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Although *JAOA* cannot acknowledge the receipt of your letter, we will notify you if the letter has been accepted for publication. Rejected letters and illustrations will not be returned unless accompanied by a self-addressed stamped envelope.

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OMT’s Effectiveness Already Proven

To the Editor:

I have read the *Journal of the American Osteopathic Association* with interest since 1934. I graduated from Kirksville College of Osteopathic Medicine, Kirksville, Mo, in 1935 and established a practice in Springfield, Minnesota, in 1935.

I believe I had the most extensive osteopathic medical practice in Minnesota, which operated for more than 53 years. In addition, from 1940 to 1971, I directed the only osteopathic medical hospital in Minnesota—then or since. In those early days, the practice of osteopathic medicine was greatly limited in most states, though not as limited in Minnesota, Iowa, Missouri, and Michigan.

Students at Kirksville College of Osteopathic Medicine were there because they had had an experience with osteopathic medicine. Some had a relative who was an osteopathic physician, but most had personal experience with the osteopathic structural examination and osteopathic manipulative treatment (OMT).

After graduation, most students opened private practices but were limited to providing only OMT to patients. In Minnesota, however, osteopathic physicians could also perform minor surgery and provide obstetric and gynecologic services.

For years, we worked hard to improve our practices, wondering all the while if our profession was coming to an end.

I decided to become an osteopathic physician because OMT saved my maternal grandmother’s life and stopped my having convulsions during childhood fevers. Of greatest impact, however, was my experience with a segmental dysfunction, which I still like to call an osteopathic lesion.

During my busiest practice years, I provided care to between 45 and 55 patients daily and then made as many as nine house calls in the evening. Approximately 80% of my patients were given OMT, and I had patients coming from 100 miles and further to receive the care I provided.

In my earliest years of practice, I provided 30 minutes of OMT to each patient but learned to perform structural diagnosis and provide treatment more quickly after hearing a chief surgeon from Kansas City describe the extensive structural work that could be achieved in 5 minutes.

I almost always included soft tissue treatment in my manipulative care for diagnosis, movement of venous blood and lymphatic systems, and mobilization of the articulations. The osteopathic physician of my childhood, E.C. Dymond, DO, had studied under A. T. Still, DO, MD, and always included soft tissue treatment, which I assumed he had learned from Dr Still.

On three occasions, Kirksville College of Osteopathic Medicine contacted me about joining the staff of one of their satellite clinics, but I was so entrenched in Minnesota that I did not go. I am soon to become 89 years old. Were it not for my age, I would be glad to teach OMT.

I do not know the answer to the problem of osteopathic physicians abandoning OMT. I believe some of the causes include the desire to become a physician, regardless of which type, and teaching that was questionable, dealing only with the correction of a segmental dysfunction; and failing to teach the value of treatment in general diseases. Osteopathic medical students today are overeducated and, yet, may not receive needed training in OMT in their years of internship or residency.

It is hard for me to understand why we continue to talk about proving the value of the structural examination and OMT. All of us old-timers know its value.

These days, it seems that many in the osteopathic medical profession prefer to build financial resources and contribute to stores of research and clinical experience, while ignoring the single, most important feature of our profession. I hope we can redirect our energies—perhaps beginning in colleges of osteopathic medicine—to wholeheartedly embracing and reprioritizing the role of OMT as the core mode of therapy provided by osteopathic physicians.

Robert M. Tessien, DO
Springfield, Minnesota
To the Editor:

When I completed my residency in obstetrics and gynecology in 1961 and entered practice, a moderately priced home cost approximately $20,000, a new Chevrolet automobile cost approximately $2000, and a stamp cost 3 cents. At that time, my annual malpractice premium cost $150. Today, a moderately priced home costs approximately $200,000, a new Chevrolet costs approximately $20,000, and a stamp costs 37 cents. Malpractice insurance in my specialty has risen to approximately $150,000 per year in some states and more in others.

I may just be a country doctor from the Pine Barrens of New Jersey, but I have learned some basic math through the years. Although there has only been a tenfold increase in the cost of many staple items in the United States, the cost of medical malpractice insurance has multiplied a thousandfold. Am I missing information that would help explain why malpractice insurance rates are completely out of line with the rest of our economy?

