The journey of a thousand miles is worth the trip

Osteopathic medicine has long suggested that manipulative therapy is an important tool in the treatment of common disorders. However, the evidence for this assertion has been sparse. With the advent of newer modes of therapy, the role of manipulation has become clouded further still. As a pulmonologist, I have seen my patients experience significant improvement with appropriate manipulative therapy. But in all fairness, this does not constitute scientific, quantitative proof.

One of the first instances of evidence that osteopathic manipulative interventions benefited patients with pulmonary disease occurred during the "Spanish flu" epidemic of 1918. Although methodologic problems were inherent in studies from that era and some of the findings were contentious, these early investigations strongly indicated that manipulative intervention improved outcomes. Obviously, these studies were conducted before the advent of antibiotics. Since then, the mortality and morbidity associated with pneumonia have significantly improved in large part due to the use of antimicrobial agents. These extraordinary improvements could lead one to believe that manipulative therapy is no longer of benefit in this disorder.

In an attempt to address this very issue, Dr. Noll and his colleagues undertook a pilot study, "Adjunctive osteopathic manipulative treatment in the elderly hospitalized pneumonia," the results of which are reported in this issue of the JAOA, beginning on page 143. Although the researchers studied an older population at greater risk for complications, they also tried to select control subjects who did not have any other major illnesses, which might have skewed the findings. These control subjects also were assessed using standardized measures. Unlike other studies, Dr. Noll and co-investigators studied those patients who were treated with antibiotics and who received blinded manipulative intervention. Although results from the majority of the comparisons were not statistically significant, many measures showed trends that favored the manipulative intervention.

Some may view these results as discouraging, in that the study was not a resounding success. Yet, this should not be the "take-home" message. Analysis of the numbers and design reveals several points worth noting. First, the study cohort was too small to show a difference, given the expected variance for length of stay of patients with pneumonia. To see a statistically significant difference would have required nearly double the number of subjects. Nonetheless, the trends uncovered in this study suggest that osteopathic principles function in concert with other established therapeutic interventions. These results should provide a basis for future studies and should encourage other osteopathic medical investigators to determine what went "right."

As with many other areas of research, this current study serves as a starting point. Difficulties with implementation and the methodology encountered in this investigation should help researchers refine future protocols. Specifically, developing manipulative techniques that can be used on bedridden patients is not something routinely taught; they must be developed. With the advent of such techniques, then, the methodology used in this current study would be improved on for future applications. Likewise, sources of variance that affect the application of manipulative therapy also should be addressed, if possible, in future protocols.

As these difficulties are addressed, we will undoubtedly learn more about that application of manipulation and its effect on the disease processes that we are seeking to change. Future results, whether affirmative or indeterminate, will give us a better understanding of the functional principles at work. As in other areas of medicine, our clinical questions and theories involving osteopathic principles should encourage sound scientific investigation. Findings from such research will enhance our ability to help our patients become healthy once more. That process from inquiry to clinical application may seem like a journey of a thousand miles, but it is one worth taking.

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Meeting the challenges of the ‘triple threat’ makes for a complete osteopathic physician

The Louisa Burns Lecture is given each year at the AOA Bureau of Research Conference. The Lecture was instituted in 1969 to honor Louisa Burns, DO, for her pioneering research in various aspects of the osteopathic lesion. This research spanned nearly 50 years and produced a large—but nearly untapped—body of data and interpretation. The person selected to deliver the address each year is chosen based on a long-standing commitment to research and scholarly activities in the osteopathic medical profession. The speaker has wide latitude to share the fruits of his or her experience and perspectives.
The 1998 Louisa Burns Memorial Lecturer is Thomas Yorio, PhD, of the University of North Texas Health Science Center at Fort Worth—College of Osteopathic Medicine. His lecture is published in this issue of the JOURNAL, beginning on page 157.

Dr Yorio chose not to reprise his long and productive career; rather, he reviews and synthesizes the academician's various roles and the pressures placed on these individuals, as well as what influences may produce a successful academic environment. His remarks, which may cast him as an academic conservative in some circles, are quite insightful and interesting.

The “triple threat” of the traditional academic environment to which Dr Yorio refers is the “three-legged stool” of teaching, research, and service. As in the increasing specialization of medicine, the academic environment is facing increasing pressure to limit participation by academicians to one or, at most, two of these areas. The rationale for this limitation is that it is perceived as not possible to do two of these, let alone all three, with expertise.

Dr Yorio makes several insightful comments regarding this trend. He recognizes that for most of us, it is difficult to do a credible job of teaching, research, and service and to balance them well. It is particularly difficult at most of our osteopathic medical institutions because of the limited number of faculty. He points out, however, that teaching and research are complimentary—not exclusive; that participating in research gives credence to teaching, and that teaching provides a means to keep up with and apply research insights and data. More important, he asserts that research takes many forms, not just “bench time.” Research is intellectual curiosity. Its source is the wonder of what is going on and why. It keeps the teacher passionate. Research is done at the bench, in the classroom, in the clinic, and in one’s community.

