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Letters to the editor are considered for publication in the *JAOA* with the understanding that they have not been published elsewhere and that they are not simultaneously under consideration by any other publication.

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Letter writers must include their full professional titles and affiliations, complete preferred mailing address, day and evening telephone numbers, fax numbers, and e-mail address. In addition, writers are responsible for disclosing financial associations and other conflicts of interest.

Although the *JAOA* cannot acknowledge the receipt of letters, a *JAOA* staff member will notify writers whose letters have been accepted for publication. Mailed submissions and supporting materials will not be returned unless letter writers provide self-addressed, stamped envelopes with their submissions.

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Although the *JAOA* welcomes letters to the editor, readers should be aware that these contributions have a lower publication priority than other submissions. As a consequence, letters are published only when space allows.

Osteopathic Approach to Diastolic Heart Failure

To the Editor:

I read with interest the article by Sunil Dhar, MD, and colleagues,¹ in the April issue of *JAOA—The Journal of the American Osteopathic Association*. This article represents an expansion of the medical profession's thinking about cardiac insufficiency. As the article suggests, diastolic heart failure—an inability of the heart to relax, dilate, and fill—may account for half of the cases previously

thought to be caused by the heart's inability to contract and eject.²⁻⁶ The authors¹ credit this deficit in diastole to the following factors:

1. increased passive stiffness
2. abnormal active ventricular relaxation
3. changes in calcium metabolism and adenosine triphosphate availability
4. degenerative changes in the myocardium caused by age
5. myocardial ischemia
6. changes in the extracellular matrix

7. negative intrathoracic pressures from chronic obstructive pulmonary disease and obstructive sleep apnea

Treatment, evidence, and prognosis are discussed adequately by Dhar and coauthors,¹ and the conclusions they offer are sound. However, what is lacking for me in the article is an insight and approach to this issue based on osteopathic medicine.

I suggest that osteopathic physicians consider three additional factors in the care of patients with diastolic heart failure:

- **Sympathetic hypertonia to the heart driven by somatic dysfunctions of the upper thoracic spine and ribs**—An overfunctioning of the sympathetic nervous system could contribute to the problems listed above as numbers 1, 2, and 5.

Decades of osteopathic medical research have documented the pathophysiologic consequences to the heart from somatic dysfunction in the upper thoracic spine. Most of these ill effects are mediated through hyper-sympatheticotonia, as noted by Robert C. Ward, DO,⁷ as well as by Michael L. Kuchera, DO, and William A. Kuchera, DO.⁸ Louisa Burns, DO, DScO,⁹ reported on "cardiac changes following certain vertebral lesions," and Irvin M. Korr, PhD,^{10,11} provided much excellent research on the relationships between somatic dysfunction, the autonomic nervous system, and end-organ damage.

It seems a shame to have osteopathic practitioners of cardiology so underinformed about the many decades of osteopathic medical research directly applicable to cardiology.

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■ **The internal contours of the inferior thorax**—My observations suggest that if the sternum is “too close” to the spine as a result of kyphosis, pectus excavatum, or internal rotation of each hemithorax, the diastole will be inadequate because of the physical constraints of the available space for the heart to expand its diastolic volume. The heart cannot expand further into diastole when wedged between the anterior thoracic spine and the posterior sternum. This structural constraint could contribute to the problems listed on the previous page as numbers 2 and 4.

■ **The respiratory diaphragm**—The right side of the heart is attached to the superior surface of the diaphragm. As the diaphragm descends during inspiration, the heart is widened while being carried inferiorly. Absent this widening, diastole must be reduced, contributing to the problem listed on the previous page as number 2.

I have treated several patients in congestive heart failure that responded immediately to improved diaphragm function, with visible reductions in their dyspnea and edema. It is possible that their heart failure was primarily diastolic in nature, and using osteopathic manipulative treatment to enlarge the available space for diastole was sufficient for symptom relief.

Perhaps heart failure will eventually be understood to result from a continuum of causes, with inadequacies of systolic forces and diastolic spaces both contributing to cardiac insufficiency. Wouldn’t it be ideal for the osteopathic medical profession to lead the way in such research, contributing to standards of care by demonstrating our unique approach to medicine?

