Hey AOA, Give Us a Break!

To the Editor:

I graduated in 1974 from what was then the Chicago College of Osteopathic Medicine, now part of the Midwestern University/Chicago College of Osteopathic Medicine (MWU/CCOM) in Downers Grove, Ill. During my senior year at CCOM, I was president of the Council of Student Council Presidents (then only seven members strong). Foreseeing a time when there would be more graduates of colleges of osteopathic medicine (COMs) than osteopathic internships, we recommended that the osteopathic medical profession partner with allopathic residency programs to create the needed space for COM graduates. We also suggested a way for allopathically trained osteopathic specialists to be formally recognized by the osteopathic medical profession upon completion of training; this recognition would not have required membership in the American Osteopathic Association (AOA) or large fees.

Unfortunately, our recommendations were politely ignored by the AOA.

I was lucky enough to match with a fine osteopathic internship program. However, I subsequently went into the armed services and took my residency in the US Navy. At the time I completed the Navy program, the American osteopathic board examination for my specialty (preventive medicine and aerospace medicine) was in its infancy and not yet approved by the Navy. Therefore, I took, passed, and was certified through the specialty board examination administered by the allopathic Accreditation Council for Graduate Medical Education. Imagine my surprise when I was then told that to gain official recognition from the osteopathic medical profession, I would have to rejoin a political organization (the AOA)—which I had previously left because I could no longer afford the dues—as well as take an additional examination! I didn’t do these things then, and I still haven’t.

In light of these experiences, the letter by George Mychaskiw II, DO, in the May 2006 issue of JAOA—The Journal of the American Osteopathic Association (“Will the last DO turn off the lights?” 2006;106:252–253,302) struck a chord with me. The existing AOA certifying board examination in my specialty is also considered rather easy. I, too, have associates who failed the allopathic board examination and went on to pass the osteopathic board examination with little difficulty. Why is that? Did they study harder for the osteopathic board examination? Or did they pass the osteopathic boards because these examinations were not as difficult as the allopathic boards? For whatever reason, there is a perception that the osteopathic boards are easier, and this perception

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 colleges of osteopathic medicine, and others within the healthcare professions to submit comments related to articles published in the 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 the 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 editing and abridgement. 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 be 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. In addition, writers are responsible for disclosing financial associations and other conflicts of interest.

Although the 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 letter writers provide self-addressed, stamped envelopes with their submissions.

All osteopathic physicians who have letters published in the 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 the 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.
colors the decisions of many young medical graduates.

My allopathic board certification should be good enough to allow me to be listed in the AOA physician directory as a specialist. More importantly, I and many other osteopathic physicians with allopathic board certifications could contribute to the osteopathic medical profession, which we love. Yet this profession appears to have rejected us.

When I was beginning my career in the armed services, I could not afford the very large annual dues required to maintain membership in the AOA, and I could no more pay for a set of additional boards than fluff my arms and fly around the building. Although I can afford the dues now, why should I rejoin a political organization that has made it very plain that it does not accept my skills or care about me or my situation?

Give us a break, AOA! Open the doors, and a lot of osteopathic physicians with training in allopathic programs will return. Our skills will help the osteopathic medical profession, and our experience might just help the AOA. I fear that if the AOA fails to do this, our profession may not be here for its 200th anniversary.

DAVID W. YACAVONE, DO, MPH
Captain, US Navy (Retired)
Virginia Beach, Va

Editor's note: The letter by Dr Yacavone continues a discussion that began in the Letters to the Editor section of the May 2006 issue of JAOA—The Journal of the American Osteopathic Association. For a response to the letter by Dr Mychasiw referred to by Dr Yacavone, see the letter by Michael I. Opiari, DO, in that issue ("Response." J Am Osteopath Assoc. 2006;106:302–303. Available at: http://www.jaoa.org/cgi/content/full/106/5/302).

Tracing the Decline of OMT in Patient Care

To the Editor:
Norman Gevitz, PhD, offers a complete review of the philosophy and practice of osteopathic medicine in his editorial in the March 2006 issue of JAOA—The Journal of the American Osteopathic Association (“Center or periphery? The future of osteopathic principles and practices.” J Am Osteopath Assoc. 2006;106:121–129). My father and I practiced osteopathic medicine for almost a century combined, and I have seen and experienced many of the changes in the osteopathic medical profession that Dr Gevitz so accurately describes and fairly interprets.

When I was an osteopathic medical student during the 1940s, the clinical instructors in college described both the drugs and the techniques of osteopathic manipulative treatment (OMT) that they used to address specific problems with their patients. Later, as medical specialization became more complex, courses were taught by specialists who did not use OMT in their practices or mention it in the classroom.

