Osteopathy—Fifty Years Later*

Founders Memorial Lecture

RALPH L. FISCHER, D.O., M.Sc. (Ost.)

Philadelphia

It is not the purpose of this paper to eulogize the patriarchs of the osteopathic profession in Pennsylvania; but the occasion of fifty years of organization should not pass without an examination of the results of their pioneering. Progress and retrogression of a system of healing are relative; conditions differ too widely from decade to decade, to allow accurate evaluation of the elements which determine these things.

However, it is apparent at once that our osteopathic organizations have become bigger; on the other hand, a handful of pioneers secured for the profession a law, two osteopathic examining boards, and a college during the first 25 years of the Pennsylvania Osteopathic Association. Their legislative act has been good enough to permit us to practice quite satisfactorily for half a century. The examining boards operate efficiently. The college expanded miraculously during the first 3 decades of osteopathy in Pennsylvania. This record of our founders reflects their efficiency with the material elements which shape the foundation of a system of healing.

It is important, also, to explore what has been done by those who have chosen to carry on the principles of osteopathy which were first laid down by these founders. The literature, the written record of the osteopathic profession, furnishes one criterion in this connection. At the turn of the century and for a few years thereafter, the enthusiasm of the early practitioners was committed to bound volumes. Osteopathic physicians at that time did not hesitate to propose the tenets of a new system of healing to the world. They put these tenets into a permanent record. Their story was good enough to convince an ever-increasing number of students to undertake the study of a new art. It is a compliment to the fearless and independent thinkers of earlier days that their literature is brought to attention at this time.

Nostalgia has little place in a professional paper, but short journeys into the past can point up observations in the present. Osteopathy has been based upon the principle that the body contains within itself the properties necessary for preventing, alleviating, and curing disease. It opposes the introduction of such foreign materials as may interfere with the physiology of the body unit. These principles, first laid down by Andrew Taylor Still, apply today with equal force. Biological laws do not change with the discovery of a new or fascinating drug. Rather, the place of the newer drug must be matched against the older biological laws. The physiopathology of disease has been changed much more by mechanical measures, such as manipulation, surgery, and physical agencies, than it has with the use of drugs. Few drugs are physiologic in their actions and most of them carry harmful potentialities. Yet, the same foreign materials which osteopathy opposes will save lives occasionally under some circumstances.

At no time in the history of medicine have there been as many pharmacological advances as during the last 3 decades. Insulin and biological extractives for diabetes and anemia and vitamins for pellagra, scurvy, and beriberi have proved their worth and each of them is as effective today as it was when it was discovered. None of them bring deleterious aftereffects. On the other hand, certain antiphlogistic drugs also seem to have a significant, if limited, usefulness. The antibiotics are valuable in a small percentage of cases, the dangerous anticoagulant drugs have been useful occasionally, and some incurable diseases have been held in check by antifungal acid formulas and radioactive substances. Yet none of these materials has had any salutary effect upon pathology. Pathology is removed by surgery, destroyed by rays of various kinds, and cured by the natural forces of the body. There are no other ways of combating pathology and since pathology causes disease, there are no other logical methods of curing disease. Not infrequently, one of these methods will supplement the others. If he thinks of it at all every physician, of whatever school, will grant these axioms.

In the broad approach to treatment, then, there is no difference among physicians. It is in the details and in emphasis that opinions will vary and it is with etiology and rational, the first irrevocably related to the second, that a system of healing has to do. Osteopathy is justified as an independent school of medicine if it can show a distinctive etiology and a
different approach to therapy. All physicians of every school utilize the same basic agencies in treatment. Some emphasize the mechanical, others the chemical, and all recognize the worth of adjunctive physical and electrical agencies. There are many who believe that the trials and tribulations of going through life and the years of senescence account for a large percentage of symptoms. These ideas are not the property of one school of medicine and division between schools is not justified in these categories.

The determination of the cause of a disease is the sine qua non of its treatment. Hence, the analysis of etiology becomes the basic criterion of a system of healing. If there were a common understanding in the sphere of etiology, there would be a relative uniformity in therapy, and there would be need for but occasional courses in therapy. To osteopathy has reached that point where its principles include wide acceptance of the etiology proposed by another school, it has become a part of that school and has lost its right to be designated as a separate and distinct system. Manipulation of the spine and other parts of the body is practiced by many physicians. The old school doctors have accepted this practice and designated it as "physical medicine" or "mechanical medicine." They call it a specialty—not a school of healing. Manipulation alone no longer sets the osteopathic physician apart from other doctors.

