As the premier scholarly publication of the osteopathic medical profession, JA O A—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 JA O A and the mission of the osteopathic medical profession. The JA O A’s editors are particularly interested in letters that discuss recently published original research.

Letters to the editor are considered for publication in the JA O A 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 JA O A staff with photocopies of referenced material so that the references themselves and statements cited may be verified.

Letters to the editor are considered for publication in the JA O A. Readers should be aware that JA O A cannot acknowledge the receipt of letters, a JA O A 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 JA O A 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 JA O A 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.

Combat-Related Posttraumatic Headache: Diagnosis, Mechanisms of Injury, and Challenges to Treatment

To the Editor:

I am concerned that the original contribution by CPT Matthew Kozminski, DO,1 in the September 2010 JA O A does not discuss effective treatment options for soldiers with posttraumatic stress disorder (PTSD) and postconcussion syndrome (PCS). Dr Kozminski1 clearly describes the challenges of poor follow-up and overuse of headache-aborptive medications in soldiers with chronic headache. However, the lack of any discussion of effective ways to treat these soldiers is unfortunate.

Data from the Department of Defense show that more than 1.6 million military personnel have been deployed to the conflicts in Afghanistan and Iraq since late 2001.2 According to Dr Kozminski,1 more than 95% of soldiers face combat-related posttraumatic headache attributed to PTSD and PCS—and traumatic brain injury (TBI) may be the underlying cause of both of these conditions. If we are to improve the quality of life of these soldiers, treatment plans must be included and investigated in our osteopathic medical literature.

In cases of PCS, amitriptyline hydrochloride is probably the most commonly used medication. Studies have shown that amitriptyline is effective against such nonspecific symptoms as depression, dizziness, fatigue, insomnia, and irritability.3 Intravenous dihydroergotamine mesylate and metoclopramide hydrochloride may provide relief of refractory chronic posttraumatic headache.4 Greater occipital neuralgia frequently responds favorably to greater occipital nerve block using a local anesthetic, which can be combined with an injectable corticosteroid.5 A trial comparing either propranolol hydrochloride or amitriptyline alone with both these drugs in combination revealed a high favorable response rate in patients with posttraumatic migraine.6 Patients with posttraumatic paroxysmal hemicrania and hemicrania continua have responded favorably to treatment with indomethacin.7,8

Donepezil hydrochloride has produced beneficial results in preliminary studies of patients with severe TBI, but this medication has not been studied extensively in patients with PCS.9 Treatment with oxiracetam was described as being helpful for patients with PCS.10 Patients with mild TBI who also met criteria for major depression and were treated with sertraline hydrochloride for 8 weeks achieved substantial remission in depressive symptoms, as well as improvement in cognitive measures.11 An open-label study of 20 patients with depression after TBI showed symptomatic improvements following treatment with citalopram hydrobromide and carbamazepine.12

For symptoms of PTSD, selective serotonin-reuptake inhibitors are first-line treatment.13 Tricyclic antidepressants and monoamine oxidase inhibitors have been shown to decrease intrusive nightmares and flashbacks in patients
with PTSD. Adverse effects of these medications must be weighed against their benefits.

A meta-analysis of seven randomized, controlled clinical trials suggested that atypical antipsychotic medications reduce PTSD symptoms compared to placebo. Anticonvulsant medications that have demonstrated mood-stabilizing properties, including carbamazepine, lamotrigine, and valproic acid, may be effective in managing impulsive behavior, hyperarousal, and flashbacks in patients with PTSD. Prazosin hydrochloride decreased nightmares of patients with PTSD in small randomized studies.

In addition to pharmacotherapy, there needs to be discussion about psychotherapy, cognitive therapy, and stress management for patients with PTSD and PCS. All of these treatments have shown promise and, for completeness, should be mentioned in any article about chronic headache in soldiers.

Our soldiers are put in extraordinary situations with extreme stress. As osteopathic physicians, we must understand the causes of their symptoms, as Dr Kozminski describes. However, to optimally address this issue, we must remember to include effective treatment options as part of the discussion.

