assessment serves as a means to direct institutional activities in support of the institutional mission.

I would submit that the institutional mission and outcomes assessment are valuable tools in our attempt to maintain the identity and viability of the osteopathic medical profession.

Michael K. Cope, PhD
Associate Dean for Preclinical Education
West Virginia School of Osteopathic Medicine
Lewisburg, WV

To the Editor:
I have just read the article “Osteopathic medicine: A call for reform” (JAOA 1993;93:473-485). I agree with the authors that primary care should be emphasized; it should be the goal of osteopathic medicine—now and in the future. However, I find the remainder of their conclusions disturbing. It appears that Drs Meyer and Price are under the impression that most DO graduates enter allopathic residencies for subspecialty training.

The majority of residents whom I have encountered enter allopathic training programs in the primary care specialties. They do so for a number of reasons, including higher pay, lack of positions in osteopathic residency programs, perceived better clinical training in allopathic medical residencies, and the like. However, the bulk of osteopathic medical students do not enter subspecialty training, contrary to what Drs Meyer and Price conclude.

I was extremely dismayed that the authors think that no need exists for osteopathic medical specialists, because, they assert, that allopathic medical specialists can adequately fill this need. As a DO, I would much rather send my patients to an osteopathic medical specialist than to an allopathic medical specialist. My preference is not just because osteopathic medical specialists offer manipulative treatment. Rather, it is because of DOs' approach to the patient.

Requiring all osteopathic medical specialists to complete a general practice residency is not practical and would only add to the osteopathic medical students' indebtedness, which, in many instances, is higher than their allopathic counterparts. This indebtedness would cause students to further abandon osteopathic graduate medical education. I strongly support the concept that all osteopathic medical students should be required to do a rotating internship and the abandonment of the specialty tracks for interns established by the American Osteopathic Association (AOA).

The allopathic medical education system abandoned rotating internships years ago, but an increasing demand by MDs that they return to rotating internships could change that status.

I agree with the authors that colleges of osteopathic medicine (COMs) should excel in primary care. However, the idea that the majority of faculty be primary care specialists is not the answer. Primary care should be emphasized, but I think that specialists should teach specialty areas. They have the knowledge, experience, and interest in the area to convey this information to the students.

As for reforming MD/DO relations and securing recognition by the American Medical Association (AMA), I think it imperative that lines of communication exist between the AOA and the AMA. Yet, I fear that should the authors' proposed changes be implemented, they would soon result in the absorption of osteopathic medicine into traditional allopathic medicine and that osteopathic medicine as a profession would cease to exist.

I have never been comfortable with the phrase “separate but equal” in describing osteopathic medicine. I propose that the phrase “separate but better” would be a more acceptable description.

Dwight A. Wagenknecht, DO
Buckhannon, WV

Response

To the Editor:
We are encouraged by continued letters to the editor regarding our article “Osteopathic medicine: A call for reform” (JAOA 1993;93:473-485). We continue to believe that more debate is needed regarding the future role of osteopathic medicine in healthcare in the United States. We agree with Dr McPartland that considerable headway has been made regarding reimbursement for osteopathic manipulative treatment (OMT). Nonetheless, we are not sure that such reimbursement correlates with a resurgence in interest in OMT. A problem remains in that OMT is deemphasized in hospital internship and residency programs and, as a result, the student tends to
letters
(continued)

FLUORI-METHANE® (Dichlorodifluoromethane 15% Trichloromonofluoromethane 85%)

INDICATIONS AND USEAGE Fluori-Methane Spray is a vapocoolant intended for topical application in the management of myofascial pain, restricted motion, and muscle spasm, and for the control of pain associated with injections.

Clinical conditions that may respond to Spray and Stretch include low back pain (due to muscle spasm), acute stiff neck, torticollis, muscle spasm associated with osteoarthritis, ankle sprain, tight hamstring, masseter muscle spasm, certain types of headache, and referred pain due to trigger points. Relief of pain facilitates early mobilization in restoration of muscle function.

