Osteopathic Medicine Approach to Pain Management

With a holistic approach to patient care—encompassing the integration of structure and function, emotional and social aspects of health and healing, and a more heuristic biopsychosocial approach to pain assessment and management—osteopathic physicians are uniquely positioned to manage patients with chronic pain.

Editor's note: Throughout the country, chronic pain patients are being treated by many disciplines. For example, in rural and urban settings the patient may simultaneously be treated by not only a medical physician but also a physical therapist, nurse practitioner, and psychologist. Some settings are fortunate enough to have many disciplines under one roof. Regardless of whether the patient is treated at a single or multiple sites, it is important to know the strengths and capabilities of each profession and discipline. The osteopathic physician has the unique capability to medically prescribe plus provide traditional manipulative therapy.

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Pain—specifically chronic pain—often requires a diverse interdisciplinary approach for its effective management. The interdisciplinary treatment team should include an osteopathic physician (capable of providing unique musculoskeletal diagnostic examinations and manual therapies), physical therapists, occupational therapists, and psychiatric health care professionals. Unfortunately, osteopathic manipulative medicine (OMM) and its role in the treatment of pain is widely misunderstood and underutilized. The major purpose of this article is to discuss the philosophy of osteopathic medicine (of which OMM is but one component) to provide a better understanding of its role in the treatment of pain.

At the outset, it will be helpful to discuss the similarities of, and differences between, osteopathic physicians (DOs) and allopathic physicians (MDs). Osteopathic and allopathic physicians are similar in many ways. They both typically have a four-year undergraduate degree, a four-year medical education and they take comparable licensing examinations. Moreover, they are licensed to practice the full scope of medicine and surgery in all 50 states, they practice all specialties of medicine and complete postgraduate training at many of the same institutions. Despite all their similarities, there are a few differences that impact the practice of osteopathic medicine and, particularly, the approach to managing chronic pain. Osteopathic medicine focuses on primary care and emphasizes a holistic approach to the patient, as well as the relationship between structure and function. All osteopathic physicians are trained to use OMM to help diagnose and treat their patients.

Osteopathic Principles and Practices

Osteopathic medicine is one of the fastest growing health professions in the United States, including more than 60,000 osteopathic physicians. In spite of this, public awareness, perceptions, and understanding of this profession within the allopathic medical community still remains poor. If lay persons and health care professionals claim to know something about osteopathic medicine, they are often mistaken in their understanding. They commonly look at osteopathic medicine as a “second-tier profession,” “not real doctors,” or as being chiropractors. Quite to the contrary, osteopathic medicine is a complete system of medicine that utilizes all available modalities of diagnosis and treatment. Contrary to public opinion, it is not just osteopathic manipulative treatment (OMT) that makes osteopathic medicine different; it is the osteopathic philosophy on which the whole osteopathic system of medicine is based. At its July 2008 Annual Meeting, the American Osteopathic Association’s House of Delegates approved a consensus statement on the four tenets of osteopathic medicine:

- The body is a unit; the person is a unit of body, mind, and spirit.
The body is capable of self-regulation, self-healing, and health maintenance.
Structure and function are reciprocally interrelated.
Rational treatment is based upon an understanding of the basic principles of body unity, self-regulation, and the interrelationship of structure and function.

Perhaps the most important of these tenets is the first one—that the person is composed of body, mind, and spirit. Thus, to treat the whole person, one needs to treat all three aspects. These tenets are at the core of osteopathic medicine and are what makes the osteopathic view of a patient distinct.

Conventional pain treatment in the United States has consisted of treating the physiological aspects of pain (nociception, mechanical compression, neuropathy and inflammation) and has, until quite recently, neglected the psychosocial aspects of pain. OMM integrates osteopathic philosophy with the principles of evaluating somatic dysfunction and treating it using OMT.

**Osteopathic Medicine and the Biopsychosocial Model of Illness**

It can be argued that osteopathic tenets and principles for the management of pain actually preceded the now widely accepted and heuristic biopsychosocial approach. This biopsychosocial model views physical disorders—such as pain—as the result of a dynamic interaction among physiological, psychological and social factors that perpetuates and may worsen the clinical presentation. A wide range of psychological and socioeconomic factors can interact with physical pathology to modulate a patient’s report of symptoms and subsequent disability. Thus, “knowing the whole person” is important in this model as well as in the osteopathic approach. It has been recently noted that, in general, this biopsychosocial model is quite congruent with osteopathic principles and that it provides a great deal of empirical evidence that supports the osteopathic approach.