Eric S. Felber, DO
McLean, Virginia

References

Dr Kozminski was shown this letter and declined to comment.

brief report of a clinical trial on the duration of middle ear effusion in young children using a standardized osteopathic manipulative medicine protocol

to the Editor:
We read with great interest the preliminary analysis of the prospective, randomized, blinded, controlled study on the use of osteopathic manipulative treatment (OMT) for children with middle ear effusion (MEE) by Steele et al in the May 2010 issue. The analysis included the first 9 months of study data; the authors plan to publish final results later this year. It is clear that many challenges exist when designing a study that seeks to objectively validate OMT techniques when compared with standard treatment practices. These challenges are compounded for studies that enroll infants and young children. Furthermore, it is best when the design of the study not only validates the OMT techniques, but also is directly applicable to using OMT in a busy medical practice. Because MEE and acute otitis media rank among the most common reasons for visits to pediatric practices, the impact of OMT in reducing morbidity and surgery in patients with these conditions can be substantial.

A core principle of osteopathic medicine is that structure and function are interrelated. As such, a detailed understanding of eustachian tube development enables one to comprehend the tube’s role in pathologic processes. At birth, the eustachian tube is 13 mm long and angled at 10 degrees to the base of the skull. An adult’s eustachian tube is 33 mm long, with an angle of 45 degrees. By age 7 years, a child’s eustachian tube reaches the adult length and angle as a result of vertical elongation of the skull and widening of the skull base’s angle. In addition, children have smaller surface areas of the tensor veli palatini muscle—an anatomic feature that assists in opening the tube to allow for equalization of pressures and drainage. This anatomic characteristic results in decreased drainage and increased reflux of secretions into the middle ear.

Combined, the anatomic differences in eustachian tube length and angle and tensor veli palatini surface area in children vs adults account for the frequency of middle ear infections, as well as the added complications of MEE, in children. Equally noteworthy is that the lymphatic drainage of the pharynx and nose joins that of the ear to create a
plexus, which drains into the retropharyngeal nodes. Obstruction of this plexus contributes to serous otitis media.

A discussion about optimal design of studies to investigate the effects of OMT on MEE is important for validation and application of the OMT techniques used. We understand that problems of patient recruitment and retention exist in all facets of clinical research, especially in studies on acute otitis media. Evidence of these problems is the huge discrepancy in recruitment and retention noted between the two referral/treatment sites evaluated by Steele et al. We can offer no easy solution; suffice to say that recruitment and retention are best tailored to the patient population studied and the location of that study group. Limiting the number of research sites and practitioners may minimize variability in outcome, though we acknowledge this would come at the expense of reducing sample size.

Likewise, to minimize confounding results, we believe that a standardized treatment protocol should be used. Many manipulation techniques were performed in the study by Steele et al., making interpretation of results difficult—especially considering the possible low enrollment of study participants.

If one were to prioritize the OMT techniques used in such a study, we believe that direct techniques, such as Galbreath treatment and anterior cervical mobilization, may prove more practical and better suited for MEE analysis than the techniques used by Steele et al. Galbreath treatment, developed by William Otis Galbreath, DO, produces effects on several components of the middle ear. It facilitates lymphatic drainage to the jugulodigastric nodes from the pharynx and ear, increases blood flow, releases peripharyngeal fascia, and changes pressure within the middle ear and eustachian tube. Galbreath treatment has the added benefits of being easy to perform on young infants and to teach to parents—benefits that may aid in decreasing rates of MEE as a result of more frequent treatments (ie, typically 3 times a day). We do not understand why the treatment interval of 1 week was chosen by Steele et al.

Another direct maneuver that may be beneficial in its application—though it would be difficult to perform in pediatric patients—is the Muncie technique, which opens the eustachian tube by intraoral manipulation. Although balanced ligamentous tension, myofascial release, and osteopathy in the cranial field were all used in the study by Steele et al. and can facilitate MEE drainage, these OMT techniques may also be less practical to perform in the office of a busy pediatric practice. Cooperation of a 2-year-old toddler who is the recipient of OMT lasting 15 to 30 minutes seems unlikely. We predict that in the final results of the analysis by Steele et al., most patients enrolled in the study will be less than 1 year of age.

