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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 the *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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**What is the True Number of Victims of the Postal Anthrax Attack of 2001?**

*To the Editor:*

The US Centers for Disease Control and Prevention (CDC) counts as victims 22 people who were involved in the postal anthrax attack of 2001. We disagree. As scientists it is difficult to accept that fewer than 68 people were harmed in this event. There is no debate that at least 5 people died from inhalational anthrax, 11 people had cutaneous anthrax develop, and 6 people had diagnosed inhalational anthrax and survived. The debate concerns those individuals at the periphery: 38 people at the Hart Senate Office Building, Washington, DC, and 5 people at the America Media Inc building, Boca Raton, Florida, in whom anthrax was detected by nasal swab. These people were treated with antibiotics for 60 days and offered the anthrax vaccine, which many agreed to receive. Although they were treated like victims, because they did not have symptoms of anthrax, they were never counted as victims of that attack.1

The state of Delaware postal worker who tested positive for anthrax antibodies, but had a rash that appeared different than would be expected from anthrax, therefore was not counted as a victim because the rash was atypical.2 The CDC laboratory technician who had an abrasion while working with anthrax samples from the attack and, subsequently, had cutaneous anthrax develop was not counted as a victim.3 Finally, the US postal inspector in whom “aborted anthrax syndrome” developed after being exposed to large amounts of anthrax and becoming seriously ill4 was yet another victim not counted in this category.

That totals 68 people.

Bioterrorism affects more people than those who express the worst or classic case of an ensuing illness. Weaponized anthrax is a new illness that is still not understood.

If we are to learn from this attack we need to start with an open mind.

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**References**


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**Osteopathic Medical Training: Developing the Seasoned Osteopathic Physician**

*To the Editor:*


The first thing that struck me about Dr Smith’s letter was his signature: “Adam B. Smith, MSIV” (now Adam B. Smith, DO). At my suggestion, the American Academy of Osteopathy has embraced the concept of brand identity and, consequently, adopted a signature designation of OMS (osteopathic medical student) with whatever Roman numeral appropriate for that student’s year.

Our students are not medical students; they are osteopathic medical students. In the name of unity within the osteopathic medical community, I encourage the American Osteopathic Association (AOA) to adopt a similar concept of branding.

As the heads of most successful corporations of the world will tell you, brand identity is something to be preserved and
protected with great vigor. Regardless of how good one’s product or service is, without brand identity, no one will have an immediate awareness of either. This may translate into a lack of customer loyalty.

During my years in osteopathic medical school, education was a 2.5-year academic year curriculum with a 1.5-year clinical curriculum followed by a 1-year rotating internship. Most of those who graduated from internships went into practice; only a few who were going into specialties proceeded into residencies. Over time, as we all know, that has changed, and most osteopathic medical schools now have a 2-and-2 program with typically 3 years of graduate experience.

It strikes me that the clinical astuteness seen in today’s graduates on completion of their residencies seems to be much the same as when we completed our internships. Over time, I have seen a change in osteopathic medical students’ perspectives from “What do I have to know to be a good physician” to “How little do I have to know to pass the next test?” This is no way applicable to a particular student, but only as a generality that I see occurring with greater frequency.

I realize that many osteopathic medical school students wrestle with the dilemma of whether to choose an osteopathic internship and graduate training program versus an allopathic graduate training program. In some cases, the choice is made for them; for example, those in a US military branch are likely to adhere to the military pathway because they have made a choice that takes them in a particular direction. Other osteopathic medical students may have a particular practice location in mind or a particular mentor they wish to follow.

Several of my friends faced the same dilemma, and most chose the osteopathic medical pathway because their choice to join the osteopathic medical profession was their first priority. They believed in the profession and wished to abide by and practice its principles. Some reported that their osteopathic training programs were exceptionally osteopathic in orientation, and others reported otherwise. A few friends who took the allopathic medical pathway have found that in some cases, there is no “osteopathic thinking” involved. The result was that these students felt like the proverbial fish out of water. Other friends discovered that their newfound allopathic medical colleagues embraced them because they had the potential to offer something different and more. So there is great diversity and disparity between training programs within both the osteopathic medical and the allopathic medical professions.

Dr Opipari provided several examples in response to the question, “What are the incentives?” In my third and fourth years of osteopathic medical school, I was given well-defined responsibility with virtually no authority. I had numerous duties, took dozens of histories and physical examinations (H&P), and wrote the orders I was told to write. I was carefully guided as I managed the care of a few patients. During my internship, I oversaw osteopathic medical students. As my skills improved and my clinical acumen increased, physicians who had trained me allowed me to begin to actively manage the care of patients while they observed my ability. Any time I needed guidance, those teachers stepped in to keep me on track. I was given great latitude.

