

THE JOURNAL *of the* AMERICAN OSTEOPATHIC ASSOCIATION



The Journal of the American Osteopathic Association

(JAOA) encourages osteopathic physicians, faculty members and students at colleges of osteopathic medicine, and others within the health care professions to submit comments related to articles published in the JAOA and the mission of the osteopathic medical profession.

The JAOA's editors are particularly interested in letters that discuss recently published original research.

Letters must be submitted online at <http://www.osteopathic.org/JAOAsubmit>.

Letters to the editor are considered for publication in the JAOA with the understanding that they have not been published elsewhere and are not simultaneously under consideration by any other publication.

All accepted letters to the editor are subject to editing and abridgment.

Although the JAOA welcomes letters to the editor, these contributions have a lower publication priority than other submissions. As a consequence, letters are published only when space allows.

Updated Recommendations for Diagnosis and Management of the US population for Hepatitis C

To the Editor:

On January 11, 2013, the US Centers for Disease Control and Prevention (CDC) sponsored a special meeting at its headquarters in Atlanta, Georgia, to disseminate new recommendations for screening the US population for hepatitis C. The CDC wanted to inform all medical practitioners, especially primary care physicians, of the new recommendations. As a gastroenterologist and a DO, I was pleased to represent the American Osteopathic Association and the large number of primary care physicians in the osteopathic medical profession.

An estimated 3.5 to 4 million people in

the United States have hepatitis C, and most of them are unaware that they are infected.¹ After several years, a substantial number of those infected will develop cirrhosis and possibly 1 of its lethal complications such as hepatocellular carcinoma, gastroesophageal varices, or ascites.¹ The infection usually produces no symptoms until end-stage liver disease and cirrhosis are already established.¹

Eradication of the virus can prevent the development of cirrhosis and its attending complications, such as esophageal varices, intractable ascites, and, in advanced cases, hepatocellular carcinoma.¹ With recently introduced and more effective medications to manage hepatitis C,² the infection can often be cured. To accomplish this, hepatitis C infection must be diagnosed before severe liver damage occurs.²

Until now, screening the population for hepatitis C has consisted of discerning

whether a patient has a risk factor for contracting the disease and then preemptively examining the patient for it.² These risk factors include elevated liver enzyme levels, a history of intravenous drug use, transfusion of blood or blood products prior to 1990, and multiple sexual partners.² Because screening on the basis of these risk factors has failed to reveal the majority of persons in the United States with hepatitis C,² the CDC has investigated different strategies for identifying people with hepatitis C.

Results of cost analysis revealed that a reasonable strategy would be to screen all individuals born between 1945 and 1965.^{3,4} Approximately 70% of all US adults that have hepatitis C were born during this period.² In addition, the CDC recommends a brief alcohol screening for patients that are infected because alcohol use accelerates liver damage.²

Osteopathic physicians in family practice, general internal medicine, geriatrics, or any other area of primary care can be especially effective at discerning people with this disease. A simple blood test for the antibody to the hepatitis C virus is inexpensive, and the test results have good positive and negative predictive values in determining which persons need further evaluation.²

Persons of any age group with risk factors as noted above should continue to be screened, but it now should be standard practice to also screen the cohort of people born between 1945 and 1965 who do not carry any of these risk factors.

With most osteopathic physicians in the United States serving in primary care practices, we have the opportunity to contribute extensively not only to the

well-being of our individual patients, but also to the well-being of the entire country.

More information on updated hepatitis C guidelines can be found at <http://www.cdc.gov/hepatitis/HCV/GuidelinesC.htm> and <http://www.cdc.gov/hepatitis/HCV/index.htm>.