PRECAUTIONS Care should be taken to minimize inhalation of vapors, especially with application around the head and neck. Avoid contact with eyes. Fluori-Methane should not be applied to the point of frost formation.

ADVERSE REACTIONS Cutaneous sensitization may occur, but appears to be extremely rare. Freezing can occasionally alter pigmentation.

CONTRAINdications Fluori-Methane is contraindicated in individuals with a history of hypersensitivity to dichlorodifluoromethane, and/or trichloromonofluoromethane. This product should not be used on patients having vascular impairment of the extremities.

WARNINGS
For external use only. Dichlorodifluoromethane and Trichloromonofluoromethane are powerful local anesthetics. Based on animal studies and human experience, these fluorocarbons pose no hazard to man relative to systemic toxicity, carcinogenicity, mutagenicity or teratogenicity when occupational exposures are below 1000 ppm over an 8 hour time weighted average.

Contents under pressure. Store in a cool place. Do not store on or near high frequency ultrasound equipment.

DOSAGE AND ADMINISTRATION
To apply Fluori-Methane, invert the bottle over the treatment area approximately 12 inches (30 cm) away from site of application. Open dispensal spring valve completely, allowing the liquid to flow in a stream from the bottle.

1. SPRAY AND STRETCH TECHNIQUE FOR MYOFASCIAL PAIN
Spray and Stretch technique is a therapeutic system which involves three stages: EVALUATION, SPRAYING, STRETCHING.

The therapeutic value of Spray and Stretch becomes most effective when the practitioner has mastered all stages and applies them in proper sequence.

I. EVALUATION
During the evaluation phase the cause of pain is determined as local pain or an irritated trigger point. The method of applying the spray to a muscle spasm differs slightly from application to a trigger point. A trigger point is a deep hypersensitive localized spot in a muscle which causes a referred pain pattern. With trigger points the source of pain is seldom the site of the pain. A trigger point may be detected by a snapping palpation over the muscle, causing the muscle in which the irritated trigger point is situated to "jump".

II. SPRAYING
A. Patient should assume a comfortable position.
B. Take precautions to cover the patient's eyes, nose, mouth, if spraying near face.
C. Hold bottle in an upside down position 12 to 18 inches (30 to 45 cm) away from the treatment surface allowing the jet stream of vapocoolant to meet the skin at an acute angle to lessen the shock of impact.
D. The spray is directed in parallel sweeps 1.5 to 2 cm apart. The rate of spraying is approximately 10 cm/sec. and is continued until the entire muscle has been covered. The number of sweeps is determined by the size of the muscle. In the case of a trigger point, the spray should be applied over the trigger point, through and over the reference zone.

III. STRETCHING
During application of the spray, the muscle is passively stretched. Force is gradually increased with successive sweeps, and the slack is smoothly taken up as the muscle relaxes, establishing a new stretch length. Reaching the full normal length of the muscle is necessary to completely inactivate trigger points and relieve pain.

A. After warming, the procedure may be repeated as necessary. Moist heat should be applied for 10 to 15 minutes following treatment.

For lasting benefit, any factors that perpetuate the trigger mechanism must be eliminated.

2. PRE-INJECTION ANESTHESIA
Prepare syringe and have it ready. Spray skin with Fluori-Methane from a distance of about 12 inches (30 cm) continuously for 3 to 5 seconds; do not frost the skin. Swab skin with alcohol and quickly introduce needle with skin taut.

HOW SUPPLIED
4 ounce amber glass bottle.
Calibrated Fine Spray …………….. NDC 036-0003-04
Calibrated Medium Spray …………….. NDC 036-0003-05

CAUTION Federal law prohibits dispensing without a prescription.

leave it on the "back shelf" rather than developing skills that will be useful as a future practitioner. Finally, although many schemes have been discussed regarding the delivery of primary care, including the use of nurse practitioners, such individuals will still require supervision from physicians grounded in primary care. Thus, we would not anticipate too many duels with the American Nursing Association.