One of the most important of Dr Yorio’s observations rings true to those of us who have been fortunate enough to have trained students. He notes, “...students provide faculty with the intellectual stimulus....” More than ever, this fact is true. Having curious and somewhat naive students under your mentorship is at once one of the most stimulating—and challenging—aspects of anyone's career. Students challenge your ingrained thought processes; they make you think about what you are doing; they require you to make sure you know your material; and occasionally, they question your authority. In doing so, they can be threatening. Some shy away from training students because of this threat. Others act in very authoritarian ways to discourage the threat. Still others take up the challenge students present. These teachers always profit from meeting this challenge.

A second observation regarding this lecture that deserves special merit is Dr Yorio’s statement: “Historically, it was the physician who initiated discovery through observations and inquiry.” Most of the leads for scientific discovery in medicine have stemmed from the observation and curiosity of the practicing physician. This is research at its most fundamental form. This is the marriage of service and intellectual curiosity. It was the spark that ignited the flame of osteopathic medicine in A.T. Still. This spark was evident in such giants of the profession as Charles Bowles, DO, one of the pioneers of the functional technique. I recall sitting with him at his lakefront home on Squam Lake in New Hampshire, fascinated as he discussed with me his concepts of functional technique in terms of feedback signals. These insights were derived from his observations and knowledge of marine navigation. He was still exploring these ideas even though he was retired and relatively isolated. Dr Bowles was a true clinician-researcher, always curious and exploring.

Osteopathic physicians are very good at service, but they do not always consider themselves researchers. Many do not realize that research is within their grasp in the form of curiosity and wonder. Too often, dogma is simply accepted without question. Many osteopathic physicians do not realize that teaching is an integral part of practice. Too often, the challenge of teaching is gone out of fear of the challenge itself. The fact that a physician’s patients are really students is often overlooked. Patients as students? But after all, “doctor” means “teacher.”

The “triple threat” of academia is not just something that those of us in academics should practice and for which we should be accountable. It is something that also applies to the practicing physician in his or her office. Service is paramount. Research is the spark that stimulates and energizes. Teaching is the vehicle that brings service and research together. As physicians or academicians participate in each of these efforts, so will their careers be increasingly fulfilled. Meeting challenges of the triple threat is to become the complete osteopathic physician.

Dr Yorio gives us valuable insights. Please take the time to read his article.

Michael M. Patterson, PhD
Associate Editor, JAOA

The case for the case report

Practicing clinicians manage patients (“cases”) every day. How we choose to care for our patients reflects a unique combination of published scientific literature, the opinions and practices of our mentors, and our personal clinical experiences. JAOA regularly publishes case reports. The time has come to revisit this feature, to ask why we should continue it, what kinds of cases deserve attention, who should submit them, and who is interested in reading them. By musing about the who, what, and why in a public forum, I invite you, our readers, to participate in the dialogue and help to keep JAOA vital, evolving...alive!
Editorials continued

JAOA represents the official voice of the osteopathic medical profession. We are diverse! From neurosurgeons to rural primary care givers, from forensic pathologists to manipulative specialists; yet, we all share common roots in history, educational foundations, and philosophy. Can we bring this uniqueness to our case reports? Can we capture the essence of osteopathic holism? Can we inspire the imagination of our readers? I believe each case report has the promise and the potential to do this. Our JOURNAL should highlight the distinctiveness of osteopathic medical practice. Esoteric fascinomas have a place in the medical literature. Is it in JAOA? Ask yourself, if you are attracted to a case report of an esoteric condition outside of your specialty. What ingredient is it that will broaden the base of interest within our readership? Perhaps, the holistic, humanitarian, or primary care dimensions of even the most molecular biologic condition need some attention to make the report clinically relevant and interesting.

Thoughtful clinical observations and reports of unique presentations, management strategies, or outcomes are welcome regardless of the location and station of the observer. The freshest thoughts are often from the naive, open, and inquisitive minds of our students. Their perspective on patients and management can inspire senior clinicians to reevaluate the status quo. Collaboration between new and older clinicians is beneficial to all. Practitioners have as much stake in our professional discourse as academicians. All are welcome.

We must never cease in our effort to try to understand the unexpected outcomes. Andrew Weil has challenged modern medicine to more closely examine the "miracle cure," the person who defied the odds and spontaneously heals. Let us, as osteopathic physicians, report these cases and highlight the natural homeostatic tendency found in all human beings. Let us take a fresh look at the everyday patient and share our triumphs, frustrations, beliefs, and identity. The patients are our reason for being. Let us share their stories in order to enhance their care and our satisfaction as care givers.

We all do our best to give at the office. I ask you to consider giving your experience to JAOA. Through sharing your personal pride and satisfaction as a clinician, you can only grow!

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