Perhaps today’s osteopathic medical students do not need to do as many H&Ps and (in their third and fourth year) have far more opportunity for independent clinical practice without a safety net than that of my cohort. I frankly doubt it.

Dr Opipari works around the question but never asks it point-blank. Therefore, I will: “Did Dr Smith choose the osteopathic medical profession because he researched the profession and wished to become a member? Or did he join the osteopathic medical profession after his first choice, allopathic medicine, did not consider him worthy; and therefore, osteopathic medical school was his second choice?” If the former is the case, then I am inclined to be sympathetic to his protestations. If the latter is the case, then I suggest he be grateful to those who viewed him as a person capable and worthy of becoming a physician and embrace the profession that was willing to extend its hand of membership so that he could pursue his career goal.

The issue of osteopathic manipulative medicine (OMM) is one that is near and dear to my heart, as I am a specialist in that area. I do not believe for 1 second that the osteopathic medical profession insists on maintaining exclusive rights. I can tell you from personal experience and the experiences of past teachers that the reason we have had to work diligently to maintain osteopathic manipulative treatment (OMT) as the centerpiece of our profession is that our counterparts in the allopathic medical profession, for the most part, do not care to learn OMT. Those new to OMM who are sincerely interested in learning these practices are welcomed by osteopathic physicians and teachers with open arms and ulti-
mately become more osteopathic in their thinking and their self-image than many in the osteopathic medical profession.

It is sad that there are many in the osteopathic medical profession who feel disdain for OMT when it is the mode of therapy that makes us unique. To paraphrase Norman Gevitz, PhD, "If somebody cannot see or feel the difference between two practitioners, then there is none."

Osteopathic manipulative treatment is the most significant characteristic of osteopathic medical practice. It is visible and palpable. We can talk to a great degree about differences in philosophy and thinking between osteopathic medicine and allopathic medicine, but patients do not see it or feel it to the extent that they see and feel OMT.

If Dr Smith were to refer to the charter of the American School of Osteopathy (now the Kirksville College of Osteopathic Medicine of A. T. Still University of Health Sciences, Kirksville, Mo, he would find that osteopathy as defined by A. T. Still, MD, DO, was designed to improve the practice of medicine, obstetrics, and surgery. The reason Still created a profession that is separate from allopathic medicine is that the allopathic medical profession, of which he was a member, refused to accept and share his ideas. Therefore, Still had to begin a new medical profession. People came to Still to learn the new therapy and, by building a strong foundation, helped to bring the osteopathic medical profession to where it is today. Therefore, I believe there is nothing wrong with the rotating internship; it provides a good real-world experience of the spectrum of patients' problems that a new physician may encounter.

Here is a consideration for the student who is convinced that he knows the path he wants to take: I have noticed that people having a broad educational background beyond their narrow interest area can often solve complex problems more effectively than their counterparts with comparable training who do not have a broad-based perspective.

Therefore, my suggestion to students who are contemplating such training questions is to take the rotating internship, if possible. If you cannot, do the best you can to receive the broadest experience possible. The more your training covers a spectrum of possibilities, the better physician you will ultimately become. Every practicing physician has had to make compromises to circumstances that were bigger than he or she could handle. Laws are made by political bodies, not by professional organizations. If you do not like the law, contact a representative of your profession's political body to change it. And last, when you joined the osteopathic medical profession, you asked to become a member. I am reminded of a long-standing military officer who once said that the best officers who took command gave their initial order of “All existing orders stand.” Then, only after some time of truly observing the installation and its operations, were changes made, if any.

To all osteopathic medical students and to this student in particular, I would say: You do not have the experience of being in a command role, of being in a practice role, of being in the osteopathic medical profession long enough to demand that changes be made. Give it time. If you still feel the way you do now in another 2 to 5 years, then lobby your delegates to the AOA and other organizations affiliated with this profession to bring about the changes you believe need to be made. But, until you have lived it for a while, back off. Focus instead on advancing your knowledge and skills to that of those who have preceded you.

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Reference

Response
I read with interest the letter submitted by Robert C. Clark, DO, MS, in response to my previous letter to the editor, and it has only reinforced my belief that I would not be where I am today had I allowed myself to be constrained by such outdated dogma.

The issues I raised represent not only my personal interests, but those of my colleagues as well. They are the issues of an emerging osteopathic medical profession. My primary concern is the question of having a new generation of physicians trained in this century dealing with academic and professional challenges that are distinctly different from those of yesterday. Nowhere in my essay did I demand a particular change. I simply asked questions and provided arguments for my point of view.

The responses I have received thus far, however, including that of Michael I. Opipari, DO (J Am Osteopath Assoc. 2004;104:231) have been defensive, unenlightened editorials that have provided little evidence in support of the status quo they defend. They have not addressed the questions I raised, nor have they attempted to do so.