Jack Bragg, DO

AOA representative, Hepatitis C Recommendation Provider Implementation Panel, Centers for Disease Control and Prevention

Associate Professor of Internal Medicine, Division of Gastroenterology, University of Missouri-Columbia School of Medicine

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2. Smith BD, Morgan RL, Beckett GA, et al. Recommendations for the identification of chronic hepatitis C virus infection among persons born during 1945-1965 [published correction appears in *MMWR*. 2012;61(43):886]. *MMWR Recomm Rep.* 2012;61(RR-4):1-32.
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International Health Electives: Strengthening Graduate Medical Education

To the Editor:

Reading the December 2012 issue of *The Journal of the American Osteopathic Association*, I was encouraged by the article by Sidney Coupet, DO, MPH,¹ on the use of international health electives to strengthen graduate medical education programs. I thought the article was scholarly, cogent, and timely. In reflecting on the subject matter, however, I believe that we in the US osteopathic medical community are overlooking an important element in the global evolution of medicine and culture: parallel to the progressive involvement of US-trained osteopathic physicians and osteopathic medical students in international medical missions and rotations is the rapid evolution of international osteopathy as a cohesive profession.

The aspects of our education and professional activity that make US osteopathic physicians distinctive are repeatedly scrutinized and debated, and they are perennially evolving. I have formed this opinion after 30 years of participation in faculty discussion, as well as participation in national and international organizations, committees, and associations. This process of self-scrutiny and refinement, which involves deciding what is essentially distinctive about our profession and then improving it by adapting best practices from different streams of the

osteopathic profession, is a benefit of participating in the osteopathic medical community.

For those not well versed in the history or current status of international osteopathy, the 2006 article “A Global Snapshot of Osteopathic Medicine” by Jane E. Carreiro, DO,² is still largely relevant. Developments in international osteopathy are ongoing, as is evident from the reports of representatives of different countries presented at the March 2013 Osteopathic International Alliance (OIA) Spring Board Meeting in Orlando, Florida.

Establishment of the OIA in 2004, as well as formation of the now discontinued World Osteopathic Health Organization, initially stemmed from the desire of US-trained osteopathic physicians to be recognized globally and to enhance developments in osteopathic medicine around the world. The creation of these organizations complemented a desire among European osteopaths for recognition and enhancement of both competency and educational standards. Formation of the European Federation of Osteopaths, European Register for Osteopathic Physicians, Forum for Osteopathic Regulation in Europe, and Osteopathic European Academic Network, among other organizations, reflects the wide-spread effort to fulfill this wish.

So far, these organizations (including the OIA), and their active members, have had a substantial impact on catalyzing the global osteopathic medical profession. Many communities that have had osteopathy and osteopathic medicine introduced by diverse historical routes

have reflectively pursued a future with more in common than different. Ongoing consensus discussions among OIA participants in Europe, Asia, and North and South America have led to the development and promulgation of the World Health Organization's *Benchmarks for Training in Osteopathy*.³ In addition, the OIA, along with its constituent organization members, provides information and support to those implementing osteopathy or osteopathic medical care in new political or cultural settings.

In discussions of US-trained osteopathic physicians and our professional identity, the elephant in the room remains to be addressed. Although training in osteopathic manipulative medicine is compulsory for all osteopathic medical students in the United States, very few of these students develop everyday competency in this distinctive practice and choose to use it.

A survey by Allee et al⁴ showed that 67.9% of osteopathic physicians in American Osteopathic Association–approved family medicine residencies claimed to use manipulation regularly, compared with 39.5% of those in family medicine residencies approved by the Accreditation Council for Graduate Medical Education. In addition, a number of the latter's allopathic peers reported interest in learning osteopathic manipulative treatment.⁴ However, in another survey of osteopathic physicians in Ohio (a state relatively heavily saturated with osteopathic physicians), 79% of respondents reported hardly ever using osteopathic manipulative treatment; those in special-

ties reported using none.⁵

From personal experience, including teaching abroad, I have noted that the manner of integrating osteopathic principles and practice into a health care setting varies. Foreign-trained osteopathic physicians, however, seem to particularly value these principles and apply them with specific intention and with more passion than many of our US osteopathic medical school graduates. Exposure to foreign-trained osteopathic physicians and their means of integrating manual therapy into clinical practice may spark a renewed interest by US osteopathic medical students and graduates in the uniqueness of osteopathic medicine. It might also inspire them to practice osteopathic medicine with the same intention and passion as foreign-trained osteopathic physicians.

