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Readers are encouraged to prepare letters electronically in Microsoft Word (.doc) or in plain (.txt) or rich text (.rtf) format. The *JAOA* prefers that letters be e-mailed to jaoa@osteopathic.org. Mailed letters should also be sent electronically, in one of the aforementioned electronic formats on an IBM-compatible compact disk or a 3½-inch diskette, and addressed to Gilbert E. D’Alonzo, Jr, DO, Editor in Chief, American Osteopathic Association, 142 E Ontario St, Chicago, IL 60611-2864.

Letter writers must include their full professional titles and affiliations, complete preferred mailing addresses, day and evening telephone numbers, fax numbers, and preferred e-mail addresses. Authors are responsible for disclosing financial associations and other conflicts of interest.

Although the *JAOA* cannot acknowledge the receipt of letters, a *JAOA* staff member will notify writers whose letters have been accepted for publication. Mailed submissions and supporting materials will not be returned unless authors provide self-addressed, stamped envelopes with their submissions.

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Although the *JAOA* welcomes letters to the editor, readers should be aware that these contributions have a lower publication priority than other submissions. As a consequence, letters are published only when space allows.

### Time to Accept Allopathic Physicians Into AOA-Approved Residencies?

**To the Editor:**

To quote folk singer Bob Dylan’s 1964 hit, “... the times they are a-changin’.”

In the past, I have been fortunate to have had several letters to the editor published in *JAOA*—The *Journal of the American Osteopathic Association* challenging the routine granting of AOA credit under Resolution 42 (A/2000), the so-called hardship exception.12 This AOA resolution allows osteopathic graduates who choose to enter non–AOA-approved residency training programs to seek AOA approval for that training.

Graduates of colleges of osteopathic medicine have become a highly desirable “commodity” in Accreditation Council for Graduate Medical Education (ACGME) residency training programs.3 In fact, in my home state of New York, more than 50% of graduates from the New York College of Osteopathic Medicine (NYCOM/NYIT) in Old Westbury go directly into ACGME-approved residency programs.3 Many NYCOM/NYIT graduates are now accepted into the very best programs in New York State.

When I graduated from NYCOM/NYIT in 1983, only a handful of new osteopathic physicians were considered for even mediocre allopathic programs. Clearly, the success of the profession—as measured by the desirability of our graduates—is now outstanding.

In contrast, hundreds of funded positions in residency training programs approved by the American Osteopathic Association (AOA) remain unfilled.4 This fact puts the future of AOA-approved residency training programs in jeopardy because programs that don’t fill their funded positions can lose them—and can also eventually lose their accreditation status.

Another reason for maintaining—and even expanding—AOA-approved residency programs is the likely increased competition for residency positions by an increased number of allopathic graduates. As Tod Ibrahim,5 Executive Vice President of Alliance for Academic Internal Medicine, wrote earlier this year in his quarterly update for *Academic Internal Medicine Insight:*

> Responding to concerns about an impending shortage of physicians, the Association of American Medical Colleges (AAMC) last February reversed a decade-long policy and now promotes a 15% expansion in the first-year class size at US medical schools. This change caused the largest percentage gain in overall first-year enrollments in nearly 30 years. Sources indicate that AAMC will increase its recommended expansion from 15% to 30% in the near future.

A substantial increase in allopathic medical graduates, along with an increasing number of osteopathic medical graduates,4 will continue to increase demand on a limited number of residency positions, be they AOA approved or ACGME accredited. Without AOA programs to “fall back

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on,” our osteopathic graduates may be unable to find the residency positions required to continue their careers.

Based on these factors, I join Bradley H. Werrell, DO, in his October 2005 letter to the editor (“The 'Big DO.'” 2005;105:442–443), when he notes the “irony” of not allowing allopathic trainees (MDs) to apply to AOA-approved residency training programs. Although Dr Werrell suggests that “our profession offer MDs some type of certificate of added qualification[s] in osteopathic principles and practice by completing qualifying coursework ... allowing MDs to participate in osteopathic residency programs.” Indeed, given the current circumstances, it makes little sense to discriminate against allopathic applicants based solely on the type of medical school they attended.

