Editorials

What? Use OMT in treating Parkinson's? ... Never!

The above is the response I would expect from many osteopathic physicians and most other healthcare professionals if they were asked about the use of osteopathic manipulative treatment (OMT) in treating Parkinson's disease patients. We all know that Parkinson's disease is a deterioration of the dopaminergic systems of the brain. It is not susceptible to simple musculoskeletal modalities or other "alternative" treatments.

The study "Standard osteopathic manipulative treatment acutely improves gait performance in patients with Parkinson's disease," by Dr Wells and colleagues, beginning on page 92, details a rather small investigation comparing various gait parameters of patients diagnosed with Parkinson's disease before and after receiving a standardized OMT protocol. The results from this treatment group were compared with the results from patients who underwent a sham protocol with the same parameters, and a normal control group given the OMT protocol. The results showed significant gait improvement in the treated patients, no effect in the sham group, and no alterations were found among the normal control subjects.

This investigation is remarkable in several respects. It showed a significant improvement in several measures of walking in Parkinson's patients with one treatment protocol. It found these differences with the use of very small numbers of subjects; it found these effects with a disease process not generally thought to be affected by manual medicine techniques. Also remarkable was the authors' rationale for the use of OMT protocols with such a disease process.

Specifically, the researchers hypothesized that the use of OMT protocols would allow patients to better use their remaining functions, which is apparently precisely what happened. In fact, this very rationale is what is often implied or, less frequently, stated as a reason for the use of OMT in the first place. By using OMT to enhance function and to remove barriers to function, patients should be able to live a better life. And, perhaps, by breaking the cycle of loss of function that leads to even poorer function, the underlying disease may be ameliorated or have its time course affected.

The study had as its primary purpose to find what gait parameters might best be used in looking for the effects of OMT on gait. Furthermore, it sought to determine what measures would be most sensitive to the possible changes caused by the treatment. In this latter point, this investigation seems to have been successful as well. Dr Wells and colleagues now have a set of gait measures that they can use in more extensive studies.

Is this study the final answer? Of course not. The number of subjects was small. There is little knowledge of the real variance within the data. There is no determination of how long the effect of the OMT protocol may last. But, as a start, this study is a great one. It not only showed that some of the measures of gait are sensitive to OMTs' effects, but it also showed that measures of gait may be quite powerful indicators of these effects.

It is not likely that OMT will be shown to "cure" Parkinson's disease. However, if further studies show evidence that OMT can affect the quality of life for these patients, it would be a very valuable adjunctive treatment. What if it was then shown that by increasing the patient's function, the actual progress of the disease was affected?

Use OMT in treating Parkinson's patients? It sure looks like a real possibility.

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What We Have to be is What We Are
—Thomas Merton

Matching our professional definition with the public's perception of our role and function remains a fundamental challenge to the osteopathic medical profession. During the first half of the 20th century, this new and vibrant profession enjoyed remarkable success in its educational and professional activities. The mirror of public opinion accepted—and endorsed—the distinctiveness and vitality of Andrew Taylor Still's philosophy, science, and art. For much of the past 50 years, however, others have increasingly viewed this same profession with confusion and as having an incomplete identity.

The American Osteopathic Association (AOA), through its Task Force on Osteopathic Unity, the precursor to the current ongoing Campaign for Osteopathic Unity, has recognized a "growing perception that osteopathic medicine is losing its distinctiveness as a separate and equal branch of human medicine." The Task Force—and subsequently the Campaign for Osteopathic Unity—has two main objectives:

■ to raise the visibility and distinctiveness of osteopathic medicine in all aspects of public and commercial awareness, and

(continued on page 77)
to revive the sense of distinctiveness and vitality that was present during the beginnings of our profession.

The need for such revival is aptly illustrated by the results of the study, beginning on page 101, by Drs McPartland and Pruitt, “Opinions of MDs, RNs, allied health practitioners toward osteopathic medicine and alternative therapies: Results from a Vermont survey.” The researchers surveyed a total of 191 healthcare professionals, asking them to respond positively or negatively to six questions regarding osteopathy and 18 other alternative therapies. The questions gauged safety, efficacy, personal experience, patient referrals, interest in learning more about alternative therapies, and the provision of alternative therapies at the regional Vermont hospital, where many of the respondents were on staff.

The response of MDs to this survey proved revealing. Their general acceptance of osteopathy was less than that for alternative therapies. Their opinions toward osteopaths mirrored the opinions they held regarding chiropractors. Notwithstanding these responses, MDs still indicated a more positive response to osteopathy than did the RNs and alternative healthcare practitioners.