The proposition resolves itself, then, into a consideration of etiology. I believe in the osteopathic concept of etiology and I am convinced that it is as sound now as it was 50 years ago. We know that there are patients and diseases which do not react favorably to a manipulative program. But the failures, I am sure, take nothing away from the osteopathic point of view. Rather, these failures focus upon the need for more diligent work to improve our techniques. The basic principles are sound.

Environment and occupation are important factors in producing symptoms and disease. Emotional disturbances, too, play a part. Without bacteria and viruses, there would be less infection. Automobile and other accidents will always provide a traumatic etiology. If one swallows enough carbonic acid, he will die, regardless of his previous general condition or the alignment of his vertebral column. Congenital defects lead to disease. It might be said briefly, then, that pathology and disease are brought about by infection, by environmental circumstances, by trauma and poisons, and because of congenital defects.

We can dig deeper than this into the causes of disease. At least we must search beneath the superficial causes of etiology in order to arrive at a logical explanation of many illnesses. Let us accept these stereotyped causes in their most advanced forms, but, at the same time, delve beneath the surface for the real underlying factors of etiology. It is here that we find the crux of the situation in disease. Crichton called some diseases, "diseases of civilization." Alvarez has referred to a large group of patients as "constitutional inadequates." Others have used various terms to describe the large number of patients who, otherwise, cannot be classified etiologically. Neither striking names nor "catchy" phrases will uncover the underlying factors, and neither advanced forms, but, at the same time, delve beneath the surface for the real underlying factors of etiology.

The bizarre nature of infections has been a subject of great interest for many years. All clinicians know that some of those who are in contact with pathogens become diseased though they are apparently as healthy and sound as those who escape the illness. Physiologists have proved that the "normal" body is immune to disease, but they have left the explanation right there. They never have set the criteria for this kind of "normal."

Andrew Taylor Still supplemented, several generations ago, the still popular physiological interpretation of "normal" by putting forward the additional proposition that normality of organs depends upon structural integrity. Subsequently, pathologists have demonstrated circulatory changes in the upper thoracic portions of the spinal cord, underlying the identical areas of the specific diabetic lesions that Still described in cases of acute lung disease. Potter's has placed great emphasis upon the changes found in the superficial tissues, skin, glands, and muscles between the scapulae in lung disease. But neither the pathologists nor Potter have accepted Still's earlier explanation of the phenomena. To furnish a place for the proper utilization of the principles evolved from Still's basic proposition, a new school of thought and therapy is justified, for the osteopathic lesion has not been accepted by the old school.

The great influenza-pneumonia epidemic of 1918 took its greatest toll and showed the highest incidence of infection in the first few decades of the ordinary span of life. The mortality rate among young soldiers, presumably the physical "cream" of our population, was the highest of any group. One can assume that persons in the earlier decades of life are more sound physiologically than those in the older age groups, yet hundreds of thousands of youths died of this epidemic while their elders escaped unscathed. None of the advances which have been made in immunology since 1918 have explained the unusual age distribution any better than a major in the Medical Corps of the Army at that time. I asked him about the incidence of influenza and he answered, "Some get it; some don't."

It is not likely that variable strains of infectious agents could affect, so specifically, one age group throughout the world. Nutritional, environmental, and hygienic factors were also too variable at that time to have contributed much to the age incidence. One must conclude, then, that a decreased sensitivity determined the greater sensitivity of those afflicted. Likewise, the protean severity of the disease reflected a varying repulsion to the infecting agent.

The success of osteopathic manipulative therapy during the great epidemic of 1918 was the first acceptance by the public of this new therapy for acute diseases. The osteopathic record, which included many cures of young pregnant women in whom the death rate was almost 100 per cent under old-school therapy, was made without the use of drugs.

Something other than the bacteria or viruses which invaded the lungs of many victims of influenza was involved in the distribution of the disease. I submit that those who became ill did so because they had specific osteopathic lesions which caused the lowered resistance of the tissues of the respiratory tract. If this be true, the infective agent is secondary and the germ theory of disease must be modified in the light of osteopathic etiology.