Let me be clear, however, that I believe that allopathic graduates should be allowed to compete for AOA-approved residency positions only when those positions have not been filled by osteopathic graduates through the AOA match. Separate application deadlines for osteopathic and allopathic candidates would ensure that osteopathic graduates retain “first crack” at all AOA-approved residency positions.

Furthermore, I would recommend that, at the conclusion of trainees’ AOA-approved residency periods, each osteopathic program director be required to certify that each resident—both osteopathic and allopathic—has developed competency in osteopathic principles and practice.

It is also important to note that, as an increasing percentage of AOA-approved residency training programs are based at nonosteopathic hospitals and the number of purely osteopathic hospitals continues to dwindle, it is increasingly problematic to eliminate allopathic graduates automatically from consideration for these residency positions. Given that the osteopathic medical profession relies on support from a multitude of allopathic physicians to help train osteopathic residents, how can we possibly deny consideration to allopathic trainees for our programs?

Furthermore, in the creation of new AOA-approved residency training programs, how can a program director expect to get the support of mostly allopathic medical staff to start a new AOA-approved residency training program when allopathic graduates would be ineligible to apply? From personal experience, I can assert that this scenario is a very difficult situation to find yourself in. At the graduate medical education committee level, it is extremely difficult to make a convincing argument for a new AOA-approved program—especially when there are osteopathic trainees in just about every ACGME residency program in the same hospital.

Following is one specific example I would like to provide. I am the director of medical education for osteopathic and allopathic medical residents (and a rotating internship) at a predominantly allopathic institution on Long Island. We have a total housestaff of 300; of these, 60 are osteopathic physicians. I have substantial support from hospital administration and clinical department chairs to develop AOA-approved residency training programs in several attractive specialty areas, such as obstetrics and gynecology as well as cardiology.

Because these proposed programs could not consider allopathic applicants, however, there is also major political opposition—even from those who otherwise support osteopathic graduate medical education. I have been asked repeatedly why allopathic graduates would be ineligible to apply for these new programs. And, yes—before you can pose the question I know you have ready—there has been considerable interest expressed in an osteopathic cardiology fellowship from a number of allopathic medical residents currently enrolled in our internal medicine residency program.

It makes sense for us to work collaboratively with our allopathic colleagues on tort reform legislation, limits on resident work hours, and Medicare reimbursement for graduate medical education. I would like to suggest that now might be the time for the osteopathic profession to reconsider its restrictive approach to residency training programs.

Although there is no doubt that osteopathic physicians were discriminated against in the past—and perhaps some still are in certain programs today—two wrongs do not make a right. The survival of AOA-approved residency training programs, ironically, may depend on opening the doors to allopathic applicants.

For those of us trying to fill our residency programs with quality physicians, this idea deserves serious consideration. And besides, isn’t it true that even A.T. Still started out as an MD?

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References

Letters


Will the Last DO Turn Off the Lights?

To the Editor:

I have read with interest the continuing debate concerning osteopathic graduate medical education (GME) and the future of the osteopathic medical profession.1–12 My story in relation to this debate is not unique. In fact, I think it is typical of the majority of graduating osteopathic physicians.

As a medical student in 1986, I was advised, “Go to the best residency you can find, regardless of whether it has an allopathic or osteopathic affiliation.” I selected an internship and residency with an allopathic affiliation, knowing that I was obtaining quality GME while sacrificing practicing in states in which an American Osteopathic Association (AOA)-approved internship and AOA certifying board examination are required for licensure. My rotating internship at the Hospital of St Raphael in New Haven, Conn, and my subsequent residency at the Yale-New Haven Hospital were not approved by the AOA. Thus, I was unable to take part 3 of the National Board of Osteopathic Medical Examiners (NBOME) licensing examination (the precursor to the Comprehensive Osteopathic Medical Licensing Examination–USA). Instead, I took the allopathic Federal Licensing Examination.