This conjecture undoubtedly will be dismissed by many individuals who have a false sense of our identity as US-trained osteopathic physicians in relation to our colleagues who are practicing osteopathy in other countries around the world. I believe that exposure to global health care techniques during individual professional development, however, could contribute to an understanding of the real power and potential of maintaining the uniqueness of osteopathic medicine, including the judicious inclusion of manual diagnosis and manipulative treatment as a resource for patients. Reciprocally, such exposure would also offer opportunities to showcase the osteopathic medical profession's potential to integrate osteopathic principles into contemporary full medical practice.

I suggest that, to some extent, we merge international health electives with opportunities for exposure to international osteopathy. The American Association of Colleges of Osteopathic Medicine and the OIA have initiated small-scale discussions of how to implement more international exchanges into US osteopathic medical education, and individual osteopathic medical schools have taken the initiative to promote such exchanges. No such undertaking is simple, but I believe that this debate would benefit from wider exposure and a discussion of the issues.

Zachary Comeaux, DO

Professor at the West Virginia School of Osteopathic Medicine in Lewisburg, member representative to the Osteopathic International Alliance, and former president of the World Osteopathic Health Organization

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2. Carreiro JE. A global snapshot of osteopathic medicine. *Osteopathic Family Physician News*. May 2006;6(5):14-16.
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(continued)

Response

I appreciate the evaluation¹ by Zachary Comeaux, DO, of my December 2012 article on strengthening graduate medical education through the use of international health electives (IHEs).² I want to thank Dr Comeaux both for his comments and for his dedication to his vision of merging IHEs with opportunities for exposure to international osteopathy. However, I believe that to build a global understanding of osteopathic medicine, US-trained osteopathic physicians will be required to become players in global health through actively participating in the delivery of international health care services, academia, and policy making.

Osteopathic physicians trained in the United States have integrated osteopathic manipulative treatment (OMT) into westernized medical practices, which have become the framework for the delivery of osteopathic medicine. When US-trained osteopathic physicians, residents, and medical students volunteer for international medical missions and rotations, they expose the international community to OMT, thereby shaping the osteopathic medical profession in a global context. These osteopathic physicians practice within their specialties while incorporating osteopathic principles and practices. I believe that practicing in low-resource countries such as Haiti has the potential to bring the osteopathic palpatory techniques of our physicians to the forefront. Because access to expensive imaging modalities and advanced therapeutics is limited in such countries, US-trained osteopathic physicians have the

opportunity to revisit the diagnostic and therapeutic advantages offered by OMT. Participation in international health care workforce capacity-building programs such as Doctors United For Haiti offers US-trained osteopathic physicians just such an opportunity.³

Academic approaches (including teaching and research) will also help develop a better understanding of our practice of osteopathic medicine in international settings and establish new opportunities for expansion of the osteopathic medical profession. In my view, in a predominantly agrarian country like Haiti the use of OMT has potential not only as a diagnostic and therapeutic intervention but also as a means of building trust among Haitians. Because of their traditional ethnomedical practices, Haitians may be more willing to work with westernized medical practitioners who are using the laying-of-the-hands (high-touch) approach of OMT.⁴ I believe that these benefits of OMT reinforce the need for US-trained osteopathic physicians to be leaders on the front lines toward improving health care in developing countries like Haiti around the world. For some, this stance may be a bit of a leap; however, I believe that with appropriate academic support and financing, we can build an osteopathic medical school in Haiti, with the goal of establishing this school as a research institution. Haiti would be a favorable site for such a project in light of the ethnomedical beliefs of its inhabitants and its proximity to the United States.

Involvement of US-trained osteopathic physicians in developing international

health policy is paramount. The Institute of International Health at the Michigan State University College of Osteopathic Medicine is currently supporting this vision of global involvement by developing an IHE in the city of Mérida in the Yucatán state in Mexico. After diligently studying the Yucatán population, the Institute of International Health identified an urgent need to establish a department of OMT in a training hospital in Mérida. The local government and the Yucatán State Department of Health have provided strong support for this initiative. In a joint effort, the Michigan State University College of Osteopathic Medicine and the American Osteopathic Association were able to secure medical licensing rights for US-trained osteopathic physicians who wish to practice osteopathic medicine in the state of Yucatán. The IHE currently is in the first phase of development, with the Michigan State University College of Osteopathic Medicine working to establish a permanent osteopathic medical clinic, both to serve the health care needs of the people of Yucatán and to provide clinical training to US osteopathic medical school undergraduates and postgraduates. If this IHE is established successfully, it can serve as a model for developing similar initiatives in other countries around the world.