At the time of my internship in 1945, there were “routine orders” in osteopathic hospitals that applied to all patients but were not written in the patients’ medical records. This system of patient care allowed providers to make individual decisions regarding such actions as changes in diet, complete blood cell count, and daily OMT. Because of these routine orders, interns and residents administered OMT to each patient every day using their own preferred techniques. Many staff physicians, including general practitioners and surgeons, also administered OMT to their patients.

Although the OMT used by different osteopathic physicians varied in technique, it was usually nonarticular in nature. For example, a physician might use rib raising to improve lung function, the lymphatic pump and freeing-up of the clavicular area to aid in lymph flow, and cervical relaxation and lumbar paraspinal relaxation as needed. Occasionally, mobilization techniques were also used.

Daily administration of OMT had many advantages. The patients enjoyed and appreciated the attention and the physical contact, which helped boost the reputation of osteopathic hospitals. The interns learned more about the patients and developed an appreciation for both the psychological and medical value of OMT. There is much anecdotal evidence than patients recovered more rapidly, required fewer analgesics, and felt better after receiving OMT.

The routine orders began to lose their validity in the 1950s and 1960s, when various forms of hospital insurance and Medicare went into effect. To ensure that the hospital and its physicians were financially reimbursed, new requirements stipulated that there be a formal order for any OMT procedure, evidence justifying the use of the procedure, and evidence in the patient’s medical record that the procedure was performed. These requirements posed problems not only because many DOs did not issue formal orders for OMT, but also because OMT would probably not be reimbursed by insurance policies, many of which did not allow the participation of DOs.

As hospital care became more technical and inpatient stays became shorter, osteopathic physicians came to ignore the real advantages of OMT in aiding in recovery from the presenting complaint. Also ignored were OMT’s role in aiding recovery from the secondary effects resulting from bed rest and technical testing, as well as the primary and secondary effects of surgical procedures on the sympathetic-parasympathetic balance.

As a result of these changes within the healthcare industry, osteopathic medical students lost the opportunity to develop skills and confidence in osteopathic manipulation and philosophy.

When I was in the early years of my office practice, the typical osteopathic physician attempted to analyze the reason for a particular medical problem and, by appropriate manipulation, restore the patient’s normal nerve, lymph, and blood supply. “Find it, fix it, and leave it alone” was the prevailing philosophy in osteopathic medicine in the 1940s.
Osteopathic manipulation was a common part of patient care when my father practiced osteopathic medicine, from 1910 to 1960. In fact, many of my father’s patients scheduled regular appointments for OMT to maintain their health and normal body function. With some exceptions, every patient received OMT in addition to prescriptions or other medical procedures. The manipulative techniques used could be specific for the patient’s problem or they could be part of general osteopathic treatment.

As DOs became more specialized and as more fancy drugs were developed (and as pharmaceutical companies were permitted to advertise their drugs to the general public), more patients ended up leaving their osteopathic physician’s office with a handful of prescriptions on their way to a massage therapist for muscle relaxation therapy. In order to receive OMT from an osteopathic physician, patients increasingly have had to schedule appointments with the shrinking number of DOs who specialized in manipulation.

It is true that the traditional osteopathic medical approach of determining the cause of a problem requires more concentration and intellectual acuity from the physician than simply writing a prescription targeting a specific symptom. It is also true that administering OMT requires more strength, coordination, and time than writing a prescription. Yet, using OMT to eliminate the cause of a patient’s problem and normalize the inherent functions of the body could result in long-term improvements without adverse effects, drug interactions, or toxicity to the body.

Are we leaving behind the most physiologically sound approach to maintaining patient health that has ever been proposed? Are we teaching our students about all the latest medicines but relegating the teaching of OMT to almost an afterthought? Is there no longer any effort to integrate palpatory diagnosis and the value of osteopathic manipulation into the total care of the patient?

It seems that Dr Gevitz has raised important questions in his editorial. I hope that educators, clinicians, and continuing medical education programs will all take a long, hard look at where the osteopathic medical profession is headed.

MARTYN E. RICHARDSON, DO
Scarborough, Me

---

OMT: Evidence, Research, and Practice

To the Editor:

I am writing in response to the many recent letters published in JAOA—The Journal of the American Osteopathic Association that question the validity of osteopathic manipulative treatment (OMT), decry a lack of evidence for its efficacy, or piously insist that a physician’s practice must be limited to evidence-based methods of treatment.1–3

I must agree that clinical research into OMT can be scarce and lacking in rigor and is often limited to pilot studies. In addition, some studies indicate a limited efficacy for OMT, concluding that it is clinically equivalent to using a high dose of pain medication.4,5 Compared with the many well-funded pharmaceutical studies by allopathic researchers, the osteopathic medical profession’s evidence for the efficacy of OMT does seem slight. However, I submit that this paucity of evidence is the result of the various factors addressed in this letter.

