

# Few Practitioners Practice Osteopathic Manipulative Medicine

Taylor GM\*

Department of Medical Sciences, University of New South Wales, Sydney, Australia

## Abstract

As We've Noted before, primary care-focused education, not research bears the heaviest emphasis within the mission statements of osteopathic medical schools. In addition to this deliberate focus on education, a key issue contributing to this lack of emphasis on research is the disparity in research funding between allopathic and osteopathic institutions.

**Keywords:** Allopathic counterparts; Biomedical sciences; Medical students; World report summit; NIH Grant; Primary care

## Introduction

Despite steady yearly increases in research funding from various sources, including the National Institutes of Health, pharmaceutical companies, state and local sources, and private foundations, osteopathic medical schools still significantly trail their allopathic counterparts in funding from all of these source categories. For instance, in 2010, 133 institutions affiliated with allopathic medical schools in all U.S. states and territories received funding from the NIH, the primary U.S. agency responsible for biomedical and health-related research [1]. The total amount of NIH funding for these institutions was upwards of \$11.5 billion, representing over half of the total NIH U.S. funding granted that year. This funding was predominantly geared toward research, but also was utilized for training, fellowships, and construction. Out of the 133 institutions receiving NIH funding, the median dollar amount received was at the University of Arizona, which was granted about \$45.2 million. In contrast, only 13 academic institutions affiliated with osteopathic medical schools received funding from the NIH in 2010, with a grand total of \$75.2 million combined [2]. The median amount received by an osteopathic institution was the just over \$1.5 million granted to Touro University College of Osteopathic Medicine - California.

## Discussion

It should be noted, however, that these figures represent the amount of funding granted to the academic institutions as a whole, not necessarily the individual colleges of medicine or osteopathic medicine. Osteopathic medical schools sometimes exist within a University setting in which there are other colleges or schools under the university umbrella. There are many factors that contribute to this wide disparity in funding. First, the majority of osteopathic medical schools are private, graduate-level institutions not affiliated with large, undergraduate institutions [3]. In fact, only six of the 30 osteopathic medical schools are public, and only four are affiliated with undergraduate institutions. Another possible factor could be reputation or simply precedence, as many osteopathic medical schools were not founded until the 1970s and beyond. In fact, only five of the current schools were established before 1969. Still, diverse opportunities exist for osteopathic medical students to enrich their educational experience. Eight osteopathic colleges currently offer medical scientist training programs, and 24 offer other joint degree programs combined with the DO degree, including Master's degrees in epidemiology, public health, biomedical sciences, health care administration, and business administration, as well as the Juris Doctorate degree. Eleven schools even offer joint-degree BS/DO or BA/DO programs. The summit

participants also raised flaws in utilizing faculty-to-student ratios and MCAT scores as quality indicators. Many suggested that more tangible measures of program quality be used, including board scores, residency match results, numbers of hours of clinical experience, available research opportunities and/or overseas rotations, and frequency of student-authored publications. Dr. Jules, went so far as to propose that prospective medical students would be better off going to their schools' pre-medical advisors for information rather than relying on the rankings [4]. Another suggestion for improving the U.S. News & World Report methodology is that because medical schools' educational missions significantly differ from one another, these differences should be reflected in the ranking system. Alternative methods of ranking the schools have been proposed, many including factors related to how well a school fulfills its own unique, individual mission. Other systems incorporate more under-appreciated variables, such as proportions of primary care graduates, graduates serving in underserved health professional-shortage areas, and/or graduates with minority backgrounds underrepresented in medicine. A George Washington University study combined these variables and others into a social mission score with which to rank medical schools. Its ranking system placed many prestigious programs that consistently top the U.S. News & World Report rankings much lower, or even at the bottom in some cases. Osteopathic medical school programs' ranks varied, as their primary care physician outputs were consistently high but their proportions of under-represented minority graduates were found to be lacking. Osteopathic Physicians are well-recognized as having the propensity to enter primary care [5]. In fact, the 2014 U.S. News & World Report reported that the top four U.S. medical schools producing the most primary care residents were osteopathic medical schools. Furthermore, an additional eight osteopathic schools were listed in the top 20 schools producing primary care residents. However, there has been much debate as to whether or not the U.S. News & World Report's criteria for major ranking categories, including research and primary care, provide a fair assessment of medical schools. Although some

\*Corresponding author: Taylor GM, Department of Medical Sciences, University of New South Wales, Sydney, Australia, Tel: 061293852478, E-mail: gila@unsw.edu.au

**Received:** 28-Mar-2023, Manuscript No. JPAR-23-95839; **Editor assigned:** 30-Mar-2023, PreQC No. JPAR-23-95839(PQ); **Reviewed:** 13-Apr-2022, QC No. JPAR-23-95839; **Revised:** 18-Apr-2023, Manuscript No. JPAR-23-95839 (R); **Published:** 25-Apr-2023, DOI: 10.4172/2167-0846.1000501

