

Osteopathic approach may be helpful in war on terrorism

To the Editor:

The October issue of the *Journal of the American Osteopathic Association* arrived the same week as the October 11, 2001, issue of the *New England Journal of Medicine*. Both journals contained editorials about the terrorist attacks of September 11, 2001 (JAOA 2001;101:569-570 and *N Engl J Med* 2001; 345:1126). Both journals called for the knowledge and skills needed to care for the survivors of terrorist attacks.

As stated in the *New England Journal of Medicine*, "we are physicians, not politicians." However, there are specific issues the osteopathic medical profession should step up to and raise that reflect our concern for disease prevention and the ramifications for public health. Consider this idea: If the terrorist attack has irreversibly changed life in America, as all seem to agree, the war on terrorism demands new ways of thinking, not the old responses.

We need to eliminate all financial, moral, and psychological support for the Taliban. The primary source of revenue for the Taliban has been international drug trade, generating \$30 billion per year. In fact, Afghanistan holds the dubious distinction of producing 80% of the world's heroin. As the war on terrorism clearly must be fought on many fronts, Americans need to rethink our nation's approach to the war on drugs. Until now, our government has confronted the problem overseas as the isolated political or military failings of foreign governments, rather than as a complex social problem with international ramifications and shared humanitarian responsibilities. Any new approach must include a larger, more international sensibility, integrating the demand for respect of human rights and the elimination of torture overseas.

It is increasingly recognized that the strategic genius behind the work of Osama bin Laden is Ayman Al-Zawahiri, an Egyptian physician who learned his trade as the leader of Al Jihad. It is said that Zawahiri became a terrorist because of his experi-



Smoke billows from the World Trade Center after terrorists crashed commercial aircraft into the twin towers of the New York City landmark on September 11, 2001. (Photo by Robert B. Goldberg, DO)

ence in an Egyptian prison. According to his friends, he was tortured so severely that "something snapped," which led directly to his transformation into an international terrorist.

Similarly, a commitment to humanitarian issues might influence the millions of people who provide financial and moral support to international terrorism. Bin Laden no more represents Islam than David Koresh represented Christianity in Waco, Texas. Nonetheless, if even 99.9% of Muslims despise bin Laden and the terrorism he promotes, millions of people remain sympathetic to his cause. A war of propaganda needs to be aimed at this segment, and the weapons successful in that war are likely to be humanitarian aid and medical assistance to developing countries. The conversion of at least some of the disaffected to terrorism may be preventable.

Let's consider a public health analogy. If we are to wage war on lung cancer, our approach is not to build more hospitals and develop newer surgical techniques to

remove cancerous tumors. New cases of the cancer would continue to occur. Instead, we need to learn the epidemiologic factors of lung cancer; we need to convince people who smoke cigarettes to stop; and we need to influence young people never to start smoking.

In a similar way, eliminating a few terrorists is not going to solve the larger problem because others will soon emerge. We need to eliminate the sources of support for terrorism.

The legacy of osteopathic medicine as a healing profession that emphasizes disease prevention and restoration of health provides a worldview which may prove helpful in the war on terrorism.

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More on terrorism

To the Editor:

I could not agree more with Gilbert E. D'Alonzo, Jr's, DO (JAOA 2001;101:569-570) call for refined skills to address the enormous grief, anxiety, and panic that has resulted from the terrorist attacks that occurred September 11, 2001. It is likely that the fear generated by any future terrorist attacks, including plane crashes or bioterrorism events, will pale in comparison to the fear that we are still confronting as a result of the events on that day. It seems the most potent medicine we could offer our patients would be a simple, inexpensive, and rapid solution for addressing fear and anxiety.

I have been practicing natural medicine for more than 10 years, and I am the founder and senior editor of a top-rated wellness Web site (www.mercola.com)—roles that have allowed me the opportunity to evaluate many nontraditional techniques thought to improve health. I would like to share my experience with the emotional freedom technique (EFT), developed in 1980 by Roger Callahan, DO. Although no comparative trials exist, EFT is clinically similar to eye movement desensitization and reprocessing;

yet it is simpler to implement, has increased effectiveness, and provides a more rapid onset of relief.