The highest incidence of influenza in 1918 occurred in the military and in pregnant women. It
takes no great stretch of the imagination to account for vertebral changes in pregnancy. The lumbar lordosis of pregnancy must be compensated for by changes in the segments of the upper column in the area of the cord which supplies the lungs. Long hours of drill in badly fitted shoes, unorthodox prone positions used for the rifle and prone maneuvers, and carrying a 60-pound pack strapped across the shoulder girdle epitomized Army life in 1918. Those who served with the combat troops will remember their "barking dogs," feet that cried out night and day against the unusual rigors of training and war. It has been said that Army shoes were provided in two sizes—too large and too small. Some men slept standing up in a trench or lying on the ground and others draped over their artillery pieces, but none enjoyed the luxury of inner-spring mattresses. Canvas cots provided the same or sleeping accommodations available to the soldier. The majority of the young soldiers in World War I had done nothing for conditioning their backs to Army life, before they were called upon to slish, crawl, and sleep in the mud of France.

It is generally conceded that altered weight bearing, unusual stress points in the vertebral column, and unphysiologic sleeping will cause spinal changes. The 1918 soldier endured all of these circumstances. Rifle and pack placed unusual stress upon the upper dorsal area; faulty weight bearing resulted in spondylitic strain with secondary effects in the upper column. Unphysiologic sleeping positions caused specific vertebral changes. It seems very clear to me that the new life, a hard army life, caused vertebral changes, bony spinal lesions, which rendered soldiers especially susceptible to the infecting organisms of influenza in 1918, for the incidence of the disease and its severity were much less in the Navy than in the Army.

If such an estimation of the etiology of influenza and influenzal pneumonia in 1918 is sound, it can be applied with equal force to all acute lung infections before and since that time. Likewise it might be pertinent to the incidence of the inevitable infections of all armies, from Caesar's to today's. This analysis concurs with the osteopathic thinking of 50 years ago.

Let us go further with the germ theory of disease. There are few who do not believe that certain diseases follow chronic infections. Most important in this connection is rheumatic fever. It is generally conceded that diseased tonsils provide the commonest infective nidus. Even if these opinions are accepted as the basic foundation for rheumatic fever, they do not explain the incidence of this disease. Why do children, and adults, develop rheumatic fever years after their tonsils have been removed? Why do many children with badly diseased tonsils and others with recurring sore throats go through life with neither joint pain nor heart murmurs, though they have never had their tonsils removed? Statistical surveys, aimed to study the question, have provided no answers. Investigations among large groups of school children have served to cloud the issue rather than to decide it.

For a time, it was believed that a deficient supply or the inadequate metabolism of vitamin C provided the underlying etiology. All forms of substitution therapy were tried; vitamin C intake was matched against its elimination, with inconsequential conclusion. Chronically diseased paranasal sinuses have been held responsible for the recurrence of both this pathologic and the rheumatic fever. But here again the same discrepancy arises. There are many patients with sinus involvements but without rheumatism and many cases of rheumatism without usual sinus involvement.

Germ, viruses, or toxins might be exciting causes but no antibiotic or no antitoxin has proved of real value in combating rheumatism. The predisposing factor, the basic foundation of the disease, has escaped researchers. The correction of osteopathic vertebral lesions is followed by clinical improvement so these lesions must be related in one way or another to rheumatism and to its sequela. They might be predisposing. If so, they would be causative.

The valvular heart disease which so often follows rheumatic fever is of major concern, not only because of the altered cardiac physiology, but also because it is the underlying pathology of subacute bacterial endocarditis. Before the antibiotic era, just about every patient with this disease died, with or without osteopathic manipulative treatment. Since that era, a high percentage survive. We must concede that antibiotics are life-saving in bacterial endocarditis. There has been a noticeable reduction of its incidence, too, during this period. Attribution might be a factor but the more important reason is the use of antibiotics before and after tonsillectomy, tooth extraction, and during pregnancy and delivery in those with heart murmurs. Antibiotics are not bactericides. Their greatest value lies in preventing the multiplication of organisms. Bacteria cannot reproduce if the medium is unsatisfactory and it is thought that an effective concentration of antibiotic changes the blood medium so that most of the organisms which cause the septicemia of subacute bacterial endocarditis cannot multiply and blood stream infection and subacute bacterial heart disease do not develop. This theory has worked out well in practice.

