As the premier scholarly publication of the osteopathic medical profession, JAOA—The Journal of the American Osteopathic Association encourages osteopathic physicians, faculty members and students at osteopathic medical colleges, and others within the healthcare professions to submit comments related to articles published in JAOA and the mission of the osteopathic medical profession. The JAOA’s editors are particularly interested in letters that discuss recently published original research.

Letters to the editor are considered for publication in JAOA with the understanding that they have not been published elsewhere and that they are not simultaneously under consideration by any other publication.

All accepted letters to the editor are subject to copyediting. Letter writers may be asked to provide JAOA staff with photocopies of referenced material so that the references themselves and statements cited may be verified.

Readers are encouraged to prepare letters electronically in Microsoft Word (.doc) or in plain (.txt) or rich text (.rtf) format. The JAOA prefers that letters be e-mailed to jaoa@osteopathic.org. Mailed letters should also be sent electronically, in one of the aforementioned electronic formats on an IBM-compatible CD or a 3 1/2-inch disk, and addressed to Gilbert E. D’Alonzo, Jr, DO, Editor in Chief, American Osteopathic Association, 142 E Ontario St, Chicago, IL 60611-2864.

Letter writers must include their full professional titles and affiliations, complete preferred mailing addresses, day and evening telephone numbers, fax numbers, and preferred e-mail addresses. Authors are responsible for disclosing financial associations and other conflicts of interest.

Although JAOA cannot acknowledge the receipt of letters, a JAOA staff member will notify writers whose letters have been accepted for publication. Mailed submissions and supporting materials will not be returned unless authors provide self-addressed, stamped envelopes with their submissions.

All osteopathic physicians who have letters published in JAOA receive continuing medical education (CME) credit for their contributions. Writers of original letters receive 5 hours of AOA Category 1-B CME credit. Authors of published articles who respond to letters about their research receive 3 hours of Category 1-B CME credit for their responses.

Although JAOA welcomes letters to the editor, readers should be aware that these contributions have a lower publication priority than other submissions. As a consequence, letters are published only when space allows.

**Attention Applicants: Please Submit Emotional Intelligence Scores**

To the Editor:
The variables used to select medical school applicants should be robust and provide practical information. They should be valid, reliable, transferable from one context to another, and demonstrate candidates’ effectiveness in decision-making processes.

As medical school applicants progressed from high school through college, they demonstrated the ability to learn new material (ie, aptitude). Their undergraduate grade-point averages (GPAs) and Medical College Admission Test (MCAT) scores confirm that they have learned a substantial body of knowledge (ie, achievement).

Since 2000, JAOA—The Journal of the American Osteopathic Association has published 12 articles examining various relationships between academic achievement and performance on the Comprehensive Osteopathic Medical Licensing Examination (COMLEX-USA).1–12 The most analyzed variables have been MCAT scores,1,4,6–9,12 undergraduate GPAs,1,4,7,12 individual course grades in osteopathic medical school,1,4,5,7,10 and osteopathic medical school GPAs.1,2,4–12 A number of conclusions are evident from these findings.

First, the grades osteopathic medical students receive in individual medical school courses and their medical school GPAs are much better predictors of COMLEX-USA performance than are MCAT scores and undergraduate GPAs.1,2,4–12 The former variables explain up to 72% of the variance in COMLEX-USA scores, while the latter only explain up to 20%.1,2,4–12 The corollary of this statement is that COMLEX-USA performance is at least 80% dependent upon factors that seem unrelated to undergraduate GPAs and MCAT scores. We are left to wonder what these unnamed variables comprising 80% of students’ potential success—as measured by COMLEX-USA—might be.

The affective domain includes patterns of behavior that signify one’s response to emotions. These characteristics may hold the answer for osteopathic medical schools that are seeking to screen and evaluate applicants for the personal traits that will help them become successful as medical students.

In a 2002 book titled *Primal Leadership: Realizing the Power of Emotional Intelligence*, Daniel Golman et al13 describe emotional competence as a capability, based on “emotional intelligence,”14 that is related to success at work. Emotional competence is the product of varying degrees of personal competence (self-awareness, self-regulation, and motivation) and social competence (empathy and social skills).