Emotional freedom technique is a form of psychological “acupuncture.” The mechanism of action is clear; the health provider taps specific acupuncture meridians on the head and chest while activating the neural circuits that are involved with fear and anxiety. All this is done while the health provider gives a positive affirmation to the patient, which the patient states. The combination of tapping and positive affirmations appears to disrupt the field that is created from the emotion and its consequences on one’s physiology, thus normalizing the bioenergy disruption. The appealing characteristics of this technique are that it is quickly learned, does not require drugs or supplements, has no side effects, and is inexpensive. However, the most significant reason to consider this mode of therapy is its effectiveness; it works in minutes and the results appear to be permanent.

The emotional freedom technique has been used primarily by the psychological community and some psychiatrists for the past 10 years to successfully treat thousands of patients with emotional trauma. Unfortunately, there are virtually no primary care physicians using this tool and no published trials documenting its efficacy. Nevertheless, I have successfully used EFT for hundreds of patients in my clinical practice and can vouch for its effectiveness. A lack of peer-reviewed clinical trials would never have stopped Andrew Taylor Still, MD, DO, from implementing a simple, harmless technique with great potential for healing.

I have been searching for truth in health for many years, and it is my opinion that EFT-type technology may be a quantum leap in the management of emotional trauma. Adeptly implemented in a primary care setting, EFT-type technology has the potential to bring the osteopathic profession back to the basics that Still formulated over 100 years ago. Further information is available at <http://www.emofree.com>.

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Low-cost solution removes barriers

To the Editor:

We are besieged each day with increasingly expensive solutions to our basic medical needs. But what if our needs are great and money is scarce? Several years ago, I was asked by the University of Arizona to solve such a problem.

A severely handicapped applicant was to be hired as a receptionist if he could meet the job requirements. He would be required to answer two-line phones in two rooms and forward these calls as requested to the appropriate parties. The applicant was severely handicapped, having severe spastic disease in addition to his other disabilities. In the interview process, he repeatedly dropped

the phone and had difficulty pressing the correct buttons on the handset. Could a solution be found that would allow him to assume these job duties? The situation also required, however, that costs be nonrecurring and within the applicant’s budget.

A metal rod seven eighths of an inch in diameter was fastened to the side of the applicant’s chair. A polyvinyl chloride tee was fluted, and a deadlock was filed into the base of the flute (*Figure*), allowing the applicant to slide the phone onto the rod and drop the phone into position, locking it in place and spacing it so as to keep the handset just above his lap. A two-line roving phone from Radio Shack was then fastened onto this bracket. No detachment from the bracket was required to remove the phone for recharge. Jacks were wired into the side

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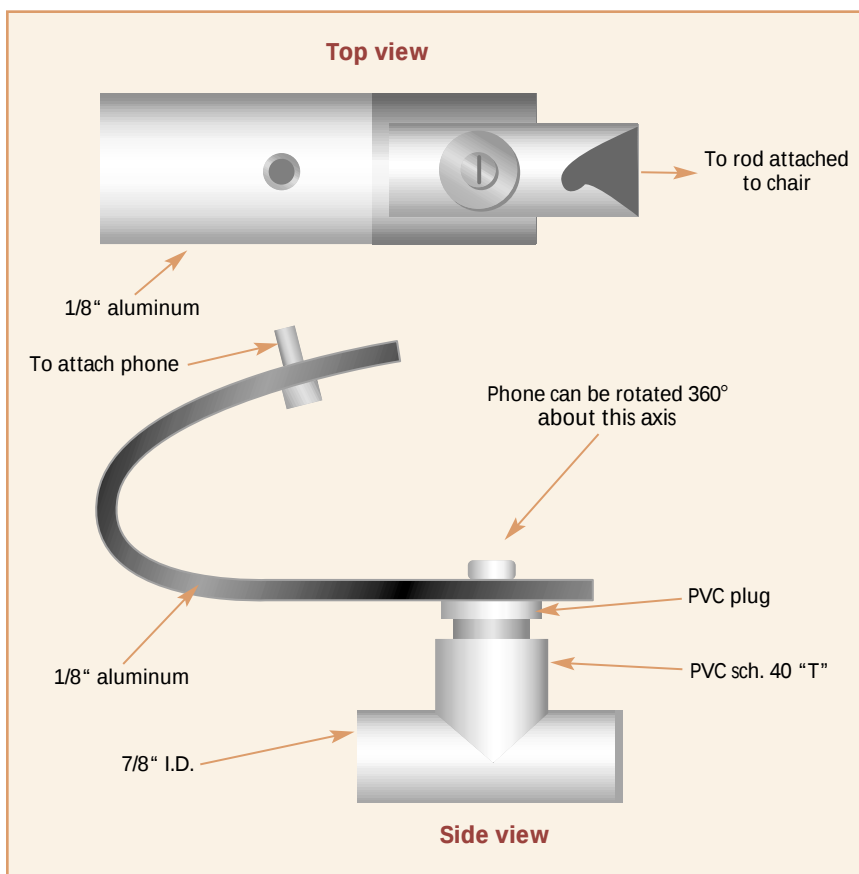


