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Original article

A profile of osteopathic care in private practices in the United Kingdom: A national pilot using standardised data collection

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ABSTRACT

Increasing interest is being shown in osteopathy on a national and international basis. Since little prospective data had been available concerning the day-to-day practice of the profession, a standardised data collection tool was developed to try and address this issue. The tool development process has been described in an earlier paper. The standardised data collection (SDC) tool underwent national piloting between April and July 2009 in United Kingdom private practices. Osteopaths volunteered to participate and collected data on consecutive new patients or patients presenting with a new symptom episode for a period of one month; follow-up data were collected for a further two months. A total of 1630 completed datasets from the SDC pilot were analysed by the project team. Data generated from the national pilot showed that lumbar symptoms were the most commonly presented in patients (36%), followed by cervical spine (15%), sacroiliac/pelvic/groin (7.9%), head/facial area (7%), shoulder (6.8%), and thoracic spine (6%). A total of 48.8% of patients reported comorbidities, the most common being hypertension (11.7%), followed by asthma (6.6%), and arthritis (5.7%). Outcome data were collected looking at the patients' response to treatment, and any form of treatment reactions. The profiling information collected using the SDC tool provides a contemporary picture of osteopathic practice in the United Kingdom.

1. Introduction

Osteopathy now forms part of the provision of musculoskeletal services in the United Kingdom (UK) appearing in national and international guidelines (Hildebrand et al. and the chronic low back pain guideline working group, 2004; van Tulder et al. and the acute low back pain guideline working group, 2004; Department of Health, 2006; Savigny et al. and Guideline Development Group, 2009); however this provision focusses on one particular type of osteopathic technique, i.e. spinal manipulation. The clinical recommendations are most notably for low back pain, a condition representing a significant cost burden to national governments (Maniadakis and Gray, 2000; Dagenais et al., 2008). The information about the wider extent of current osteopathic practice in the UK is limited; some data have been collected from isolated surveys, usually conducted on a single day, in one private or NHS osteopathic practice, or in one clinic attached to an osteopathic educational institution (OEI) (Burton, 1981; Pringle and Tyreman, 1993; Hinkley and Drysdale, 1995; General Osteopathic Council, 2001; McIlwraith, 2003).

While the vast majority of the evidence supporting the use of osteopathy relates to the use of spinal manipulation, this is only one technique among a range of more than 100 different osteopathic techniques or procedures which have been described in the literature (Owens, 1963; Jones, 1981; Heilig, 1986; Still, 1992; Di Giovanna and Schiowitz, 1997; Lesho, 1999; Evans, 2002; Evans and Breen, 2006; ; Furlan et al., 2009). In response to this lack of data regarding osteopathic approaches, the National Council for Osteopathic Research initiated the development of a standardised data collection (SDC) tool to gather baseline data about current osteopathic practice. This was developed by an iterative process using a nominal group technique involving volunteer private practitioners (Fawkes et al., 2009); its development is reported in a separate paper (Fawkes et al., 2014). This paper reports the results of the first large national pilot data collection using the SDC tool. The aims of the study were to test the performance of the newly-developed SDC tool, and gather information to help to describe the scope and range of osteopathic practice in terms of patient demographics, symptom profiles, management strategies, outcomes of care, and the costs associated with treatment.

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2. Methods

The previously developed osteopathic SDC tool was used to gather prospective data on individual patient consultations within a cross section of volunteer osteopathic practices across the UK. It should be stressed that the data analysed represents pilot data from the newly-developed SDC tool.

2.1. Recruitment and sampling

All registered osteopaths in private practice in the UK were eligible to participate in the SDC pilot. Recruitment was voluntary, and effected through advertisements at regional osteopathic groups, in the osteopathic press, email networks, and at national osteopathic conferences.