These observations are not unlike reports from previous surveys covering a period of nearly 20 years. In an AOA survey taken in 1981, Ohio residents reported having a low awareness level concerning osteopathic medicine. Osteopathic physicians reported spending a great deal of time explaining what is a DO, as well as how they practice and how they are distinctive from their other healthcare professionals, according to a study by Agwu, conducted in 1996. Another study, conducted by the Michigan Osteopathic Association in 1988, found that 50% of the surveyed public were aware of allopathic physicians.

Drs McPartland and Pruitt also raise the question of whether the osteopathic medical profession’s uniqueness is linked with alternative medicine, as is the case with European MDs’ perceptions of DOs. Admittedly, this consideration does not represent the AOA’s viewpoint. A review of the historical record, however, demonstrates that Dr Still’s reform movement was offered as a rational alternative to improve the system of medicine in general. The state of Vermont enacted the first law regulating the practice of osteopathy in November 1896. Little more than a century later, public opinion in that state suggests that various alternative forms of practice are more popular than osteopathic medicine. Perhaps public opinion is now the mirror in which we are seeing that what we have to become is what we already are.

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References

Kevorkian kills patients along with the clinical research to help them

A few months ago on a Sunday night, my oldest son called from his home in Denver and asked, “Dad, did you see it?” Normally, this kind of question would be related to a major football game that was on national television. This time, however, I knew what he meant. My first-born wanted to know if I had watched Jack Kevorkian kill someone. I replied that I had not; I chose not to do so. Having spent the past 20 years conducting preclinical and clinical research studies designed to improve the management of pain, I could not watch that patient be put to death.

In 1983, I received a fantastic privilege to spend 6 months in the Hematology/Oncology Service at Walter Reed Army Medical Center. As a clinical pharmacologist, I was invited to join the staff to conduct my research project: the use of combination drugs to provide improved analgesia for cancer patients. I also worked daily with physicians to help them in their general pain management responsibilities. It was my best clinical experience and the beginning of my clinical research career. I learned how to control pain using narcotics and non-narcotic analgesics (ibuprofen and acetaminophen, for example). I also observed many nondrug methods that patients were offered to make them feel more comfortable. These methods included hypnosis and massage. Patients were also encouraged to have low-key talk sessions with clergy, nurses, social workers, and psychologists to address their spiritual and emotional needs. From this experience at Walter Reed, I saw how a dedicated staff worked together to improve the quality at the end of a patient’s life.

In sad contrast, we have Jack Kevorkian’s awful policy. It is not a complex policy. Kevorkian says to patients, “When you reach a certain point in your disease that you cannot or will not tolerate, just call me. I will come over and end your life!” Why doesn’t he join those of us conducting clinical research? Why doesn’t he try to improve the problems terminally ill patients experience instead of providing only one final solution?

Fortunately, I work with several physicians who have many patients who volunteer to participate in my clinical research projects. They range from those who undergo major surgery to cancer patients; they all want to improve pain control. These subjects allow me and my colleagues to test new drug
Editorials continued

combinations with the goal of making their—or future patients'—lives less painful. One of my earlier studies has already shown that giving patients a dose of a narcotic immediately before surgery helps to decrease their pain after the operation. Preliminary results from my research now in progress at City Avenue Hospital in Philadelphia show that patients also benefit from receiving osteopathic manipulative treatment after surgery.

Patients who have amyotrophic lateral sclerosis do face more problems than most other terminally ill patients. They lose muscle activity; they have difficulty breathing and swallowing their saliva. They are depressed. We recognize that many cancer patients are depressed, which is understandable.

Cancer patients also experience pain. However, we can treat this depression and pain with pharmacology and psychotherapy. When we are successful in reducing such problems, we also decrease the desire of patients to commit suicide. This treatment knowledge was gained through clinical research on terminally ill cancer patients. On a similar level, ongoing clinical research will provide solutions to ease the suffering of ALS patients.

Actor Christopher Reeve, paralyzed from the neck down after falling from a horse, has discussed his thoughts of suicide. I think that anyone in his situation would have the same feelings; I am sure I would. However, he has moved in a positive direction by supporting research to improve his life and those of other paraplegics.

Jack Kevorkian’s method decreases the opportunity for clinical researchers to work with terminally ill patients. It reduces the development of procedures that will provide more comfort at life’s end. It is Kevorkian’s policy that should be terminated—not the lives of patients.†

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