First, OMT is not a drug. Yet it is often studied using the protocols that pharmaceutical companies use to verify the safety and efficacy of their medications. Researchers who wedge OMT into the double-blind, placebo-controlled research model must construct sham treatments to compare against “real” OMT. However, OMT is the application of a set of procedures and, thus, should be studied using the protocols that evaluate medical procedures. “Sham OMT” is as illegitimate as “sham appendectomy” would be in the study of lower abdominal pain.

Second, many studies of the efficacy of OMT use osteopathic medical students as physicians surrogates6,7 or as surrogates for patients.8 The clinical potency of OMT varies widely among practitioners, accumulating with the experience of the physician. Students are our weakest (ie, least experienced) practitioners, so using students to administer OMT—mainly because of

---

References


their easy availability and low cost—is like a pharmaceutical company using expired drugs in its research. Students cannot generate the clinical potency of seasoned physicians.

Furthermore, students cannot technically apply true OMT, because, by definition, OMT is the application of manually guided forces by a licensed physician.\(^8^{,}9^{,}10\) Judging the efficacy of OMT by the results achieved by students is a deeply flawed concept and unfair to the seasoned physicians who are able to treat their patients with much greater clinical effect.

Third, OMT is designed to treat sick patients, yet it is mostly studied in healthy subjects, primarily because healthy students are the subjects who are most readily available to the academics conducting research.\(^9^{,}10\) The use of healthy subjects can make a big difference in study results. The most that OMT can do is deflect the patient's physiologic mechanisms toward normal/ optimal conditions. The size and duration of that deflection are proportional to the clinical skills of, and the time invested by, the osteopathic physician. The amount of measurable deflection toward the normal physiologic state is minimal when the subjects studied are already healthy. An OMT procedure that may be a lifesaving treatment in a very ill patient may just make a healthy subject feel better for a few hours.

For the osteopathic medical profession to conduct OMT research that undeniably demonstrates significant clinical potency, OMT must be studied as it is delivered by seasoned osteopathic physicians to the clinically ill. We must abandon “sham OMT” as a seriously flawed concept and recognize that students are unsuitable for either providing or receiving OMT during research. I recommend the following published articles as examples of studies that not only incorporate these principles, but also demonstrate favorable outcomes for OMT:


These three studies used seasoned osteopathic physicians who treated actual patients, and the conclusions were based on clinical outcomes. Subjective measures, such as pain scores (McReynolds and Sheridan), and objective measures, such as incidence of meconium staining (King et al) and tympanogram quality (Mills et al) were significant. Students were not used as subjects or as surrogate physicians. Sham OMT was not included. Each study demonstrated clear clinical benefits from OMT—benefits beyond the reach of conventional allopathic medicine.

Each of these studies should have justified a change in practice patterns for the osteopathic medical profession: Emergency department physicians now are fully evidence-justified in using OMT instead of injectable nonsteroidal anti-inflammatory drugs; obstetricians in using OMT in prenatal care; and pediatricians in using OMT in cases of chronic otitis media. (Additional research supporting the latter use of OMT was published in the June 2006 issue of \textit{JAOA}.)

I wonder, however, did any osteopathic physician shift his or her practice patterns to incorporate (or refer for) OMT after learning that the evidence justifying such a decision is now published in respected journals? If not, perhaps we are less evidence based than we think.

THOMAS M. MCCOMBS, DO
Osteopathic Hospitalist
Department of Osteopathic Manipulative Medicine
Touro University, College of Osteopathic Medicine—California
Vallejo, Calif

References

(continued on page 423)
Sexually Activated or Transmitted?
Questions About HPV

To the Editor:
I would like to commend Paul M. Krueger, DO,1 for overseeing, and Bethany A. Weaver, DO, MPH;2;3 Daron G. Ferris, MD;4 and Anthony H. Dekker, DO;5 for participating in, the production of a thoughtful and timely March 2006 JAOA supplement on human papillomavirus (HPV) vaccines.

The availability of a vaccine for HPV raises many questions about the virus, including: How is it spread? How does it cause cervical cancer?6

The main question my patients ask when they are told that HPV is sexually transmitted, the conversation becomes confusing. If HPV is sexually transmitted, where and when did my patient or the patient’s partner become exposed? Should both partners be treated?