Indeed, as noted by Gatchel et al, the emergence of this biopsychosocial approach has paralleled the evolution of scientific thought in medicine:

“During the Renaissance, increased scientific knowledge in the areas of anatomy, biology, and physiology was accompanied by a biomedical reductionism, or a ‘dualistic’ viewpoint, that mind and body function separately and independently. This perspective dominated medicine until quite recently and affected the understanding of the relationships between mental health and pain. The gate control theory of pain introduced by Melzack and Wall (1965), however, began to highlight the potentially significant role that psychosocial factors play in the perception of pain. Pain is now viewed as a complex set of phenomena rather than as a simple, specific, or discrete entity.”

This biopsychosocial approach was widely embraced by osteopathic medicine, well before conventional allopathic medicine.

**Osteopathic Manipulative Medicine and Osteopathic Manipulative Treatment**

In addition to a standard history and physical examination, the osteopathic physician performs an osteopathic structural examination looking for impaired or altered function of the musculoskeletal system (bone, joints, muscles and fascia) and its related lymphatic, vascular and neural structures. These impaired or altered functions are called somatic dysfunction. Somatic dysfunction predisposes one to pathology and can maintain it once established. Somatic dysfunction is manifested in the body as palpable changes in tissue texture, tenderness, asymmetry and loss or restriction of motion.

“It can be argued that osteopathic tenets and principles for the management of pain actually preceded the now widely accepted and heuristic biopsychosocial approach.”
The trained osteopathic physician is able to use this palpatory information to elicit factors involved in the patient’s presenting condition. Not only can one refine the source of pain generation, it is also possible to glean additional information from the osteopathic examination—such as the presence of viscerosomatic reflexes and the acuteness or chronicity of the tissue changes. This will enable the osteopathic physician to consider distal inputs into the patient’s pain or dysfunctional areas. For example, a patient with chronic recurrent pain between the shoulder blades may have tissue texture changes (doughy, boggy, or fibrotic tissue) suggestive of a chronic viscerosomatic reflex that leads the osteopathic physician to question the patient for a history of gastroesophageal reflux disease (GERD) based on the known spinal cord level innervation to the upper gastrointestinal tract.13,14

Upon further questioning, the patient may admit to chronic intermittent GERD, and he/she may also admit that the back pain seems to become worse with increased GERD symptoms. Without this information, a physician might continue to treat only the patient’s somatic complaints, and miss the patient’s intermittent, yet long-standing, GERD which is contributing to the patient’s back pain. As another example, empirical data from a case-control study have demonstrated abnormal osteopathic palpatory findings at the T11-L2 spinal cord levels suggestive of a renal viscerosomatic reflex in subjects with type 2 diabetes mellitus.15 Moreover, the putative renal viscerosomatic reflex was greatly strengthened by the presence of co-morbid hypertension and the duration of type 2 diabetes.

In addition to assessing specific areas for somatic dysfunction, the osteopathic structural examination focuses on the body’s overall postural alignment and gait.14 Posture and gait give the osteopathic physician insight into the body’s efficiency or inefficiency, as well as chronic stress and strain patterns within the body. Chronic pain conditions have been linked to postural imbalances such as altered lordotic and kyphotic curves, scoliosis, and sacral base unleveling (“short-leg syndrome”).16 Postural stress and strain is a major contributor to the propagation and chronicity of somatic dysfunction.16 As such, the osteopathic history and examination looks to also identify treatable causes of postural decomposition, including ergonomics at home and work. The structural and biomechanical changes seen during pregnancy represent a unique opportunity for osteopathic intervention.

Recently, a randomized controlled trial demonstrated significantly better functional outcomes in subjects who received OMT during the third trimester of pregnancy compared with subjects in the control groups.17 Also of note is how the “laying on of hands” by an osteopathic physician changes the doctor-patient relationship. The relationship becomes more personal and patients become more open and relaxed during the interaction. This, in turn, builds trust with patients and often allows them to express the emotional and spiritual aspects of their pain. This extra step in the physical examination allows osteopathic physicians to not only further define and locate the patient’s pain generator(s), but also allows them to assess the functioning of the spinal segments involved in the generation of pain. This promotes an expanded differential diagnosis and the development of a management program that includes OMT together with conventional and other complementary and alternative medicine treatments that may be available.18