The “inadequacy” of my clinical training in the eyes of the AOA prohibits me from being licensed as an osteopathic physician in those states that require an AOA-approved internship and the NBOME exam. Nevertheless, I function quite well today in an entirely allopathic world. Although I have maintained my AOA membership and I try to be active in the Mississippi Osteopathic Medical Association, I am invisible in the eyes of the AOA, except for my yearly membership dues check.

Were the experience I describe here limited or isolated, it would not be important. However, I believe that my experience is typical of today’s graduating osteopathic physicians, many of whom choose to enter allopathic GME programs.13 If we are all invisible to the AOA, what does this say for the future of the osteopathic medical profession? If there were a nationwide initiative today similar to the one that offered conversion of doctor of osteopathic medicine (DO) degrees to doctor of medicine (MD) degrees in California in the 1960s,14 how many DOs would be left?

In my view, there are several factors that, if not corrected, will ultimately result in the death of the osteopathic medical profession as we know it. These factors include the following:

- **Failure to objectively evaluate the quality of osteopathic GME.** It is interesting to note that the growth of osteopathic undergraduate medical education has been inversely proportional to that of filled GME positions—such that there are now more osteopathic internships available than there are graduates willing to fill them.15 As the number of AOA-accredited hospitals shrinks, more and more osteopathic residencies are served in allopathic medical institutions.13,16,17 These residency programs may or may not have dual accreditation by the AOA and the Accreditation Council for Graduate Medical Education (ACGME).

In addition, osteopathic GME programs tend to be in relatively small facilities, which may be sufficient for osteopathic residents in primary care programs but not for residents in other specialties. For example, the complexity of anesthesiology residency requires the presence of a large tertiary- or quaternary-care medical center. Indeed, the ACGME Residency Review Committee limits anesthesiology residency training in small hospitals by requiring residents to serve substantial amounts of time in complex critical care environments.18 These kinds of allopathic training programs do not need dual accreditation.

The ACGME is also moving toward integrating internships into the residency continuum.19 Although this will happen slowly, it is a sure sign that the traditional rotating internship is going away. Whether this is a good thing is highly debatable. It is, nevertheless, going to happen.

For many graduating osteopathic medical students then, there is no real choice but to enter residencies at large allopathic medical centers if they wish to pursue specialties in areas other than primary care. (Even primary care may be better taught in the large medical centers.)

Having highly trained subspecialists is important to the future of the osteopathic medical profession. If we remain satisfied with only primary care physicians, the allopathic medical profession will view DOs as little more than glorified nurse practitioners. The osteopathic medical profession needs to embrace osteopathic subspecialists, regardless of their residency affiliations.

- **Inadequate and nonrigorous osteopathic specialty board certification processes.** In the casual opinion of many in the allopathic world, the AOA specialty boards are widely considered to be “easier” and less credible than the allopathic certifying
boards. I previously thought that this attitude was just “sour grapes” on the part of the allopathic medical profession. During the last several years, however, I have concluded that this MD opinion of the AOA boards may be accurate. I have personally encountered several osteopathic physicians who, after completing allopathic residency training, were unable to pass the allopathic board examinations—though they were able to pass the osteopathic board exams with ease. In all of these cases, these osteopathic physicians were viewed by their allopathic colleagues as unworthy of board certification.

The allopathic boards are the gold standard for residency training certification. Following my medical training, I had no intention of pursuing anything but this credible and universally accepted credential. The AOA needs to seriously re-evaluate its board-certification process.

**Overemphasis of osteopathic manipulative treatment (OMT).** It may be heresy to put this forth, but OMT is vastly overemphasized by the AOA. The practice of OMT is important in osteopathic medical education and in the practices of some osteopathic physicians, but it is not necessary for many other osteopathic physicians. Osteopathic medicine and osteopathic principles do not start and end with OMT.