Penicillin continues to be the antibiotic of choice for the prevention and treatment of subacute bacterial endocarditis. However, like every effective drug it has side effects and it is not entirely safe. In fact, the history of penicillin therapy is paralleling that of the sulfonamides. Penicillin has been used just as indiscriminately in sprays, salves, tablets, and injections. In the last few years, almost everyone with fever, as well as those having surgical operations and tooth extractions, have been given penicillin in some form or another. As the dosages have increased, the effectiveness of the drug has diminished. Bacteria have become more resistant to it, and the indications for penicillin have decreased space.

Heralded early after its discovery as a harmless drug except for its production of occasional urticaria penicillin has been proved in a few years to follow the well-known pattern of every effective drug in the history of medicine. Dangerous side effects minimize its usefulness in practice, confirming the axiom as modern today as it was 50 years ago that a considerable number of people have become sensitized permanently to penicillin. More important, these penicillin reactions can kill. We are seeing an alarming increase in the incidence and in the severity of such reactions. Toxicity, anaphylactic edema, bronchial asthma, glottal swelling, polyserositis, and urticaria, singly and in various combinations, are common, and the literature reports liver fatalities.

The antibiotics, so dramatically beneficial for penicillin rash in the past, have lost much of their magic for penicillin reactions. With the passage of time, these simple drugs have showed their other
side. They are not as harmless as claimed originally.

An interesting case is that of a 24-year old man who on August 9, 1950, developed urticaria on the extremities. On the preceding night he had eaten a large lobster salad. Oral Benadryl was started and the dose increased as the urticaria spread to his buttocks, feet, and face. His usually fine appetite decreased until he ate practically nothing. Beginning on August 11 he alternated full doses of Benadryl and Chlor-Trimeton. His condition became worse; he swelled all over, and his joints became very painful. On August 13 he was given Benadryl intravenously with no effect. Headache, nausea, anorexia, and a fever of 101.5° complicated his case enough that he became bedridden. Alkalization was intensified and intravenous calcium gluconate was administered on August 14. A blood count was normal on that day. All of the symptoms worsened; the young man became sick all over—swelling, pale, and almost unable to walk. The redness and pain of the joints extended over the muscles and skin nearby, the patient became hoarse and dyspneic, and both eyes almost completely closed. He hobble to an allergist on August 15. The first question was “When had you penicillin?”

Almost forgotten in the search for food allergies was the injection of 300,000 units of penicillin and a few tablets of penicillin taken on the day of and the day after the extraction of a tooth 2 weeks before. This youth, whose health had been perfect for many years, had suffered a delayed reaction to a small amount of penicillin. He had been sensitized to the drug by a few doses given for “lymphangitis,” which was probably hives, while he was serving with the armed forces in the Pacific 5 years before. Now, he cannot use penicillin again, even if it be indicated in a future illness, because sensitivity lasts an indefinite time. This case provides but one example of the increasing number of serious penicillin reactions. Many of them are diagnosed incorrectly.

Within 10 years after they were proclaimed “wonder drugs,” the sulfanamides were all but forgotten. Penicillin was discovered in 1942, and even now it is used with more hope than confidence. When its complications are more widely recognized, I predict that penicillin will cease to be a panacea.

On the other hand, penicillin combats successfully a few bacterial infections which previously had proved to be refractory. Pneumococcal meningitis carried a 100 per cent mortality until penicillin proved effective against it. Other cocci meningitis respond, too, to this antibiotic. And when it was used first in pneumococcal, streptococcal, and in the almost uniformly fatal staphylococcal pneumonias, the favorable results were truly miraculous. Today, these pneumonias are rare; most pneumonias are viral—the primary atypical pneumonia of unknown etiology.

Two conclusions can be drawn from clinical experience with penicillin. First, the pathology caused by the bacteria is unchanged although the infective properties and the destructive mechanism of the bacteria are destroyed. Secondly, many of the bacteria which were sensitive to penicillin at first have now become resistant to it.

Bacterial pneumonia is serious and during the time that antibiotics have controlled the infecting organism, its death rate has been reduced by about one half. On the other hand, nonbacterial pneumonia, which had been of little clinical concern previously, has become a very dangerous disease causing grave complications. Its pathology and the clinical features often resemble the findings of the bacterial form. The pathogenesis leads to chronic lung changes which bring about recurring exacerbations for many months after the temperature has returned to normal. Pleural disease, pericarditis, liver and bile passage disorder, and segmental lung disease are the serious complications which defy all efforts in drug prophylaxis. The immediate death rate has increased and the mortality from complications is astounding.