Finally, it is understandable that Steele et al. used tympanogram and acoustic reflectometer readings to measure MEE in an effort to remain objective. We agree with this strategy, but we believe that these techniques could be backed up by provider visualization of the tympanic membrane coupled with insufflation to visualize mobility. Although these visual techniques may introduce a degree of clinical bias, they provide a realistic measure of MEE resolution that can confirm or refute tympanometry findings, and they minimize tympanometry results that are “not readable.” We realize that the addition of this component is controversial.

It is encouraging to see formal research being performed in a difficult patient population, and we applaud the efforts of Dr Steele and her colleagues to validate OMT in the treatment of children with MEE. We look forward to publication of the final results of the analysis by Steele et al. in the near future.

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References

Response
We thank Student Doctor Prakash and Dr Michalik for their thoughtful response to our brief report, which described our experiences with a clinical trial. Although the well-known details of the anatomic structure of the pediatric eustachian tube and middle ear lymphatic system are important in constructing a clinical trial of osteopathic manipulative medicine (OMM), we did not believe that these details were appropriate to include in a report intended to describe our experiences in implementing such a trial.

Prakash and Michalik correctly identified what we thought to be the most important observation—the difference in recruitment between the two referral/treatment sites. We attributed this discrepancy to the presence of an onsite research assistant at site B and to the loss of three of the five committed referring providers at site A.

Furthermore, we agree with the
commentary by Prakash and Michalik on Galbreath treatment and anterior cervical mobilization when used with older children. However, these techniques were not included in the previously published study upon which our research was based; a study that demonstrated statistical significance in outcomes for young children treated with a similar OMM protocol. In our experience, Galbreath treatment has not been found to be as helpful for treatment of very young children with otitis media as it is for older children. This lack of efficacy may be the result of anatomic differences between younger and older children in the mandible, hyoid bone, tensor veli palatini muscle, and pterygoid processes and the subsequent effects of these differences on soft tissues.

In regard to the treatment protocol, Prakash and Michalik seem to be under the impression that the OMM techniques used in our study varied between subjects. The OMM protocol that we used was the same for all subjects and was designed with the following three goals in mind:

1. To use techniques that have some evidence of clinical effectiveness and that are commonly taught in colleges of osteopathic medicine (COMs). The techniques and treatment intervals chosen had been used by one or more treatment providers in a previous study and are known to be commonly taught in COMs.

2. To address the key areas of somatic dysfunction in children with otitis media, based on a review of published literature and of unpublished documentation from previous otitis media studies.

3. To use techniques that take less than 15 minutes to perform.

Our treatment protocol will be elaborated upon in our final report. Although there are many OMM techniques and combinations of techniques that may be helpful to children with otitis media, the protocol tested in our study was designed to meet the aforementioned criteria.

Prakash and Michalik suggest that the use of otoscopic (ie, provider) visualization to confirm or refute tympanometry findings might decrease the number of unreadable tympanometry evaluations. This method could well be a useful addition to future studies though—as noted by Prakash and Michalik—it would introduce a level of clinical bias. Moreover, tympanometry and acoustic reflectometry are typically used as diagnostic techniques for children when otoscopic examination results are ambiguous—not vice versa. Although a comparison of otoscopic visualization vs “gold-standard” tympanometry and acoustic reflectometry might be an interesting project, in our experience the amount of infant crying and noncompliance is directly proportional to the probability of an unreadable tympanometry recording and an ambiguous otoscopy finding.

Very few studies have been published evaluating the clinical efficacy of OMM in children, and there is a strong need for many more such studies. We are grateful for the interest that Student Doctor Prakash and Dr Michalik have shown in our brief report, and we hope they will join the ranks of those of us who are interested in studying the use of OMM in children.

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References


Is Something Wrong With Osteopathic Graduate Medical Education?

