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Letter writers must include their full professional title(s) and affiliation(s), complete address, day and evening telephone numbers, fax number(s), and e-mail address(es). Letter writers are responsible for disclosing financial associations or other possible conflicts of interest.

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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DO Outlines Steps to Malpractice Reform

To the Editor:

Recently, I contributed toward the cause of the Osteopathic Political Action Committee (OPAC) in Washington, DC, with the following reservations:

- The message put forth by OPAC must reach a wider audience than just DOs. Osteopathic physicians understand many of the issues, yet the American Osteopathic Association still hesitates to challenge a segment of trial lawyers and their physicians who testify for plaintiff’s counsel without accountability. Where is the American Medical Association in all this? Does that organization approve their physicians generating income this way? Before trial, these attorneys move the judge to limit information from the medical records that can be presented to the jury. The collaborating physician then bases his testimony and opinion to the jury solely on this limited information.

- The Osteopathic Political Action Committee must support intellectually honest and thoughtful candidates on both the state and national levels. Most Democrat and Republican candidates depend heavily on their political action committees’ ability for rhetoric and for raising money. Do money or action speak louder than words? Look outside the usual two-party system of candidates.

- The media slant on malpractice reform must be put in check. Insist on live, one-on-one interviews—whether for minute-long or half-hour segments. This will promote clarity and an emphasis on the issues.

There is much to do. These ideas give some idea of the magnitude.

Roger G. Michaud, DO
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Response

I read with great interest the letter submitted by Roger G. Michaud, DO. Dr Michaud makes some notably pointed and valuable remarks regarding how accountability standards should be raised for political candidates who receive funding through the osteopathic medical profession’s political action committee. Osteopathic physician leaders may want to factor in the general line of reasoning outlined by Dr Michaud, as well as some of his more specific points in their future strategic deliberations.

I would like to specifically respond to Dr Michaud’s comments regarding the American Osteopathic Association’s (AOA) position on physician expert witnesses in medical malpractice cases. Without question, a physician who acts as an expert witness is often one of the most important figures in malpractice litigation. Despite the general distrust that exists between physicians and attorneys, physicians have an obligation to testify in court as expert witnesses on behalf of the plaintiff or defendant as appropriate. Ethical concerns arise, however, when physicians act in a partisan manner during the legal proceedings or accept compensation dependent on the outcome of those proceedings.

I cannot speak to the views of other medical organizations; however, the AOA is closely studying and monitoring this issue. For instance, the AOA’s Bureau of State Government Affairs is currently compiling information on varying state laws regarding expertise and credentialing requirements for physician expert witnesses. The AOA’s Committee on Ethics is further reviewing the possible establishment of AOA-endorsed qualifications and guidelines for DOs who serve in this capacity.

To help address physicians’ increasingly complex litigation matters such as the role of expert witnesses, the AOA Litigation Fund was recently established. Historically, the AOA has limited its participation in lawsuits to amicus curiae briefs at the appellate level, which allowed the AOA to advise the court on a matter of law without directly being involved in litigation. The new litigation fund provides a mechanism by which the AOA may consider and provide financial support for members’ legal cases at the trial or appellate levels. The fund will apply only to legal matters of national significance to the osteopathic medical profession and those supportive of the programs, policies,
and mission of the AOA. I encourage DOs who need assistance in a case such as this type to contact the AOA’s Division of Socioeconomic Affairs for more information.

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The Elephant in the Room: Does OMT Have Proved Benefit?

To the Editor:

I would like to congratulate John C. Licciardone, DO, MS, et al on another high-quality study, “A Randomized Controlled Trial of Osteopathic Manipulative Treatment Following Knee or Hip Arthroplasty,” evaluating the efficacy of osteopathic manipulative treatment (OMT) (J Am Osteopath Assoc. 2004;104:193-202). The results of this randomized controlled trial indicate that OMT in the setting of postoperative knee arthroplasty is ineffective. Further, on one outcome measure, OMT actually decreased rehabilitative efficiency.

This study is an important contribution to osteopathic medicine’s knowledge base. It has findings similar to those of Dr Licciardone and colleagues’ earlier study that showed no added benefit of OMT over sham treatment for chronic low back pain.1 The earlier study, also a randomized controlled trial, was published in a predominantly allopathic medical journal and has not been openly discussed in the osteopathic medical literature.

In the last paragraph of his article, Dr Licciardone and colleagues state what many osteopathic physicians have come to believe: Healthy patients derive more benefit from OMT than those who are ill or injured. This seems intuitive and supports the hypothesis that OMT has a minimal effect. Such an effect may be all that is needed for people who are healthy; people with injury or illness, however, are not as likely to receive significant benefit from OMT. Moreover, one could argue that when OMT does have an effect, it is little more than the classic placebo effect. It certainly offers some Pygmalion effect; however, which occurs when a persistently held belief becomes a perceived reality.