The steadfast position of the AOA regarding the practice of OMT is shortsighted as if the American Medical Association were to hold digital subtraction angiography as one of the foundations of allopathic medical practice. The AOA needs to realize that, in and of itself, OMT does not make one an osteopathic physician. A true osteopathic philosophy of practice is a far deeper thing, involving a holistic, patient-centered approach to care and excellence.

Our residency training program at the University of Mississippi School of Medicine seeks out and actively recruits osteopathic medical graduates not because of their abilities in OMT, but because we know that they are consistently exemplary residents who can be relied on to provide our patients with safe, thorough, and compassionate care. Indeed, most of our chief residents, who are selected for their clinical and administrative skills, have been DOs. This has nothing to do with their abilities to perform OMT. In my practice of pediatric cardiac anesthesiology, I do not use OMT. I do, however, practice osteopathic medicine, and I believe that I offer my patients a philosophy and method of care that compares favorably with that offered by allopathic physicians.

I consider my patients to include the parents of the children to whom I am administering an anesthetic for high-risk procedures. If anything is a hallmark of an osteopathic physician, I believe it is a compassionate, holistic, and respectful approach to caring for our fellow human beings—coupled with an honest appraisal of the limitations and potential of pharmacologic, surgical, and osteopathic interventions.

**Failure to welcome all osteopathic physicians.** Those of us DOs who trained in allopathic GME programs and who practice in the allopathic world are increasing in number and may very well be the majority of practicing DOs in the United States. We are proud of our profession and identity, though we are largely ignored by the AOA. We are successful clinical and academic practitioners and leaders in many fields. It is foolish for the AOA to treat us as if we do not exist. The AOA should take the “big tent” approach to the osteopathic medical profession and welcome all DOs as active participants with emotional investment in the success of the profession.

I suggest that the AOA create a committee to explore these issues and find ways to welcome back the DOs, like myself, who love the profession more than it loves us.

This is the reality. If the situation I’ve described in this letter does not change, there will be fewer and fewer DOs involved in the AOA and in national advocacy of osteopathic medicine. In time, DOs and the AOA will disappear entirely, leaving the DO degree as an academic curiosity—or as an MD degree with different letters behind the graduate’s name.

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**References**


(continued on page 302)
Response

I read with great interest the letter from Dr Mychaskiw about osteopathic graduate medical education (GME). I found the letter to be a very negative review of the current state of GME in the osteopathic medical profession. In my role as the chairman of the American Osteopathic Association’s Council on Postdoctoral Training, I feel compelled to respond.

Dr Mychaskiw indicates that he was advised while in osteopathic medical school in the mid-1980s to “go into the best residency you can find, regardless of whether it has an allopathic or osteopathic affiliation.” It is unfortunate that many of the advisers at colleges of osteopathic medicine fail to indicate that the quality of many AOA-approved internships and residencies is every bit as good or even better than many of the GME programs accredited by the Accreditation Council for Graduate Medical Education (ACGME).

Having observed many reviews of ACGME-accredited programs, I know that there are just as many training programs of questionable quality accredited by the ACGME as there may be by the AOA. However, because no one has ever agreed on an objective definition of “quality” in medical education—other than meeting a set of minimum standards for accreditation—the evaluation of any program is often a personal, subjective matter.

I am certain that Dr Mychaskiw obtained a fine academic and clinical education in his internship at the Hospital of St Raphael in New Haven, Conn, and his residency at the Yale-New Haven Hospital. However, he cannot blame all of his subsequent adverse experiences regarding the osteopathic medical profession on the AOA. His ineligibility to participate in part 3 of the examination of the National Board of Osteopathic Medical Examiners (NBOME) was the result of criteria established by the NBOME—not the AOA. Furthermore, his inability to practice in certain states resulted from his ineligibility in accordance with state licensing laws—not AOA rules or regulations. The AOA does not regulate licensing criteria in any state.