I encourage the osteopathic medical profession to explore these suggestions. Research may prove that reduction of upper thoracic somatic dysfunction, expansion of the antero-

posterior diameter of the lower thorax, and enhancement of diaphragm mobility—all of which are obtainable through osteopathic manipulative medicine—can provide additional, synergistic clinical benefits to patients with diastolic heart failure.

Shouldn’t osteopathic medicine be about more than back pain?

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Dangers of For-Profit Education: More Than Just Words

To the Editor:

The letters of Peter B. Ajluni, DO,¹ and Ronnie B. Martin, DO,² in the October 2007 issue of *JAOA—The Journal of the American Osteopathic Association* dismiss the for-profit status of Rocky Vista University College of Osteopathic Medicine (RVUCOM) in Parker, Colo, as a mere difference in “tax status,” compared with nonprofit colleges of osteopathic medicine. The implication of these letters—both of which were responses to an earlier letter of mine³—is that the term “tax status” is just a legalistic technicality that is important only on an obscure line of a corporate 1040 tax form.

In fact, nothing could be further from the truth. The tax status of a school is critically important in defining the overall philosophy and mission of that school—and it goes to the heart of what is wrong with for-profit education.

Dr Ajluni¹ is quite correct in his assertion that there are many socially minded for-profit corporations, but the comparison of a medical school with such a corporation (eg, Dell Inc), or even with a for-profit hospital, is as invalid as comparing the proverbial apples and oranges. A school’s mission should be the education of its students, whereas a for-profit corporation’s mission should be the maximization of profit for its investors.

Socially minded corporations engage in charitable activities because such acts are good business. The general public will always see a responsible corporate member of the community as being more worthy of its business. In the end, such a public perception will boost the corporation’s bottom line. No for-profit corporation would engage in charitable activities at the expense of profit—that is, there comes a point at which the goodwill gained by charitable activities is no longer exceeded by the secondary increase in revenue. At that point, charitable activities stop. To

do otherwise in a for-profit environment would be irresponsible.

Both for-profit and nonprofit institutions must produce a high-quality product to stay competitive in the marketplace. However, the difference between these two types of institutions lies in their use of excess revenue. In the case of a nonprofit medical school, all excess revenue is returned to the institution and used to improve its facilities, expand its programs, and engage in research to increase the existing body of medical and scientific knowledge. Frequently, these endeavors realize no short-term reward for the school and would be viewed as fruitless in the for-profit world. Yet, valuable medical discoveries are often built on years of seemingly inconsequential basic science research.

Thus, it is fair to ask, where will a for-profit medical school draw the line in conducting research? This is a matter of simple economics: to make a profit and generate a return to its investors, a for-profit medical school is likely to divert funds that could otherwise be used to engage in the aforementioned research activities, while at the same time maximizing price (ie, tuition) to competitive market levels.

For-profit medical education is an anathema to the larger medical community. Most for-profit medical schools exist in impoverished, legally permissive locales, such as the Caribbean region, to exploit the desires of individuals who are willing to pay a premium in tuition—and sacrifice education quality and personal credibility—to become physicians. Certainly, many students who graduate from Caribbean for-profit schools become qualified and respected physicians in the US medical community—but such results happen in spite of, rather than because of, their medical schools. The graduates of foreign for-profit medical schools typically struggle to gain acceptance into US residency training programs, and they frequently must settle for less desirable or unwanted residency slots.⁴ Considering these realities, I am concerned

for the graduates of RVUCOM, the first for-profit medical school in the United States since 1930.⁵

Other for-profit medical education ventures have been attempted in the United States in recent years. In 1999, Ross University School of Medicine, a for-profit allopathic institution on the Caribbean island of Dominica, planned to open a branch campus near Casper, Wyo, under the same clarion calls sounded by RVUCOM—meeting the needs of underserved rural communities in the Rocky Mountain West.⁶

Through the efforts of the Liaison Committee on Medical Education (LCME), the American Medical Association, and the Natrona County Medical Society, this initiative was vigorously fought and defeated—despite the ostensible support of “many local physicians” and politicians.⁶ At the time, plans called for the Wyoming campus to be accredited under the auspices of the home campus on Dominica, rather than the LCME.⁶

Despite Dr Martin’s² liberal use of the LCME as an example of an accrediting body, the LCME standards state that a medical school should be a nonprofit institution.⁷ Although this provision in the LCME standards is not an outright prohibition against for-profit medical schools, it still is a long way from the explicit statement by the Commission on Osteopathic College Accreditation (COCA)⁸ that an osteopathic medical school can be either a for-profit or nonprofit institution.

