

Unity may preserve osteopathic ideals

To the Editor:

Results of a recent published survey (*JAOA* 1999;99:408) indicated that 12.9% of the 1992 osteopathic graduates obtained their internship training in a non-AOA-approved program and that 46.7% chose residencies in allopathic medical postgraduate programs. Nearly 50% of osteopathic physicians are training elsewhere, due to geographic location, lack of funded AOA-approved residencies, or for other reasons. As one of those graduates, I know the reality behind these statistics.

In years past, the AOA has frowned on such behavior. However, in response to these and other alarming statistics, the AOA's Campaign for Osteopathic Unity created an alternate pathway to allow those who have entered such institutions to become board eligible/certified within the osteopathic medical profession.

As a second-year osteopathic resident training in an allopathic medical institution, I am disturbed by these findings. Many of the allopathic-educated residents begin to lose their distinctiveness and ties with their osteopathic medical foundations. After completing an osteopathic internship in Michigan, the University of Minnesota graciously allowed me to complete my preparation in family medicine, accepting my internship for the first year. I found that, under the auspices of an allopathic umbrella, one is easily lost to the masses of allopathic colleagues. Without an osteopathic preceptor, residents miss out on a unique perspective, not only in studies of osteopathic manipulative treatment, but also the view of patient care distinctive to the osteopathic medical training they received.

The osteopathic medical profession is facing an internal dilemma from the numbers of osteopathic medical graduates educated outside the professional boundaries.

The osteopathic traditions and principles instilled throughout medical school are diminishing, as well as interest in AOA, which leads one to question why this is occurring. Is it simply that osteopathic physicians' confidence in osteopathic manipulative treatment is low, or do osteopathic physicians feel that the American Osteopathic Association is not an entity worth supporting? Do graduating osteopathic residents and interns feel that the AOA is a small force in the medical community, unable to do anything for them? Or have they developed distaste for the association because it shunned so many for so long? It is imperative, especially in today's medical arena, to stay in touch with a heritage that has allowed so many the opportunity to fulfill the desire to help and care for others. With the current emphasis on Unity, it appears that a new light is being infused into the Association and the profession.

One of the many goals of the Campaign for Osteopathic Unity is to unite the profession, to preserve osteopathic principles and philosophy. This pathway to unity and preservation (Resolution 285: Ongoing Training in OPP and OMM/Pathway to Certification and Membership in the AOA), which will exist for the next 6 years (why only 6?), allows DOs to obtain AOA board certification if they complete training in residency programs accredited by the Accreditation Council for Graduate Medical Education (ACGME), without serving an AOA-approved internship. DOs were previously ineligible to take the examination of AOA certifying boards if they had not completed this vital year, and could not apply for approval after beginning their second year of allopathic residency. The criteria for Resolution 285 are as follows:

- A. Complete all AOA board requirements.
- B. Be a member in good standing of the AOA.
- C. Have begun residency training no later than October 31, 1999.
- D. Have residency training approved by the

appropriate AOA specialty college, and then by the Executive Committee of the Council on Postdoctoral Training (ECCOPT).

E. Complete 100 hours of AOA CME Category 1 (25 hours including OPP/OMT) within 2 years, prior to applying for residency approval.

or

Attend three scientific-specialty college meetings, each with a designated portion dedicated to OPP/OMT.

or

Submit a letter from the dean of a college of osteopathic medicine verifying faculty status for 5 years, and that applicant has taught students and demonstrated the use of OPP/OMT.

Many osteopathic medical professional colleges have established mechanisms that aid residents in affiliating with that particular osteopathic medical community. According to the American College of Osteopathic Family Physicians (ACOFFP), if a resident has completed an osteopathic internship and transferred into an allopathic institution, he or she should contact the college at the completion of each academic year to obtain documents for approval into the college. These documents are forms on which residents summarize their caseloads and the number of procedures performed from each rotation. These forms also include a program director's report outlining the academic year and the resident's accomplishments. This is paper pushing. In many allopathic medical programs, such as the University of Minnesota, all procedures required to complete the program are cataloged into a master computer system. Also, residents who have graduated from any of the medical schools that require monthly logs are routinely familiar with the complexities of documentation with patient contact. Numerous clinics and inpatient rotations possess daily schedules that are easily duplicated.

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"Residents who did not complete the osteopathic internship," states Betty Warner, Assistant Executive-Director of the ACOFP, "must not only complete the above procedure, but also submit a non-publishable, or publishable, scientific research paper approved by their respective residency programs." Some allopathic medical institutions, many affiliated with large universities, possess entire research departments committed to such activity to develop the residents' skills. Scientific papers may range from intense laboratory experimentation to community-based health projects or safety education programs. Currently, my residency program is creating a study analyzing low back pain resulting from job injuries, comparing healing modalities—osteopathic manipulative treatment and conventional medicine versus standard allopathic medical care.