When an attorney prepares a will, he or she typically charges a fee for time, expertise, and paperwork. He does not strike a deal that allows him to receive one third or one half of your estate, nor does he prepare the will on a contingency basis. Let us hold the reality of that financial arrangement—fee for services rendered—as we discuss contingency fee and pro bono arrangements in the legal profession and their application in the medical profession.

The legal profession maintains that contingency fees in medical malpractice cases allow people who otherwise could not obtain legal counsel to do so. Attorneys also pride themselves on offering pro bono programs to the public, guaranteeing legal representation.

How many in the medical profession have called to the emergency departments of our hospitals to tend to an automobile accident victim, a woman with an incomplete abortion, or a woman having a ruptured ectopic pregnancy? How many in the medical profession have refused to render care to those patients because of their inability to pay? How many in the medical profession have conducted clinics for the needy in our communities without renumeration or have waived fees for patients in our offices when they had fallen on hard times? If attorneys offered their pro bono and contingency fee programs to alleged victims of malpractice who cannot afford services and, on successful settlement, then collected a fee for hourly services and expenses, that would be a fair and equitable system and would ultimately result in lower malpractice insurance rates. I would call that pro bono plus.

Another way to bring down the number of expensive medical malpractice lawsuits involves a time-honored system to deal with injury in the workplace. It is called compulsory arbitration. The injured employee has his or her case reviewed by an arbitration board, usually consisting of a union representative, a physician who is an expert in the area of practice, an attorney, and a lay member. Responsibility is assigned, contributory negligence is determined, and the board recommends a dollar amount as an award. The employee has the option of accepting the decision or taking the issue further with a lawsuit. If the case makes it to trial, the jury may be informed that the plaintiff turned down an award recommended by the arbitrators.

This system has operated successfully in industry for many years. It helps deter costly lawsuits with fees that may include discovery costs, expert witness charges, and court costs. Compulsory arbitration could be as effective in medical malpractice cases, helping to drive down costs appreciably. Realistically, however, it is unlikely that attorneys would kill the goose laying all of those golden eggs.

There is a move afoot at both the state and federal levels to put a cap on awards for noneconomic damage (ie, pain and suffering). Arguments abound on both sides of the issue, but I have no doubt that limiting awards to reasonable amounts would help to drive down the cost of malpractice insurance. Once again, however, we face the obstacle of attorney-dominated legislatures.

Attorneys have another gimmick to unnerve and harass the medical profession and generate even larger legal fees: punitive damages. A physician being sued has to seek private counsel to defend against punitive damage, as that aspect is not covered in a malpractice policy. The threat of the question of liability may force many physicians to rush to settlement. This aspect of the law should be handled the same as for noneconomic damages discussed earlier to rein in the runaway costs of malpractice insurance.

It has been estimated that approximately 6% of physicians account for 100% of medical malpractice cases. If this is true, we, as a profession, had better police ourselves more effectively and act quickly when indicated. There are several ways to deal with chronic offenders. A supervisor could be assigned to oversee patient care provided by a physician with a history of malpractice lawsuits. A similar program could be instituted in a private practice. Finally, physician retraining programs could be initiated by hospitals and medical schools. The physician in question should be held responsible for all costs associated with his or her rehabilitation program. The state boards of medical examiners have to become more involved in the process, suspending or revoking the licenses of chronic offenders who defy rehabilitation.

Will true reform ever take place in the arena of medical malpractice? I think that it had better—and soon. Our brightest people are being forced to leave specialty areas with particularly high malpractice insurance rates, leaving academic environments for more rural areas of the country with lower medical malpractice insurance rates. What a sad loss for our academic institutions.

Will young scientific minds continue to be attracted to the medical profession? I fear that most will find other ways to pursue careers in the sciences. Although the cost of malpractice insurance continues to rise and the fixed costs of running an office are also increasing, the revenues in physicians’ practices continue to decline in an inverse ratio as the result of decreased managed care reimbursements. Let us hope that the crisis that we currently face will be resolved by clear- and forward-thinking people in government and that the future of medicine will once again be promising and desirable.

