DOs question intent of challenge

To the Editor:
We would like to respond to the letter by James M. Norton, PhD, “Questioning of OCF should rouse osteopathic response” (JAOA 2000;100:763), concerning osteopathy in the cranial field (OCF).

First, Professor Norton refers to studies published in physical therapy journals in which the reliability of assessing a patient’s cranial rhythmic impulse (CRI) was called into doubt. Physicians familiar with OCF know that the CRI is highly variable, that it can change many times during the course of treatment, and that there are multiple rates palpable within any given patient. These rates can change according to the level of the physician’s autonomic nervous system, and, in fact, some physicians who practice OCF pay little attention to these rates. The CRI is not to be confused with the primary respiratory mechanism—the CRI is merely one manifestation of the primary respiratory mechanism.

Second, Professor Norton writes that “the burden of proof of efficacy lies squarely with practitioners of OCF.” While we would certainly appreciate outcome studies verifying the efficacy of this work, most physicians (regardless of their specialty) are clinicians, not research specialists, and have neither the time nor the expertise to perform such studies. We do know that the American Academy of Osteopathy is addressing the need for further studies and more research. Richard Smith, editor of the British Medical Journal, wrote that “only about 15% of medical interventions are supported by solid scientific evidence...This is partly because only 1% of the articles in medical journals are scientifically sound and partly because many treatments have never been assessed at all.”

Second, a Congressional Office of Technology Assessment study also found that only an estimated 10% to 20% of the techniques physicians use are empirically proven. In addition, in late 1999, the Institute of Medicine of the National Academy of Sciences released its study of medical mistakes. The study estimated that the number of patients in the United States who die each year from medical errors ranges from 44,000 to 98,000. Given the statistics, OCF, a conservative and noninvasive therapeutic modality, has great appeal to the public.

Last, we are concerned about the tone of Professor Norton’s challenge. “My findings were presented as a challenge, to which I have received no response from the osteopathic community.” It is clear from this statement that Professor Norton does not feel himself to be a part of the osteopathic community, though he teaches at a college of osteopathic medicine. He presented virtually the same letter to the American Academy of Osteopathy Journal, to which he received a lengthy reply; yet he continues to state “...I have received no response.”

We feel that these challenges may have gone beyond the friendly pursuit of science and are, perhaps, meant to be disruptive. We are not sure of Professor Norton’s motivation for these challenges, but we are concerned that he may be creating an unfriendly, negative environment for students interested in studying traditional, hands-on osteopathic medicine. We invite Professor Norton to join the osteopathic community rather than challenging it. We recognize that he is a gifted teacher, and we would welcome his contributions to osteopathic medicine.

We remain grateful to W.G. Sutherland, DO, for unveiling the primary respiratory mechanism, which continues to benefit us and our patients as it inspires us on a daily basis.

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References
Osteopathic medical schools should foster sense of identity

To the Editor:

The survival of osteopathic medicine into the 21st century is a testimony of the intrinsic strengths of our profession. We gained parity in the medical marketplace long ago, and our graduates have prospered in both the US military and prestigious university settings. Our prescient notions of holistic care and the importance of the primary care physician in healthcare delivery have been accepted by insurance companies, medical economists, the Health Care Financing Administration, and most important, the public.

Despite these incredible gains, repeated surveys have demonstrated limited public recognition of our accomplishments. Seeking to reverse this finding, the American Osteopathic Association is now engaged in a national promotional campaign. In a country where only 50% of eligible voters went to the polls, and a sizable percentage of citizens could not name national candidates running for office, it is not surprising that only a minority of the public are aware of our alleged uniqueness. To most, the DO is just a physician “like an M.D.”

The general public may not be aware of our distinctiveness because people are consumed by the chaotic world about them. They are too busy to think about us. However, the public’s ignorance of osteopathic medicine can also be attributed to our inability to promote our profession. To properly inform others of our mission and identity, we must have a defined mission and a secure identity. Unfortunately, the osteopathic medical community appears uncomfortable with its osteopathic identity.

The crisis over osteopathic identity is most evident in many of our schools of osteopathic medicine. Initiation into a profession and the acquisition of cultural identity comes from the passing on of legends while teaching the art of practice. Although a few of our students deny the clinical validity of osteopathic principles from day 1 of their freshman year, most strongly desire to believe in the clinical efficacy of osteopathic theory. Yet, after 6 months of that first year, many become disenchanted with the “osteopathic” in their osteopathic medical school.