Men may be infected with the virus, but we usually do not treat them. Clinical expression of HPV in men is rare, with the exception of genital warts or anogenital cancers that develop in a small number of men who have the virus. And it is not understood why some men are asymptomatic while others have disease progression, though it is known that the disease will develop in men in regions of greater irritation or friction.7

Although we tell people that HPV is sexually transmitted, we also know that HPV can be found in women who have never had sexual intercourse, with one study claiming the rate of HPV infection in virgins is 14.8%.8 And we also know that HPV infection can be transmitted from mother to child.9

In conversion of HPV to cervical cancer, any type of trauma accelerates the process. We also know that T-cell recruitment to the site of HPV infection occurs prior to transformation of the virus into a precancerous or cancerous lesion.10

It is not until after the debut of sexual activity that a person’s HPV-related problems appear. It is possible that the physical friction of sexual activity along with the presence of the virus is what activates viral transformation.

TYLER CHILDS CYMET, DO
Section Head, Family Medicine
Sinai Hospital of Baltimore
Assistant Professor of Internal Medicine
Johns Hopkins School of Medicine
Baltimore, Md

References
2. Weaver BA. HPV vaccines: are we closer to preventing cervical cancer and other HPV-related diseases? J Am Osteopath Assoc. 2006;106(3 suppl 1):51.

Response
I thank Dr Cymet for his kind words about the JAOA supplement on human papillomavirus (HPV) vaccines (J Am Osteopath Assoc. 2006;106[4 suppl 1]:S1–S20).

I believe that the idea of nonsexual transmission of HPV detracts from the real issue: HPV infection is a sexually transmitted disease with serious health consequences. Condoms offer no protection. The article that quotes a 14.8% prevalence rate in virgins used vulvar swabs in premarital testing of Chinese women who claimed to be virgins and who had intact hymens (Pao CC, et al. Eur J Clin Microbiol Infect Dis. 1993;12:221–222). Unfortunately, such identification is not conclusive and HPV can be spread through “outercourse.”

Debates about transmission detract us from the real issue. We need to keep our eye on the ball. Human papillomavirus is a sexually transmitted disease. That is why vaccination is the right strategy.

PAUL M. KRUEGER, DO
University of Medicine and Dentistry
of New Jersey-School of Osteopathic Medicine
Stratford, NJ

“Circle Turns Round”
to “Allopathic Osteopathy”

To the Editor:
After reading the supplement to the April 2005 issue of JAOA—The Journal of the American Osteopathic Association on the topic of headache, three words come to mind: symptomology, symptomology, symptomology. Andrew Taylor Still, MD, DO, must once again be rotating in his grave knowing what has happened to the profession he founded.

The title of the editor’s message, “As the ‘circle turns round’ back to neurovascular basis in migraine,” by Frederick G. Freitag, DO,1 is applicable. It describes perfectly what has happened to osteopathic principles and practice. As a profession, we are now more “allopathic” than are the MDs. I have no argument with the medical treatment modalities prescribed for adults in the publication. I do, however, take exception to the hierarchy in which the diagnoses and treatment modalities are presented.

Before treating any patient with medication, my training dictates that I ask questions and screen the patient for the cause or major contributing factors in the pathophysiology of the reported symptoms. Dr Freitag, as the supplement editor, and the authors of the articles...
appearing in the JAOA supplement advocate that physicians investigate and treat symptoms rather than seek the actual cause of the complaint and treat patients for that cause. In my patients, I have found psychosocial and musculoskeletal causes for most complaints of headaches. Why do the authors of this JAOA supplement acknowledge these causes as afterthought rather than as a primary cause?

It is interesting and revealing that David M. Biondi, DO, addresses cervicogenic headache. Articles such as his illustrate perfectly how osteopathic medicine has been convoluted into allopathic philosophy. I was surprised to read that Dr Biondi went as far as to consider the shoulders to be a possible contributing factor. Why not go one step further (thuankfully abandoning the realm of “allopathic osteopathy”) and underscore that somatic dysfunction anywhere in the body can show up in the neck and then cause the symptom of headache? I also believe that the allopathic model (treating the symptom not the cause) is the reason that most osteopathic research fails. We use the allopathic model of treating where it hurts, when osteopathic principles clearly state when osteopathic principles clearly state that we should seek the cause rather than the effect. Until this fundamental principle is applied in practice and research, we will continue to have mixed results in the effectiveness of osteopathic manipulative medicine, as in the results in the effectiveness of osteopathic manipulative medicine.