Figure. Illustration by Michele T. Mata, Art Director

of the phone for the use of a microphone and earpiece. As the applicant was deaf in one ear, an earpiece could not be used, so a radio speaker was placed in his cap to pick up the phone output. (He could not use a speaker phone because of its disruptive effect on nearby classrooms.) Either a boom microphone or a tie-tac microphone could be used as a pickup; he chose the latter. This improvised system worked, allowing the applicant to become a successful employee.

Tools found in the average home were used in this simple fabrication. The total cost was less than \$200, including the cost of the phone.

ALLAN R. CROSBY, DO
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Talents needed to build, not blend

To the Editor:

The *Journal of the American Osteopathic Association* and *The DO* have recently reached a new high in their selections of articles for publication and inclusion of special reprints. I have been personally stirred by the articles from the library, as well as recent original contributions, editorials, and articles on end-of-life care issues. I congratulate you and your staff.

Finally, I must add a few words regarding the comments of Mr. Shing, a second-year student at the New York College of Osteopathic Medicine (*The DO* 2001;42:21-22). Needless to say, I have encountered his idea of integrating osteopathic medicine with allopathic medicine before. His comments contain enough truth to be galling, but his reasons to change are not helpful. He might better use his talents to improve the existing situation rather than eroding it further. I have been through this before, and the truism "If you haven't tried it, don't knock it" comes to mind.

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End-of-life care focus critical to a complete medical education

To the Editor:

I compliment and congratulate you on the October issue of the *Journal of the American Osteopathic Association* (JAOA). The focus on end-of-life care is a contemporary issue of increasing relevance as baby boomers begin to introduce new cultural expectations of death, dying, and the care they wish to receive—or wish not to receive.

I am an associate professor at the Kirkville College of Osteopathic Medicine and a certified death educator. I have taught thanatology to medical students for 14 years and have followed with excitement the great strides that have been made in recent years via the Robert Wood Johnson Project. (The program is called Education for Physicians on End-of-Life Care (EPEC)—developed by the American Medical Association and supported by the Robert Wood Johnson Foundation.) The issue is: How are medical educators to find time in the curriculum to include more end-of-life care?

Articles such as those in the October issue of *JAOA* are helpful in convincing medical educators of the importance of death education for physicians and physicians-in-training. I hope *JAOA* will continue to serve as a critical resource for end-of-life care issues, education, and innovations. Thank you for devoting the October issue to this topic.

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More on end-of-life care

To the Editor:

I want to congratulate you on the October issue of the *Journal of the American Osteopathic Association*, which was so helpful because of its compassionate view of the end-of-life care of elderly people.

I am 94 years old and an 11-year retiree



of the osteopathic medical profession. I have had 2 great marriages and 3 blue-ribbon children from my first marriage of 40 years. For nearly 4 years I have lived alone in a house that was shared with others for 60 years.

I have a good life and I am still in control, which I credit to my exercise routine and prudent investments. I agree with former President Jimmy Carter when he emphasizes the importance of being in control as one ages in his book, *The Virtues of Aging*.

Again, thank you for the fine October issue!

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Travel road that includes complementary and alternative modes of therapy

To the Editor:

This letter is in response to American Osteopathic Association Executive Director, John Crosby's, JD, comments in "The road to be taken: AOA leadership on complementary and alternative medicine" (*The DO* June 2001;42:11-12). I would like first to applaud Mr Crosby for officially encouraging the osteopathic medical profession to explore complementary and alternative modes of

therapy (CAM). Those of us who have been consistently evaluating and using CAM for years have observed their potential for effectiveness.