Dr Mychaskiw refers to the “inadequacy of my clinical training in the eyes of the AOA.” The adequacy or inadequacy of his training is not the issue here. Every osteopathic medical student should know—or should be informed by his or her osteopathic college “adviser”—that there are established, professional criteria that must be met. The AOA, through its Council on Postdoctoral Training and its Bureau of Osteopathic Education, functions as an educational approval and accrediting agency in the same manner in which the ACGME functions. Both organizations have a responsibility to maintain the integrity of their training programs. At present, the ACGME does not recognize AOA-approved residency programs as meeting ACGME standards, and the AOA does not recognize ACGME-accredited programs as meeting AOA standards.

As far as Dr Mychaskiw’s status within the AOA, the AOA is pleased that he has chosen to maintain his membership and remain active as a DO in his state. The AOA values the professional contributions of Dr Mychaskiw and other DOs who have been trained and licensed through allopathic pathways. The AOA also looks forward to the assistance of these DOs in teaching osteopathic medical students and residents, as Dr Mychaskiw is doing in his residency program at the University of Mississippi School of Medicine. I can assure you that these DOs are certainly not, as Dr Mychaskiw charges in his letter, “invisible in the eyes of the AOA.” Rather, they are seen as important AOA members, just like any other members. In fact, a major focus of the AOA’s new branding initiative is to make sure that ACGME-trained DOs feel welcome in the AOA.1

The AOA Board of Trustees supports various policies to integrate ACGME-trained DOs into the osteopathic medical profession, including Resolution 42 (A/2000), titled “Approval of ACGME Training as an AOA-Approved Internship” (the “hardship exception”), and Resolution 56 (A/2004), titled “Certification Eligibility for ABMS-Certified DOs.” Resolution 42 permits ACGME-trained DOs to request internship approval from the AOA of their first ACGME-accredited year of training. If the AOA grants this approval, these DOs may request that the AOA approve their ACGME-accredited residency training. To date, the AOA has approved more than 90% of the requests made under this resolution (J.L. Obradovic, MA, RDH, oral communication, April 2006).

Resolution 56 permits those DOs certified by member boards of the American Board of Medical Specialties (ABMS) to request eligibility to sit for the examinations of AOA certifying boards—without requiring separate

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AOA approval of the ACGME training. This resolution provides for an expedited process to make these DOs eligible for AOA board certification.

I challenge Dr Mychaskiw’s statement that the AOA certifying board examinations do not have validity comparable with the ABMS boards. To give one example of why this statement is inaccurate, the American College of Physicians (ACP) decided in 2003 that DOs certified by the American Osteopathic Board of Internal Medicine are eligible for ACP membership because of the comparability of the AOA and ABMS certifying board examinations for this specialty. Moreover, the AOA has insisted that its certifying boards go through extensive validation processes to ensure that they are comparable with ABMS boards. The fact that several acquaintances of Dr Mychaskiw were unable to pass ABMS boards after completing ACGME-accredited residencies raises questions concerning the quality of the ACGME training.

Regarding Dr Mychaskiw’s remark that osteopathic manipulative treatment (OMT) is “overemphasized by the AOA,” I acknowledge that osteopathic medicine and osteopathic philosophy encompass much more than OMT. Nevertheless, OMT is one of the fundamentals on which the osteopathic medical profession is built. I suggest that by incorporating OMT into his cardiac anesthesia practice, just as he uses medications and gases, Dr Mychaskiw could offer even better care to his patients.

In summary, I do not believe that Dr Mychaskiw and other ACGME-trained DOs are being ignored by the AOA. Rather, they have chosen not to partake of the many benefits that the AOA has developed for them. My words of advice are: Try the AOA. You might like it!

MICHAEL I. OPPARI, DO
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References

Progressive Idea for Osteopathic Medical Education

To the Editor:
The most explosive thing in the world is an idea. I have an idea that the osteopathic medical profession should offer its services to the impoverished and other underserved members of the public on a national level via changes in the profession’s education system.

I propose that osteopathic medical schools accept qualified students after only 2 years of college, provided that the students have fulfilled all of their premedical curriculum requirements. There is precedence for such a proposal in schools of medicine and dentistry. Indeed, there are a number of models in which undergraduate colleges and medical schools combine their efforts to offer a 6-year course of study for a graduate degree.