We have heard from many osteopathic students such as Second Lieutenant Pulvischer who think that our recommendations represent an infringement on students' inherent right to pursue specialty and subspecialty training. The reforms that we recommend do not close the door on DOs who are interested in specialty training; however, they do create a series of "turnstiles" to slow movement toward specialty training and to redirect the flow toward primary care.

Osteopathic physicians would still have opportunities for specialty training within our profession, and would continue to be eligible for specialty training in the allopathic medical profession as well. Furthermore, reforms such as these would not be implemented overnight, but rather phased in gradually so that students who have pursued osteopathic medicine to become specialists or subspecialists would not necessarily be penalized.

Of course, students interested in specialty training are not the only bright, ambitious osteopathic medical students. Those individuals who pursue training in primary care are also intelligent and ambitious. Should our proposed reforms be enacted, students who enter osteopathic medicine would more likely be committed to the establishment of the profession as a leader in primary care. We do agree with Second Lieutenant Pulvischer, however, that if all specialty residency programs are maintained within our profession, then we have an obligation to improve the quality of all of these programs so that they may be competitive with specialty training offered in the MD world.

We certainly agree with Dr Cope that all colleges of osteopathic medicine should orient their mission toward primary care. After all, our greatest resources, potential, and traditions reside in this area. The idea of applying outcomes assessment techniques to the identity issues facing the profession is also worthy of consideration.

In response to Dr Wagenknecht's letter, we recognize that the majority of DO desertions to allopathic residency programs involve osteopathic physicians who are interested in primary care careers. However, if all MD specialty residency programs were readily accessible to DOs, then all of our residency programs would be empty rather than just the primary care residencies.

We agree with him that the approach of DO specialists may be different than MD specialists; however, Dr Wagenknecht is somewhat naive if he believes that osteopathic specialists routinely deliver OMT to their patients in the course of their specialty practices. Requiring all DOs to serve a primary care residency would not necessarily increase the debt load of osteopathic physicians, as only those physicians who
chosen to do a specialty residency after a primary care program would be affected negatively.

We hope that the reforms we have suggested in our article will eventually lead to an increase in the number of DOs who are only pursuing primary care training. We would be reluctant to see specialty track internships abandoned at this time, although we recognize the value of rotating internships. In fact, because the number of years required for specialty track programs has been reduced, the number of DOs interested in general internal medicine has increased. Finally, we cannot agree that our reforms would hasten the absorption of osteopathic medicine into allopathic medicine. Absorption is already underway as demonstrated by agreements between osteopathic and allopathic medical schools, mergers between osteopathic and allopathic hospitals, and the increasing number of DOs who receive their training in the allopathic medical profession.

Christopher T. Meyer, DO
President of Medical Education
Genesys Regional Medical Center
Flint Osteopathic Campus

Albert Price, PhD
Department of Political Science
University of Michigan
Flint, Mich

An MD's note to his osteopathic medical students

To the Editor:

In February 1992, I accepted, with pleasure, the position of Chairperson of Pathology at the University of Health Sciences, College of Osteopathic Medicine. Since that time, students have often asked me, “What does an MD think of the DO approach to disease?” How does our study of pathology relate to osteopathic medical traditions?” To answer these questions, I include the following short essay in our course packet.

Progressive cooperation

Today's scientific pathology had its inception in 1859 with Virchow's work. For his time, Andrew Taylor Still's ideas about disease were reasonably enlightened. Today's oath of the osteopathic physician promises that physicians will work together in a spirit of "progressive cooperation," that they will keep "in mind always nature's laws," and that they will "further the application of basic biologic truths to the healing arts and to develop the principles of osteopathy which were first enunciated by Andrew Taylor Still."

This course will focus on understanding disease in light of nature's laws as they really are—the principles of rational inquiry and the essentials of physics, chemistry, and basic biology. At the human level, your study of pathology will constantly correlate physical structure and the function of the human being at every level, just as Dr Still tried to do in the last century.

The oath also makes the promise that you will “always keep in mind...the body's inherent capacity for recovery.” Most of pathology is really the study of this capacity. In this course, you will learn how and when the body tends to heal itself,