Levine's 'osteopathic hug' for self-administered OPP and OMT

To the Editor:
Among my many ailments, I frequently have a second rib lesion develop. It hurts when I turn my head or take a deep breath. The range of motion is marked by limitation and the upper anterior and posterior rib cage is painful to the touch. I am fortunate to have 15 other active osteopathic physicians in the family, and I have the opportunity to receive osteopathic principles and practice (OPP) and osteopathic manipulative treatment (OMT) frequently. However, there are times when no DO is around and I am in pain.

A.T. Still devised a method to help himself for headache by placing his head over his jacket, which covered a rope tied taut between two trees. Remembering this treatment, I think I have devised a method to self-treat upper chest cage lesions or somatic dysfunction.

My method consists of placing the arm of the affected side on top and extending my body and taking a deep breath, thus giving myself a very tight hug. If the somatic dysfunction is acute and has not been traumatized, I may experience a "pop." However, it is not necessary to hear or feel a pop. It is only necessary to remove all the slack before taking the deep breath.

This maneuver relieves the acute pain most of the time. I am able to turn my head with a full range of motion, and taking a deep breath does not hurt. It may not relieve rib somatic dysfunction completely, but I will be pain-free until I can receive some OPP and OMT. (I always use the terms together because it is both terms—not one—that makes us distinctive.)

Before you dismiss this gem, I urge you to try it once. I would also assume that there are many other methods DOs have used to help themselves osteopathically. Perhaps someone might seek these gems out and publish the collection, thus affording us another method by which we could "accentuate our distinctiveness."

Howard M. Levine, DO
AOA Past President
Bayonne, New Jersey

Call to develop and implement dually approved residency programs

To the Editor:
I read with great interest Dr Oliver Hayes' excellent article, "Dual approval of a residency program: Ten years' experience and implications for postdoctoral training," in the November 1998 issue of JAOA (98[11]: 647-652). Encouraging the development of dual accredited postgraduate training programs serves a variety of important functions. First, it encourages collaboration between osteopathic (American Osteopathic Association) and allopathic (Accreditation Council for Graduate Medical Education [ACGME]) residency certification bodies. Second, it provides a mechanism by which standardization of residency requirements can be achieved. Third, it provides DOs with increased opportunities to pursue osteopathic postgraduate specialty training, thus alleviating the need for osteopathic physicians to receive their training at strictly allopathic medical teaching institutions. Incorporating the principles of osteopathic diagnosis and treatment into the residency curriculum would ensure that osteopathic physicians in training receive continuing exposure to the philosophy and methodology of osteopathic medicine; for allopathic physicians in training, exposure to the osteopathic medical teaching model would introduce them to diagnostic and treatment approaches that are both patient-centered and comprehensive in nature and scope.

Within a broader educational framework, the development of combined residency training programs also serves another very important purpose, which is to increase acceptance of AOA-approved internship training by allopathic residency certification bodies such as ACGME. In his article, Dr Hayes mentions that the AOA and the ACGME are currently discussing the possibility of the ACGME's accepting the osteopathic rotating internship as an equivalent to the allopathic postgraduate training year one (PGY-1).

Although a number of allopathic specialties that fall under the purview of the American Board of Medical Specialties (including family practice, anesthesiology, physical medicine and rehabilitation, pathology, and radiology) accept the AOA internship as fulfillment of the clinical base year requirement, other specialties with clinical base year requirements (such as preventive medicine) are unwilling to recognize the AOA internship year as a viable clinical base year alternative. This situation is made even more disturbing, given the fact that preventive medicine residency training programs are virtually nonexistent in the osteopathic medical profession (there are currently only three AOA-accredited preventive medicine residency programs available across the country, two in occupational medicine and one in preventive medicine).

Given the small number of allopathic preventive medicine training programs currently being offered (approximately 40 programs total), the opportunities for DOs to pursue residency training in this field are indeed limited. The exclusion of qualified AOA internship-trained osteopathic physicians from pursuing allopathic pre-
ventive medicine residency training (on the basis of the American Board of Preventive Medicine's ACGME-accredited clinical base year requirement) serves to further limit DOs from receiving formalized training in this specialty. The negative ramifications that will result for the osteopathic medical profession, as well as for the specialty of preventive medicine, are numerous and wide ranging.

For the foregoing reasons, it is therefore in the osteopathic medical profession’s best interest to encourage the development and implementation of combined osteopathic/allopathic residency training programs. This contemporary, multidisciplinary postgraduate training model may well hold the key to preserving the strength and longevity of osteopathic postdoctoral training in the future.

Helga Daftarian, DO, MPH
Epidemic Intelligence Service Medical Officer
National Institute for Occupational Safety and Health
Cincinnati, Ohio

Response

To the Editor:
I appreciate the comments regarding my article, “Dual approval of a residency program: Ten years’ experience and implication for postdoctoral training” (JAOA 1998;98: 647-652). Dr Daftarian correctly identifies several benefits that would accrue to the osteopathic medical profession from the planned development of such postdoctoral programs. Additionally, she points out the dilemma faced by osteopathic physicians who choose to pursue careers in certain specialties. Current policy regarding the osteopathic internship by the specific Residency Review Committees (RRCs) of the Accreditation Council for Graduate Medical Education (ACGME) serves to limit opportunities for osteopathic medical graduates.