Table 1. Descriptions of some of the more commonly used OMT techniques according to the Glossary of Osteopathic Terminology.11

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<th>Technique Description</th>
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<td>High velocity/low amplitude thrust involves a rapid, therapeutic force of brief duration, short distance within the anatomic range-of-motion of a joint, and that engages the restrictive barrier in one or more planes of motion to elicit release of restriction. It is also known as a thrust technique.</td>
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<td>Muscle energy involves a technique in which the patient's muscles are actively used from a precisely controlled position, in a specific direction, and against a distinctly executed physician counterforce, in order to achieve release of myofascial tissues.</td>
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<tr>
<td>Direct myofascial release engages the restrictive barrier of the myofascial tissues. The tissues are then loaded or tractioned with a constant force until tissue release occurs.</td>
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<td>Indirect myofascial release involves dysfunctional tissues that are guided along the path of least resistance until free movement is achieved.</td>
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<td>Counterstrain considers dysfunction to be a continuing, inappropriate strain reflex, and treats it by applying a position of mild strain in the direction opposite to that of the reflex. This is accomplished by specific directed positioning about the point of tenderness to achieve the desired therapeutic response.</td>
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- Osteopathy in the cranial field involves techniques based on the primary respiratory mechanism and balanced membranous tension.

OMT is the “hands on” use of force in response to somatic dysfunction in the body. The goal of OMT is to correct, remove or improve somatic dysfunction thereby allowing for the body’s self-healing, self-regulating (i.e., homeostatic) mechanisms to become more effective at restoring health. This is an example of the application of the structure-function principle. A retrospective study of 1,331 consecutive patient encounters in a primary care setting demonstrates that osteopathic practitioners commonly document somatic dysfunction, treat it with OMT, and record resolution or improvement in virtually all patients. OMT consists of a wide variety of techniques, ranging from direct (into the restrictive barrier) such as high velocity/low amplitude thrust and muscle energy techniques, to indirect (away from the restrictive barrier) such as myofascial release and counter-strain techniques. Some of the more controversial techniques comprise osteopathy in the cranial field. This group of techniques rely on the body’s inherent “primary respiratory mechanism” in conjunction with “balanced membranous tension” to affect change at the body’s intercellular level. This is primarily accomplished by treating the bony and membranous structures of the head which, in turn, influence the cerebrospinal fluid and the neurological centers located in proximity to the fourth ventricle. These techniques are most commonly associated with treatment of the cranium and sacrum but can be performed on any part of the body. They are theorized to have an effect on the body’s autonomic control centers. It is the skill and expertise of the treating osteopathic physician, as well as the patient’s history, that determine the appropriate technique to use. Table 1 presents descriptions of some of the more commonly used OMT techniques.

The goal of OMT is not necessarily to remove pain but to restore function to the dysfunctional structures and allow the body’s own self-healing mechanisms to resolve the pain. Perhaps unique to the osteopathic treatment of painful conditions is this emphasis on improving function rather removing or resolving pain during a treatment. It is more common for a patient to have palpably significant changes in the function and structures of the areas treated, and only have partial reduction in pain immediately after treatment—followed by several days of continued improvement in pain post-treatment. For example, in the randomized controlled trial of OMT during third trimester pregnancy, the OMT group not only demonstrated a statistical trend toward decreased pain but also experienced significantly better functional outcomes than the control groups.

OMT is extremely safe, with the most common adverse effects being temporary soreness and aching during the first 24 to 48 hours following treatment. Less than 10% of patients attending an OMM specialty clinic reported any adverse effect from OMT and any adverse effects, when observed, did not negatively impact clinical outcomes or patient satisfaction. Serious adverse events, such as vertebral artery dissections and disk herniations—occur extremely rarely during manual interventions of any type. A study of non-osteopathic manual therapies has shown that such serious adverse events are associated with more aggressive direct, or thrust, techniques.