The American College of Osteopathic Internists is not so lenient with those not completing an AOA-approved internship. If a resident has completed an approved internship, or fast-track program, the procedures for gaining approval of postdoctoral training and attaining board eligibility are similar to those of the ACOFP. At this point, those who did not, have no avenue to becoming AOA board certified, besides Resolution 285.

For years, Resolution 19 has served as the option to become board eligible in the osteopathic medical profession. Resolution 19 allows DOs trained in MD residencies to petition the AOA to allow their first year of training to be an AOA-approved internship for various indications (for example, economic hardship, geographic location). However, since the adoption of Resolution 285, Resolution 19 has been suspended for 6 years. If a resident began training before October 31, 1999, Resolution 19 is still in effect. However, any physician training in an allopathic medical field after this date must use Resolution 285 for approval into osteopathic medical colleges.

This does not mean, however, that any osteopathic physician who has not undertaken the above requirements is ineligible to become an active member of the AOA.

Rather, the opposite is true; all are welcome. For so long, graduates trained outside of AOA-approved programs have felt that the AOA would not allow active participation, which is simply not the case.

So, why should students, interns, and residents remain active members? For one thing, it is easier to remain active during your training years than it is once practice is under way. As residents, CME is a daily occurrence, and programs should allow advancement of osteopathic principles as they do for allopathic principles. For instance, my program allots days for CME, and if extra are required, administrators will make provisions. The residency director empathizes with the difficulty in acquiring osteopathic medical advancement credits.

A second reason to remain active is that the distinctiveness of the training and the ability to be more of a personable, hands-on physician will set you apart from your allopathic colleagues. By serving as an example of osteopathic medicine's ideals, promotion of the profession becomes easy. Remaining active also provides one the opportunity to unify and develop better allegiances with our allopathic colleagues, while maintaining the profession's individuality.

This is an exciting time in the osteopathic medical profession. The number of graduates is growing, even though the profession may be lagging behind with respect to training opportunities. This does not mean however, that one should lose sight of the overall picture. The training received in osteopathic medical institutions gives young physicians a new handle on medicine and allows competitiveness with their allopathic counterparts. You should not overlook who granted you the chance to become a physician—an osteopathic physician.

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Multiple sclerosis article ignores conventional and osteopathic treatment options

To the Editor:

Thank you for presenting Dr. Olek's excellent overview of the current "medical" treatment strategies for patients with multiple

sclerosis (*JAOA*1999;99:611). Unfortunately, the detailed article failed to list the conventional or osteopathic rehabilitation treatment options for these patients.

Please be aware that conventional rehabilitation treatment options for patients with multiple sclerosis are improving. New treatments are available for the fatigue, spasticity, urinary tract infections, viral and bladder infections, pain, depression, and other maladies associated with the disease. In addition to physical and occupational therapies and supportive services, phenol nerve/botulinum toxin muscle blocks are now being used, as well as more invasive treatments for spasticity.

Osteopathic manipulative treatment has also been helpful in the treatment of significant somatic lesions of the spinal column and peripheral joints—lesions that are frequently found in patients with multiple sclerosis.

As osteopathic physicians, we strive to treat the whole person. This is never truer than in patients with debilitating diseases.

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Flu book provides fascinating account

To the Editor:

A book has recently come to my attention, *Flu: The Story of the Great Influenza Pandemic of 1918 and the Search for the Virus That Caused It* (Ferrar, Straus, & Giroux; 1999), by Gina Bari Kolata. The book is described as a complete history of the forgotten and ignored 1918 flu pandemic. The remarkable thing about this event, which killed between 80 and 100 million people worldwide, altered the course of World War I, and decimated towns, villages, and whole tribes, is the fact that historians have ignored it. Definitive works about the tragedy are far and few.

Kolata, who has written about disease and medicine her entire career, first at *Sci-*

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ence, and later, at the *New York Times*, remembers that in her courses in biology, virology, and even the history of the 20th century, the 1918 flu was never mentioned.

She became interested in the subject because of an article in *Science* that described the continuing effort by a small group of unknown scientists in Washington, D.C., and around the world to resolve the configuration of this virus and to determine what made it so deadly. The development of this study was accelerated by the recent, small outbreak of a deadly avian strain of flu in Hong Kong (controlled by killing all the chickens in Hong Kong!).

She then began an extensive study of the flu by reading copious old newspapers, conducting long conferences with those involved, and tracking down health department statistics. She has 185 references in the book.

The author has included information about the personal lives of the people involved, as well as some of the political problems that affected how the calamity was handled. She provides a clear explanation of the virologic studies, and describes other episodes, such as the Hong Kong flu, and the unwise and aborted “swine flu” immunization program. The result is an interesting combination of history, people, and science, resulting in an excellent work that would interest all physicians. ♦

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[Editor's note: Those further interested in the topic may wish to read Dr. Richardson's article, "Role of the DOs in the 'Spanish Flu' Pandemic of 1918-1920" (*AAO Journal* 1998;8:13-14), which recounts the success of DOs in using OMT to treat patients with influenza.]

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