It is my opinion that premedical college students go to undergraduate college primarily to get into medical school, a liberal arts education being their secondary purpose. Furthermore, medical school admissions committees rely heavily on applicants’ science grade point averages—not on grades in such subjects as English, history, and philosophy.

I propose that after completing the new 6-year osteopathic medical curriculum, a student serves an additional year in an impoverished or other underserved area of the United States (eg, a rural, remote, or inner-city community) prior to receiving a degree in osteopathic medicine. Close collaboration with federal and state agencies would be required to identify the most important communities in need.

Not only would this “service year of training” provide healthcare to underserved communities in the United States, it would also save students 2 years of undergraduate college tuition. During the service year, students could receive salaries from the hospitals or clinics to which they are assigned. These programs might be modeled after traditional internships or family medicine residencies, being individually designed for the specific needs of the community being served. The American Osteopathic Association could establish such programs through existing mechanisms within its Commission on Osteopathic College Accreditation and its Council on Postdoctoral Training.

These proposed programs would be unique in that they would signify an entire profession making a commitment of service to the country. Osteopathic medical students would be afforded opportunities to offer much-needed services early in their training years. This experience may foster understanding and compassion for the less privileged of our country and encourage these students to develop the noncognitive skills that are sorely lacking in many healthcare professionals. It could only be a “win-win” situation for our country and our profession.

I fully realize that accepting and implementing this proposal would be a bold move on the part of the osteopathic medical profession. I also know that we would need to address various questions and problems, such as issues involving affiliation agreements, curriculum development, facility identification, faculty placement, and funding. Nevertheless, all progress starts with an idea. Let’s start the explosion!

DANIEL H. BELSKY, DO, MS
Boca Raton, Fla

Editor’s note: Dr Belsky is former chairman of the American Osteopathic Association’s Committee on Osteopathic Postdoctoral Training (1986–1992), former president of the American College of Osteopathic Obstetricians and Gynecologists (1977–1978), and former professor and chairman of the University of Medicine and Dentistry of New Jersey–School of Osteopathic Medicine in Stratford.

(continued on the next page)
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Response

Dr Belsky has a bold and creative idea regarding osteopathic medical education. Although implementing his proposal would involve a great deal of strategy and collaboration with people outside the osteopathic medical profession, the proposal does offer opportunities for the profession.

Abbreviated undergraduate education was formerly accepted by osteopathic medical schools. As recently as 1960, osteopathic medical schools accepted matriculants without undergraduate degrees. Although all matriculants to osteopathic medical schools today have undergraduate degrees, Dr Belsky is correct in stating that the primary objective of students is obtaining their medical degrees, not pursuing various undergraduate studies. Thus, most students would likely welcome an abbreviated undergraduate curriculum. The saving of 2 years of tuition—especially when education indebtedness is so great—would surely be welcome by students.

The osteopathic medical profession as a whole would accrue a major benefit from Dr Belsky’s ideas, specifically from his proposal to require students to practice 1 year of primary care in underserved areas of the United States. With the waning of interest in traditional internships, this proposal would promote student exposure to primary care once again. Of course, the benefit to our nation’s underserved urban and rural areas would be substantial, as would the increased visibility of the osteopathic medical profession to the public.

As Dr Belsky points out, many issues would have to be worked out to implement such a model. Still, innovation is always worth considering if valuable benefits may result. Such benefits might even include the saving of osteopathic medical education, the future health of which is threatened by declining participation in osteopathic residencies and lack of training opportunities.

Does any college of osteopathic medicine have the willingness to consider Dr Belsky’s proposal as a pilot program?

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Manual Therapies

To the Editor:
The medical education article by Brian A. Allee, DO, et al, in the December 2005 issue of JAOA—The Journal of the American Osteopathic Association was interesting (Allee BA, Pollack MH, Malnar KF. “Survey of osteopathic and allopathic residents’ attitudes toward osteopathic manipulative treatment.” 2005;105:551–561). Besides noting that most current osteopathic residents do not participate in residency training programs sponsored by the American Osteopathic Association (AOA), the authors also suggest that osteopathic physicians (DOs) who are not family practitioners have a lesser need of using osteopathic manipulative treatment (OMT) than those who are in family practice.

