New & noteworthy

Updates on activities in the profession

Curricula must promote OMM use by students

Many colleges of osteopathic medicine are in the process of revising their osteopathic manipulative medicine (OMM) curricula. The stimulus for this revision is an increased desire to integrate OMM into the entire curriculum, not just to improve manual medicine skills. In conjunction with this movement, departments of OMM are working with basic science departments and other areas of clinical medicine to demonstrate how osteopathic principles can improve patient management.

One of the major problem areas in the overall educational process at osteopathic medical schools is the lack of OMM education during the third and fourth years of training. The OMM education during the first 2 years provides a strong base on which to build in the clinical years. Unfortunately, most students do not receive enough supervision or encouragement to integrate OMM into overall patient management. In the past, OMM lectures have been delivered at hospitals throughout the United States. But without the opportunity to apply the information presented, few students attempt to incorporate OMM into patient care.

The Educational Council on Osteopathic Principles (ECOP) is working to share information and ideas so that this trend can be reversed. But the ECOP is not alone. Several osteopathic medical schools have made efforts to overcome deficits in OMM training. The West Virginia School of Osteopathic Medicine, for example, uses part of the second year to give students opportunities to use the OMM skills that they have developed on patients in clinical settings. Under this system, students work in pairs with supervision by the OMM faculty. The students—not the OMM faculty—examine and treat the patients. Working in pairs allows the students to combine their efforts and build confidence. Feedback from the faculty reinforces and guides the students' decision-making process. Confidence grows through experience and successful resolution of patients' problems. Once students have that confidence, they can be successful, as well as more likely to continue the use of their manual medicine skills throughout their medical career.

In addition, some colleges of osteopathic medicine require junior or senior rotations in OMM. Such rotations may be with practicing OMM specialists or with other physicians who use OMM consistently in their practices. The benefit of such an arrangement is that students have the opportunity to observe physicians who are successfully treating patients and who are integrating OMM into clinical practice.

One possible disadvantage, though, is that students in such rotations may be given limited opportunity to actually treat patients. This is in part because some patients do not want students treating them. It should be noted, however, that many patients are receptive to having students work on them—provided they know a physician is there to supervise the student and treat any somatic dysfunction the student is unable to resolve. But even if patients are willing, a practicing physician may not be able to afford the time it takes for a student to diagnose problems and treat patients through the use of osteopathic manipulative treatment techniques.

William H. Devine, DO, head of the Department of Osteopathic Manipulative Medicine at the Arizona College of Osteopathic Medicine of Midwestern University in Glendale, demonstrates osteopathic manipulative treatment to students.

Another model for OMM education can be found at the University of North Texas Health Science Center at Fort Worth–Texas College of Osteopathic Medicine (TCOM), which has the most elaborate and well-developed program of all the osteopathic medical schools. All students are required to do a 1-month rotation at the college. It takes 2 years for all the students to circulate through the program. The first part of the rotation involves a review of OMM material from the first 2 years to get everyone back up to speed.

After that initial review, students work with different OMM faculty members so they can see how different physicians manage patients with similar presenting complaints. The program also gives students the opportunity to diagnose problems and treat their own patients under the supervision of the OMM faculty. All these components—from review to hands-on practice—combine to provide an excellent experience for the student. In fact, it is the highest-rated rotation in TCOM's curriculum.

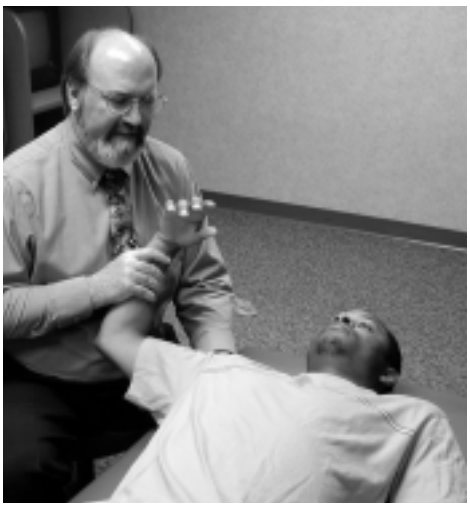
All these examples have one thing in common: They illustrate how important hands-on training is for students to develop the confidence needed to continue their development as osteopathic physicians. In every other area of medical education, students attain didactic knowledge and learn basic skills needed for practice during the first 2 years. Then, on rotation, the information is reinforced and the student grows as a physician. Only with OMM are such skills rarely reinforced, and the result for most students is a decrease in their skills and a cessation of using such knowledge and skills. This is a situation that must be reversed if the distinctive and valuable therapeutic character of osteopathic medicine is to survive and grow.