Broad-Based Osteopathic Approach to Pain

Pain and nociception are not viewed as synonymous in osteopathic medicine. Nociception is the body’s physiological response to mechanical, thermal and chemical noxious stimuli. Pain, on the other hand, is the learned psychosocial interpretation of the noxious stimuli that can vary from one person to the next based on their cumulative experiences and genetic factors. Of course, our understanding of pain and its impact on the body continues to evolve and expand. Studies of chronic pain, in particular, are beginning to show exactly how complex pain is, and how it is interrelated with the overall health or illness of the person. One good example involves studies showing brain tissue atrophy and altered sensory and neurochemical central nervous system functioning in patients with chronic pain. This is a prime example of the structure-function relationship, and how the psychosocial impact of disease can lead to pathophysiological changes in the body. Osteopathic medicine has long maintained that improvements in structural functioning can lead to improvements in the physiological functioning of the body. This more holistic view and understanding of the structure-function relationship is gaining support as
evidenced by the developing field of psychoneuroimmunology. This field focuses on the vast interconnectedness and functioning of the body and mind through neurochemical and neuroendocrine networks within the central nervous system, immune system and endocrine system.\textsuperscript{26}

**Autonomic and Visceral Considerations**

Spinal facilitation is the state in which a pool of spinal neurons is kept in partial or sub-threshold excitation. These neurons then require less afferent input to discharge or send an impulse. Once a facilitated state is achieved, it can be sustained by normal central nervous system activity.\textsuperscript{11} Spinal (or segmental) facilitation is achieved by input either from higher centers, visceral sympathetic or parasympathetic afferents, or somatic afferents (muscle spindles, golgi tendons, nociceptors, etc.).\textsuperscript{27} Once the stimulus abnormally sensitizes the spinal interneurons, they can then develop prolonged facilitation.\textsuperscript{27} When discussing spinal facilitation, it is also important to define several physiological reflex arcs and interactions. The definitions of these reflexes, as described in the Glossary of Osteopathic Terminology, are as follows.\textsuperscript{11}

- **Viscero-somatic reflex**: localized visceral stimuli producing patterns of reflex response in segmentally-related somatic structures.
- **Somato-visceral reflex**: localized so-matic stimulation producing patterns of reflex response in segmentally-related visceral structures.
- **Somato-somatic reflex**: localized so-matic stimuli producing patterns of reflex response in segmentally-related somatic structures.

It is this spinal facilitation that plays an important role in propagating chronic somatic dysfunction which can, in turn, lead to chronic pain. An example of a viscerosomatic reflex leading to spinal facilitation is that of cholecystitis. The visceral sympathetic afferents lead back to the T5-10 spinal cord segments.\textsuperscript{28} This abnormal and often chronic stimulation of the interneurons can lead to reflexive somatic changes (tightness and tenderness) in the parathoracic musculature. This chronic feedback loop can enable somatic dysfunction to develop, resulting in pain located between the patient’s shoulder blades. The reverse may also occur. Thus, a chronic somatic dysfunction can cause or contribute to visceral disease through a somatovisceral reflex arc and its interrelation with spinal facilitation of the autonomic nervous system.\textsuperscript{28}

Another aspect of chronic pain is the effect of the sympathetic nervous system on some causes of neuropathic pain. Neuropathic pain can be subdivided into sympathetically-maintained pain and sympathetically-independent pain.\textsuperscript{18} Sympathetically-maintained pain is relieved when the sympathetic efferent supply is modulated or blocked. The best known example of this is the complex regional pain syndrome that can be relieved with a stellate ganglion block. However, there is a spectrum of sympathetically-maintained pain syndromes having gross signs of sympathetic dysregulation (temperature, sweating and trophic changes) amenable to OMT via down-regulation of spinal cord facilitation.\textsuperscript{18}

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The parasympathetic nervous system, like the sympathetic nervous system, manifests both viscerosomatic and somatovisceral reflex arcs, and spinal facilitation. These reflex arcs play a role in the homeostasis of the neuroendocrineimmune system and its impact on health and pain. The majority of the preganglionic neurons of the parasympathetic system arise from the cranial (including upper cervical) and sacral spinal cord levels.
Somatic Considerations in Pain

Once non-mechanical and surgical causes of pain are ruled out, a more detailed exploration of somatic (mechanical) causes of pain can be performed. When determining if somatic dysfunction is a main contributor to a patient’s pain, it is important to isolate the pain generator. This can be achieved by palpation of the somatic dysfunction while paying attention to tissue texture abnormality, asymmetry, restriction of motion and tenderness (TART) and any pain referral pattern. Pain patterns are most commonly taught on a neurological level, looking at dermatomal or peripheral nerve distributions.