Although Dr Comeaux's recommendation to merge IHEs with opportunities for exposure to the international osteopathic medical profession could impact our professional identity on a global scale, I believe that it is only through the actions of osteopathic physicians in

global health through the delivery of international health care services, academia, and policy making that we will help enhance the global reputation of osteopathic medicine.

Sidney Coupet, DO, MPH, MSc

Founder and Chief Executive Director, Doctors United For Haiti;
Robert Wood Johnson Foundation Clinical Scholar,
Department of Internal Medicine,
University of Michigan, Ann Arbor

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3. Coupet S, Nassiri R, Aliu O, Coppola C. A long term building capacity model that prepares for effective disaster relief. *Int J Disaster Risk Reduction.* 2013;4(6):10-14. doi:10.1016/j.ijdr.2013.02.003.
4. Coupet S, Howell JD, Ross-Lee B. An international health elective in Haiti: a case for osteopathic medicine. *J Am Osteopath Assoc.* 2013;113(6):484-489.

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Corrections

The *JAOA* and the Bureau on International Osteopathic Medical Education and Affairs regret an error that appeared in the following abstract:

Beria JS, Giordano J, Jung M-K, Passafaro M, Lardner DA, Ahmed AZ. Chagas disease screening and prevalence in rural villages of El Salvador [abstract BIO1122]. *J Am Osteopath Assoc.* 2013;113(3):224-248.

The authors should have appeared in this order: Jasmine Susana Beria, OMS III; Jonathan Giordano, OMS III; Min-Kyung Jung, PhD; Deborah Anne Lardner, DO; A. Zehra Ahmed, RPA-C, MBBS; and Michael Passafaro, DO.

In addition, the *JAOA* regrets the following errors:

Shaw KA, Dougherty JJ, Treffer KD, Glaros AG. Establishing the content validity of palpatory examination for the assessment of the lumbar spine using ultrasonography: a pilot study. *J Am Osteopath Assoc.* 2012;112(12):775-782.

A study by Zink and Lawson—which was called out on page 780—was omitted at end of the reference list on page 782, where it should have appeared as follows:

18. Zink GJ, Lawson WB. An osteopathic structural examination and functional interpretation of the soma. *Osteopath Ann.* 1979;7(12):433-440.

Cohen-Lewe A. Osteopathic manipulative treatment for colonic inertia. *J Am Osteopath Assoc.* 2013;113(3):216-220.

The author's corresponding address was incorrect. The corresponding address should have read, "Adam Cohen-Lewe, DO, Provena Medical Group, Healing Arts Pavilion, 410 E Lincoln Hwy, Suite 251, New Lenox, IL 60451-1976."

Answers to the March 2013 *JAOA* CME quiz. *J Am Osteopath Assoc.* 2013;113(4):366.

The answers to questions 4 and 6 of the March 2013 continuing medical education quiz were incorrect. The answer to question 4 should have read, "(a) Idiopathic scoliosis is confirmed at a Cobb angle greater than 10°." The answer to question 6 should have read, "(d) Management of gastrointestinal visceral dysfunction below the diaphragm could include inhibitory pressure on celiac, superior mesenteric, and inferior mesenteric ganglia."

Table of contents. *J Am Osteopath Assoc.* 2013;113(4):258-259.

The title for the article by Justin Faden, DO (*J Am Osteopath Assoc.* 2013;113[4]:364-365), was listed incorrectly as "Maintaining Empathy in a Modern-Day Asylum." The title should have appeared as "Maintaining Empathy in a Locked Psychiatric Unit."

These corrections will be made to the full text and PDF versions of these articles online.