Goleman14 reports that emotional intelligence is a better predictor of career success than cognitive ability as measured through standard intelligence quotient tests. One study analyzed employees from 40 companies and demonstrated that emotional intelligence could differentiate the star performers (upper 10%) from average performers.15 In fact, emotional intelligence was twice as important as the results of standard intelligence tests in identifying the most successful employees.15

Presently, the selection of successful candidates appears to be more a matter
of art than science, as admissions committees at osteopathic medical schools choose their candidates based on objective variables (ie, measures of aptitude and achievement) that predict—at best—20% of COMLEX-USA performance. I submit that the selection process for osteopathic medical school admission could be ideally served through the creation and validation of reliable assessment tools that identify potential star performers who have the qualities related to the “best” affect or emotional intelligence.

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References

Evidence Base Presented—and Expanding—for Investment in Tobacco Dependence Curricula for Osteopathic Medical Education

We appreciate Dr Shatsky’s support for smoking cessation protocols and primary prevention in his February 2005 letter to the editor (“DO questions evidence for including tobacco dependence curricula.” J Am Osteopath Assoc. 2005;105[2]:52-53.)

Prior to our original research, published in the August 2004 issue of THE JOURNAL (“Tobacco dependence curricula in undergraduate osteopathic medical education.” 2004;104[8]:317-323 [published correction appears in J Am Osteopath Assoc. 2004;104(9):368]), the focus of the medical literature on smoking cessation protocols and primary prevention that Dr Shatsky cites was based on allopathic medical education. Despite the seeming inclusiveness of the title of the 1999 JAMA article by our coauthor, Linda H. Ferry, MD, MPH, osteopathic medical schools were not included in that original research.

Our study, unlike many others, was based on research conducted exclusively in osteopathic medical schools. We concluded that osteopathic medical education curricula were deficient in clinical training for students on topics of nicotine dependence during the third and fourth years of medical school and were not in compliance with the National Cancer Institute Expert Panel recommendations or the Clinical Practice Guidelines issued for tobacco-use cessation.

In our original contribution, we made no conclusions that were not supported by our research. Dr Shatsky is therefore mistaken to suggest that we drew “conclusions outside the boundary of that which has been measured.” We believe that the first step to improving training lies in identifying specific deficiencies, which we outlined in detail and stand by. Our “conclusions” were no more than detailed suggestions as to how to rectify identified deficiencies.

We agree with Dr Shatsky that when curricular elements, teaching methods, faculty objectives and performance-based assessments are used, medical students can learn cessation counseling skills. Can we improve the educational process and evaluate its success more fully at the medical school and postgraduate levels? Clearly, the answer is “Yes.”

In his letter to the editor, Dr Shatsky calls for a pilot study to prove tobacco dependence curricula in medical training result in physicians who are better able to assist patients with smoking cessation. Such a study is currently underway at the Bowman Gray School of Medicine Comprehensive Cancer Center at Wake Forest University, in Winston-Salem, NC, where a $1.6-million grant was funded within the Cancer Education Grant Program by the
US National Institutes of Health’s National Cancer Institute to develop a comprehensive model curriculum for tobacco intervention. This grant will teach medical students how to help their patients stop using tobacco and will be integrated throughout all four years of medical training (oral communication, J.G. Spangler, MD, MPH, May 2005). This five-year federal grant allows for extensive evaluation of the comprehensive tobacco intervention curriculum developed by Dr. Spangler and has already produced direct outcomes, including a five-lesson course that has been posted on the Internet for healthcare professionals who wish to provide guidance to their patients who require help in quitting smoking (see http://northwestahc.wfubmc.edu/learn/smokingcessation/index.htm).

Once fully developed and evaluated, this model curriculum should provide a template that medical schools nationwide can implement.

Our hope is that all medical schools will accept the challenges of teaching tobacco cessation to their students for many of the public health reasons Dr. Shatsky cited.

We recommended methods in which improved smoking cessation training could be instituted in osteopathic medical schools. We welcome objective, evidence-based research that will guide clinical performance and support the success of smoking cessation training at the medical school and postgraduate levels. Best evidence—not expert opinion alone—clearly supports the training of healthcare professionals for a statistically favorable impact on their performance and for improving counseling and cessation rates in their tobacco-dependent patients.4,6

We are confident that, based on a large body of evidence from other areas of medical education, improved curricular elements and teaching methods will improve medical students’ (ie, our future clinicians) interactions with tobacco-dependent patients, increase cessation rates, and reduce the morbidity and mortality associated with all forms of tobacco use.7

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References

Pelvic Postural Asymmetry Revisited

To the Editor:

I enjoyed reading the original contribution “Prevalence of Frontal Plane Pelvic Postural Asymmetry—Part 1,” by Juhl et al in the October 2004 issue of JAOA—The Journal of the American Osteopathic Association (J Am Osteopath Assoc. 2004;104[10]:411–421). I found the article to be both insightful and informative, and I wish to present additional diagnostic and treatment information regarding pelvic postural asymmetry that I have found helpful in my practice.