I agree that it is time for the osteopathic profession to pull its head out of the sand and courageously declare our uniqueness and our support of effective CAM modes of therapy.

Patients are not waiting for the medical profession; they are making decisions based on their experience of what works and what does not. Statistical research has shown that Americans are already spending billions of out-of-pocket dollars for alternative medical care.

I encourage Joseph M. Kaczmarczyk, DO (MPH, senior medical advisor to the White House Commission on Complementary and Alternative Medicine Policy), to seek advice, counsel, and experience from fellow osteopathic physicians who have broad-based experience in the use of CAM. Experience cannot be learned; it must be experienced.

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Must question cause of sports-related injuries

To the Editor:

In response to the article, "Elbow injuries in golf" (JAOA 2001;101:509-516), by Alan R. Stockard, DO, I am impressed with this interesting and comprehensive discussion of 1100 cases of golf injuries, with its emphasis on elbow injuries and their treatment. I would like to add a few comments to the discussion.

As osteopathic physicians, we should always ask the question, "Why did this injury happen?" In the case of an acute injury (eg, the golf club hits the ground) the answer is usually self-explanatory. But in the case that the problem appears without acute injury and progresses to the point of seeking a physician's help, questioning how the injury happened should always be foremost in the osteopathic physician's mind. In my experience treating

sports-related injuries, it has been rare not to find remote structural restrictions and abnormalities that contribute to, or are the cause of, the problem. Nowhere in medicine is the osteopathic medical approach more applicable than in sports-related injuries. The magnificent total coordination of movements, tensions, and positions of the body to accomplish a split-second physical feat is a marvel to behold. Key restrictions anywhere in the body at that moment will adversely stress a vulnerable area—in the case of golf, this can be the elbow, shoulder, wrist, or lower back.

Structural history, evaluation, and simple nontraumatic muscle energy techniques quickly and logically enhance the body's ability to correct itself (ie, heal).

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An alert regarding Canada's financial aid for an osteopathic medical education

To the Editor:

Canadians who pursue osteopathic medical schooling and residency training in the United States may encounter a surprising oversight in Canada's financial aid legislation. Because of the high cost of an osteopathic medical education and the resulting student loan payments, the typical take-home pay of a resident can be disproportionately low. Thus, many Canadian osteopathic students who rely on the Canada Student Loan Program to finance their education in the United States would likely plan to apply for interest-relief benefits throughout their residency. This program allows those who qualify to delay making payments on their loans after graduation for a certain time. However, a hidden regulation could leave some residents and their families in a financially catastrophic situation.

The literature commonly directed toward initial borrowers by the Canadian Government and lending institutions ad-

resses interest relief and the criteria for eligibility; it does not include information that is imperative for osteopathic students to make informed decisions about how to finance their educations. As the Canadian Government readily lends to students attending osteopathic medical school in the United States, it is reasonable to assume that the location of their residencies would be irrelevant when applying for interest relief. However, most Canadian student loan recipients are probably not aware that an osteopathic medical school graduate is not eligible for interest relief unless he or she lives in Canada, which is problematic because completing an osteopathic residency in Canada is simply not a realistic option for a medical graduate at this time. In fact, the American Osteopathic Association's 2000/01 *Yearbook and Directory of Osteopathic Physicians* currently puts the number of US-trained Canadian DOs at 19. Due to Part 5, subsection 19(a) of the Canada Student Financial Assistance Act and its Regulations, an osteopathic medical school graduate who matches in a residency outside of Canada could be required by law to make extremely burdensome loan payments without regard to his or her financial situation.

The Canadian Government should be made aware of the unique situation of Canadian osteopathic medical residents. Proper consideration and appropriate changes should be made to the legislation and, in the meantime, student loan literature should be altered so that financial hardship for Canadians who graduate from American osteopathic medical schools is avoided.

Any Canadian osteopathic medical physician or osteopathic medical student who has been or is currently affected by this legislative oversight can have his or her name added to a list of those who support calling the Canadian Government's attention to this matter by e-mailing campbellangelina@hotmail.com. It would also be helpful to e-mail Jane Stewart, Minister of Human Resources Development, Canadian House of Commons, at min.hrdcdhrhc@hrdcdhrhc.gc.ca. ♦

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