Florida-based businessman and real estate investor Yife Tien, BSc, and his wife are the sole owners of RVUCOM.⁹ There is no reason why, were business to decline, the RVUCOM campus could not be converted overnight into another office park in the rapidly growing Denver metroplex.

The American University of the Caribbean, which was established by and is owned by Mr Tien’s father⁹ and for which Mr Tien himself has served as chief operating officer, has no traditional connection to osteopathic

medicine—aside from the fact that its dean for clinical medical sciences is an osteopathic physician.¹⁰ This same individual is also a member of RVUCOM’s board of trustees.⁹

In a strict business sense, given the popularity of the MD degree, investors would most likely prefer to open allopathic medical schools rather than osteopathic medical schools, if that were possible.

The LCME is aware of the precedent set by RVUCOM and is currently considering the issue of for-profit educational initiatives in the context of its present standards (B. Barzansky, PhD, written communication, August 2007).

Nevertheless, there is no evidence to support the concept of for-profit educational institutions as superior to or more efficient than nonprofit educational institutions.¹¹ Furthermore, there is speculation that for-profit medical education will not provide students with an opportunity for a complete experience of humanity, professionalism, and ethics—factors that are ingrained in the nonprofit model of medical education.¹¹

For osteopathic medicine, the dangers of for-profit education are very real. Regardless of whether RVUCOM provides an education equal in quality to the nonprofit model, there has been no cogent argument put forth as to why the osteopathic medical profession—which has struggled for more than a century to establish its credibility and gain acceptance—needs to take this step. I believe that the individuals who invested in RVUCOM have jeopardized our profession—and, thus, our patients—merely to turn a profit.

As the “baby boom” generation enters retirement, the United States faces a healthcare challenge heretofore unseen. The “perfect storm” of an aging population, expanding and costly medical technology, and decreasing fiscal resources is looming as a threat to the economy and national security of the United States.

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In the face of these serious problems, it is difficult to justify the establishment of for-profit medical schools in the United States under the guise of osteopathic medicine. When the healthcare funding crisis occurs, as it inevitably will, what is going to get cut first—the large nonprofit medical schools (providing patient care, education, and research) or the smaller for-profit medical schools (generating income for real estate investors)?

In summary, the “tax status” of a medical school is more than just words. It goes to the very heart and philosophy of a medical school—much more so perhaps than a mission statement, as required by COCA. Although we live in 2008 rather than in 1910, when educational theorist Abraham Flexner^{5,12} issued his report critical of for-profit medical education, some things do not change and, indeed, should never change. Considering the healthcare challenges facing the United States in the 21st century, the words of Mr Flexner^{5,12} resonate as strongly today as they did a century ago:

Such exploitation of medical education is strangely inconsistent with the social aspects of medical practice...the medical profession is an organ differentiated by society for its highest purposes, not a business to be exploited.

Dr Martin² maintains that RVUCOM is “...the right school in the right location at the right time, created for the right reasons.” I respectfully disagree.

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Responses

In his most recent letter to the editor, George Mychaskiw II, DO, continues to express a deeply convicted personal position on the evils of for-profit education, as he has before in *JAOA—The Journal of the American Osteopathic Association* (2007;107:246-277). However, he is not able to present facts to support his position. Rather, Dr Mychaskiw chooses to make his points through conjectural attempts at linking together disparate and unrelated events.

Dr Mychaskiw and I agree that there are substantial problems with the current healthcare system in the United States. In this regard, it should be pointed out that organizations like the one that employs Dr Mychaskiw are classic examples of a healthcare delivery system centered around academic and tertiary care medical centers with reliance on tertiary care medical specialists. Such systems—which tend to reward procedures (eg, quadruple coronary artery bypass grafting, aggressive cancer management at the end of life) rather than concentrating on access to timely primary care, wellness, preventive care, and quality of life—are systems designed for failure. This is precisely the kind of approach to healthcare that has led the United States to impending crisis.