I have observed that the os coxae sometimes contains intraosseous strains, making the innominate assume the distorted shape of a “bent wheel.” These distortions usually originate along the developmental junctures of the ilium, ischium, and os pubis. All three of these bones unite at the acetabulum and at the ilioischial and ischiopubic junctions.

I have also observed that intraosseous strains affect not only the width and depth of the pelvic structure on the side of the strain. They can also affect the flaring of the lower extremity (a crucial factor in tracking while walking) and the depth of the acetabulum (an important factor in leg length and in developmental dysplasia of the hip in infants).

I have discovered an easy and effective diagnostic method for assessing the degree of pelvic asymmetry. It involves the use of two landmarks: (1) the pubic tubercle, and (2) the inferior aspect of the anterior superior iliac spine. One performs this assessment after normalizing pubic and sacroiliac mechanical malalignments. I usually place my thumb on the pubic tubercle and my index or middle finger under the anterior superior iliac spine to compare the relationships between these landmarks.

I offer the figures on page 425 for your consideration. Figure 1 shows a normal pelvic structure, with width and height symmetrical on both sides of the structure. Figure 2 shows a pelvic structure with less height on the left side. Figure 3 shows a structure with greater width on the right side. These figures exaggerate the magnitude of the typical pelvic asymmetry condition and are offered only to illustrate the osseous aspect of the somatic dysfunction involved in pelvic asymmetry.

Effective treatment of such asymmetric conditions consists of removing the intraosseous strain and normalizing the shape and symmetry of the right and left innominate bone. Many methods exist to achieve this normalization, (continued on page 425)
but I usually find that myofascial release, peripheral application of the cranial concept, or neurofacial release are the most effective. Although I have found this normalization to be efficacious for leg length discrepancies, many of my patients have also reported improvements in pelvic organ function in various conditions, including irritable bladder syndrome, irritable bowel syndrome, painful menses and other menstrual conditions, recurrent cystitis, and dyspareunia.

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Response

Dr Davidson’s letter describes an approach to physical examination and treatment that begins with an evaluation of intraosseous strains after having normalized pubic and sacroiliac mechanical malalignments. Physical examination is the sine qua non of osteopathic medical theory and practice. Our article1 concerns itself with the statistical evaluation of a series of standing lumbosacral radiographs. The degree to which such radiographic images can be used to support the concept of the osteopathic lesion has long intrigued researchers in osteopathic medicine.2,3

Apparent differences in the dimensions of the hemipelvis as seen in radiographic images can be due to rotation about oblique, transverse, or vertical axes, variations in the size or shape of a bone, or different relationships between bones that move on each other.4 Studies, including those documented by Travell and Simons,5 based on physical examination of patients and skeletons, have shown that physical asymmetries in hemipelves exist. Travell and Simons5 reviewed literature on the small hemipelvis in both volumes of their work, but they did not differentiate bony intraosseous asymmetries from bony intraosseous strains.

I am not ready to make correlations between pelvic patterns of asymmetry on standing radiographic films and patterns of somatic dysfunction. We plan to address this topic in part 2 of our study. The more correlations between radiographic and physical examinations can be elucidated, however, the more firmly our understanding of somatic dysfunction and compensatory patterns can be linked into an evidence-based format. The radiographic information on pubic displacement from the midline and the relative measurements from the pubic tubercle to the inferior aspect of the anterior superior iliac spine may be useful, but this information was not collected in our database. We collected measurements we described as “standing hemipelvis” and “seated hemipelvis,” which we also plan to discuss in part 2 of our study.

I look forward to additional light being shed on these issues by Dr Davidson and other authors.

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References

(continued from page 403)

Figure 1. Normal, symmetric pelvic structure.

Figure 2. Asymmetric pelvic structure, with less height on left.

Figure 3. Asymmetric pelvic structure, with greater width on right.