We will continue to have mixed results in the effectiveness of osteopathic manipulative medicine, as in the results in the effectiveness of osteopathic manipulative medicine. Why not put all this effort and energy into a different approach to patient care? Many patients are abandoning “conventional healthcare” for complementary alternative medicine modalities because of dissatisfaction with overall treatment.

STANLEY W. WISNIOSKI III, DO
North Palm Beach, Fl

References

Response
It would appear from his statements regarding the series of articles appearing in the supplement to the April 2005 issue of the JAOA that Dr Wisnioski may have failed to understand the meaning of the word cause. Without understanding the pathophysiologic process that produces the clinical sympotms reflected in a disease state, then such causes that he refers to as “psychosocial and musculoskeletal” would not result in the production of the clinical characteristics that we know as migraine. Certainly, as advanced as Andrew Taylor Still, MD, DO, was in his teachings, so too the advances that have occurred in medicine would not have been lost on him. Without the underlying genetic constitution, it’s doubtful that migraine and other primary headache disorders would exist.

If the genetics necessary to cause migraine were not required, then every menstruating woman would experience menstrual-related migraine with each menses since the cause, as Dr Wisnioski implies, occurs in all women—a situation that thankfully does not exist.

Special supplements to the JAOA have strict page restrictions that limit the number of articles to be submitted and the number of words per article. Thus, it would not be possible to cover all the potential clinical and basic science issues that constitute our knowl- edge of migraine and other headache disorders. Therefore, any such series of articles will be limited in their scope of presentation. Dr Wisnioski’s knowl- edge of the literature is obviously limited, because the issue regarding Dr Biondi’s article has been extensively addressed in the journal Headache.

Dr Wisnioski infers that we have become more “allopathic” in our approach because we have moved beyond merely holding to tenets espoused 130 years ago. Rather, it may well be that others in the healthcare field have become more “osteopathic.” Certainly, many of the concepts that some osteopathic physicians feel are ours alone are practices and ideas that other healthcare professionals use on a daily basis. These include manual medicine, as well as the holistic concepts that truly unify the basic tenets of osteopathic medicine. The authors of the articles in the JAOA supplement...
devoted to headache could have consumed not only the entire special issue, but also more pages elaborating on the holistic principles that specialists in the field of headache use to evaluate and treat their patients.

Addressing the issue of manual medicine, I agree in part with Dr Wisnioski’s statement regarding the mixed results seen with this approach, at least when it comes to migraine and headache. I am most disappointed that steps taken by several of the authors of this special supplement have failed thus far in their efforts to promote well-controlled clinical trials of osteopathic manipulative medicine or have met with an uncertain fate at the hands of investigators, thus leaving us with only scientifically poor trials on which to base osteopathic manipulative treatment.

Dr Wisnioski takes us to task for the “unapproved use” of medications in the pediatric population, whereas the osteopathic medical profession itself promotes: “Only therapies proven clinically beneficial in improving patient outcome should be recommended.” Were we to have followed this approach, then the lack of evidence for manual medicine in the management of migraine would suggest, in the logical pursuit of our own tenets, that it not be used. That is something that would be most unwise in my clinical experience. Just as unwise is the concept that only approved indications for drugs be followed in their prescriptive use. If we were to adhere to this guidance, then millions of patients with headache, at the least, would bear the consequences in the form of disability, discomfort, and the likelihood of disease evolution.

FREDERICK G. FREITAG, DO
Diamond Headache Clinic
Chicago, Ill

DAVID M. BIONDI, DO
Spaulding Rehabilitation Hospital
Boston, Mass

GEORGE R. NISSAN, DO
Diamond Headache Clinic
Chicago, Ill

PAUL K. WINNER, DO, FAAN
Palm Beach Headache Center
Nova Southeastern University
West Palm Beach, Fla

References

Addressing Substance Abuse in Medical School Curricula

To the Editor:

In their excellent review in the supplement to the June 2005 issue of the JAOA, Wyatt et al1 highlight the importance of the problem of substance abuse disorders to the osteopathic medical profession. They also emphasized the need for improvement in the education of osteopathic medical students and physicians in this area.

As a pharmacologist and medical educator, I have long thought that this was an issue that needed to be addressed more completely in medical curricula. To provide an opportunity for students at the Midwestern University/Chicago College of Osteopathic Medicine to obtain more in-depth training in this area, I have developed an interdisciplinary elective course, “Aspects of Drug Abuse,” that is offered to osteopathic medical, pharmacy, and physicians assistant students on our Downers Grove, Ill, campus. The students have received this course extremely well. Therefore, I offer a general description of the course for readers who are dealing with the issue of substance abuse education.