Nevertheless, it is hard to conceive how the establishment of Rocky Vista University College of Osteopathic Medicine (RVUCOM) or any other new medical school—regardless of tax status—could have a direct effect on this dysfunctional healthcare system or on the aging and uninsured populations of the United States. It almost seems as if Dr Mychaskiw is implying that the last 40 years of healthcare policy in the United States have been the result of the establishment of RVUCOM in 2006. In that vein, I am surprised that the impending disasters projected to result from global warming have not also been credited to the recent establishment of RVUCOM.

Dr Mychaskiw uses speculation to describe what RVUCOM may or may not do to provide for its students—without commenting on or having direct knowledge of the quality of our programs, facilities, faculty, or curriculum—or of our established commitments to public service. He acknowledges that RVUCOM will graduate competent osteopathic physicians. However, he also feels that RVUCOM may jeopardize all patients of DOs by embarrassing the osteopathic medical profession.

I do not understand how competent osteopathic physicians who provide access to high-quality healthcare for medically disadvantaged patients are an embarrassment to the osteopathic medical profession. But, of course, Dr Mychaskiw is entitled to his opinion.

Dr Mychaskiw also implies that when the impending healthcare funding crisis occurs, for-profit educational institutions and their students will suffer. However, he neglects to explain that RVUCOM provides access to an osteopathic medical education for our students and to expanded medical services for the public without using scarce state or federal funding resources.

If all medical schools followed our model, think of the billions of dollars currently directed to support medical schools and faculty that could be freed up to provide healthcare for millions of "baby boom" retirees, patients without health insurance, and other individuals without appropriate access to healthcare.

Dr Mychaskiw deemphasizes the fact, or entirely misses the point, that no institution can be successful without operating an efficient business model, producing a high-quality product, maintaining the support of its customer base, and meeting the expectations of society. These necessities apply to all other current medical schools as well as they apply to RVUCOM.

As a for-profit institution, we will have fewer excuses if we do not meet these expectations. We will not be able to blame any shortcomings on state budget cuts, increased expenses, or lack of student preparedness. We are and will continue to be responsible for our own outcomes—and we are prepared to deal with that reality.

At RVUCOM, we are confident of the professional performance of our graduates because we have planned and engineered our educational systems and curriculum to make their success possible. We provide our students with strong role models in osteopathic primary care. These role models are

involved in all aspects of student education. Our clinical education program exposes students to community-based experiences with excellent university-credentialed faculty, in addition to a challenging hospital-based curriculum. Students rotate during their third year of medical school in community and underserved settings with primary care providers—before they make their residency choices. This approach allows the students to be exposed to the professional opportunities and rewards provided by such disciplines as family practice, pediatrics, internal medicine, public health, and women's health. The community-based experiences of our students also include required rotations in osteopathic manipulative medicine designed to strengthen their appreciation and use of the profession's distinct philosophy.

In addition, RVUCOM has other public service requirements and opportunities for students, ranging from local and in-state to international medical experiences. The "shadowing" experiences of our students throughout their first 2 years of medical school are predominately in community and public health settings. Such experiences encourage students to maintain the spirit they expressed when entering medical school—the spirit of wanting to make a difference in the lives of people and to serve individuals who are disadvantaged and in need of healthcare.

It is not merely our students who will provide service to our community. In another example of our public service commitments, many members of our faculty have agreed to work with several local schools to foster the interests of young students in the sciences and medical professions. Other RVUCOM faculty members provide leadership for the osteopathic medical profession through the American Osteopathic Association and affiliated organizations.

We are proud to hold our commitment to service up to public scrutiny because striving to improve the lives of those with whom we interact is an

integral part of our mission and vision—and it coincides with the strong commitment to excellence that we expect from our students, faculty, and all those associated with RVUCOM.

If RVUCOM is to grow and expand as a university, as currently planned, the resources for this success must come from our own efforts. We will not be able to go to government agencies or other funding resources to obtain an endowed auditorium, a standardized patient laboratory, or a clinic building. Instead, we will have to fund such infrastructure improvements out of that "excess revenue" to which Dr Mychaskiw refers.