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Loyalty to the Profession, Not the AOA: Evidence Base Necessary for Member Support of Association Policies

To the Editor:

The exchange of letters among Drs Smith,1,2 O’Connor,3 and Hornbeck,4 with responses by Dr Opipari5–7 representing the American Osteopathic Association’s (AOA) Council on Postdoctoral Education, shares opinions, policy, and few facts.

First, as osteopathic physicians, we all took an oath to support and “develop the principles of osteopathy which were first enunciated by Andrew Taylor Still” (see http://www.osteopathic.org/index.cfm?PageID=ado_oath). We did not take an oath to support all policies as promulgated by the AOA. We are not disloyal if we disagree with the AOA’s policies, nor are we necessarily disloyal if we express no opinion at all.

Second, there is not one scintilla of evidence that a one-year rotating internship does or does not contribute to early postdoctoral training. Our opinions and beliefs are just that: opinions and beliefs. As the osteopathic medical profession and the larger medical community demand practices consistent with evidence-based medicine, we can demand no less of our educational system.

Medical education has, with few exceptions, ignored the principles of adult education and has continued a hysterical defense of our historical system. To that practice, I say: Stop! Prove that the rotating internship provides an intrinsic value to osteopathic interns—or stop defending it.

Third, state medical licensure requirements—including years of required postdoctoral training and, in states with a board of osteopathic medical examiners, an AOA-approved internship—touch upon the rights of all practitioners to direct their own future plans. If there is a shadow of a chance that a future osteopathic physician is going to move to a state that has internship requirements, that future physician obviously needs to be able to take that requirement into account.

Once studies are conducted to determine any intrinsic value to internship requirements, we can move on.

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References

Teacher, Heal Thyself

To the Editor:

According to The American Heritage Dictionary of the English Language (2000), the word doctor has its roots in the Latin words doctus and docere, which mean “teacher” and “to teach.”

As physicians, we sometimes tend to forget our role as teachers. Each day, our patients, nurses, residents, medical students, and others ask us questions that require and deserve answers and explanations.

We must remember that we are healers and educators. We have chosen a profession that depends on our ability to teach. Not only are we teaching people how to care for themselves and for others, as osteopathic physicians, we are also responsible for teaching osteopathic medical students and residents how to care for others in our shared tradition.

It is critical that we develop the skills and experience necessary to become good teachers as soon as possible, and that we retain a lifelong commitment to improve upon our skills and experience throughout the course of our working lives. We must live up to the title the osteopathic profession has given us: doctor of osteopathy, which also means teacher of osteopathy.

Those who aspire only “to get the day over and done,” or simply to see as many patients as possible, have perhaps forgotten what it is that they have set as their life’s mission.

Although some within the profession may have made a deliberate decision not to teach at a college or university, there is still an opportunity for clinicians to stretch their skills beyond diagnosis and treatment—to discussing disease processes and unusual cases with students or residents they may encounter, for example, or fully explaining the administration of medications and their potential adverse effects to patients. However, there is a Chinese proverb that says, “A teacher can but lead you to the door; learning is up to you.” Those who become good learners will become good teachers. Learn to become a good teacher, and teach to become a good learner—and start early. Bring the profession to a new level.

I want to take a moment to encourage everyone—but especially osteopathic medical students, residents, and program directors—to take time out of their busy schedules to learn and to teach. The best way to teach is to set an...
Letters

example for others. Become that example, especially for those who will become the future of the profession. It is my hope that my fellow doctors of osteopathy will choose to recommit to our life’s mission: becoming teachers of osteopathy.

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Correction

Three errors occurred in the Figure appearing on page 208 of the review article “Slowing progression along the renal disease continuum,” by Nelson P Kopyt, DO (J Am Osteopath Assoc. 2005;105[4]:207–215). “Glomerular Sclerosis” should have been “Glomerular Sclerosis”, arrows indicating “GFR” (glomerular filtration rate) and “Serum Creatinine” were reversed: GFR should be indicated as decreased (down arrow), and Serum Creatinine, increased (up arrow). The corrected Figure appears below:

**Figure.** The renal disease continuum. Ang II indicates angiotensin II; CHD, coronary heart disease; CVD, cardiovascular disease; DM, diabetes mellitus; GFR, glomerular filtration rate; IGT, impaired glucose tolerance; RAS, renin-angiotensin system; UAER, urinary albumin excretion rate.