These responses have not addressed the lack of incorporation of osteopathic manipulative medicine (OMM) into osteopathic internship or residency programs. Further, the responders made little effort to explain why the American Osteopathic Association (AOA), which has worked successfully to expand practice rights for US-trained osteopathic physicians throughout the provinces of Canada, appears to have no interest in lobbying the few remaining US state agencies to change their requirements for osteopathic internship. It stands to reason that our goal as a profession should be to ensure equal practice rights for osteopathic physicians, regardless of their choice of internship.

The questions I raise have everything to do with maximizing opportunities available to osteopathic medical students and osteopathic physicians alike. Medical school students coming after us deserve more than smoke and mirrors. If answering such questions is too much to ask, then I suggest that Dr Clark grind his axe elsewhere so that those interested in addressing the issues relevant to osteopathic medicine in the 21st century can do so in a productive manner.

Regarding Dr Opipari’s June response to my letter evaluating the rationale of the osteopathic internship, I was surprised to find so many questions left unanswered.
He did mention some incentives for the internship. For example, he noted that that internship year serves as a bridge from classroom to clinical decision-making, it must be said that though true, it is a feature that is not unique to the osteopathic internship. Dr Opipari further presents the osteopathic internship as providing a year of clinical growth and maturation. Again true, but again he neglected to say that this feature is the basis for every internship program everywhere. Dr Opipari further describes the osteopathic internship as a year of added clinical experience that does not represent an extra year of training within the osteopathic medical system. Why then are osteopathic residency programs offering a greater number of so-called specialty-track programs, whereby the first year of their residency is counted as an osteopathic medical internship, and, according to the American Osteopathic Web site, may reduce the total number of years of postdoctoral training?

Let us put our money where our mouths are and explain how the two systems of medical training are different, how the curricula vary between traditional osteopathic medical and allopathic medical rotating internships, and why students should accept a particular point of view. This will, by the way, require more than opinion.

Interestingly, Dr Clark states that osteopathic manipulative treatment (OMT) is the most significant and distinctive characteristic of osteopathic practice, while Dr Opipari, Chairman of the Council on Postdoctoral Training for the AOA, states clearly in his June response that OMT is not the distinguishing characteristic. The profession is riddled with these inconsistencies, which I find concerning. Such inconsistencies point toward the real problem, which is not a student questioning the system in good faith but a rift in the governing philosophy of our profession.

I am familiar with the charter of the American School of Osteopathy, as well as the work of George W. Northup, DO, Osteopathic Medicine: An American Reformation,1 which I would recommend to all who read this letter. Dr Northup reminds us, as Dr Clark has, that Dr Still’s original intention was not to create a separate and distinct form of healthcare, but as the title reads, to reform the healthcare system. It was in response to the close-minded establishment of his day that he founded the osteopathic medical profession. For that reason, I believe he would have encouraged us to share our ideas to improve the landscape of osteopathic medicine, and, in doing so improve the landscape of medicine as a whole.

We need not be separatists, nor promote artificial distinctions. To my mind, we are the Apple Computer in an International Business Machines Corporation world. Our challenge, similarly, is to define ourselves. But to do that, we must first answer hard questions about who we are and what we want. Our challenge as we move forward is that of integration, not isolation.

Perhaps it would help if Dr Clark knew that I have worked as a creative director in the development of brand management strategies for companies such as Harley-Davidson and Eastman Kodak before beginning medical school, and I am not just some impatient youth hurling epithets at the establishment. Perception is certainly a key issue in the successful evolution of the osteopathic medical profession. Therefore, I can tell you, from experience both as a professional and as a student, that it is not beneficial to the perception of the osteopathic medical profession for our students to be penalized for pursuing the residency program of their choice.

Regardless of my stand on these issues, I am proud of the choice I have made. I have yet to experience disdain for OMM or for the osteopathic medical profession of which I am a member. Where would I be now if I had allowed my postdoctoral training opportunities to be limited by the mandate of the osteopathic internship? Certainly not at Yale University, New Haven, Conn, where I am confident that I will receive an excellent, broad-based education in primary care internal medicine.

My suggestion to students who are contemplating the question of osteopathic versus allopathic residency is this: Do not limit yourselves or your options. Choose the program that is right for you. You have invested many dollars and countless hours in your education. You deserve every opportunity available to you as an osteopathic physician. Furthermore, do not be afraid to ask the questions that need to be answered if we are to further improve the quality of our product and the equity of the osteopathic medical profession.

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Reference

Common Problems With Uncommon Presentations

To the Editor:

As clinical director of the Eastcentral PA Allied Health Education Center, Lehighton, Pa, I have had the opportunity to provide rural rotations for medical students and residents in a rural primary care setting. Diseases present differently at different ages. As a board-certified physician in both internal medicine and pediatrics, I would like to submit a series of educational papers in a board-style format to help educate our future clinicians.