Daniel H. Belsky, DO, MSc
Boca Raton, Florida
Osteopathic Physicians Provide Quality Care—With or Without OMT

To the Editor:
Although the article by Donald G. Spaeth, DO, PhD, and Alfred M. Pheley, PhD, “Use of Osteopathic Manipulative Treatment by Ohio Osteopathic Physicians in Various Specialties” (J Am Osteopath Assoc. 2003; 103:16-26), is interesting, I disagree with some of the authors’ conclusions. The article points out the complete lack of use of osteopathic manipulative treatment (OMT) by 17 specialties and the rare or occasional use of OMT by many other specialties. The authors conclude that clinical and specialty programs need to improve instruction in the use of OMT. I submit that these programs to improve OMT training, the results would be the same due to the difference in OMT use that occurs in clinical training programs and in practice.

As an internist, I have had to manage more complicated, chronically ill patients because of the changing landscape of medicine over the past 25 years, leaving no time to provide OMT. This does not reflect less regard for osteopathic principles and practice, but rather the reality of the needs of my patients and the impact of external forces in the practice of medicine today. That specialists report using no OMT reflects the fact that OMT is not what they are trained to do and is not expected in these specialties.

The authors note “a disturbing trend” in the low use of OMT for patients with chronic obstructive pulmonary disease (COPD) and asthma by nearly all osteopathic specialists in Ohio. It is noteworthy that the number of critical care and pulmonary physicians in Ohio who have increased their use of OMT since starting practice is zero. I believe this statistic would likely apply nationally and suggest that the reason for this is that there is no scientific evidence OMT makes a meaningful difference in either condition. The reference cited by the authors that “dysfunctions in the thoracic area are reported to benefit from OMT” is vague, anecdotal, and more than half a century old.

Truthfully, no colleagues that I know of believe that OMT has any impact—positive or negative—on either COPD or asthma, other than perhaps the psychological benefit derived from a laying on of hands. I believe it would take randomized, prospective studies to prove or disprove whether OMT could alter any of the following: excessive bronchial mucous secretion seen in both COPD and asthma; the role of cytokines from tissue mast cells, eosinophils, T lymphocytes, macrophages, and other mediators of subacute inflammation seen in asthma; or improvement in lung elasticity and alveolar function due to alveolar wall destruction in emphysema. If such studies showed convincing evidence of a positive effect from the use of OMT, I believe most osteopathic physicians would be glad to add this mode of therapy to their armamentarium for these conditions.

The authors suggest that it is the responsibility of clinical and specialty programs to emphasize OMT as well as to determine its effectiveness. Although specialty colleges can track the use of OMT, it is more logical that the American Osteopathic Association and affiliated academic research institutions bear the standard for determining effectiveness of OMT in any particular disease entity that clinical and specialty programs can then confidently teach.

In their summary, Drs Spaeth and Pheley appear to admonish the entire profession by pointing out “room to increase the use of OMT” and that “each osteopathic physician must work to improve the use of OMT and other aspects of osteopathic principles and practice.” The authors note that OMT is only a part of osteopathic principles and practice, yet suggest that the lack of use of OMT implies lack of belief in the “mandate for distinctiveness of the osteopathic medical profession.” Nothing could be further from the truth. To reiterate, OMT is not used by many specialists because it is not indicated, nor has it been proven to be of benefit. In other instances, OMT is not used because of time constraints. These realities are not mutually exclusive of specialists’ belief in osteopathic principles and practice. Most osteopathic physicians are proud of their osteopathic medical heritage and are grateful for the opportunity to provide treatment for their patients as osteopathic physicians. The unique distinctiveness in the care provided by our profession is not lost on our patients who receive good medical care—with or without OMT.

Ronald M. Crow, DO
Little Rock, Arkansas

Response

We appreciate Dr Crow’s comments about our article. His concern about maintaining our “osteopathic difference” is one that is shared by many in the osteopathic medical profession. Dr Crow’s statement, “That specialists report using no OMT reflects the fact that OMT is not what they are trained to do and is not expected in these specialties,” is precisely what we hope to bring to the attention of osteopathic physicians.