There are, however, two other commonly overlooked pain patterns that can confound the physician in locating the patient’s pain generator. These are the sclerotomal and myotomal pain patterns. The sclerotomal tissues (i.e., bones, joint and ligaments) and myofascial tissues commonly refer pain to distant sites and often mimic radicular pain patterns. The sclerotomes and their referral patterns are commonly used by physicians who perform prolotherapy (a series of dextrose solution injections into weak ligaments or tendons to encourage increased blood supply and repair of the tissue) or platelet-rich plasma injection therapy.

Ligamentous tissue, in particular, is extensively innervated and is a common location of pain generation. These sources of somatic pain generation can often be confirmed by their response to a local anesthetic injection or OMT. The myotomal pain patterns have been extensively mapped out and characterized by Travell and Simons. These sources of pain generation are very common in patients with chronic musculoskeletal disorders and are, unfortunately, too often overlooked. Osteopathic medicine places more emphasis on these concepts of pain generation. To osteopathic physicians, these fall into the category of somatic dysfunction and related pain. Knowing these patterns of pain and their most common sources (i.e., muscles and ligaments) can be extremely beneficial in patients having radiating pain without radiographic or neurodiagnostic evidence of radiculopathy.

The Clinical Thought Process in Osteopathic Medicine

Osteopathic physicians perform comprehensive histories and physical examinations, as do their allopathic physician counterparts. Additionally, they perform an osteopathic structural examination as described above. It is during this examination that osteopathic physicians begin to synthesize their collected data and reconcile the “allopathic” differential diagnoses with the “osteopathic” diagnoses (i.e., types of somatic dysfunction). Osteopathic physicians also listen to patients and probe for any underlying psychosocial or emotional factors relating to their health status and presenting complaints. Indeed, osteopathic physicians have been shown to more often discuss the social, family, and emotional impact of illness with their patients than allopathic physicians. A beneficial aspect of practicing “hands-on care” is that it enables a qualitatively different approach and thereby a better understanding of the needs and concerns that underlie the patient’s complaints. It is becoming clear that a patient’s mental health is directly related to physical health. By no means does this suggest that osteopathic physicians are the only health care providers who assess psychosocial aspects when evaluating patients. However, it can be argued that it is this more expansive view and physician-patient interactions that make osteopathic physicians unique. The following cases demonstrate this distinct osteopathic approach.

Low Back Pain. A 46-year-old female presents with chronic intermittent low back pain. She denies numbness, tingling, burning in the lower extremities, weakness, history of any trauma, as well as any loss of bowel or bladder control. She describes her pain as “deep” and “achy” with occasional radiation bilaterally into the buttocks and posterior thighs, stopping at the knees. She has no family or personal history of arthropathies. She reports that over-the-counter non-steroidal anti-inflammatory drugs and home exercise help. She has had physical therapy and massage therapy, which also help, but the benefit seems not to last. Pain is aggravated by bending at the waist, sitting for prolonged periods and heavy lifting. The rest of the history is non-contributory. She has had several imaging studies in the past, which showed mild degenerative changes of the L4-5 facets bilaterally, but were otherwise “normal.” On physical examination, she is neurologically intact to light touch, strength is 5/5 in both
upper and lower extremities, and deep tendon reflexes are 2/4. All provocative orthopedic testing is negative. However, upon osteopathic structural examination, it is noticed that she has a slight leftscoliosis of the lumbar spine in addition to somatic dysfunction of the lumbar spine, sacrum and pelvis. OMT is performed, with a subsequent marked improvement in the somatic dysfunction, both objectively and subjectively. The patient returns to the clinic in two weeks with recurrence of her low back pain and the same somatic dysfunctions on examination. Due to the chronic nature of the condition, her slight lumbar scoliosis, and the fact that it improved only temporarily in response to successful OMT, more attention is now focused on postural considerations in this patient. Further questioning reveals that she has to have one pant leg hemmed shorter than the other and will wear out the sole of one shoe faster than the other. After performing OMT for the present somatic dysfunctions, the bony landmarks of the lower extremity are compared to evaluate for a short leg (functional or anatomic). Both the medial malleoli and patella on the left are superior, suggesting a possible left short leg. A postural study is ordered, and she is found to have sacral base unleveling of 15 mm on the left. At the next visit, a series of progressive heal lifts and a home exercise program is added to her treatment plan. After several OMT treatments and increases in the heel lift, she is now pain free between visits.