This begs the question of why members of the osteopathic medical profession continue to teach an outdated and ineffective system of healthcare to undergraduate osteopathic medical students.

It is important that osteopathic medical students know the history of osteopathic medicine and the ideas that A. T. Still, MD, DO, professed. But Still lived in the preantibiotic and presurgical era. His findings, though important at that time, are of little more than historic interest today. He did the best with what he had. Likewise, practitioners such as Christian Friedrich Samuel Hahnemann, MD, the founder of homeopathy, did the best with what they had as well. But under the scrutiny of the scientific method, such antiquated practices as homeopathy and magnetic healing have fallen by the wayside.2 It seems that OMT will and should follow homeopathy, magnetic healing, chiropractic, and other outdated practices into the pages of medical history.

I received an excellent undergraduate medical education and am proud to be a DO, but I cannot continue to support an antiquated system of healthcare that is based on anecdote or, in some cases, pseudo-science. As a medical school student, I was taught to critically analyze problems and practice evidence-based medicine. When it came to courses in osteopathic principles and practices, however, my peers and I were asked to put aside our critical, evidence-based medical skills and accept the tenets of OMT on faith. When we questioned such esoteric practices as craniosacral therapy and energy field therapy, we were told that “we needed to believe.” Likewise, when less than 5% of the class “felt” the craniosacral rhythm, the rest of the class was derided for a lack of faith—to the point that ejection from the medical school was threatened. When we complained that some students were using barbecue strikers to stimulate invisible “energy fields,” we were told that in time, we would come to understand and believe.

In osteopathic medical school, OMT courses were so steeped in history, tradition, and anecdote that a question included on a final examination asked the name of the mascot of the American School of Osteopathy in 1906, a query without any clinical relevance whatsoever. When my classmates and I inquired into the science of OMT, we were given copies of studies that were little more than statements of faith published in the Journal of the American Osteopathic Association more than 50 years ago. As Mark Twain wrote in his book, Following the Equator, “Faith is believing what you know ain’t so.”

How can the osteopathic medical profession deliberately seek the brightest college graduates to become osteopathic physicians and at the same time, ask those students to believe in and practice modes of therapy that have little or no proved effect? Likewise, how can osteopathic physicians, with a straight face, ask those students to believe that the fused bones of the skull move in a magic rhythm that mainstream researchers have never been able to document?3,4 (Perhaps the findings of these researchers would be different if they had “faith.”) How can we ask students to believe that the body has an energy field that cannot be seen or objectively measured or ask students to believe that providing myofascial release will cause the tissues to “remember” the trauma that caused their injury? This is what we were taught; it did not make sense then and makes even less sense now.

Therefore, I express my congratulations to Dr Licciardone and his colleagues. I hope they continue to ask and answer the hard questions. The testament to osteopathic medicine as a profession will be whether it responds to accumulating scientific evidence and modifies its practices accordingly or simply reverts to a call for faith. Osteopathic medicine has found a niche in modern medicine, not one of a medical specialty that practices OMT, but as a medical specialty that produces well-rounded primary care physicians. The future of osteopathic medicine is bright. But, the future is in the continued graduation of competent and compassionate primary care physicians and not in the historic dogma of OMT.

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References

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Response

Dr Bledsoe’s letter raises important questions that deserve comment and discussion within the osteopathic medical community. Osteopathic medical education and practice, particularly with regard to osteopathic manipulative treatment (OMT), must be based on rigorous, evidence-based findings. Beyond the methodologic challenges in conducting OMT research, most, if not all, clinical trials of OMT to date have not been sufficiently powered to demonstrate small to moderate treatment effects. Many osteopathic physicians are currently conducting research that will contribute to a growing body of knowledge that attempts to rectify this situation.

The original teachings of Andrew Taylor Still, MD, DO, suggest that the body has the capacity to maintain health and that OMT may be useful in augmenting that capacity by preventing or treating disease. Osteopathic manipulative treatment may be viewed through the prism of preventive medicine by examining the three levels of prevention within the natural history of disease.

Not surprisingly, the benefits of OMT are likely to vary according to the patient’s disease and the stage at which OMT is administered in the disease’s natural history. This variance in benefit explains why OMT may be useful for patients who have acute low back pain, but may not be as useful for the patient who has late-stage knee osteoarthritis that requires total joint replacement. To suggest that OMT has minimal effect because it is more beneficial in healthy patients (ie, in the early, or even subclinical stage of disease) is fallacious. Certainly, the effects of many primary and secondary preventive measures in clinical practice would not be classified as minimal.