Our profession is being required to support its claims of being different and better than the allopathic medical profession. We quote “vague, anecdotal, and more than half a century old” references relating to pulmonary diseases because that is all there is to quote. Osteopathic manipulative treatment [OMT] has long been reputed to be of benefit to patients with pulmonary diseases, but where are the studies that support or disprove these claims? Hopefully, further research will be stimulated so our profession will have the support needed to promote our distinctiveness, or at least discontinue implying inaccurate claims.

We agree with Dr Crow that the American Osteopathic Association and the specialty colleges need to determine the effectiveness of OMT in various disease entities. Specialty colleges need to supply the leadership in establishing the applicability of OMT to their specialties, as they know best the pathophysiology and details of diseases with which their members deal. For specialty colleges to remain passive and leave the initiation of such research to others is shirking responsibility and limiting potential contributions to the osteopathic medical profession. Indeed, researchers outside of the specialty may not see themselves as qualified to understand the issues most in need of empirical support. Lack of specialty involvement in OMT research is a missed opportunity to make the greatest impact on our profession.
In acknowledging our use of outdated references, we challenge Dr Crow and others to identify current references in the literature that continue this dialogue. Osteopathic physicians and other individuals who work to promote the future of the osteopathic medical profession must consciously move beyond the usual “vague, anecdotal” statements our profession promulgates. Unfortunately, the overall tone of Dr Crow’s comments are typical of the profession’s current leanings; unless each of us stops relegating our understanding of OMT to others, the osteopathic profession is headed for its demise.

Donald G. Spaeth, DO, PhD
Director of Medical Education
Highlands Regional Medical Center
Prestonsburg, Kentucky

Alfred M. Pheley, PhD
Professor and Chair, Community and Rural Medicine
Assistant Dean for Clinical Research
Edward Via Virginia College of Osteopathic Medicine
Blacksburg, Virginia

Evidence-based Epidural Mnemonic Provides Quick Referral

To the Editor:
Labor pain and methods to relieve it are of major concern to childbearing women around the world. In developed countries, most women use epidural anesthesia for labor analgesia.

Epidural analgesia carries with it a set of complications derived from randomized studies. These complications can be difficult to remember by nurses, medical students, midwives, and residents when they are faced with questions or concerns from the patient.

To contribute to the completeness of the process of obtaining informed consent by general practitioners, family physicians, anesthesiologists, and obstetrician-gynecologists regarding epidural analgesia, or while teaching, we composed a mnemonic—which is also an acrostic, as the first letter of each sentence read vertically forms the term epidural (see box). It is important to note that each of the mnemonic phrases is based on level-1 evidence (randomized controlled trials) as defined by the United States Preventive Services Task Force.

As most of our colleagues have found this mnemonic to be valuable for teaching and during practice, we decided to share it with all osteopathic physicians. We believe this tool promotes excellence in the clinical practice of evidence-based obstetrics.

Gary Ventolini, MD
Director
Associate professor

Elton Kerr, MD
Assistant professor
General Obstetrics/Gynecology Division
Wright State University
Dayton, Ohio

Reference

Response
Although this mnemonic is a useful tool for students, residents, and physicians to help remember the risks and benefits of epidural analgesia for women in labor, we must make sure that the mnemonic does not replace a true discussion.

We must present these risks within the context of absolute risk versus relative risk. What is the clinical significance of women in labor being more likely to receive pitocin, as complications of pitocin use are rare and pain relief is almost universal?

Some of these suggestions are controversial. For example, the randomized, controlled trial referenced by the authors actually concludes that nulliparas do not have an increased incidence of cesarean section for dystocia when using epidural analgesia.

Finally, no mnemonic is exhaustive. This one does not mention sequelae of inadvertent spinal tap. A mnemonic cannot replace discussion. Analgesia should be taught in prenatal classes. And remember, conversations about pain relief are best held in our office, not in the labor room.

Paul M. Krueger, DO
Assistant dean for education and curriculum
University of Medicine and Dentistry of New Jersey School of Osteopathic Medicine

Reference