Auramycin, although it is one of the newer oral antibiotics, has been tried on a great number of patients with viral pneumonias so its clinical characteristics can be assessed quite readily. It has never been tolerated well by humans. Even when antacids, stomachics, and vitamins are given with it, nausea, vomiting, and diarrhea are common. In fact, every patient has digestive symptoms if adequate amounts of another antibiotic, when the dosage is reduced below the effective range, there is little therapeutic benefit. Often, the smaller doses which have sometimes been used have a deleterious effect. No one claims that auramycin alters the pathogenesis of pneumonias favorably, and there are some who believe that resolution is prolonged and also that the lung pathology becomes chronic and complicated.

An illustrative case is that of a male patient, 48 years of age, who had been taking 1.5 gm. auramycin daily before admission to the hospital on October 30, 1949. He had two episodes of chest pain with fever, the first on September 25 and the second a week before admission. He had a pleural effusion. X-ray examination demonstrated bilateral basal pneumonitis, not consolidative. After intensive osteopathic manipulative and irradiation therapy to both lungs and sinuses for two months, the roentgenograms still showed diminished radiolucency and decreased ventilation in both lungs. The ST segment changes in the electrocardiogram were suggestive of adhesive pericarditis as the cause of the precordial pain which was still present on December 24 when the patient was discharged from the hospital.

Since penicillin and streptomycin have been used, all bacterial types of pneumonia have decreased, but the atypical form has increased in incidence, in severity, and in mortality. Viral infection, previously an attenuated form, might now become a grave affection of the lung. This drastically changing picture is new in the history of pneumonia.

Mrs. B. died of primary carcinoma of the lung on September 1, 1950. She was 44 years of age, and she was admitted to the hospital on March 23, 1950. Previously in good health, she had contracted a cold and cough 3 weeks before for which antibiotics had been ineffective. She had a rapid pulse and moderately elevated temperature. Cough and right chest pain persisted. X-ray examination proved a pleural effusion overlying a poorly ventilated, pneumonic right base. Later studies suggested segmental collapse and bronchosopic examination revealed a purulent, stenosed right bronchus. The sputum contained pneumococci in each of several specimens. Here is a case of pneumonia with later pneumococcal invasion, despite antibiotic treatment. The patient exhibited an unusually rapidly fulminating case of lung cancer which was fatal in 6 months. It is known that viral infection will activate a dormant lung cancer; it might even be the inciting factor in some cases. Greater virulence of viruses has been evident since antibiotic drugs have
been used. This might well have to do with the concurrently higher incidence of cancer. If the new drugs are responsible, one wonders where the use of antibiotics will lead us.

Acute lung diseases, and pneumonia especially, are just as prevalent as they were before the antibiotic era. It is logical to assume, therefore, that the infecting organism or the virus is an exciting factor rather than the cause of pneumonia. The bony osteopathic lesion, with its soft tissue components, is a constant feature in all cases. It seems to me that the osteopathic physician might reexamine his fundamentals in the light of the clinical experience with the antibiotics. If we believe that the cure of disease follows the removal of the causative factor, we will treat the osteopathic lesion. On the other hand, if we are carried away by a desire to be the first ones to use a new “weaker drug,” we will jump from drug to drug and leave behind us a long line of complications. Unfortunately, antibiotics have been used for fever, with too little forethought in the analysis of the cause of the fever. The following is a case in point.

41 year old female 9 days postoperatively suddenly developed a rise in temperature from normal to 104.5 F. She was given 500,000 units of penicillin followed by 500,000 units every 3 hours. The fever persisted, so 1.5 gm. of streptomycin was added along with 6 gm. of aureomycin over the next 16 hours. The penicillin and streptomycin were continued, but the temperature rose to a high of 106 F. during the next 2 days. The lungs were clear, the wound clean, and the kidneys normal. The only symptoms were those of dehydration. Antibiotics were discontinued and 7,000 cc. of water were given intravenously in the next 48 hours, at the end of which time the temperature had dropped to 98 F. and the patient had no more fever until discharge a week later. Dehydration is a common cause of fever.

In all of this, I believe that an osteopathic physician is a physician first. As such, it is his duty to give his patient every opportunity to recover from illness. If osteopathic manipulative therapy fails, he should seek other means of treatment. But he should think of osteopathy first and then consider its relation with other agencies.

