DOs’ approach to patient is ‘wholistic’—not holistic

To the Editor:
I found the article “Opinions of MDs, RNs, and allied health practitioners toward osteopathic medicine and alternative therapies: Results from a Vermont Survey,” by McPartland and Pruitt (JAOA 1999;99:101-108) to be fundamentally flawed. The idea of labeling “osteopathy” as an alternative therapy from which one can select among biofeedback and bee-sting therapy entirely abrogates the importance of osteopathic medicine as a source of core medical care. I am not sure that I understand what the alternative therapy “osteopathy” as listed in this study is. Does it refer to the comprehensive primary care that I provide as a board-certified family practice physician? Does it identify the care that my father provides as a general surgeon or that my cousin provides in emergency medicine?

The answer here is certainly obvious. If we as a profession are to gain the recognition we desire, we will have to get past the myth of osteopathy. Osteopathy is not solely the art of performing osteopathic manipulative treatment (OMT). OMT is simply not what makes us unique. It is just a valued tool in our therapeutic and diagnostic armamentarium. What distinguishes us as osteopathic physicians is our training based in the philosophy of an wholistic (not holistic) approach to the patient. We differ from our allopathic colleagues in this encompassing method of patient care.

The reality is that as a function of our broad scope, many of us tend to be holistic as well. The limitation of the Vermont survey study is that it chooses to evaluate the profession based on flawed perceptions. Unfortunately, if we continue to measure our value as a profession strictly in the terms that I believe this article is proposing, then we are certainly selling ourselves short, and we may well be proverbially digging our own graves. The challenge that we face in osteopathic medicine is not establishing our identity in the realm of alternative, but reeducating the populace—both lay and professional—regarding our value in comprehensive care.

The vast majority of osteopathic physicians practice mainstream medicine and wish to be regarded as practitioners of such. Our thrust as a profession should not be as the authors state to “follow the European model and link osteopathy’s uniqueness with alternative medicine.” The American Osteopathic Association’s effort should be to change the paradigm so that Eisenberg’s definition of alternative medicine becomes “any medical intervention not taught widely at American medical schools whether they be allopathic or osteopathic.” That the government and the insurers recognize our training as comparable is important. What is vital, however, is that our colleagues view us as equals and the public views us first as physicians.

I entirely agree with McPartland and Pruitt’s comment that efforts should be made to obtain National Institutes of Health (NIH) grants to further research on OMT. Sadly though, validation of manipulative treatment will not provide the impetus toward reaching the goal of increased public awareness that we indisputably need. The difficulty at present is that we can no longer ride the identity fence. Although it is vitally important to maintain the uniqueness of the profession, it should not be at the risk of pushing ourselves to the professional fringe.

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Response

Dr Gotfried says that osteopathy is not synonymous with osteopathic manipulative treatment (OMT); our (u)holistic approach distinguishes us from allopathic physicians, whereas OMT is merely one of our tools. I disagree with the second clause—palpatory diagnosis and OMT may not be synonymous with osteopathic philosophy, but they are central to our uniqueness. I have argued this point before.1

True, our holistic approach separates us from mainstream, allopathic physicians. But that is changing. As more and more MDs embrace holism, they will become what DOs already are—holistic healers. What, then, will make us unique? I would say OMT. Do “the vast majority of osteopathic physicians practice mainstream medicine,” as Dr Gotfried asserts? I hope not. Mainstream medicine is not holistic. Unfortunately, many DOs seem to be relinquishing holism. Why? the closure of many osteopathic hospitals may be a factor, forcing DOs to complete their clinical training at tertiary medical centers. I can speak from experience that holism is hard to accomplish in the emergency department of a level 3 trauma center. Perhaps MDs and RNs disapprove of our retreat from holism, which would explain why our survey indicated a loss
Screening for hemochromatosis can prevent serious disease

"Iron overload, public health, and genetics by Mendel and colleagues which appeared in the December 1, 1998 supplement to the Annals of Internal Medicine (1998;129-996) is the most thorough review of iron overload states and a call to action for primary care physicians. Although first postulated to be an inherited disorder in 1935, the recent cloning of the HFE gene has unequivocally established the genetics of hemochromatosis. Classic medical school curriculum seems to have painted this condition as a rare, confusing disorder with a difficult and hazardous diagnosis best left to the hematologist or hematologist.

The primary care physician may have little time or interest to study the single G-to-A mutation that results in the cysteineto-tyrosine substitution (C282Y), which accounts for 60% to 100% of the cases of hemochromatosis. But hemochromatosis has arrived both in the understanding of what causes this iron overload state and in the realization that this is a very common genetic alteration whose potential to cause disease can be completely and simply eliminated.

Hemochromatosis is very rare in Oriental populations and also seems so in African-American and Hispanic populations, but the HFE gene may be found in as many as 1 in 200 people of northern European ancestry, making this the most common hereditary disorder in this patient group.

The diagnosis of hemochromatosis is simple and inexpensive. A liver biopsy is not needed to establish this diagnosis, and the potential hazards of this procedure can be avoided. The finding of an elevated serum ferritin level may be a clue to the diagnosis. Indeed, there is a strong correlation between ferritin levels of greater than 1000 μg/dL and iron overload, but because ferritin is an acute-phase reactant, there are many other conditions that may elevate the ferritin concentration.

The transferrin saturation is the best tool for screening for hemochromatosis. The transferrin saturation is calculated by dividing the serum iron level into the iron-binding capacity and multiplying by 100%. A transferrin saturation of greater than 60% is virtually diagnostic of hemochromatosis, and a transferrin saturation of 45% or greater warrants at least close follow-up and a second testing, if not therapy.

It must be kept in mind that hemochromatosis is not a disease in and of itself, but disease only becomes manifest when visceral organ iron accumulation results in organ dysfunction. The patient is not well served if the diagnosis is delayed until the disease exists. It must also be kept in mind that hemochromatosis is not a blood disease. There is nothing wrong with the blood of a patient with HFE. Phlebotomy can be diagnostic in that if it takes the removal of only 2 or 3 units of red blood cells to drop the transferrin saturation to normal range, the patient does not have hemochromatosis. Phlebotomy can be therapeutic, as it indeed is the only way to safely and effectively remove excess iron from the patient and will completely prevent disease. Phlebotomy can also be beneficial to the community in that patients with hemochromatosis can be a source of blood products for the local blood bank.

Blood bank policies have not been to accept these units for use in patients. These policies are not rational and are wasteful. Pressure is being exerted to change these policies, a movement primary care physicians are being invited to join.

A greater problem is that of getting insurance companies to pay for screening for hemochromatosis. A transferrin saturation test is not costly, and the benefits of successful detection are enormous. Again, it is the primary care physicians who must fight on behalf of the patients.

The key to solving both of the aforementioned problems is an increased
understanding that hemochromatosis is not a rare disease cared for by specialists only. It is not a disease, but only becomes one when the risk for development is missed by not screening. Screening is cheap. Treatment is simple, treatment is cheap, and proper treatment is completely successful at preventing serious disease.

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Erratum
In the letter, "Coordination of research efforts tied to defining profession's identity," appearing on page 199 of the April 1999 issue of JAOA, the author's name was incorrectly spelled. The author of that letter is Michael Engle, DO.

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