To the Editor:

According to data released in February 2010, 1,896 graduates of colleges of osteopathic medicine (COMs)—representing only 48% of eligible COM graduates—participated in this year’s American Osteopathic Association (AOA) Intern/Resident Registration Program (ie, the AOA Match), the residencies of which started in July 2010. That participation rate compares with 51% of eligible COM graduates who participated in the 2009 AOA Match and 52% of eligible COM graduates who participated in the 2005 AOA Match. Clearly, this trend is heading in the wrong direction.

The 2010 AOA Match results also document that although 2,443 funded AOA-approved internship or residency positions were offered, only 1,473 (60%) of these positions were filled, leaving 970 positions (40%) open. These unfilled positions are in the subspecialties as well as in primary care—and in all types and sizes of hospitals with AOA-approved training programs. At the same time, in the 2010 National Resident Matching
What are the implications of this trend? Can AOA-approved training programs be made more competitive to attract more COM graduates to fill their slots? Do AOA-approved training programs need to be made more competitive? If so, whose job is it?

As a graduate of a COM who completed strictly AOA-approved postgraduate training, I have predominantly worked at allopathic medical institutions. All these institutions have accepted my AOA-approved training and certification as equivalent to allopathic medical training.

I currently work as a medical director for the third largest nonprofit health system in the United States—the North Shore-Long Island Jewish Health System in New York State. This system has a $4 billion annual budget and 38,000 employees. My job is located just a few city blocks from where I lived as a child, in Glen Oaks, Queens. I have never regretted pursuing AOA-approved residency training, nor have I ever felt “held back” because of my training.

Furthermore, there are hundreds of other COM graduates who have been equally successful as I have been—or even more successful—after completing AOA-approved residency training. Clearly, completing osteopathic graduate medical education is an established pathway to career success.

Considering this record of success, I can’t help but wonder what is so wrong with osteopathic graduate medical education that decreasing percentages of COM graduates are participating in the AOA Match, while COM graduates are instead choosing, in increasing numbers, to participate in ACGME-accredited residency training programs.

Osteopathic Medicine’s Holistic Approach Is More Important Than Ever

To the Editor:

Who would have imagined just a few years ago that certain major corporations would be out of business, bankrupt, or just remnants of what they once were? Yet, this is my concern for the future of osteopathic medicine. Although our profession has undergone unprecedented growth, the growth alone will not guarantee future success. The main strengths of osteopathic medicine are our philosophy and training, which provide a more holistic and comprehensive approach to treating patients than does allopathic medicine. However, we currently seem to be swept up in a tide to emulate allopathic medicine, and we are eroding the principles that it truly takes to be the most well-rounded and educated physicians.

A tremendous amount of information is learned in medical school, but the vast amount of our clinical knowledge and expertise is acquired after graduation. Regardless of specialty or expertise, a physician needs to have a solid and well-rounded knowledge of medicine and surgery. The traditional osteopathic rotating internship helps to foster our philosophy and to promote this solid foundation. Unfortunately, the...
“deregulation” of this traditional rotating internship by the American Osteopathic Association (AOA) to allow specialty-tract internships is a grievous mistake. These specialty-tract internships will not provide the comprehensive exposure and knowledge that a physician should possess to provide the best possible patient care.

As an allergy specialist, I believe that now—more than ever—a holistic philosophy and approach as developed in the traditional osteopathic rotating internship is invaluable.

Many patients are referred to me by primary care physicians or specialists for allergy treatment. In some cases, I find that these patients have been misdiagnosed as a result of failure by the referring physicians to use a holistic approach. For example, I commonly see patients who have been diagnosed as having chronic allergic cough, but who in reality have asymptomatic gastroesophageal reflux disease—a condition that can also be exacerbated by certain medications. One of my patients had been diagnosed by her cardiologist as having an exacerbation of asthma, but she actually had congestive heart failure.