The lower likelihood of OMT use among many DOs outside of family practice is predictable and understandable, especially when one asks what the immediate need is for any kind of manual therapy to be performed by such specialists as endocrinologists, pathologists, and radiologists. My wife is a DO who is an anesthesiologist, and she does not practice OMT.

However, as a practicing physiatrist (specializing in physical medicine and rehabilitation), I find that OMT is a valuable therapeutic tool. Therefore, I frequently use it with my patients.

Allee et al pose a question asking whether allopathic physicians (MDs) should or could become proficient in manual therapy. They then argue that OMT helps “to maintain a clear distinction between DOs and MDs.” From my point of view, this argument is humorous because, when performed properly, manual therapy is not chiropractic, osteopathic, or orthopedic medicine—rather, it is basic anatomy and physiology.1

A case in point: I was originally a practicing chiropractor. I then went to osteopathic medical school and served the first year of my postgraduate training in an AOA-approved program. Following this, I served a residency in physical medicine and rehabilitation in a large allopathic program in Baltimore, Md. Does this education and training mean that, as a practicing physician, I perform chiropractic manipulation, OMT, or orthopedic manual medicine?2

The answer is that there is no clear distinction between practicing these forms of manual therapy. The good physician simply does what he or she medically and physically can for the best interest of the patient.

My 26 years of clinical experience with manual medicine is best summed up as follows: The chiropractor performs no unique clinical service and, by definition, has no medical background. Manual therapy is not performed by MDs to any extent in the United States.Physiotherapists who do perform manual therapy are not physicians. Therefore, DOs are in the best clinical position to perform manual therapy for the patient.3

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Osteopathic Manipulative Treatment is for All DOs

To the Editor:

I’m writing in response to the letter by Robert M. Tessien, DO, that appeared in the November 2005 issue of JAOA—The Journal of the American Osteopathic Association (“Osteopathic manipulative treatment out of a horse and buggy.” 2005;105:496–497. Available at: http://www.jaoa.org/cgi/content/full/105/11/496). In his letter, Dr Tessien relates his many years of personal and professional experience supporting the efficacy of osteopathic manipulative treatment (OMT). I believe that my experience, too, can shed light on how OMT has been used successfully by primary care osteopathic physicians who have integrated it into their busy practices. Although I see on average only about 30 patients per day—compared with the 40 to 70 patients per day that Dr Tessien typically saw during his career—I also frequently perform OMT, in approximately 60% of my patient visits.

Osteopathic manipulative treatment has long been a useful tool at the disposal of primary care physicians. However, the attitude of many osteopathic physicians (DOs) today is that OMT has become a specialized procedure, with the average DO no longer believing that it is a useful skill that can be effectively integrated into daily practice.1 Some of the fault for this turn of events lies with the profession itself. In colleges of osteopathic medicine, osteopathic theory and methods are frequently taught by specialists in neuromuscular medicine, who themselves have limited and focused practices of musculoskeletal medicine. This may be one reason that many students end up feeling that the proper practice of OMT is so complicated and involved that they would never be able to successfully integrate it into their own practices—whether their practices are in primary care or other specialties.

Of course, the theories and methods of osteopathic manipulative medicine must be taught in osteopathic medical schools by experts in the field. Nevertheless, I believe that our profession needs to do more to help students realize that OMT can be performed not only by experts who are adept at treating those patients with complex musculoskeletal disorders, but also by all DOs in daily practice.

The osteopathic medical profession was built on the backs of primary care physicians who used OMT with proven results for their patients. As his letter makes clear, Dr Tessien did not administer long treatments, but he did win an excellent reputation and had patients coming from long distances to receive his treatments. His experience shows the beneficial results of manual therapy delivered by the hands of an osteopathic primary care physician. In addition, Dr Tessien showed that the skillful delivery of OMT is not limited to those DOs who specialize in neuromuscular medicine.