In February, 1950, I examined a young woman who was 2 months pregnant. She had had a variable but continuing fever of 99 to 100 F. for more than 2 years. Tiredness, weakness, headache, and dizziness were constant symptoms. In Missouri a diagnosis of brucellosis had been made and it was confirmed in a Michigan laboratory which is noted for the study of brucellosis. Tests were mildly positive. There was a lymphocytosis. Before her pregnancy, the patient had had regular osteopathic manipulative treatment for a long time with no appreciable change in her condition.

She was hospitalized on February 20, 1950, with a fever of 100.8 F. A severe dose of chloromycetin was started, and after 24 hours all symptoms disappeared. They have not returned. The pregnancy has been uneventful and the patient feels better than in years. She has had no fever, and is due to be delivered between September 28 and October 4.

This is a good case. My results with other brucellosis patients under antibiotic treatment have not been as outstanding. Sulfas in all combinations, penicillin, streptomycin, and aureomycin, with and without benzylpenicillin, have been very disappointing. Chloromycetin surpasses its successes, but it has benefited some patients who had not responded to manipulative treatment.

Unlike the philosophy of osteopathy which has not changed in 75 years, old-school practice has experimented with this and that throughout its entire history. Many of you can recall the enthusiasm for serum therapy. You remember, too, how quickly serum treatment was cast aside, when sulfonamides became available in 1936. Now, anaphylaxis, serum reactions, and sensitivity, which came with serums, vaccines, and antitoxins, have been amplified into a branch of practice devoted to allergic diseases.

Adrenalin-like substances have been used and are being used with good results in certain of the allergies, especially hay fever and asthma. Recently, a multitude of drugs called antihistaminics have been developed. They have been useful, particularly for urticaria, angioneurotic edema, and various other sensitizations. The following case is an example of prompt relief and early cure.

On May 30, 1950, a 33-year old female suffered a puncture wound in her left foot for which tetanus antitoxin was given. Forty-eight hours later a reaction took place at the site of the injection. Penicillin, aureomycin, and Chlor-Trimeton were given. The site of injection became inflamed, edematous, and itchy. The patient suffered from nausea and vomiting with a rise in temperature to 101.4 F. on June 3. These conditions continued to June 6 and there were muscle pains and spasms, redness of the skin, and edema of the eyelids, face, and arms, cervical stiffness, and adenopathy.

The patient was placed in the hospital on June 7 with a diagnosis of tetanus. Intravenous Benzyladyl was given. Within 12 hours the fever abated, the edema receded, and the neck could be moved without pain or stiffness. In another day the patient was out of bed and she was discharged in a normal condition in 1 week, having stayed 2 or 3 days longer than necessary because of her fear of a return of the symptoms.

At the present time medical thought is very confused about the causes of allergy. There is proof that histamine is responsible in many instances, and it is assumed that all cases are chemical in origin. Time has proved that inheritance is a factor. Some investigators have tied allergy to psychosomatic medicine and an article in the September issue of a popular lay magazine places emphasis upon “mental rejection” of an unwanted child as a cause of allergic episodes. Out of the whole gamut of available facts and half-truths one can derive very little pertinent information. However, when he ponders over the mountainous data relating to this field, he can arrive at but one irrefutable conclusion. The greatly increased incidence of allergy is not a coincidence. It has been concurrent with the universal use of serologic and antibiotic materials.

Analysis of family histories and personal inventories reveal interesting data. The greatest number of allergies are found in those born after 1930. The incidence of allergy is almost as great among those who are now 50 years of age or less. Every one in this area who is under 50 has been vaccinated against smallpox and many of them have been subjected to various and sundry forms of “shots” for diphtheria, scarlet fever, typhoid and typhus, whooping cough, and cetera. In comparison, allergic diseases were formerly extremely uncommon and they did not increase during the nineteenth century.

Downloaded From: http://jaoa.org/pdfeaccess.aspx?url=/data/journals/jaoa/931966/ on 11/26/2018
The biological circumstances of life are no different today from what they were two generations ago. The variable factor is the introduction of foreign materials into the body. Sensitivity to these foreign materials is a much easier etiology to understand than any of the fantastic hypotheses which have been offered. It is entirely possible that we inject a permanent sensitivity to many things when we use a serum, a vaccine, or any one of the newer antibiotics.

