



Osteopathy in its early adulthood, 1945–1955

In the middle of the 20th century, osteopathy was just more than 50 years old. It had been through much during its childhood and adolescence and could now be considered a young adult. It had successfully responded to the challenges of the educational reforms begun with the Flexner report¹ and had consolidated its schools into reputable institutions. It had endured two world wars and the tremendous advances made in medicine with the advent of the “wonder drug” penicillin. The data gathered during the great influenza epidemic of 1918–1919 provided strong evidence that osteopathic theory and practice produced results. There were beginnings of greater understanding of disease processes produced by the rapidly growing understanding of bacteria and viruses. The forces of organized medicine were still bent on seeing osteopathic medicine forced out of existence. Where did that leave the osteopathic medical profession as it entered its second 50 years?

This question is the topic of the two articles reprinted here. In the first, J.S. Denslow, DO, contemplates the place of the osteopathic concept in the healing arts. Denslow was in the midst of a robust research program begun about 1940 under the tutelage of some of the finest biomedical scientists of the time. Most were allopathic physicians at prestigious institutions. His contacts in the world of research had begun with Alan Gregg of the Rockefeller Foundation and led to the concept of the facilitated segment and valuable information about visceral and somatic interactions. Denslow here examines what osteopathic medicine had contributed to the healing arts and what it can be expected to contribute in the future. He concludes that one of the basic contributions of osteopathic medicine is a system and philosophy of practice based on natural laws. He goes on to discuss the fact that the allopathic medical community had shunned the osteopathic medical profession from the beginning and still maintained that stance. He believed that the future contribution of the profession lay in its recognition of the complex interactions between body systems in maintaining health (or disease) and the physician as a human engineer. He points to the concept of the osteopathic lesion as central to this understanding and to the scientific acceptance of the osteopathic medical profession. He ends his paper by urging rapid scientific inquiry into viscerosomatic and somato-visceral interactions. His analysis is insightful in the fact that it urges scientific inquiry into the unique aspects of osteopathic philosophy and clinical practice.

The second article, a lecture by Ralph Fischer, DO, MSC, was presented 4 years later as an assessment of where the

profession had been in the 50 years since its inception and what it needed to do for continued existence. Fischer makes very interesting observations about the evolution of the osteopathic medical profession, what it had accepted into its fold and what had remained constant about it. Here again, the message is almost the same as Denslow's: the profession is unique because of its philosophy and approach to health and disease. The osteopathic medical profession had accepted some drugs into its armamentarium (after a bitter fight in the 1930s and 1940s) but had done so on the basis of the philosophy, not in spite of it. Fischer maintains that all such advances should be measured against the philosophy of practice, not accepted out of hand. He points out that manipulation alone no longer set the osteopathic physician apart from other practitioners of the healing arts. Rather, the point of separation is the way disease is conceived as an entity, the philosophy. He goes on to discuss the germ theory of disease and how it falls short in explaining both the variability of disease and the action of drugs. He argues that as Andrew Taylor Still, MD, DO, saw the human with its individual complexity as the reason for both health and disease, this philosophy remains the basic reason for the distinctiveness of the osteopathic medical profession. And as did Denslow, Fischer cites the osteopathic lesion as a major factor to be considered by the osteopathic physician.

These two presentations are remarkable in the confluence of their ideas at the middle years of the profession. Both point to the philosophic basis of the profession as its strong and distinctive feature. This set of ideas and concepts of function were seen to lead to a rational basis for treatment based on sound physiologic principles. These ideas and concepts provide a benchmark against which to measure new modes of therapy and treatment modalities. Perhaps what was sound thinking 50 years ago for the osteopathic medical profession is still sound today.

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Reference

1. Flexner A. Medical Education in the United States and Canada. A Report to the Carnegie Foundation for the Advancement of Teaching. Bulletin Number Four Boston, Mass: DB Updike, The Merrymount Press. 1910.