A 20-hour elective course was designed to provide students with an in-depth understanding of the pharmacology of the common drugs of abuse, including alcohol, cocaine, hallucinogens, inhalants, marijuana, nicotine, opioids, phenycyclidine, sedatives, stimulants, and tobacco. Particular emphasis is given to basic pharmacokinetic and pharmacodynamic mechanisms as they relate to the effects of the drugs and to the development of drug tolerance and dependence. Current theories regarding the physiologic basis of drug-seeking behavior and the development of drug dependence are presented. Various social, legal, and ethical aspects of substance abuse problems are considered. Students receive instruction in the diagnosis and treatment of overdose for each of the major classes of drugs of abuse. They also receive instruction in current medical approaches for recognizing and treating drug-dependent patients, including drug testing procedures, intervention techniques, detoxification procedures, maintenance procedures, and procedures for weaning the patient from drugs. In addition, topics discussed include nonmedical approaches for the treatment of drug-dependent individuals, particularly support groups such as Alcoholics Anonymous, as well as the problem of drug abuse among healthcare professionals.

This course is interdisciplinary and is usually presented by a team of instructors with expertise in a wide variety of areas, including pharmacology, public health, emergency medicine, forensic toxicology, and substance abuse counseling. Faculty use a variety of methods of instruction, including lectures, group discussions, assigned readings, and patient-oriented problem-solving exercises. Because it is an elective course, the instructors try to maintain a relaxed atmosphere and present the material in a manner that makes learning fun.

Until 2 years ago, all students in the course were required to attend an open
Learning how other colleges of osteopathic medicine have addressed this issue in their curricula.

WALTER C. PROZIALECK, PhD
Professor and Chairman
Department of Pharmacology
Midwestern University/Chicago College of Osteopathic Medicine
Downers Grove, Ill

Reference

Response
I applaud Dr Prozialeck on the development of his comprehensive program surrounding the neurobiology, pharmacology, identification, and treatment of substance use disorders. I also appreciate his positive remarks concerning our article (“Medical education in substance abuse: from student to practicing osteopathic physician.” J Am Osteopathic Assoc. 2005;105(6 suppl 3):S18–S25). My concern is that a program such as his should remain elective.

There is increasing evidence that current treatment modalities for a variety of medical illnesses are now at a level where improvement in treatment is resulting in limited yield. Although I fully support further research in improving medical treatment, there is strong reason to now look to prevention as the area that will most significantly impact the future health of our patients—and colleagues, as Dr Prozialeck notes. All osteopathic physicians can make a valuable impact in this area by being competent in the screening and brief intervention of substance use problems.

Substance use disorders contribute significantly to a wide variety of medical problems in the United States and around the world. For this reason alone, the screening and brief intervention of substance use disorders should be a mandatory part of the core competencies of all graduating osteopathic medical students. Graduating students should also be aware of recent significant advances in the medical treatment of patients with these illnesses. To this end, an effort is currently under way in the osteopathic medical profession, led by the American Osteopathic Academy of Addiction Medicine (AOAAAM) and encouraged by various federal organizations, to ensure that the following areas are well covered in our medical schools:

- screening, prevention, and brief intervention;
- evaluation and management of substance use disorders;
- management of co-occurring disorders;
- legal and ethical issues surrounding the treatment of patients with a substance use disorder;
- proper prescribing of drugs with abuse potential; and
- issues surrounding impaired health professionals.

I strongly support Dr Prozialeck’s call for others in osteopathic medical education—either currently teaching addiction medicine or seeing the importance of enhancing their programs—to speak up and share their curricula and insights. This action could have a tremendous impact on the care delivered by our graduating students. I believe greater competence and confidence in the understanding of addictive illnesses will result in a more fulfilling career for our students no matter what specialty area of medicine they pursue.

STEPHEN A. WYATT, DO
Stonington Institute
North Stonington, Conn

Cochrane Library’s Summary of Review on Manipulative Treatment Misleading, Cheats Readers

To the Editor:
In its “Cochrane for Clinicians” section, the February 1, 2005, issue of American Family Physician presented a summary
of a review from the Cochrane Library on low back pain and spinal manipulative therapy. The article, “Spinal Manipulative Therapy for Low Back Pain,” is written by Katherine Margo, MD, in the Department of Family Practice at the University of Pennsylvania at Philadelphia.1

Although two of Dr Margo’s references have “osteopathic manipulation” in the title,2,3 none of the six citations are to articles published in JAOA—The Journal of the American Osteopathic Association. One referenced text concludes: “There was no evidence that manipulation was better for any subgroup of low back pain.”2 The other reference concludes: “Osteopathic treatment for chronic pain found that therapy was as effective as sham treatment.”3 These conclusions mislead both physicians and nonphysicians.

