulation in qualitative research. Oncology Nursing Forum; 2014. 2014.
[29] Brosnan C, Kirby E. Sociological perspectives on the politics of knowledge in health care: introduction to themed issue. Taylor & Francis; 2016.
[30] Strategic Plan 2015-17, [http://www.physiotherapy.asn.au/APAWCM/The_APA/About_The_APA/Strategic_Plan/APAWCM/The_APA/About_The_APA/Strategic%20Plan.aspx].
[31] Strategic Plan 2015-18, [https://chiropractors.asn.au/about-caa/caa-vision-and-values].
[32] Brosnan C. 'Quackery'in the academy? professional knowledge, autonomy and the debate over complementary medicine degrees. Sociology 2015;49(6):1047–64.
[33] Choudhry NK, Liao JM, Detsky AS. Selecting a specialist: adding evidence to the clinical practice of making referrals. Jama 2014;312(18):1861–2.
[34] Lau R, Stevenson F, Ong BN, Dziedzic K, Treweek S, Eldridge S, Everitt H, Kennedy A, Qureshi N, Rogers A. Achieving change in primary care—causes of the evidence to practice gap: systematic reviews of reviews. Implement Sci 2015;11(1):40.
[35] Brownson RC, Colditz GA, Proctor EK. Dissemination and implementation research in health: translating science to practice. Oxford University Press; 2017.
[36] Greenhalgh T, Robert G, Macfarlane F, Bate P, Kyriakidou O. Diffusion of innovations in service organizations: systematic review and recommendations. Milbank Q 2004;82(4):581–629.
[37] Steel A, Rapport F, Adams J: Towards an implementation science of complementary health care: some initial considerations for guiding safe, effective clinical decision-making. Adv Intergr Med., https://doi.org/10.1016/j.aimed.2018.02.002.
[38] Murthy V, Adams J, Broom A, Kirby E, Refshauge KM, Sibbritt D. The influence of communication and information sources upon decision-making around complementary and alternative medicine use for back pain among Australian women aged 60–65 years. Health Soc Care Community 2017;25(1):114–22.
[39] Brosnan C. Epistemic cultures in complementary medicine: knowledge-making in university departments of osteopathy and Chinese medicine. Health Sociol Rev 2016;25(2):171–86.
[40] Cohen AM, Stavri PZ, Hersh WR. A categorization and analysis of the criticisms of evidence-based medicine. Int J Med Inf 2004;73(1):35–43.
[41] Steel A, Adams J. The interface between tradition and science: naturopaths' perspectives of modern practice. J Alternative Compl Med 2011;17(10):967–72.
[42] The Facts on University Funding, [https://www.universitiesaustralia.edu.au/Media-and-Events/submissions-and-reports/The-facts-on-university-funding].
[43] Detsky AS, Gauthier SR, Fuchs VR. Specialization in medicine: how much is appropriate? Jama 2012;307(5):463–4.
[44] Medical Specialties and Specialty Fields, [http://www.medicalboard.gov.au/Registration/Types/Specialist-Registration/Medical-Specialties-and-Specialty-Fields.aspx].
[45] CAA Clinical Interest Groups, [https://chiropractors.asn.au/about-caa/caa-clinical-interest-groups].
[46] Specialisation as awarded by the Australian College of Physiotherapists, [http://www.physiotherapy.asn.au/APAWCM/Careers/Career_Paths/Specialisation_Pathway/APAWCM/Careers/Career_Paths/Specialisation.aspx].
[47] Paulus S. The core principles of osteopathic philosophy. Int J Osteopath Med 2013;16(1):11–6.
[48] Johnson SM, Kurtz ME. Perceptions of philosophic and practice differences between US osteopathic physicians and their allopathic counterparts. Soc Sci Med 2002;55(12):2141–8.
[49] Steel A, Adams J, Sibbritt D, Broom A, Gallois C, Frawley J. Determinants of women consulting with a complementary and alternative medicine practitioner for pregnancy-related health conditions. Women Health 2013;54(2):127–44.
[50] Kirby ER, Broom AF, Adams J, Sibbritt DW, Refshauge KM. A qualitative study of influences on older women's practitioner choices for back pain care. BMC Health Serv Res 2014;14(1):131.
[51] Grbich C. Qualitative research in health: an introduction. Sage; 1998.