Only a small number of osteopathic physicians use osteopathic manipulative treatment (OMT). Nevertheless, the vast majority of osteopathic physicians should at least incorporate basic palpatory skills to improve their diagnostic acumen. I frequently see patients who were diagnosed as having “sinus headaches” that I find, upon palpation, resulted from musculoskeletal causes. One of my patients with chest discomfort had been incorrectly diagnosed by her primary care physician as having costochondritis. After performing a complete physical examination of the patient, including palpation, I concluded that a chest radiograph was warranted. The radiograph revealed a pneumothorax.

I have a longtime friend who writes business-oriented books and tours the country as a highly paid speaker and business consultant. In his work, he always stresses the critical importance of having one’s own niche, so one does not need to compete with others. This advice is especially important during these increasingly difficult times. The osteopathic medical profession already has its perfect niche carved out—yet we are squandering our great potential by trying to emulate our allopathic colleagues. In fact, some members of the osteopathic medical profession are even promoting a change of our DO degree to be more like the MD degree.

High-quality evidence-based studies, as Felix J. Rogers, DO, has promoted, could help propel us to the preferred physician status in the United States. Such studies could be the centerpiece of an effective public marketing campaign, which has been sorely lacking, to introduce and promote the superiority of osteopathic medicine. In addition, Norman Gevitz, PhD, has stressed that for the osteopathic medical profession to thrive, young osteopathic physicians need to practice distinctive osteopathic medicine and to dedicate themselves to conducting research on osteopathic principles and practice and fighting for professional autonomy.

A number of published studies have indicated benefits from osteopathic medicine for a variety of conditions. For example, a study by Licciardone et al in the January 2010 issue of the American Journal of Obstetrics and Gynecology presented evidence that OMT may ease late-pregnancy back pain, though the authors called for further investigations. In another example, Guiney et al found statistically significant improvements in peak expiratory flow rates in pediatric patients with asthma after OMT.

At the AOA’s Annual Convention and Scientific Seminar in Las Vegas, Nevada, in October 2008, one presented abstract described a small pilot study designed to assess whether OMT could reduce the need for cesarean sections. If beneficial results of OMT for such cases are demonstrated in larger, controlled studies, OMT may not only help patients, but it may also help reduce medical and surgical costs. Furthermore, results of such studies would increase patient demand for osteopathic medical services.

We currently find ourselves at what may be the dawning of monumental changes in the US healthcare system. With the ballooning deficits of the federal government, healthcare dollars will most likely dwindle in the future. Residency positions that are funded by the Medicare program may also decrease, creating keen competition for the remaining spots. Allopathic residency slots in many fields are still plentiful, but in certain fields, such as dermatology, competition for these slots is already extremely competitive. Moreover, according to Michael E. Whitcomb, MD, the availability of allopathic graduate medical education programs will cease to exist for osteopathic medical students in the foreseeable future.

In addition, slots that remain unfilled in the AOA Intern/Resident Registration Program (ie, AOA “Match”) may disappear with decreased funding, creating the “perfect storm” of fewer slots and more competition. Residency program directors will have their pick of the top medical students in the country. By surrendering our unique osteopathic medical training, we would force residency program directors to consider other information about candidates, such as medical school attended, college grades, and Medical College Admission Test (MCAT) scores. This development would place us at a greater disadvantage. According to 2009 statistics from the Association of American Medical Colleges and the American Association of Colleges of Osteopathic Medicine, allopathic matriculants have higher grade point averages (GPAs) and higher MCAT scores than do osteopathic matriculants (allopathic GPA = 3.66 and MCAT=30.8, osteopathic GPA = 3.48 and MCAT=26.19).

Further denigrating our profession are those applicants who wish to become physicians and have no interest in osteopathic medicine, but whose grades and...
board scores were not competitive enough for admission to allopathic medical schools. Upon graduation from osteopathic medical schools, such students will simply skip the rotating internship and enter the allopathic “Match” and then blend into the allopathic medical profession.

The second-rate image of osteopathic medicine was fostered by a *New York Times* article in February 2010 that discussed the keen competition for admission into allopathic medical schools. According to the article, an individual who was rejected from 28 of 30 medical schools was told by his pre-med adviser that, with his 3.3 GPA, he should apply only to osteopathic medical schools.