Background: The purpose of this series is to present a classic case in a board-style examination question format. The scenarios will then be changed to test the clinician’s ability to discern differences between common problems in not-so-common age groups.

Study Objective: To increase student and physician awareness of clinical presentations based on the age of the patients in question.

Method: A variety of cases sampled from a private internal medicine and pediatric practice in rural Pennsylvania, as well as multiple morning reports, grand rounds and teaching rounds at the Children’s Hospital of New Jersey at Newark Beth Israel Medical Center and St Michael’s Medical Center, both located in Newark, New Jersey. (1) A 16-year-old girl is seen with fatigue, fever, pharyngitis, and lymphadenopathy. All of the following are consistent with a
diagnosis of acute infectious mononucleosis in an adolescent except:
   a. elevated liver enzymes
   b. mild leukocytosis with lymphocytes
   c. heterophile antibody test positive within 24 and 72 hours
   d. positive EBV IgM test result
   e. Monospot test negative within 24 and 72 hours

(2) A 4-year-old boy is seen with fatigue, fever, pharyngitis, and lymphadenopathy. All of the following are consistent with the diagnosis of acute infectious mononucleosis except:
   a. negative heterophile antibody test
   b. negative EBV IgM test result
   c. splenomegaly
   d. thrombocytopenia
   e. chest x-ray film positive for interstitial infiltrates

(3) A 41-year-old man is seen with fatigue, fever, pharyngitis, and lymphadenopathy. All of the following are consistent with a diagnosis of acute infectious mononucleosis in an adult except:
   a. jaundice
   b. microcytic anemia
   c. atypical lymphocytes on peripheral smear
   d. Guillain-Barré syndrome
   e. encephalitis

Infectious mononucleosis is popular at all levels of testing. Adolescents and young adults are the most commonly infected age groups, but adults and children may be infected by the Epstein-Barr virus (EBV), a member of the Herpesviridae family that accounts for 90% of infectious mononucleosis cases. Physicians may consider other causes of infectious mononucleosis (eg, cytomegalovirus, adenovirus, toxoplasmosis) in patients with persistently EBV-negative titers. This syndrome may be seen in all age groups.

Question 1 is the classic case students and interns will encounter on part 2 and part 3 of the board examinations. Liver enzymes often rise to between two and three times normal levels and return to baseline within 1 month. When such a patient undergoes a complete blood cell count, a mild leukocytosis with a relative lymphocytosis is the classic finding. The EBV IgM test is positive within a short time after acute exposure. The EBV IgG titers will persist for life and have little clinical value in the acute setting.

The correct answer to question 1 is “c.” Heterophil antibodies will often be negative within the first week of infection, warranting repeating the test in 1 or 2 weeks to confirm the diagnosis. Examination pearl: A negative mononucleosis spot test (Monospot) result does not rule out infectious mononucleosis. Know your time lines!

Question 2 tests students’ and interns’ ability to discern laboratory values in the young child. In adolescents and adults, results of the heterophile antibody test, or mononucleosis spot test (Monospot) are nearly always positive after 1 week, whereas in children younger than 5 years, results are rarely positive.

The correct answer is “b.” If necessary for confirmation of disease presence (ie, elevated liver enzymes of unknown etiology), the EBV-IgM (and/or CMV-IgM) test is the “gold standard.” “Mono” in any age group is a great masquerader and may present with a variety of chest x-ray findings including interstitial infiltrates. Thrombocytopenia is often found along with a lymphocytosis on a complete blood cell count. Examination pearl: The results of the monospot are usually negative in young children.

Question 3 demonstrates that adults may suffer from acute infectious mononucleosis. The patient generally has jaundice, intense headaches (possibly even encephalitis), as well as myriad other systemic complaints. Board examinations focus heavily on central nervous system pathology, such as Guillain-Barré syndrome. Results of the mononucleosis spot test (Monospot) are usually positive, with atypical lymphocytes present on a peripheral blood smear.

The correct answer to question 3 is “b.” Hemolytic anemia may be present with infectious mononucleosis but never in a patient with microcytic anemia in the acute setting. Microcytic anemias are usually found with iron deficiency, lead exposure, sideroblastosis, and chronic disease.

Examination pearl: In adults with jaundice and no signs of sepsis, hepatitis, or malignancy, think of infectious mononucleosis.

John R. Manzella, DO, FACOI, FACOP
Jim Thorpe, Pennsylvania

Bibliography
Outlines in Clinical Medicine on Physicians’ Online; Epstein-Barr Virus, pages 1-6. Updated on May 19, 2003.