As Dr Mychaskiw is surely aware, research in the United States is not funded principally by the "excess revenue," or "profits," of medical schools. These meager funds would not support the level of commitment that is required to expand medical knowledge and support medical research. At RVUCOM, we are committed to expanding medical knowledge and contributing to research. Our faculty will be expected to develop research projects and concepts and compete for grants to support these research efforts from extramural sources (eg, state and federal governments, private foundations), just as faculty at other medical institutions compete for such funds. As Dr Mychaskiw knows, research grants obtained from these sources are very specific regarding how the funds can be used. The funds cannot simply be added to "profits." They must be fully accounted for and used as intended to support the research and the researcher. In other words, RVUCOM is required to play by the same rules as any other medical research institution.

I acknowledge that the education of our osteopathic medical students; the careers of our faculty; and our service to the profession as well as the citizens of our state, region, and nation represent the primary missions and goals of RVUCOM. At this point in our development, research is not our principle vision. Only time will tell if and

how this aspect of our work may change in the future.

In my more than 30 years in the osteopathic medical profession, I have found that it is not the research that suffers at many medical schools. Instead, it is the schools' commitment of resources and faculty to teaching, public health, and public service that often becomes downgraded. I have heard, in my private conversations, many a dean lament that the education of his or her students and the support of core faculty are frequently overlooked under our current medical school system, in which the "holy grail" consists of the income generated by the medical specialists on faculty (who typically practice more than they teach), the hospital, and the research grants. These considerations often take priority over the education of the students.

At RVUCOM, by contrast, we believe that our primary obligations are to the education of our students and the advancement of our faculty. We have acted and will continue to act with these primary obligations foremost in mind.

We recognize that we have an obligation to consider "social consequences," more so than does a private manufacturer or a corporate operator of hospitals because we are engaged in the business of preparing medical students to serve and advocate for improvements in the lives and healthcare of others. Our commitments to service, professionalism, and humanity are reflected in the ways in which we have designed our curriculum, selected our students and faculty, and dedicated our resources.

I respect Dr Mychaskiw's commitment to his beliefs and his willingness to engage in debate on this subject. Critical examination is required to improve any process—and all of us wish for improvement in the health of our citizens and in the healthcare system of our country. Dr Mychaskiw and I diverge regarding how the needs of medical students and patients can best

be served. Unlike Dr Mychaskiw, I believe there is room for and a need for both for-profit and nonprofit models in educational establishments.

I continue to believe that RVUCOM is the right school in the right place at the right time for our osteopathic medical students and for the citizens of Colorado and the western United States. History will judge which one of us is correct in our beliefs.

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I am disappointed with the most recent letter from George Mychaskiw II, DO. He has mischaracterized my earlier letter to the editor,¹ in which I cautioned against a priori condemnation of an institution simply because of its for-profit or nonprofit tax status.

Tax status determines a number of financial considerations for an institution, including the allowable methods of raising funds, the tax treatment of received revenues, and the distribution of those revenues. The main point noted in my previous letter¹ was that the leadership of any organization is a larger determinate of that organization's character than is its tax status. Despite Dr Mychaskiw's lengthy correspondence, I still hold this conviction.

Dr Mychaskiw naively heralds the blanket superiority of nonprofit institutions of higher learning by claiming that all excess revenue at such institutions is used to improve facilities, expand programs, and engage in research. However, Dr Mychaskiw fails to mention that the nonprofit approach can be wasteful—in a number of ways that have previously been documented. For example, universities across the United States have been known to use excess revenues to fund large salary and staffing increases and to build luxurious facilities.² Many universities have purchased impressive athletic facilities and opulent student unions that are far more ostentatious than functional—

such as the 53-person Jacuzzi at one large state university.³

These kinds of wasteful decisions on deployment of resources can be made in nonprofit and for-profit organizations. It is leadership—not the tax code—that will be the key determinant of an organization's character and spending habits.

I must say that, after receiving and responding to several communications from Dr Mychaskiw,^{4,5} I am struck by his lack of understanding of the factors that drive commercial free-market businesses. Profits are generated by a company because satisfied consumers value the company's products or services; find those products or services to be available at prices that are acceptable; and are willing to purchase products or services from the company. When these factors are no longer met, consumers seek other sources to fulfill their needs.

This system of checks and balances is not perfect, as recent scandals in the financial markets demonstrate. Nevertheless, any institution of higher education that no longer meets the needs of its potential students will survive only with great difficulty and at great cost—regardless of its tax status.