What is our goal for excellence? If an individual is truly committed to becoming an osteopathic physician, he or she should be willing to commit to completing a rotating internship and then be free to pursue any residency. One additional year of training over a lifetime of practice is little sacrifice and will result in an immense payoff in terms of both personal and professional satisfaction.

Another problem that we face involves lack of the holistic approach in coordination of care between physicians and patients. This deficiency is becoming a major obstacle in delivering quality medical care. A letter in the July 2009 issue of JAOA—*The Journal of the American Osteopathic Association* by David Stuart Tabby, DO, illustrated this problem. Dr Tabby’s father, a retired osteopathic family physician, was hospitalized in the intensive care unit at a Philadelphia hospital. Dr Tabby described his frustration regarding the lack of communication between his family and his father’s physicians. The letter revealed that even in an intensive care setting where both the patient and his son are physicians, there is no continuity of care, and no one seems to be in charge. Unfortunately, this situation appears to be a growing epidemic that is exacerbated when physicians know nothing outside their realm of expertise, resulting in a “medical Tower of Babel.”

In summary, it is critical in these changing times that the osteopathic medical profession not be embarrased by our history and embrace what has brought us as far as we have come—a holistic approach to patient care and a comprehensive osteopathic training program. We must also demonstrate through evidence-based studies that we practice thorough and sound medicine. If we continue along our new path of following allopathic colleagues, I fear that our prognosis is guarded.

**Paul M. Goldberg, DO**
Alexandria, Virginia

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**Osteopathic Medical Terminology—Redux**

To the Editor:

Fifty years ago, the American Osteopathic Association established a policy that the term *osteopathic medicine* should replace the term *osteopathy*.

During the AOA House of Delegates’ meeting in 1960, a principal argument proffered for considering the policy was that the term *osteopathy* is considered by many to be restrictive and suggests limited training and restrictive privileges (as in foreign-trained osteopaths). As a result, a policy was adopted that the terms *osteopath* and *osteopathy* be reserved for “historical, sentimental, and informal discussions only.”

By the late 1970s, colleges of osteopathy had changed their names to
colleges of osteopathic medicine, and several years later, the colleges adjusted the degree designation from doctor of osteopathy to doctor of osteopathic medicine. Most osteopathic medical associations adopted the change in terminology.

Today, only the American Academy of Osteopathy continues to use osteopathy in its name. In addition, the Glossary of Osteopathic Terminology makes an exception for the term osteopathy in the cranial field, which describes the palpatory techniques and osteopathic manipulative treatment used to assess cranial dysfunction and to treat patients with such dysfunction.

In 1993, I wrote the editorial that is reprinted on this page to outline in JA O A—The Journal of the American Osteopathic Association the reasons that AOA publications follow the AOA’s 1960 mandate in preferred terminology. However, some osteopathic physicians continue to use outdated terms. So it is not a surprise that patients still do not realize that we are fully licensed physicians.

Words have meaning. Is it not time for the entire osteopathic medical profession to join together to erase the confusion that still exists because of the continued use of confusing terminology?

Thomas Wesley Allen, DO, MPH
AOA Editor in Chief Emeritus

References

Editor’s note: Dr Allen was not involved in the decision to publish this letter or the reprinted editorial that follows.

This editorial was originally published in the J A O A in September 1993.

‘Osteopathic physician’ defines our identity

Behind every name or label lies an idea, or an understanding. A misnomer, then, creates a misunderstanding. Certainly, this logic played some part in the resolution adopted by the House of Delegates of the American Osteopathic Association (AOA) on July 20, 1960:

Be it resolved, that the American Osteopathic Association institute a policy, both officially in our publications and individually on a conversational basis, to use the terms osteopathic medicine in place of the word osteopathy and osteopathic physician and surgeon in place of osteopath; the words osteopathy and osteopath being reserved for historical, sentimental, and informal discussions only.

