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Response: Musculoskeletal Examination Needs to be a Matter of Habit

Michael M. Patterson

I suggest that students need to know that *spinal* somatic dysfunction may be a clue to the cause of vague or acute symptoms. The dysfunction may reflexly delay the healing of organic problems using medical therapy. Correcting the dysfunction will probably support and accelerate the healing response. In other cases, these dysfunctions may be incidental to the patient's chief complaint, but they may be of significance in the patient's long-term health.

Despite these points, many osteopathic hospitals fail to include the musculoskeletal examination as part of each patient's physical examination. In surveying a number of charts from osteopathic hospitals, I found in one large osteopathic teaching hospital 120 cases of chest pain diagnosed as "noncardiac" or "not otherwise specified." All these patients were admitted to the hospital through the emergency room and underwent thousands of dollars of tests. I evaluated 10 random charts of patients with these diagnoses. Not one patient had in his or her chart any record of musculoskeletal findings, such as pain in the ribs or sternum, spinal curves, or the like.

None of these records in this osteopathic hospital had included any history of the patient's lifestyle, possible trauma, or other symptoms present in other systems. Many patients were discharged with no suggestions given as to the cause of their dysfunction or were discharged without instructions for managing their condition. They were told they did not "have a heart attack."

(As a side note, I found one allopathic hospital in Michigan in which 50% of the patients' physical examinations included documentation of osteopathic somatic dysfunction by MDs. These findings were related to the chief complaint or incidental problems.)

Before the 1970s, it was routine for every patient in an osteopathic hospital to receive osteopathic manipulative treatment (OMT) at least once every day. Patients appreciated the OMT and often came to better understand their condition by talking with their physician about it while undergoing the OMT.

During the 1970s, it was decided that all therapies should be administered by order only; thus, routine manipulation was discontinued, and routine orders signed by the physician did not include OMT. The previously used spineogram was no longer acceptable, and spinal findings had to be written. This took longer and was more difficult. Because of this difficulty, many physicians recorded the patient's musculoskeletal findings as being "normal," "negative," or "not significant."

Similar problems were uncovered by Harry Friedman, DO, and his colleagues in their research (*JAOA* 1996;96:529-536). It appears that the philosophy of osteopathic medicine and the value of and attention to musculoskeletal symptoms in the care of all patients must be reinforced at all levels of osteopathic medical training and practice, and it must be documented.

I offer the following suggestions. In the education of osteopathic medical students, interns, and residents, the importance of the osteopathic medical philosophy must be taught—and constantly reinforced—*by those persons who understand and believe in it*. The diagnosis of somatic lesions and the importance of proper manipulative management must be incorporated into all areas of teaching. So often, these students are taught the laboratory and imaging diagnostic techniques and pharmaceutical therapy on one day, and then during another class they are shown the musculoskeletal treatment component.

Fifty-five years ago, practicing DOs with an interest in the subject actually taught the clinical courses. These instructors all used and taught palpatory diagnosis and OMT every day for each of the body systems. Internships and residencies were evaluated using the same criteria for therapy.

The curriculum for graduate and postgraduate education, as well as the requirements for practicing in accredited institutions issued by the American Osteopathic Association (AOA), should be coordinated with the work being done at the specialty colleges, the American Association of Colleges of Osteopathic Medicine, the American Academy of Osteopathy, and the Bureau of Healthcare Facilities Accreditation, among others. Together these groups should develop uniform guidelines that balance all aspects of diagnosis and care for patients.

Martyn E. Richardson, DO
Scarborough, Me

Response

To the Editor:

Martyn Richardson, DO, in his response to my editorial, suggests several interesting points. The lack of palpatory diagnosis and osteopathic manipulative treatment (OMT) records in hospital charts—despite the requirements for these records—is widely recognized. His analysis is important and insightful.

Perhaps chief among the reasons he cites are the lack of perceived importance and the perceived complexity of the process. Are we making the teaching of osteopathic medical diagnosis and OMT so complex that students are perceiving it as a specialty that they cannot really do? Are we failing to communicate the true importance of the somatic component of health (and disease)? If osteopathic physicians perceived the importance of musculoskeletal function and dysfunction in all aspects of health and disease, there would be much more use made of the palpatory, diagnostic, and treatment modalities, especially if recording the findings could be done easily.

