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 readers e-mail letters 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 address, day and evening telephone numbers, fax numbers, and e-mail address. 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.

Realigning the JAOA to Sharpen Our Focus

To the editor:
In the November 2009 issue of JAOA—The Journal of the American Osteopathic Association, an editorial by Felix J. Rogers, DO, outlined ideas to help promote the profession by focusing on several key tenets, including the one that has defined the profession from its inception: The musculoskeletal system plays a primary role in health and disease.

The problem is, in my opinion, that tenet is not true. The concept that the musculoskeletal system has a major influence on a person’s health was first proposed by the surgeon and anatomist John Hilton in 1863 and was affirmed a decade later by Andrew Taylor Still, MD, DO, who became convinced that this system was critical for maintaining good health. Three years after the first osteopathic school was opened, in 1892, Daniel David Palmer, a magnetic healer, started the chiropractic profession.

Both Still and Palmer concluded that impairment in the flow of information from nerves to various organs was the source of all medical conditions, from croup to liver disease.

As Dr Still wrote, “I could twist a man one way and cure flux, fever, colds, and the diseases of the climate; shake a child and stop scarlet fever, croup, diphtheria, and cure whooping-cough in three days by a wring of its neck, and so on.” We know today that none of these claims could be true. Mr Palmer decided that when a bone was out of place, it pressed on a nerve and impaired the flow of some special force that he called the “Innate” (always with an initial capital letter), a force he believed was necessary to allow the body to heal itself.

The ignorance of both gentlemen living in the late 19th century is understandable. There was little to no understanding of disease (the germ theory was still a hot topic), and there were no modern studies in physiology or biochemistry. Medicine was still in its infancy. Today there is no excuse to hold to such a belief. The musculoskeletal system does not play a primary role in health and disease. Compared with many other organ systems, the musculoskeletal system would rank near the bottom as an agent of disease prevention (certainly more important are the immune system, the circulatory system, the endocrine system, the integumentary system, the respiratory system, and even the digestive system).

While some today may still argue otherwise, I know of no evidence that spinal adjustments improve the function of these other systems. It should be pointed out, however, that musculoskeletal problems are exceedingly common. Back pain and related problems are the second most common reason for visits to primary care physicians. Injuries, headaches, and fibromyalgia are other reasons people fre-
quent various healthcare providers at times, looking for options other than medications.

If the osteopathic medical profession must focus anywhere, it seemingly should be on these musculoskeletal problems. Our profession can and should embrace the ability to offer manual medicine in these cases. The superiority of osteopathic manipulative treatment (OMT) compared with other treatments remains debatable, but few would argue against its potential value in musculoskeletal problems, and everyone recognizes the demand for this kind of care.

More importantly, we must be completely willing to abandon any and all unproven claims in which good evidence is lacking, and especially distance ourselves from claims that OMT may prevent disease or modify illness when there is no reasonable physiologic explanation or proof that can be offered.

Daniel K. Mangum, DO
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References

Response
I thank Dr Mangum for his provocative letter. The first step is to defuse our reaction to the language used by Dr Still in materials Dr Mangum quotes. While Still is widely revered throughout the osteopathic medical profession as creative and innovative, the fact is that he sometimes used outrageous language to emphasize a point or to shake up conventional thinking. I think the hyperbole described by Dr Still is just such an example.

Dr Mangum issues a clear challenge: that the tenet describing the primary role of the musculoskeletal system in health and disease is simply not true. When our ad hoc committee got down to the task of developing the new tenets and principles that we proposed in 2002, we faced several challenges. The first was to be sure that the tenets and principles accurately reflected the published record of our profession. Largely due to the efforts of Michael Seffinger, DO, and his careful assessment of a century of osteopathic literature, I am confident that we did so.

Implicit in Dr Mangum’s thoughtful letter are two other important concerns. First, is the tenet “The musculoskeletal system plays a primary role in health and disease” in fact true? The first stumbling block is the word primary. Who of us would doubt the primary role played by the cardiovascular, pulmonary, neurologic, and gastrointestinal systems in health and disease? In fact, how many “primary” systems can there be? My November editorial indicated we were staking out new territory to provide evidence that this tenet can be demonstrated in research-based practice and the scientific literature. I welcome this challenge, and I hope that we will answer concerns about this and the other tenets as well. Over the next several months, these articles will deal with the role of the musculoskeletal system in type 2 diabetes mellitus, the role of lifestyle modification including exercise in the treatment of chronic coronary disease, and sports medicine, where the application is much more obvious. In each of these instances, the research evidence in support of osteopathic manipulative treatment (OMT) as an intervention into the musculoskeletal system is scant.

The second, equally important issue is this: what has the osteopathic profession done to advance this tenet about the primary role of the musculoskeletal system, either in clinical practice, research, or scholarly publications? I part company with Dr Mangum when he states that our profession needs to focus on back pain and musculoskeletal problems per se. The authors of these tenets and the section editors for our new series in the JA O A all support the idea that a much more comprehensive and all-inclusive approach to the musculoskeletal system is necessary. Palliative diagnosis and OMT are valuable tools, but we have other options in the toolbox, many of which are interventions into the musculoskeletal system with proven value.

Dr Mangum is right on the money with his letter, and his challenge is a critical one for all of us. Tenets should not be adopted. Instead, tenets should be challenged and tested. If they prove their worth in the scientific arena, then they are valuable. Otherwise, these tenets and principles are just slogans that could be shortened for bumper stickers or marketing tag lines.

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References

Editor’s Note: Original research related to the discipline of osteopathic medicine remains the journal’s top publication priority.

(continued on the next page)
Total Hip Arthroplasty: Comparison of Two-Incision and Standard Techniques

To the Editor:
I read with great interest the January original contribution by Dana R. Desser, DO, and colleagues comparing the two-incision and standard techniques for performing total hip arthroplasty (THA). It is encouraging to see original research articles on such important topics published in the premier journal of the osteopathic medical profession.

Although Desser et al are quick to point out the advantages of the two-incision technique, they are careful to also discuss the increased rate of complications associated with this technique in their small study. Complications from the two-incision approach—such as increased operative time, increased incidence of femoral fracture, and increased incidence of femoral nerve palsy—have been well discussed in the orthopedic literature.

In addition to describing their own experiences and difficulties with the two-incision approach to THA, Desser et al make a valid point regarding the expansion of interest among patients and physicians in minimally invasive surgical (MIS) techniques. The authors note that patients are inquiring about MIS techniques more often as a result of aggressive direct-to-patient marketing on television and the Internet. This issue has generated concern in the orthopedic medicine community. It should be of equal concern to the cadre of osteopathic primary care physicians who are on the “front lines” interacting with patients who have chronic orthopedic conditions, such as osteoarthritis.

Considering the increased complication rate and the steep learning curve associated with MIS techniques, specifically the two-incision THA technique, osteopathic physicians should find it disconcerting that such techniques are being marketed to patients so brazenly. The two-incision MIS approach has been characterized as “more hype than hope” in a presentation to the American Academy of Orthopaedic Surgeons. As such, this surgical approach should be cautiously and fairly discussed with patients.

I hope to accomplish two goals through the present letter. First, I would like to encourage the American Osteopathic Association to continue its support of scholarly work similar to that of Desser et al in all facets of osteopathic medicine. Second, I implore all osteopathic physicians—especially those in primary care disciplines—to take a second look at the article by Desser et al and to perhaps conduct their own studies on this matter. We need to be aware of the various aspects behind MIS techniques, because this could be a topic of interest to many of our patients.

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References