Proactive undertakings by the American Osteopathic Association (AOA) with the ACGME could serve to ameliorate this situation. However, I would advise careful consideration in both negotiation with the ACGME and any subsequent adjustment of postdoctoral education policies. In my opinion, any policy modification must consider how osteopathic physicians are represented in the residency faculty and leadership. The long-term success of our emergency medicine program is directly related to the presence of osteopathic physicians as core faculty (fully one half of our core faculty are DOs). This osteopathic medical faculty provide many critical functions:
- serving as role models,
- leading important residency committees,
- ensuring instruction of osteopathic principles and practice (OPP),
- protecting interests of the osteopathic medical profession in the residency program, and
- demonstrating to our allopathic medical colleagues our commitment to quality osteopathic graduate medical education.

For purposes of credibility, our profession cannot allow the development of dually accredited residency programs where there is only token presence of osteopathic physicians. Such programs provide a disservice to our residents, erode the educational credibility of osteopathic medicine, and will ultimately weaken osteopathic graduate medical education. I echo Dr Daftarian’s call for our profession to vigorously pursue the development and implementation of dually approved or combined osteopathic/allopathic residency programs.

Oliver W. Hayes, DO, FACC
Section of Emergency Medicine
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East Lansing, Michigan

Coordination of research efforts tied to defining profession’s identity

To the Editor:
I have read quite a lot about the osteopathic medical profession and the struggle for self-identity and the future. I recommend that the American Osteopathic Association (AOA) set up an “Osteopathic Center for Research Excellence.” The purpose would be to assist our colleges and hospitals in obtaining research grants in basic and clinical sciences pertaining to osteopathic philosophy (that is, manipulation, holistic approach, etc). The same approach is used by the National Institutes of Health (NIH) Office of Alternative Medicine; they help researchers obtain grants from other sources including different NIH offices but do not grant the funds directly.

This approach will help to coordinate our research efforts. It could even be seeded with a one-time assessment on dues.

Michael Engel, DO
Plymouth, Indiana

Response

To the Editor:
Dr Engle’s suggestion has been a topic of discussion by the Bureau of Research of the American Osteopathic Association for several years. The Bureau acknowledges that the modern era of research in osteopathic medicine began with the establishment of a multidisciplinary program in basic science and clinical research at the Kirksville College of Osteopathic Medicine, Kirksville, Mo, in the late 1940s. Today, we would describe that as a center for excellence in osteopathic research. At the present time, five colleges of osteopathic medicine have research programs that are of a sufficient magnitude that they can support the development of a center of excellence. I believe that Dr Engle’s letter correctly implies that the development of this center for excellence is tied to defining the identity and future course of osteopathic medicine.

The AOA Bureau of Research has actively recruited an individual who will work in development and grant writing. This individual will help to establish the financial basis to develop a center for excellence.

Felix J. Rogers, DO
Chairman, Bureau of Research
Associate Editor, JAOA
Encourage all physicians to practice OMT

To the Editor:
It is surprising to me that the American Osteopathic Association recently elected to not give a certificate of added qualifications in osteopathic manipulative treatment (OMT) to allopathic physicians who have studied with our DO experts in colleges of osteopathic medicine. In my area, we have an MD colleague who studied with a variety of osteopathic physicians at Kirksville College of Osteopathic Medicine and Michigan State University College of Osteopathic Medicine and is now practicing full-time osteopathic manipulation only and is quite proficient at it. My older son is an allopathic surgeon in Mississippi, and he has learned OMT from me and another DO at New England College of Osteopathic Medicine. He uses OMT to treat all his patients who come to his office with back or neck pain. He is also interested in learning sclerotherapy or prolotherapy to strengthen ligaments and tendons.

How many times have I had patients visiting other areas of the United States who called DOs for treatment, only to be told by those offices that “OMT is not performed here”?

It would seem to me that we should encourage all physicians to practice OMT as a most valuable part of our practices to enhance patients’ well-being and relieve pain.

Ronald Woodworth, DO
Past President
American College of Osteopathic Pain Management and Sclerotheraphy
Bennington, Vermont

Medicines for the dying patient

To the Editor:
The last physician, before the patient meets the Greatest Physician, can be found in three long-term settings: the hospital, the nursing home and, more and more, in the home.

When all other traditional scientific approaches such as psychotherapy, traditional medicines, and so forth have been exhausted, there are four medicines left that are available to physicians; they should be used with utmost vigor to ease the patient through the transition of care between the last physician and the Greatest and Eternal Physician.

These four medicines are:
- the medicine of compassion,
- the medicine of respect,
- the medicine of hope, and
- the medicine of love.

These are the four medicines that the Greatest Physician gives to the last physician to use on the dying patient. These medicines should be given by the physician to the patient and to the family with instructions to the family on how to give these medicines to the patient. It is important that the family be given these medicines because, in the absence of the last physician, the family becomes the last physician.

The medicine of compassion has in it the ingredients of sympathy, empathy, understanding, and forgiveness.

The ingredients of respect are the acknowledgment of wisdom and the recognition of fortitude, past, present, and future.

The medicine of hope comprises the ingredients of togetherness, happiness, and everlasting eternity.

The ingredient of love is the recognition of eternal divine intervention held deeply within the soul of the heart.

These four medicines must be given to the dying patient by the last physician—in most cases, the family or caretaker—continuously until the Greatest Physician takes over the case.

Robert G. Ginski, BS Pharmacy, MBA, DO
West Bloomfield, Michigan

The physician

The patient came to me, innocence on his mind.
He may have perceived something that I could not find.
When we were done, nothing was the same.
All that I know did not get us to this point.
These changes came by chance with natures anointed
What a turn of fate!
Mysteries abound
Lives thrown around.

Lawrence I. Silverberg, DO
West Friendship, Maryland

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