Manual therapy has modest benefit for patients with back pain

Interest continues in the investigation of spinal manual therapy in caring for patients with low back pain. Peter Curtis, MD, Timothy S. Carey, MD, MPH, Paul Evans, DO, and colleagues (including Michael P. Rowane, DO, MS) recently reported on a project to provide limited training in manual therapy to 31 allopathic general practitioners.

These primary care MDs were trained to perform at least four or more maneuvers in manual therapy, with which they could treat patients with low back pain. Dr Carey and his associates examined the outcomes of 295 patients with acute low back pain who were

John C. Glover, DO, administering osteopathic manipulative treatment to a student. Dr Glover is section head of osteopathic manipulaive medicine at the Oklahoma State University College of osteopathic Medicine in Tulsa.



John C. Glover, DO, (left) and Alexander S. Nicholas, DO, (right), standing beside a skeleton with severe scoliosis. Dr Nicholas is head of the Department of Osteopathic Manipulative Medicine at Philadelphia College of Osteopathic Medicine (PCOM). The skeleton is from the collection of Angus Cathe, DO, who was a professor of anatomy and osteopathic principles and practice at PCOM. The college maintains Cathe's collection.

randomly assigned to receive either optimal low back care (enhanced care) or enhanced care along with a sequence of eight standard manual therapy techniques. The patients were interviewed by phone at 1, 2, 4, and 8 weeks after their initial visits.

More patients who received manual therapy had complete recovery after their first visit as compared with patients in the control group (14% vs 6%). However, 2 and 4 weeks later, the proportion of fully recovered patients was nearly identical for the two groups. Some evidence suggested that the intensity of manual therapy may affect outcome. The mean time to functional recovery was 11.1 days for patients receiving only enhanced care, 10.4 days for those receiving low-intensity manual therapy, and 7.8 days for those receiving high-intensity manual therapy. Despite some concerns about using manual therapy in practice, the physicians were positive that its use had improved patient care. The full report of this study appears in *Spine* (2000;25:2954-2961).

Time, talent, and treasure: AAO's research contributions

For some years, the American Academy of Osteopathy (AAO) has dedicated significant resources to advance the research agenda for the osteopathic medical profession. As part of its strategic planning since 1992, the AAO's board of governors has adopted goals to document the clinical outcomes of the use of osteopathic manipulative treatment in patient care. It should be noted that this dedication predates the 1992 strategic plan. In fact, since 1987, the AAO leadership has funded eight research projects through appropriation of more than $127,500 from its reserve funds.

However, one of the most notable contributions of the Academy and its members during this period may have been the dedication of time and talent to the advancement of the profession's research agenda, such as through in-kind contributions. The members of the AAO's Louisa Burns Osteopathic Research Committee (LBORC), for example, have served as consultants to many osteopathic physicians in identifying research questions and designing research protocols. These scientific contributions have helped to fill gaps as the profession has worked to develop a research infrastructure conducive to the acquisition of major grants.

In recent years, the AAO's LBORC has contributed to the profession's research agenda in the following ways:

- It provided steering committee leadership in development and implementation of two Osteopathic Collaborative Clinical Trials Initiative conferences.
- It developed a research training workshop for practicing clinicians. This workshop was delivered at the March 2001 AAO Convocation, it will be repeated on October 21 at the AOA convention in San Diego, and it will be made available for replication at conventions of other AOA affiliates.
- It helped to establish a standardized format for research data collection by developing the Outpatient Osteopathic SOAP Note Form and Usage Guide. It also conducted a validation study comparing data recorded on the SOAP note form with transcribed physician notes (study published in the October 1999 issue of *JAOA*).
- It developed an Internet-based resource called the National Osteopathic Clinical Database, which includes a standardized data collection form and patient satisfaction surveys (SF36, GHAA, and development of specific osteopathic questions).
- It has offered consultation services to the AOA and the American Association of Colleges of Osteopathic Medicine.
- It composed and transmitted a letter of intent to the AOA for funding of the AOA Center for Osteopathic Research.
- It researched mechanisms for integrating key terms from the AOA's Glossary of Osteopathic Terminology into nomenclature databases at the National Library of Medicine to help to establish a standardized nomenclature for the profession.

Obviously, the AAO is not the only organization that has contributed to the overall research agenda of the profession. But these activities help to illustrate that even small organizations in the profession can have significant impact when acting in concert with other entities in the osteopathic family.

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