**Headaches.** A 36-year-old male presents with chronic headaches and intermittent upper back pain for the past four years. He describes the headaches as achy pressure in the base of his skull, going up the scalp and behind his right eye. He denies photophobia, phonophobia, nausea, visual changes, or a history of seizure disorder. He has had CT and MRI scans of the brain that were negative for any intracranial processes. He has been seen by several physicians, including a neurologist. He reports that over-the-counter analgesics and massage help with his headache. He describes his upper back pain as “deep,” “dull” and “achy.” He points to the right inter-scapular area as the area of greatest discomfort. He has no known history of trauma and works as an electrical engineer. His job requires him to sit at a computer for extended periods of time. He also admits to being under a great deal of pressure at work because of an approaching design deadline and reports that his headaches seem to get worse when he is under such stress. On physical exam, his neurological findings (including cranial nerve examination) are negative for gross pathology. On musculoskeletal examination, there is tenderness along the right paraspinal musculature and right suboccipital region, accompanied by significant somatic dysfunction at the atlanto-occipital joint and T5-9 spinal cord levels, with fibrotic yet boggy tissue texture changes in the right paravertebral musculature. Pressure on the right suboccipital muscles produces referred pain behind his right eye. Suspecting a viscerosomatic reflex component and knowing the autonomic innervation arising from the atlanto-occipital joint (vagus/parasympathetic) and T5-10 (sympathetic) regions, leads to further questioning about the gastrointestinal system. With some probing questions, the patient admits to having a history of mild to moderate “heart burn” for which he takes over-the-counter famotidine as needed. He has never been evaluated for GERD or gastric ulcers. He denies any gastrointestinal red flags or symptoms suggestive of cholecystitis. His stool was guaiac negative. An abdominal examination reveals discrete tenderness over the duodenal bulb and a negative Murphy’s sign. He was placed on a proton-pump inhibitor for his “heart burn,” OMT was performed, and he was instructed on proper workplace ergo-nomics and breathing exercises for stress reduction. With sustained proton-pump inhibitor therapy and only a few OMT treatments, his headaches and back pain significantly subsided in duration and frequency.

Summary of Cases. The patient with low back pain illustrates the importance of posture on pain and the rationale for an osteopathic structural examination for postural decompensation or asymmetry. The patient with headache and upper back pain illustrates the diagnostic importance of palpation and its use to help guide the differential diagnosis. It also exemplifies the osteopathic clinical thought process that integrates seemingly unrelated symptoms and the holistic approach to treatment which is often needed in managing patients who suffer from chronic pain. The argument can also be made that these two patients could benefit from cognitive behavioral therapy since there is clear and growing evidence of the impact that such therapy can have on patients with pain.1

**Benefits of the Osteopathic Approach**
The benefits of an osteopathic approach can be many-fold including: fewer unnecessary imaging studies; decreased use of prescription pain medications; decreased time in physical therapy; decreased need for referrals; and a decrease in direct costs associated with pain. The osteopathic physician’s emphasis on the musculoskeletal system, combined with a mind-body approach to patient care, leads to an expanded differential diagnosis that includes somatic dysfunction. This expanded understanding of disease, combined with the osteopathic physician’s knowledge of complex neuroendocrine reflex systems, can help integrate seemingly unrelated symptomatology and develop a holistic plan to achieve health in their patients. Because chronic pain patients are often very difficult to treat successfully, it would be to their advantage to have an osteopathic component in their assessment and treatment.

Summary and Conclusion

Since osteopathic medicine’s acceptance into the medical mainstream in the United States, there has been a challenge to articulate its distinctiveness from allopathic medicine. Often, osteopathic distinctiveness is described as the use of OMT. However, the osteopathic profession’s holistic approach to patient care, encompassing the integration of structure and function and its tradition of considering emotional and social aspects of health and healing, uniquely position osteopathic physicians to manage patients with chronic pain. Indeed, as we discussed, osteopathic medicine embraced the more heuristic biopsychosocial approach to pain assessment and management well before conventional allopathic medicine did so. Additionally, osteopathic medicine’s focus on primary care provides an opportunity to integrate these holistic components of care in a potentially cost-effective manner by reducing referrals for specialty care and surgery for many pain patients before chronic problems develop. However, this unique role of osteopathic physicians in the United States—as providers of both conventional medical treatment and OMM for pain—remains largely unrecognized. Enhancing awareness of the osteopathic approach to patient care provides an opportunity to optimize collaboration between osteopathic physicians and other health care providers to maximize healing for patients.

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