Students should be exposed to OMT both in the classroom and on clinical rotations. I advocate increasing the exposure of osteopathic medical students to primary care physicians skilled in using OMT. This will help students learn how to incorporate into practice the theories taught in the classroom by more specialized instructors.

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Reference
created stress in the femoral-coxal joint, and with the resultant stress on the pyriformis and gemelli, led to sciatica. When the normal fluid interchanges were encouraged to flow freely via inherent lymphatic motions, the iliac crests leveled in the standing position. Other compensatory corrections resulted in complete relief within three weekly visits.

Each of the above patients had sciatica, yet each required a different osteopathic treatment. Paul Kimberly, DO, my professor at Kirksville College of Osteopathic Medicine of A.T. Still University of Health Sciences (Mo) instructed us in “the manipulative prescription.” This prescription is the osteopathic analysis, individualized to each patient. The named disease condition gives very little osteopathic mechanical evidence. Only a comprehensive musculoskeletal examination can elucidate the region of dysfunction.

Once the osteopathic physician locates the source of the strain, he or she chooses a technique and then continues sequencing the strains and compensations until the results of the examination reveal enough change for that treatment (dosage). Over a course of treatment, the process is continued until the patient is well, has reached maximum improvement, or has not progressed, and another clinical course of action is needed.

Andrew Taylor Still, MD, DO, wrote on this principle of individualization. Considering this approach in our osteopathic research protocols will demonstrate the clinical effectiveness of individualization for a wide range of named clinical conditions.

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Phoenix, Ariz

Reference

Osteopathic Physicians and Disaster Relief

To the Editor:

In light of the devastation caused by Hurricanes Katrina and Rita, I wanted to inform the osteopathic medical community about volunteer opportunities available to physicians and other healthcare workers through the nation’s Disaster Medical Assistance Teams (DMATs).

A DMAT is a group of professional and paraprofessional medical personnel supported by a cadre of logistical and administrative staff that is designed to provide medical care during times of natural disaster or after mass-casualty events. These DMATs, which operate under the guidance of the National Disaster Medical System, a subdivision of the Department of Homeland Security, deploy to disaster sites with sufficient supplies and equipment for a 72-hour period, and provide medical care at a fixed or temporary site. In mass-casualty incidents, DMAT responsibilities include patient triage, basic medical care, and (when injuries are too severe to treat locally or onsite) patient evacuation. The DMATs supplement local medical care until other federal and/or contract resources can be mobilized or until the disaster situation has resolved. Members of DMATs are initially volunteers, but they become paid employees of the federal government once their respective team has been activated.

Each team recruits members independently and has openings at different times throughout the year. Physicians, physician assistants, paramedics, and nurses are often in high demand. Every DMAT could benefit from the experience and training of an osteopathic physician.

In August 2005, after Hurricane Katrina devastated the Gulf Coast, the first author (B.K.) was deployed with the New Jersey DMAT to provide relief in Gulfport, Miss. This author (B.K.) is a licensed physician assistant and a third-year osteopathic medical student at the University of Medicine and Dentistry of New Jersey–School of Osteopathic Medicine (Stratford). The second author (M.J.L.), a fourth-year osteopathic medical student, works as a deputy commander and paramedic for the team and is a student at the Philadelphia College of Osteopathic Medicine in Pennsylvania. Brian Kloss has been involved with the New Jersey-1 DMAT since early 2002, and Matthew J. Levy has been involved with the team since 1998.

We are both very grateful for having had the opportunity to serve our country at a time of need and are appreciative of our respective universities for granting us the allowances necessary to participate in this service. Both of us look forward to serving as DMAT physicians at the conclusion of our residencies.

We encourage any physician interested in volunteering with the National Disaster Medical System and DMATs to visit http://www.oep-ndms.dhhs.gov and http://www.nj1dmat.org for more information.

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