In his current letter to the editor, Dr Mychaskiw intimates (I believe) that research is important at colleges of osteopathic medicine (COMs). I certainly agree with this point. However, COMs need to devote appropriate amounts of their limited resources to research. As with any other activity, research is not immune to the law of diminishing returns. Throwing money at research, or any other activity, can be wasteful. Likewise, using tuition at a nonprofit COM to finance a pharmacy or veterinary school is not necessarily the best use of that COM's funds. We must all rely on our leaders to make prudent spending decisions.

Because markets are imperfect, we put safeguards in place to help them function appropriately. The accreditation standards developed by the Com-

mission on Osteopathic College Accreditation (COCA)⁶ require COMs to "make contributions to the advancement of knowledge and the development of osteopathic medicine through scientific research." Thus, it is the responsibility of COCA (leadership again) to ensure that all COMs and branch campuses uphold these standards in a financially appropriate manner—regardless of their tax status.

As leaders of the osteopathic medical profession, we must accept that there are times when people reach a point at which they agree to disagree and move on. This is such a time.

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Editor's Note: Dr Ajluni served as the 2007-2008 President of the American Osteopathic Association.

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Keeping the Flames of OMM Burning

To the Editor:

I am writing in response to the letter by Stephen M. Davidson, DO,¹ that appeared in the February issue of *JAOA—The Journal of the American Osteopathic Association*. Dr Davidson's analysis of education at colleges of osteopathic medicine is "right on the money" for the most part. In my experience, however, the failure of osteopathic medical students to learn how to apply osteopathic principles and practice (OPP) and osteopathic manipulative medicine (OMM) in clinical settings is a result of an almost total lack of follow-through once students get into their externships—and ultimately into postgraduate training.

If none of my attending osteopathic physicians had taken the time to show me how to apply my theoretical knowledge of physiology and pharmacology to actual clinical situations, I would never have been able to make a correct diagnosis or to prescribe the indicated treatment—pharmacologic or otherwise. I use OMM daily in my practice of physical medicine and rehabilitation, but my application of OMM is possible only because of the strong one-on-one mentorship provided to me during my externship and postgraduate training.

Frankly, all the practical knowledge I have regarding OMM was gained through my own initiative—that is, by using most of my elective time to rotate with DOs who could show me how to use my hands to make an osteopathic diagnosis and provide osteopathic manipulative treatment. There need to be more formal supports for osteopathic medical students who want to learn to use their hands. Such formal supports may even help prevent those students with only marginal interest in OMM from completely abandoning it long before they get into residency training.

The bottom line is that the osteopathic medical profession wants to have it both ways. We want parity with our MD colleagues, but we also want to stay a distinct profession. In the "real world," most of us practice allopathic medicine with a little OPP occasionally thrown in. My fear is that unless we, as a profession, commit in practice to doing things differently than our MD colleagues, we will eventually become fully assimilated

into the allopathic medical profession. This assimilation would be a tragedy because there are many unique aspects of osteopathic medicine that are of great value to patients.

As a side note, I have recently learned that the University of North Carolina at Chapel Hill (UNC-Chapel Hill) is conducting a randomized controlled trial on the efficacy of craniosacral therapy in the treatment of patients with migraine headache.^{2,3} The principal investigator in this trial is an MD neurologist, while the coinvestigators are MDs and researchers with PhDs, and the individual providing manual therapy is a registered nurse who received training at the Upledger Institute (K.R. Faurot, PA, MPH, oral communication, May 2008).

It is amazing to me that the osteopathic medical profession is not more aggressively pursuing studies of the kind taking place at UNC-Chapel Hill,^{2,3} especially since evidence-based medicine is now becoming the "coin of the realm."

Lastly, I want to thank Dr Davidson¹ and all the other mentors out there who are keeping the flames of OMM burning, and who have taken the time to pass on their knowledge to me and many others.

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Election Year's First Shot Over the Bow: Reforms Needed

To the Editor:

What do former presidents of the American College of Osteopathic

Family Physicians (ACOFP), like me, do in our spare time? We think of ways of revising the healthcare system in the United States. I hope that the readers of this letter can use the ideas that I offer both personally and professionally. I know that the Osteopathic Political Action Committee (OPAC) uses verbiage similar to the ideas in this letter on a daily basis,¹ and I thank OPAC for its ongoing efforts to support reform.