2.2. Intervention

Ten copies of the SDC tool complete with guidance notes were distributed to participants; data collection took place over a three month period between April and July, 2009. Data on new patients or returning patients presenting with a new episode were collected by the participants during April; they were followed-up for a further two months or until discharge depending on which event occurred sooner. The tool was semi-structured, recording predominantly quantitative data with some free text. To maintain anonymity and confidentiality, each osteopath was allocated a unique ID code, to which they could add a sequential code (01, 02…) for the patient identifier. Consecutive new patient-episodes were requested for data collection to prevent selection bias. Patients were eligible irrespective of the age, presenting symptoms or reason for consultation. Extra work was involved for the osteopath in completing the six-page SDC tool in addition to the usual practice case-notes at first consultation. Follow-up data relating to outcomes of care were collected during the course of treatment e.g. post treatment reactions within the first 24–48: overall outcome of care data including symptom change were collected by the osteopath after the first visit, and at discharge or the end of the data collection period depending which occurred first. On conclusion of the data collection period, participating osteopaths were asked to post their completed SDC tools back to the research team at the host institution.

2.3. Analysis

Data were input into Microsoft Excel and checked for quality. The main analysis was descriptive, using the statistical functions within Excel to summarise the data.

3. Results

A total of 394 (9.4%) of the 4198 osteopaths on the GOsC Register of Osteopaths in 2009 volunteered to take part in the project. Among the 394 volunteers, 87% of these osteopaths actively collected data. A total of 1630 completed data sets were returned to the host institution for analysis. Data quality was generally good; there were some missing values in various questions (for example age data were missing for 2.6% of patients) and no datasets had to be excluded because of poor quality data. Data were collected on patients presenting for treatment during the first month of the three month data collection period: due to this discrete time-frame for initial data collection and follow up, some patients ($n = 33$) had not completed their course of treatment at the end of the data collection period.

3.1. Patient characteristics

The socio-demographic information collected from patients is shown in Table 1. The mean age was 44.8 years (SD± 19.1 years, range 0–93 years) and was bi-modally distributed with a small secondary peak in the childhood age groups. There were 8.6% (140) patients aged under 20 with more than half of these being under 1 year old. Overall, the majority of patients were in employment (62.1%) including 14% in part time work, or retired (19%). There were 27 patients (1.7%) reported as being in receipt of disability allowance. Patient-reported ethnicity was white (93.9%), using ethnicity descriptors employed by the Office for National Statistics (Office for National Statistics, 2010).

The most common referral route to the osteopath was self-referral (79.9%), with most (69.8%) arranging treatment with a particular osteopath identified via “word of mouth”. The costs of treatment were met by the individual in 89.1% of cases; 6.6% of patients had their treatment funded by insurance schemes, 0.6% by their employer, and 0.6% by the NHS. The reasons for seeking osteopathic care included personal recommendation (64.9%), failure of other treatment(s) (1.9%), wanting a form of manual or hands-on treatment (9.1%), wanting drug-free treatment (9.1%), and waiting for an NHS appointment (1.9%). A total of 59% of the patients were new to osteopathy. The waiting times for access to care was recorded as the first available appointment offered to a patient; these waiting times were short with 16.8% of patients being offered an appointment on the same day, 71% being seen within 3 days of contacting the practice, and 84% being seen with one week of their first contact with the practice.

A total of 29% of patients had received NHS treatment or investigations prior to attending an osteopath for this particular episode of symptoms. NHS treatment included prescribed medication (20.1%), imaging (13.9%), hospital outpatient treatment (10.9%), or hospital inpatient treatment (1.3%). A total of 48% of patients reported they had consulted their general practitioner (GP) prior to their osteopathic consultation, and 8.8% had made 4 or more visits.

The presenting problem(s) was/were recorded by the anatomical site(s) of the symptom(s). Up to three anatomical sites were permitted, ranked by their importance to the patient. Table 2 shows the distribution of sites ranked most commonly by patients. The lumbar spine was the most frequently reported site of symptoms (36.0%), followed by the cervical spine (15.0%) and pelvic region (11.0%); the other sites all scored less than 10%.

The duration of symptoms related to the current problem was reported as chronic (13 weeks or more) by 32.5% of patients; sub-

Table 1
Patients’ socio-demographic data.

Patient characteristic	No. of patients	%
Gender		
Female	912	56
Male	703	43
Missing	15	1
Age range		
0–9 years	91	5.6
10–19 years	48	2.9
20–29 years	143	8.8
30–39 years	351	21.5
40–49 years	299	18.3
50–59 years	293	18.0
60–69 years	200	12.3
70–79 years	123	7.5
80+	39	2.3
Missing	43	2.6