Dr Richardson addreses these points, and in a disquieting comment, notes that in one allopathic hospital extensive use is made of musculoskeletal findings. This use is encouraging in terms of an acceptance of the importance of such findings in the treatment of patients. But it raises questions regarding the importance placed on musculoskeletal findings in *osteopathic* medical institutions. Perhaps the accrediting bodies of the American Osteopathic Association need to be more attendant to the requirements for musculoskeletal examination.

The osteopathic medical profession has a heritage of clinical use of muscu-

loskeletal findings in diagnosis and treatment, of providing research to support that use, and of developing the necessary theoretical underpinnings for clinical observations. We must now make sure that we remain in the forefront of developing that theoretical base, research knowledge, and most importantly, the clinical practice to which current and future members of the profession are heir. On this rests the future of the profession.

We challenge others to add their views on this issue.

Michael M. Patterson, PhD
Contributing Editor, *JAOA*
Professor of Osteopathic Principles and Practice Director of Basic Science
Research University of Health Sciences College of Osteopathic Medicine
Kansas City, Mo

Informing public, students will make profession 'visible'

To the Editor:

There have been many problems that have gripped the osteopathic medical profession almost to the point where one may lose site of how far the profession has come. No one is better at reminding us of our history and achievements than Norman Gevitz, PhD. So, it would only be appropriate for Dr Gevitz to warn us of our shortcomings, as well as to offer solutions to deal with them. Actually, in his latest article, published in the March issue of *The Journal of the American Osteopathic Association* (1997;97:168-170), Dr Gevitz merely expounds on what osteopathic medical students have been saying and begging the American Osteopathic Association to accomplish for years—"Spread the word."

As a new graduate, I can only add an intern's point of view to that of Dr Gevitz's. I originally considered applying to osteopathic medical schools at my friends' urging and after reading *The DOs: Osteopathic Medicine in America* by Dr Gevitz. Little did I know that when I entered a college of osteopathic medicine almost none of my peers would be as informed as I about the profession nor would they have read Dr Gevitz's book. As a result, my classmates were uncertain about the future and lacked confidence in osteopathic medical institutions. Nor were they reassured when they went through poorly regulated clinical rotations where teaching standards were hardly reinforced. This lack of knowledge about the profession does not help these students explain who DOs are when they're confronted with an avalanche of questions. Lack of knowledge fosters a lack of confidence that only snow balls.

The failure of our profession to properly inform our students about our history, along with having no informative, persistent advertising/public relations campaign targeted at the general public, has slowly—but surely—eroded the profession from within. Our hospitals and postgraduate training programs have suffered as our students seek nonosteopathic residency positions.[1] Many even ignore the osteopathic rotating internship year, thereby shrugging off the one way they can give something back to the very profession that gave them the opportunity to practice as physicians. Even more problematic, most of our graduates don't practice osteopathic manipulative treatment (OMT). The abandonment of OMT is due to the lack of confidence in our osteopathic medical institutions as they further perpetuate the problem by not using OMT during the clinical years of our education.[2]

The osteopathic medical profession has so recklessly rushed to join mainstream medicine that not even professionals within the healthcare industry can distinguish between DOs and MDs. This lack of distinction further augments our lack of recognition.

Today more than ever, because of the changes in healthcare, it makes sense for the profession to address this public invisibility. We live in an atmosphere of intense competition. Hospitals are scrambling for healthcare dollars. Yet, we are confronted with a public who has grown disillusioned with the current healthcare system; they are particularly dissatisfied with their physicians. It is in such an atmosphere that a campaign for a holistic and hands-on physician with an unlimited license to practice all modalities of medicine can only bring interest in osteopathic physicians. An informed public would restore confidence and rekindle a new interest among osteopathic physicians to finally use OMT consistently in clinical practice. The creation of a market niche for osteopathic physicians brought about by the type of public relations campaign described by Dr Gevitz would do more than just affect census in osteopathic hospitals. It would restore confidence in our postgraduate medical education programs.

Let us not be sidetracked by the increasing number of colleges of osteopathic medicine. Their success is not due to an attempt to fill an ever-growing niche for osteopathic physicians. The public is not informed enough to choose an osteopathic physician over an allopathic counterpart. Rather, the colleges are growing because of economics, availability of capital, record breaking numbers of applicants to all medical schools, and a disregard for the fundamentals of quality education, including scientific research.[3] ◆

Pouya Bahrami, DO
Fontana, Calif

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