The past and present of our profession include many superb osteopathic physicians (DOs) who specialize in osteopathic manipulative treatment (OMT) of the back. In the words of Louisa Burns, DO, regarding spinal somatic dysfunction: “If severe, the pain may be pronounced and thus lead to early treatment, let us hope, by an efficient osteopathic physician.”4 In the more recent writings of George W. Northup, DO, “somatic dysfunction of the synovial joints, particularly of the spine, is increasingly recognized as a cause of pain and malfunction of the musculoskeletal system itself...the reutation of the osteopathic medical profession was first built on its ability to treat back pain effectively with manipulation...its application requires skill and clinical judgment.”5 Dr Northup also noted that many manipulative maneuvers “involve either interssegmental joint traction or placing the joint in such a position that the joint lock is released. Clinical experience teaches every physician willing to learn such helpful personal observations.”5 Recall your favorite moment in OMM (osteopathic manipulative medicine) while at school or, more recently, while offering OMT at state and national American Osteopathic Association (AOA) conferences. Who relieved your musculoskeletal back pain and made you feel better?

If the Cochrane Library does not include the most respected journal of the osteopathic medical profession, then the Cochrane Library’s readers are being cheated out of a more thorough and critical analysis of the subject. Are osteopathic physicians involved in gathering information for databases or at least advising audiences of the limitations of the databases? The AOA should verify that Cochrane, MEDLINE, and other “accepted” databases include at least the past 25 years of the JAOA’s 100-plus years of articles supportive of OMT—especially for back pain.

Let’s face it: OMT has helped countless patients (beyond anecdotal).6 Osteopathic physicians who specialize in OMM are recruited by their MD counterparts in physical and rehabilitation medicine to be an integral part of the team at rehabilitation hospitals, such as Spaulding Rehabilitation Hospital in Boston, which has a DO on staff. I do not accept Cochrane’s conclusion that no subgroup of patients with low back pain derives benefit from OMT.

The spectrum of knowledge should be broad based and presented honestly—something we should demand every day from ourselves, authors, and editorial staff.

R. G. MICHAUD, DO
Foster, RI

References

Worlds of Western Medicine and Chinese Medicine
Learning From Each Other

To the Editor:

During a rare break from medical school, I traveled to Beijing, China. Dr Jia Li Qun, chairman of oncology at the China–Japan Friendship Hospital in the center of Beijing, organized a week-long program for me to shadow several Chinese physicians in various settings, including the hospital, an outpatient setting, and an acupuncture clinic. The 400-bed teaching hospital uniquely integrates Western medicine disciplines with the tenets of Eastern medicine. In the United States, Eastern medicine, or Chinese medicine, is often regarded as alternative medicine, but in China, it is believed to be just as effective as Western medicine.

During my week’s stay, I observed that Chinese medicine emphasizes the body’s innate ability to heal itself. Much like osteopathic medicine, physicians trained in Eastern medicine emphasize that a pathologic lesion in one region of the body can manifest itself in another part of the body, such as the tongue or the radial pulse. For example, all inpatients and outpatients who are seen on the oncology service in the China–Japan Friendship Hospital are asked to stick out their tongue for the physician to inspect. According to the belief of Chinese medicine, its practitioners can see how efficiently and properly the body is working based on the color and texture of the patient’s tongue.

After observing the patient’s tongue, the physician trained in Chinese medicine palpates the radial pulse to gain additional information in identifying the culprit. As Dr Jia instructed me, the proper way in Eastern medicine...
to palpate the radial pulse is to use three fingers. The rationale is that underneath each finger, the physician can deduce an indication of the well-being and efficiency of a specific organ. For example, the three left digits consist of the liver, heart, and kidney from distal to proximal with the proper palpating position. The right hand represents the spleen, lung, and kidney in the same fashion as the left.

Eastern and Western medicine practitioners would agree that Western interventions and medications such as chemotherapeutic agents and morphine are essential in treating oncology patients for various types of cancers and associated pain. However, Dr. Jia and his colleagues believe that there is an advantage in combining the two disciplines. I often observed Dr. Jia prescribing herbal medications rather than an opioid as first-line analgesics.

My initial goal of spending a week with Dr. Jia was to gain an appreciation and broaden my view of the differences between osteopathic healthcare and healthcare in China. I ended up not only appreciating the differences, but perhaps more important, also appreciating the similarities of the two disciplines. Although many of its practical standards are not state-of-the-art as in the United States, physicians at the China-Japan Friendship Hospital holistically care for each patient. Such care may grant each patient a chance for an expedited healing process. Perhaps one day, Chinese medicine will be a routine part of Western medicine. In the meantime, both worlds of medicine can continue to learn from each other.