Evidence also exists to suggest that the benefits of OMT for patients with chronic low back pain are substantially greater than can be attributed to a placebo effect. Additional analyses, not reported in our published paper, found that effect sizes for pain outcomes in the usual care plus OMT group versus the usual care group to be −0.77 (95% confidence interval [CI], −1.36 to −0.17) after 1 month of treatment; −1.05 (95% CI, −1.69 to −0.41) after 3 months; and −0.75 (95% CI, −1.40 to −0.11) after 6 months. A comprehensive review of placebos used in clinical trials involving pain outcomes reported a pooled effect size of only −0.27 (95% CI, −0.40 to −0.15). Thus, pain reduction with OMT in our trial was three to four times greater than expected, based on effects historically attributed to placebos.

Last, it is true that a greater proportion of osteopathic physicians than allopathic physicians enter primary care specialties. Nevertheless, OMT has been identified as the aspect of osteopathic medicine that best reflects its uniqueness. Demonstrating the efficacy of OMT will ensure the long-term survival of osteopathic medicine by establishing it as distinct from and yet equivalent to allopathic medicine. Thus, as encouraged by Dr Bledsoe, we will continue to ask and answer the difficult questions regarding OMT. We hope that others also will continue to join in the osteopathic clinical research enterprise. The future of osteopathic medicine may well depend on such efforts.

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More About the Use of OMT During Influenza Epidemics

To the Editor:
In his letter, Martyn E. Richardson, DO, was absolutely right in advocating the use of osteopathic manipulative treatment (OMT) for patients with severe acute respiratory syndrome (J Am Osteopath Assoc. 2004;104:71). However, although Dr Richardson cited the influenza epidemic of 1918 as a reference, he did not provide related statistics. As that event is the most outstanding example of the efficacy of OMT on record in the United States, related statistics have been published in a number of sources, including The First School of Osteopathic Medicine; by Georgia W. Walter and my book, Structural Healing. The 2-year influenza outbreak that occurred between 1918 and 1919 was a world-
wide epidemic. Original estimates placed related fatalities at 21 million, 1% of the world’s population at that time. Several recent estimates place the number of fatalities at 30 million.

In the United States, more than 28% of the population succumbed to the disease overall. In US military hospitals, the mortality rate averaged 36%, while the mortality rate in US medical hospitals fell between 30% and 40%, with the exception of a rate of 68% in medical hospitals in New York City.

The osteopathic medical profession had few hospitals then, but the American School of Osteopathy, now the Kirksville College of Osteopathic Medicine of A. T. Still University of Health Sciences, in Kirksville, Mo, contacted all their alumni. This effort culminated in 2445 osteopaths responding in treating 110,122 patients with influenza, with a resulting mortality of 0.25%. One of the few osteopathic medical hospitals, 400-bed Massachusetts Osteopathic Hospital, in Boston, also reported a mortality of 0.25% for that period.

Why the difference in outcome? Allopathic medical treatment for patients with influenza consisted of cough syrup and aspirin, treating the fever as a symptom, rather than recognizing fever as the body’s response to an infection. And as Andrew Taylor Still, MD, DO, stated in his autobiography, “Fever is a natural and powerful remedy.”

In contrast, osteopathic medical treatment for patients with influenza consisted of cough syrup and aspirin, treating the fever as a symptom, rather than recognizing fever as the body’s response to an infection. And as Andrew Taylor Still, MD, DO, stated in his autobiography, “Fever is a natural and powerful remedy.”

In another response to Dr Richardson in the same issue of THE JOURNAL, M. Reza Nassiri, DSc, of Lake Erie College of Osteopathic Medicine, was correct in stating that OMT has not been used in treating patients with SARS. We can assume also that OMT has not been used to treat patients with West Nile virus, nor in patients with today’s influenza epidemics, except perhaps other than in isolated cases. To conduct the large-scale studies necessary to prove the benefit of OMT for patients with these diseases, a study proposal would have to be generated by the American Osteopathic Association (AOA), rather than by an individual or a small group. This is because the public’s perception is too enamored of traditional medicine to consider funding such a project.

In Colorado, we have had two serious epidemics in recent years: West Nile virus and traditional influenza. In both instances, I contacted a leading television station in Denver, Colo (KUSA, Channel 9), which had dramatized the severity of both epidemics with the theme, “Channel 9 listens.” I reported to Channel 9 representatives that OMT plus good nutrition support the immune system and would save lives in the current crisis. I never heard a word back from them and in a life and death situation!

It would take a huge effort by the AOA to have the American public acknowledge OMT’s benefit for patients affected by these epidemics. Sadly, it is unlikely to happen because the AOA has aligned itself with traditional medicine. For 40 years, AOA officials have talked about making OMT mandatory in all osteopathic medical internships and residencies. It has yet to be done. It is tragic that osteopathic physicians are losing much of the great legacy A. T. Still left to the profession.

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References