Defining Osteopathic Medicine: Can You Put Your Finger on It?

Felix J. Rogers, DO

All of us have been in situations like this: You may have trained in a major medical center, you may work there now, or you may be attending a large educational symposium. You look around and you observe, “I am as good as anybody else here, but there is something different.” The problem is, can you put your finger on it?

As members of a “hands-on” profession, we osteopathic physicians (DOs) have been defined by professional organizations and the public on the basis of our osteopathic manipulative treatment. While it represents a distinctive feature of our practice, the reality is that only a small number of DOs use osteopathic manipulative treatment as a defining part of their medical practice. For the majority of DOs, the distinctiveness of osteopathic practice is more difficult to define.

A Daunting Task
In 2001, I led an ad hoc committee in the formulation of an updated description of the tenets and principles of osteopathic medicine. I was a little disappointed that our efforts met a lukewarm response. I think many practicing DOs believed the need to establish our identity was a battle previously fought and won, yet when I travel to our colleges of osteopathic medicine and meet with the students, I am convinced that our identity is an issue of considerable importance to them.

Despite a lack of lively debate on the proposed tenets and principles of osteopathic medicine, I am firm in my conviction that there is a solid core of practice patterns that help to define osteopathic medicine. Further, I know that the need to improve the practice of medicine is just as clear now as it was when Andrew Taylor Still “flung to the breeze the banner of osteopathy.”

In November 2009, I wrote an editorial describing my vision for how JAOA—The Journal of American Osteopathic Association could better enhance our scholarly tradition, promote an exploration of the distinctiveness of osteopathic medicine, and improve the practice of medicine. It has been a daunting experience to bring this project to fruition, but we have finally reached our goal.

Inaugural Evidence-Based Clinical Review
In this issue of the JAOA, we introduce the section “Evidence-Based Clinical Reviews.” Articles in this section will address topics of substantial interest to practicing DOs. The defining feature of these contributions will be the incorporation of the tenets and principles of osteopathic medicine. We have asked our authors to emphasize five of the tenets and principles that were originally published in February 2002 (Figure 1).

We are proud to launch this section with a clinical review by Kenneth Tobin, DO, a faculty member of the University of Michigan Medical Center in Ann Arbor.

Beginning on page 364, the article by Dr Tobin addresses the important issue of treating patients with chronic, stable coronary artery disease (CAD). As Dr Tobin points out, this condition affects about one-half of our patients who have ischemic heart disease. His article emphasizes the risk factors for CAD and the benefits of therapeutic lifestyle changes. In fact, therapeutic lifestyle changes are just as beneficial as percutaneous angioplasty and placement of a drug-eluting stent in the management of chronic CAD. Further, it is more cost effective. Dr Tobin also points out unheralded aspects of heart disease such as depression, which has a major impact on treatment outcomes. The musculoskeletal system, especially as manifest by programs of cardiac rehabilitation exercise, plays a major role in the management of chronic CAD. Notice how nicely these key points dovetail with the tenets listed in Figure 1.

Looking Ahead
In upcoming issues of the JAOA, we will publish evidence-based clinical reviews that address the timing of treatment for venous thrombembolism, a patient-centered approach to the management of atrial fibrillation, dermatologic infections in competitive athletes, and a nonpharmacologic approach to the management of the musculoskeletal system in health and disease.
of insomnia. In these articles, readers will note myriad connections to the tenets and thus a uniquely osteopathic perspective on the topics.

All of the articles in this new section will hold in common a foundation of scientific data as evidence. Health maintenance and recovery from disease, which includes prevention, will play a smaller role in some topics, and therapeutic lifestyle changes will be much more important in others. In each case, we have asked our authors to focus on the patient as an organizing principle.

Readers should not misinterpret me by taking any one of these tenets out of context as a sole, defining element of osteopathic medicine. For example, evidence-based medicine is not the invention of osteopathic medicine, though Dr Still did find this profession based on his observation that the treatments of his time did not work and caused more harm than good. Had evidence-based medicine been an operative term at that time, it is intriguing to speculate whether Dr Still would have embraced the idea.

I have heard many DOs report that they, compared with our allopathic brethren, tend to be much more focused on the care of individual patients. In fact, there is a healthy, creative tension between the practice of evidence-based or guideline-based care and the treatment of patients. Research studies involving upwards of thousands of patients provide treatment guidelines in which the relative risk reduction may actually be fairly small. And still, the practicing physician may be faced with a single patient and the question of what will work best for him or her. Sometimes the medical evidence is conflicting or yields uncertain results for specific subsets of patients. For this reason, we have invited seasoned authors to provide a perspective on this evidence base, tempered by their own extensive clinical experience.

I have been aided considerably by four section editors and an advisory council. These individuals have come from some of the top osteopathic and allopathic medical institutions in the country (Figure 2). During our monthly teleconferences, I am awed by the depth of medical knowledge of these colleagues, by their enthusiastic commitment to the advancement of osteopathic medicine, and by the broad creative thinking that they bring to this new JAOA section. All of us are eager to identify the best and brightest of the young writers and clinicians within our profession. We hope to receive a vigorous response to the articles in this series, and we look forward to suggestions and recommendations for topics and potential authors.

This series has other objectives. That is, we are hopeful that this series will help define our tenets and principles and establish our identity as a profession. Moreover, the osteopathic profession has its historical roots as a reform of medicine. Perhaps lulled by our success as practicing clinicians, at times I worry that we have lost our spirit of inquiry and our perspective of challenge to the status quo.

There is much about the practice of medicine in the United States that would benefit from the viewpoint that osteopathic medicine can provide. We owe it to ourselves and to the public to do a much better job of defining the best practices.

**References**


---

**Evidence-Based Clinical Reviews**

Robert Cain, DO, Grandview Hospital, Dayton, Ohio

Roberto Cardarelli, DO, MPH, UNTHSC, Fort Worth, Texas

Gilbert E. D’Alonzo, Jr, DO, AOA editor in chief

*Scott Kaatz, DO, Henry Ford Hospital, Detroit, Michigan*

*Robert Orenstein, DO, Mayo Clinic, Scottsdale, Arizona*

Felix J. Rogers, DO, JAOA associate editor

*James Schoen, DO, Grandview Hospital, Dayton, Ohio*

*Leo Skorin, DO, Mayo Clinic, Rochester, Minnesota*

Figure 2. Section editors and advisory council for “Evidence-Based Clinical Reviews.” *Section editor.*