The AOA publications have followed the mandate of the profession in the use of the preferred terminology. Osteopathy and osteopath are considered by many to be restrictive, because they are commonly equated with manipulative treatment only. Structural diagnosis and manipulative treatment are a means of expressing some of the basic concepts of osteopathic medicine but do not define it. Nonetheless, many individuals may think that the term osteopathy suggests restricted privileges and limited training.

The misapprehension that DOs have limited training and should have their practice privileges restricted was a consideration of early osteopathic physicians. In fact, as early as January 1902, the JA O A reported, “From what has been said the conclusion is inevitable that we are, properly speaking, medical practitioners and that we hold a coordinate rank with other schools of medicine.”

We osteopathic physicians are understandably irritated to read so often in the lay press and in professional publications, the terms, physicians and osteopaths and doctors and osteopaths. Whether used by detractors in a pejorative context, or as a contraction for osteopathic physician, the aforementioned terms are confusing. The public may infer from the juxtaposition of these two terms that we are not physicians. We are, and have been from the beginning, the osteopathic medical profession. We are osteopathic physicians.

As George W. Northup, DO, wrote, “More modern terminology relating to our profession will gain acceptance if we, ourselves, make use of it. At every opportunity, osteopathic physicians should urge correct professional identification, remembering that we cannot expect to be identified properly so long as we fail to identify ourselves properly.”

The terms osteopath and osteopathy were honorably retired more than 30 years ago and do not accurately reflect who we are today. As such, it is up to us to communicate who we are, not only by identifying ourselves properly in the written and spoken word, but also by our work.

Thomas Wesley Allen, DO
DO Editor in Chief

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It Means Just What I Choose It to Mean—Neither More nor Less

To the Editor:

The late Sen Daniel Patrick Moynihan (D, NY) was fond of saying, “We are all entitled to our own opinions, but not to our own facts.” I would add that we are not entitled to our own professional language choices, either.

To be a profession, a group should share a body of knowledge and skills. Although professionals are granted considerable autonomy in practice and the privilege of self-regulation, certain boundaries must be respected. It is my opinion that we need to maintain a consistent standard of language in describing osteopathic medicine and that the Glossary of Osteopathic Terminology defines that standard.

The American Osteopathic Association’s Foundations for Osteopathic Medicine textbook includes the following statement related to osteopathic medical terminology:

The evolution, growth, and teaching of osteopathic philosophy have been coordinated through the Educational Council on Osteopathic Principles (ECOP) of the American Association of Colleges of Osteopathic Medicine. This organization consists of the chairs of the departments of osteopathic manipulative medicine and osteopathic principles and practice from each osteopathic medical school. One of ECOP’s charges is to obtain consensus on the usage of terms within the profession.

The terminology preferences of JAOMA—The Journal of the American Osteopathic Association—differ from the Glossary in certain cases, based on AOA policy (Michael Fitzgerald, BA, personal communication, May 11, 2010). Although I am not arguing that either the JAOMA or the Glossary of Osteopathic Terminology is right or wrong, I am arguing that we need to use a common language to describe what we do as osteopathic physicians.

In the early days of the osteopathic medical profession, each school of osteopathy developed its own language to describe the manual medicine taught at the school. The resulting inconsistencies made developing state licensing examinations, national board examinations, and objective standards difficult by allowing for a bias that benefited individuals based on the schools they attended rather than on the merits of those being tested.

In 1969, ECOP was established to standardize osteopathic medical terminology and osteopathic principles and practice. Twelve years elapsed before ECOP reached agreement and the first edition of its Glossary was published in the JAOMA’s April 1981 issue.

Currently, the criteria for including terms in the glossary are as follows:

- Words to be included must have special significance to the osteopathic [medical] profession.
- Words must be a part of our language or appear in the osteopathic [medical] literature.
- Terms that [are] defined in medical dictionaries [are] excluded, unless they [have] a special significance to osteopathic physicians.

Osteopathic physicians from different specialties often speak different professional languages—even if they all use English as their vernacular language. Yet standardization of professional terminology facilitates discussions among different specialists. Furthermore, the increasing importance of clear communication within interdisciplinary healthcare teams means that we must be consistent with our language.