If this be a castigation of the osteopathic physicians who use serologic and antibiotic preparations, I must include myself for I have used both groups and I will, no doubt, use them again. Circumstances alter cases and one cannot categorize every patient and every disease under a single principle of treatment. For instance, I know of no way of treating tetanus successfully without antitoxin. The nature of the disease is such that it is unwise to disturb the muscles with mechanical maneuvers. Since osteopathic manipulation can offer nothing for this disease, the antitoxin is very welcome.

I think that we can regard the antibiotic and the antihistaminic drugs as we have learned to regard surgical treatment. In general osteopathic physicians and surgeons are inclined to be conservative in the employment of the new and more spectacular developments of surgery. However, when an appendix is abscessed it cannot be cured, and the complications of its rupture cannot be prevented, except by surgical extirpation. A gangrenous toe cannot be rescued and many cancers cannot be treated to the greatest advantage without amputation. Every method of treatment has limitations. The years have proved that ours is not an exception.

Surgery removes pathology; it does not cure it. Usually the extirpation of a part is not based upon the removal of the cause of disease, though clinical relief is expected. So it is with some drugs; they relieve the symptoms without curing the disease. When a surgical procedure is contemplated, we weigh the benefits against the possibilities of complications and death. Our aim should be the same when we consider the use of drugs. Some patients are permanently damaged or die as a result of drug administration. Others would die if effective drugs were not used.

It is not hasty to substitute another form of treatment when after careful trial osteopathic manipulative methods have proved inadequate. Osteopathy has respected the old-school attitude of utilizing the lesion theory without painstaking investigation. It seems to me that it is equally unscientific and highly improper for osteopathy to condemn, without trial, everything that does not fall within its basic philosophy.

My appeal in closing would be to urge all of you to devote thought and time to the body of the sick patient. There are no outside agencies which will cure disease. Cure comes from within; it comes from rearranging those parts which are out of order. The most important factor in cure is the correction of osteopathic lesions.

Osteopathy can go forward only as fast as its students make firm its tenets. The spinal lesion is basic. Now, we can find it and describe it more accurately than formerly. But we cannot fix it any better than—often not even as well—as it was fixed 50 years ago.

Today's practitioner of osteopathy has a rich heritage but its investment in drugs and gadgets will not bring equivalent dividends to the next generation. I have faith in the unchanged philosophy in osteopathic etiology and treatment. I have equal confidence that the wisdom of the older generation will guide the thinking of our basically well-trained and well-balanced younger generation. It is into their hands that osteopathy must be given, and it is upon their shoulders that the responsibility for the perpetuation of this art must rest. Let us resolve, here and now, to glorify the work of our founders whom we honor today! We can repay them, in kind, only by reeducating ourselves to the principles they laid down 50 years ago.

REFERENCES


1949 AND 1950 DEATH RATE FROM TUBERCULOSIS

The nation's death rate from tuberculosis dropped about 9 per cent in 1949, to 26.2 per 100,000 population, to W. Palmer Dearing, Acting Surgeon General of the Public Health Service, Federal Security Agency. During the first 11 months of 1950, a further decline of 15 per cent occurred, and the rate for this period was 22.6 per 100,000 population. These figures are provisional, as data for 1949 and 1950 were based on a 10 per cent sample of death certificates obtained from each State and the District of Columbia. Dr. Dearing also pointed out that because the death rate for 1950 was based on figures for 11 months only, no aggregate decrease in the tuberculosis death rate since 1948 can be computed at this time.

The death rate in the United States for all forms of tuberculosis has shown a downward trend for almost half a century, except for a slight rise in 1917 and 1918, during the influenza epidemic of World War I. Since 1940, the death rate for respiratory tuberculosis has decreased 86 per cent, from 174.5 per 100,000 population to 28.3, while death rates from other forms of the disease have declined 91 per cent, from 19.9 to 1.7 per 100,000 population.

For the year 1949, significant decreases were recorded for men between the ages of 25 and 64 and women between 15 and 64. Data for respiratory tuberculosis, which constitutes over 90 per cent of all deaths from the disease, show that the rate for males (32.5) is almost twice as high as the rate for females (16.6). Mortality rates from tuberculosis continue to be more than three times as high for the nonwhite groups as for the white.

Provisional figures for 1950 show decreases for the age groups between 15 and 74 years. The decreases range from nearly 9 per cent for the 65-74 year group to 23 per cent for the 25-44 year group. Each of the four geographic regions of the United States showed a death rate decrease for all forms of tuberculosis in 1950.