EDDIE WU, MPT, OMS II
University of Medicine and Dentistry of New Jersey-School of Osteopathic Medicine
Stratford, NJ

Proof-of-Concept Learning: Acrylic Templates as Empiric Evidence

To the Editor:

In his history of osteopathic medicine, Dr. Gevitz1 wrote something that, in my opinion, should be an outstanding and motivating paragraph for the profession’s researchers:

Remarkably, though, in the past two decades, no articles have been published in the JAOA that empirically test whether somatic dysfunction as specifically and objectively identified along the spinal column can be eliminated through the use of osteopathic manipulation and whether such treatments are correlated in any way with demonstrable physiological changes elsewhere in the body. Such studies are absolutely essential to testing the fundamental premises upon which the profession rests.

In a workshop I designed and have been teaching for several years, we attempt to rise to Dr. Gevitz’s serious challenge. In the course, titled “Evidence-Based Osteopathic Manipulation,” we not only correlate physiologic changes with spinal somatic dysfunctions, we also quantify the points of physiologic change for each patient.2

To accomplish this goal, workshop attendees learn to integrate direct craniofacial osteopathic manipulative treatment with making, fitting, and balancing an acrylic template (also known as an “acrylic oral appliance” or an “osteopathic oral appliance”) for each patient.2

Workshop attendees are amazed when they sense the almost total relaxation of the patient’s spinal somatic dysfunctions as the patient lies down on the table. The moment of recognition shows on attendees’ faces and is striking to me. Then I say, “Okay, just put the patient through a gentle range of motion and maybe use some gentle hand pressure to make sure the somatic dysfunctions disappear.” When workshop attendees note this improvement in patient symptoms, they know that they are experiencing “proof-of-concept learning.” After completing the course, workshop attendees learn quicker and have more confidence in their use of osteopathic manipulative treatment as a treatment modality.

Dr. Gevitz’s statement on the paucity of empiric evidence in the osteopathic medical literature has also motivated me to write a research proposal for review by the American Osteopathic Association’s Council on Research. The clinical procedure described above can be used in a college of osteopathic medicine as well as in solo practitioners’ offices. The procedure uses a clinical quantifying system3 that has been approved by the National Institutes of Health.

JAMES E. WHITE, DO
Kirksville, Mo

References

Violations of the 80-Duty-Hours Work Standard to Be Investigated

To the Editor:
As chairman of the American Osteopathic Association’s (AOA) Council on Postdoctoral Training, I feel compelled to express my gratitude to Susan C. Zonia, PhD, and colleagues for their July 2005 article on the duty-hour standards that became effective for all accredited residency programs in 2003 (J Am Osteopath Assoc. 2005;105:307–331). My thanks extend also to Brian H. Foresman, DO, for his accompanying editorial (J Am Osteopath Assoc. 2005;105:305–306). Both pieces well reflect the extreme significance of the duty-hour work standards imposed on all internship and residency programs approved by the AOA and accredited by the Accreditation Council for Graduate Medical Education.
Initially, the medical profession was flooded with anxiety, questions, and uncertainty about these restrictions. In the past several years, however, a casual attitude toward resident duty hours has regained an unfortunate foothold in some of our training hospitals, and I believe the issue is no longer given the seriousness it deserves. In these days of commitment to patient safety through the landmark Institute of Medicine report, the Institute for Healthcare Improvement’s 100K Lives Campaign (see http://www.ihi.org/IHI/Programs/Campaign), and tightening hospital accreditation standards, how can anyone deny the need for duty-hour regulations in physician training?

No one is yet certain of the impact of this restriction on the quality of physician training. But who can doubt its benefit to resident health, improved alertness on duty or in lectures and at conferences, and improved attitudes toward learning opportunities.

Modifications may well yet have to occur to training models to compensate for potential loss of continuity and volume—if, indeed, that result can be validated. However, until data are available, the validated benefits of sleep, rest, and personal time are as applicable to physicians-in-training as they are for the patients for whom we care and advise.

The Council on Postdoctoral Training encourages residents to report duty-hour violations anonymously to the AOA through the association’s toll-free Postdoctoral Program Violation Hotline at (877) 325-8197 or by e-mail at postdoc@osteopathic.org. Such violations are and will continue to be investigated seriously to preserve the educational benefits for residents, the safety of patients, and the quality of training programs.

MICHAEL I. OPIPARI, DO
Chairman
American Osteopathic Association’s Council on Postdoctoral Training
Chicago, Ill

References