The JAOMA often determines the issues discussed within the osteopathic medical profession, and the language used in the JAOMA will be repeated, quoted, and cited. If the JAOMA decides to use its own language—separate from that taught in osteopathic medical schools—unnecessary confusion will cloud professional discussions.

Discussions, as well as scientific research, cannot be accurate or productive without a standard vocabulary. People can easily talk past each other or use the same words to talk about very different things. The work of the JAOMA is too important for it to occur outside of the academic work of osteopathic medical schools.

A system is in place for considering changes to the Glossary of Osteopathic Terminology—including openness to input and lively discussion (http://www.aacom.org/people/councils/Documents/Glossary_Guidelines.pdf). I respectfully request that the JAOMA work with ECOP to maintain standardization in the language used within the osteopathic medical profession.

Tyler C. Cymet, DO
Associate Vice President for Medical Education
American Association of Colleges of Osteopathic Medicine

References


(continued)
Response

In this month’s “Letters” section of JAOA—The Journal of the American Osteopathic Association, both Tyler C. Cymet, DO, and Thomas Wesley Allen, DO, MPH, take us back in time to remind us of how important it is for osteopathic physicians to adhere to a common language in describing the unique care they provide.

Dr Cymet reminds us that before the Glossary of Osteopathic Terminology was first published 29 years ago,1 many osteopathic medical colleges used different terms to describe the same conditions and treatments. Dr Allen, in turn, reminds us that 21 years before the Glossary premiered, the American Osteopathic Association (AOA) established its first policy to use the term osteopathic medicine in place of osteopathy and the term osteopathic physician and surgeon in place of osteopath.

As the American Association of Colleges of Osteopathic Medicine’s staff liaison to the Educational Council on Osteopathic Principles (ECOP), Dr Cymet is appropriately exercising his duty as ECOP’s steward when he questions why the JAOA would adopt terminology that differs from what ECOP approved for the Glossary’s most current version.2

Like ECOP, the JAOA has long supported standardized terminology in osteopathic medicine. In fact, on nearly every major issue related to terminology, the JAOA’s style guidelines and the Glossary agree. Where they disagree on major issues are in the rare instances in which policy set by the AOA House of Delegates conflicts with the Glossary. Currently, that conflict centers on one term: osteopathy in the cranial field.

While the Glossary uses osteopathy in the cranial field, the JAOA prefers to use either osteopathic manipulative medicine in the cranial field or cranial osteopathic manipulative medicine. The JAOA’s preference is grounded in the AOA’s 50-year tradition that Dr. Allen described in his letter. The AOA House of Delegates reconfirmed that tradition in July when it passed as policy House Resolution 301 (A-2010), which is titled “Osteopath and Osteopathy—Use of the Terms.” While that 2010 policy allows for a few exceptions, it calls for the AOA to preferentially use osteopathic medicine in place of the word osteopathy and osteopathic physician in place of osteopath.

Despite the JAOA’s style preference, the Journal does allow authors to use osteopathy in the cranial field if they insist on using that term in their articles. But in deference to the AOA’s policy, the JAOA includes with those articles an editor’s note such as the following one from the JAOA’s April brief report titled “Effect of Osteopathy in the Cranial Field on Visual Function—A Pilot Study.”3

Editor’s Note: In this article, the authors use the term osteopathy in the cranial field to describe the palpatory techniques and osteopathic manipulative treatment used to assess cranial dysfunction and to treat patients for such dysfunction.

The authors use osteopathy in the cranial field because it is a more universally used term than cranial osteopathic manipulative medicine and osteopathic [manipulative] medicine in the cranial field, which are the terms preferred by the style guidelines of JAOA—The Journal of the American Osteopathic Association.

Still, Dr Cymet makes a valid point in urging the JAOA to bring its style concerns to ECOP for its consideration. The JAOA plans to do just that in the hope that ECOP can offer a solution that the JAOA can bring back to the AOA House of Delegates.

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References