**Citation:** Taylor GM (2023) Few Practitioners Practice Osteopathic Manipulative Medicine. J Pain Relief 12: 501.

**Copyright:** © 2023 Taylor GM. This is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.

osteopathic medical schools are highly ranked by the system, with one ranking in the Top 20 Primary Care Medical Schools category, most are either poorly ranked or not ranked at all. Why do osteopathic medical schools fare so poorly in these rankings? First of all, research is generally more emphasized at allopathic medical schools, and thus DO schools rank lower than their MD counterparts in this category overall as well as associated subcategories, such as NIH grant funding specifics of which are discussed in the next section of this chapter [6]. Furthermore, the criteria used to judge the schools have inherent biases against osteopathic medical schools. The four main criteria, in order of weight in a school's overall score, include: quality assessment, proportion of graduates pursuing primary care, ratio of fulltime faculty members to students, and selectivity of admissions. The first, quality assessment, is determined via opinion surveys sent out to medical school deans and department heads, as well as allopathic residency directors, requesting ratings of each of the 133 allopathic and 26 osteopathic medical schools. These evaluators consistently rate osteopathic medical schools lower on average than allopathic medical schools, perhaps due to a lack of awareness and/or understanding of osteopathic medical education, especially in regions with a limited osteopathic presence. As for the primary care proportion, many more MDs than DOs enter internal medicine residencies only to later subspecialize, but these graduates are nevertheless counted as pursuing primary care. In addition, osteopathic medical schools use a higher proportion of part-time faculty members than do allopathic schools, thus not achieving comparable full-time-faculty-to-student ratios [7]. During a recent U.S. News & World Report summit meeting entitled The Impact and Future of Medical School Rankings, a panel of prominent medical school deans representing such high-ranking programs as Duke, Harvard and Yale met to discuss the influence of and possible improvements to the current ranking system. The discussion was moderated by the editor of U.S. News & World Report and also included the company's director of data research, who has led the rankings project for many years. Concerns voiced regarding survey methodology were varied and included: the subjective and static nature of responses regarding program reputation, low response rates among residency directors, and limited knowledge of respondents about programs other than their own. Approximately 57 percent of osteopathic physicians are in primary care. In a 2013 survey of entering osteopathic medical students, percent indicated that they had decided to practice medicine in an underserved community on graduation [8]. In the 2014 American Osteopathic Match, 50 percent of DO graduates matched in Internal Medicine, Family Medicine, or Paediatrics. For the 2014 NRMP match 53 percent of DO graduates matched to those three primary care specialties. The overall graduate medical education placement rate for all DOs seeking GME was 99.45%. The effectiveness of OMM remains a topic of on-going debate and research despite past and current efforts to lay these arguments to rest. Whether an osteopathic physician uses OMM in his or her practice is based entirely on preference [9]. With that said, it is an important core discipline and primary distinction of the osteopathic profession. This section was meant to give you a better sense of what osteopathic manipulative medicine entails, and hopefully it answered most of your questions regarding OMM. It is important to note that DOs who go on to specialize in Neuro-musculoskeletal medicine and OMM obtain many more hundreds of hours of manual medicine training in a wider variety

of clinical settings than DCs and other Dos [10]. Chiropractic was first enunciated in 1895 by Daniel David Palmer, who observed that displacement of vertebrae could affect neurotransmission, thus manifesting as disease. Palmer was a magnetic healer, but unlike A.T. Still, he did not have a medical background. While the chiropractic philosophy is historically focused on the nervous system, the original notion of osteopathic medicine was the need to restore blood flow, in particular, via manipulation of the neuro-musculoskeletal system.

## Conclusion

The differences in education and training between the two professions are apparent. In recent years, there has been a large movement within the osteopathic profession to support the expansion of OMM's scientific evidence base. In 2001, the Osteopathic Research Centre was established to focus on and enhance collaborative research describing OMM's clinical efficacy and mechanisms of action. Several other independent programs with similar goals have also been launched at individual colleges of osteopathic medicine, including Michigan State University College of Osteopathic Medicine, Ohio University Heritage College of Osteopathic Medicine, and the Rowan University School of Osteopathic Medicine.

## Acknowledgement

None

## Conflict of Interest

None

## References

1. Świeboda P, Filip R, Prystupa A, Drozd M (2013) Assessment of pain: types, mechanism and treatment. *Ann Agric Environ Med EU* 1:2-7.
2. Nadler SF, Weingand K, Kruse RJ (2004) The physiologic basis and clinical applications of cryotherapy and thermotherapy for the pain practitioner. *Pain Physician US* 7:395-399.
3. Trout KK (2004) The neuromatrix theory of pain: implications for selected non-pharmacologic methods of pain relief for labor. *J Midwifery Wom Heal US* 49:482-488.
4. Cohen SP, Mao J (2014) Neuropathic pain: mechanisms and their clinical implications. *BMJ UK* 348:1-6.
5. Mello RD, Dickenson AH (2008) Spinal cord mechanisms of pain. *BJA US* 101:8-16.
6. Bliddal H, Rosetzky A, Schlichting P, Weidner MS, Andersen LA, et al. (2000) A randomized, placebo-controlled, cross-over study of ginger extracts and ibuprofen in osteoarthritis. *Osteoarthr Cartil EU* 8:9-12.
7. Maroon JC, Bost JW, Borden MK, Lorenz KM, Ross NA, et al. (2006) Natural anti-inflammatory agents for pain relief in athletes. *Neurosurg Focus US* 21:1-13.
8. Birnesser H, Oberbaum M, Klein P, Weiser M (2004) The Homeopathic Preparation Traumeel® S Compared With NSAIDs For Symptomatic Treatment Of Epicondylitis. *J Musculoskelet Res EU* 8:119-128.
9. Ozgoli G, Goli M, Moattar F (2009) Comparison of effects of ginger, mefenamic acid, and ibuprofen on pain in women with primary dysmenorrhea. *J Altern Complement Med US* 15:129-132.
10. Raeder J, Dahl V (2009) Clinical application of glucocorticoids, antineuropathics, and other analgesic adjuvants for acute pain management. *CUP UK*: 398-731.