In an endeavor to teach a classic medical school curriculum, some of our schools give no more than lip service to osteopathic principles and practice. Other schools assign the teaching of osteopathic principles and practice to believers who attempt to justify clinical relevance by strict adherence to dogma and faith. During the third and fourth clinical years, the disillusionment of our students is sealed when they are exposed to successful osteopathic physicians who completely shy away from manual medicine. By graduation, our students have concluded that, despite their confusion with professional identity, market forces will enable them to become successful medical practitioners.

Physical medicine is an essential component of modern medical practice. In the average primary care practice, musculoskeletal complaints account for at least 25% of patient visits. Yet few of our graduates practice osteopathic manipulative treatment. Low back strain in a 32-year-old otherwise healthy male; tension headaches in a 35-year-old working mother; and chest pain during a coughing episode in a 27-year-old are all amenable to strict osteopathic care.

Despite the pragmatic clinical advantages of administering manipulative medicine in these cases, many in our profession offer their patients copycat medicine. The explanation is obvious: our students have thrown out the baby with the bath water in an endeavor to completely emulate the practices of their allopathic counterparts.

Osteopathic medical schools should offer their students—particularly those who intend to enter primary care—an osteopathic identity and a competitive advantage in the marketplace. This can be accomplished by demystifying osteopathic medicine and presenting its principles and practice as the art of ambulatory orthopedics. The curriculum for osteopathic practice should then emphasize the differential diagnosis and appropriate manual treatment of low back pain, joint pain, and headache. Our students should become adept and gain confidence in the management of carpal tunnel syndrome, metabolic bone disease, stroke rehabilitation, and routine athletic injuries. Our osteopathic internships and family practice residencies should continue to foster the same principles and practice.

A sense of identity for a person entering a profession or a professional organization comes with the acquisition of authenticity and competence. The faculties of our schools of osteopathic medicine should dedicate themselves to that end. Survival of our profession into the 22nd century may then be insured.

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Without sampling information, data lack impact

To the Editor:

“Partial spectrum of microorganisms found in dentures and possible disease implications,” by R. Thomas Glass, DDS, and colleagues (JAOA 2001;101:92-94), provides an interesting perspective on an important issue. The authors present a list of pathogens found in and on the dentures of a series of patients. Although the scope of this information is important, the lack of any indicators of sample size and frequency is discouraging. Without this information, the data lack impact.

What percentage of the sampled patients, and their dentures, cultured positive for one or more of these pathogens? Was the prevalence and coexistence of these entities? Were a few patients responsible for the bulk of the positive findings (high coexistence), or was prevalence spread
Response

To the Editor:
The authors of the article “Partial spectrum of microorganisms found in dentures and possible disease implications” (JAOA 2001; 101:92-94) would like to thank Chris Simpson, DO, and Alfred M. Pheley, PhD, for their comments. We will address each of the concerns raised in their letter.

The sample size for this study was 15 dentures, divided into 4 samples. Three samples were cultured by touching the surfaces (3 times) and cut edges (3 times) on three different media for a total of 1215 samplings. The mean of microbial colonization was 3.292 based on a scale from 0 (no growth) to 4 (confluent growth).

No patient cultures or histories were performed, because the institutional review board-approved protocol assured complete patient anonymity.

All dentures were colonized with a minimum of two or more potential pathogens that included gram-positive and gram-negative bacteria and yeasts.

The frequency of denture colonization with potential pathogens was 100% with all dentures found to have substantial contamination.

From this study, it appears that all denture wearers must be considered at risk.

This study showed an unexpected wide range of both gram-positive and gram-negative bacteria and yeasts.

Appollonio et al. studied quality-of-life and mortality issues in dentulous patients, edentulous patients restored with dentures, and edentulous patients who had no dentures. While dentulous and edentulous patients with dentures scored similar in quality-of-life issues, edentulous patients who had no teeth lived longer than their cohorts who had dentures. Studies such as these address the questions of cost-effectiveness and clinical implications.

The medical and dental communities have continued to improve in decreasing disease transmission via the oral cavity by the use of autoclaved instruments, gloves, masks, and even attention to water lines in the dental office. It would just seem common sense not to place dentures that have been contaminated with frank or opportunistic pathogens in the mouth to be worn from 12 to 24 hours a day and submitted to the forces of mastication.

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Reference


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