It is fair to say that the United States has the best healthcare system in the world. We have the best-educated physicians, widespread availability of superb technology, and the finest hospitals. National polls continue to affirm that Americans are satisfied with their own physicians and the services they provide.² Yet, there is growing discomfort with the costs, structure, and direction of this system.² It is clear that the US healthcare system faces critical problems.

More than 40 million Americans have no health insurance coverage.³ Individuals may not have health insurance for a number of reasons. For example, they may have preexisting medical conditions; their employers may not provide coverage; or they may be between jobs and currently unemployed. Lack of insurance may cause an individual to delay seeking needed care for a medical condition that is readily treatable.

Millions of other Americans face the problem of having to stay in mundane jobs simply because their employers provide decent health insurance. Still other people face financial ruin because of devastating healthcare expenses that their insurance plans may not cover. People may be worried that their health insurance coverage is not adequate and that healthcare expenses will edge out other family necessities. Furthermore, even if an individual is now adequately insured, there is a possibility that such coverage will not always be there for that person. These problems must be solved!

As a physician, I am pleased that

the US Congress is making an effort this year to advance national healthcare reform legislation.^{4,5} The presidential candidates have also committed themselves to achieving healthcare reform.⁴ As a past president of the ACOFP, I call on our nation's elected leaders to find common ground so that all Americans can be assured of the following:

- healthcare coverage that is retained regardless of employment, economic status, and health condition
- choice of physicians and health insurance plans
- medical decision-making by patients and physicians, rather than by government administrators or insurance clerks
- high-quality healthcare

All Americans should have healthcare coverage at all times for a standard set of benefits. Coverage should continue even if policyholders lose their jobs, change state of residence, or become ill. Coverage for all Americans can be achieved through a variety of approaches. Such approaches may include a requirement that employers pay a percentage of the insurance premium for their employees and their families, and a requirement that individuals obtain insurance coverage—or at least pay a portion of the premium through the use of health savings accounts.

There is no single best mechanism available for achieving universal health insurance coverage. In all instances, however, the government has an obligation to pay for coverage when employers and individuals need assistance. Congress must work with all interested parties to decide the appropriate balance of responsibility (ie, employer, individual, and government) in paying for such universal coverage.

We all should be able to select our own physicians. These individual choices are and will continue to be influenced by the professional skills of the

physician, office location, characteristics of the hospital where the physician provides care, personal preferences of family members, recommendations of friends, and cost considerations. A patient should always be guaranteed the ability to make these decisions for him- or herself. No one knows better than the individual patient the special circumstances that make any physician, hospital, or healthcare plan the "best" choice. It is important that individuals have the power to make these decisions based on what they perceive to be the best option for themselves and their families.

Healthcare plans vary widely in their provisions. Some plans may limit patient choice in physicians and hospitals. Other plans may cost patients more money out of pocket. Patients should have the right to select from all qualified healthcare plans that are available in their areas, including fee-for-service plans, health maintenance organizations, preferred provider organizations, exclusive provider organizations, and benefit payment schedule plans. Guaranteed access to all qualified healthcare plans will ensure that people are able to choose the mix that is best for them.

Today's healthcare marketplace is increasingly characterized by for-profit corporations and large managed care organizations, many of which are taking aggressive actions to control the delivery of healthcare services and reduce their costs. Although efforts to cut costs are appropriate and desirable, excessive concern for costs can interfere with the availability and delivery of health services to patients, thus diminishing the quality of those services.

After any reform of the healthcare system, patients need to be able to work with their physicians to make decisions regarding the medical treatments that are best for them. All too often today, insurance company clerks or government administrators interfere with or delay the medical treatment decisions of patients and physicians. For this situa-

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tion to change, physicians must be able to act jointly in their relations with insurers. Current antitrust laws prohibit physicians from engaging in collective bargaining with private insurance companies or government insurance agencies.⁶ Legislation needs to be enacted to allow physicians to negotiate for themselves and their patients with insurance companies and the government.

Patients and their physician representatives should have a say about issues that affect healthcare quality. Patients should also have all the information they need to be able to easily compare physicians, other healthcare providers, and healthcare plans regarding value, quality, and patient satisfaction.

Instead of government and insurer control over healthcare decisions, a private/public partnership should be established to develop a national quality-assurance program for healthcare. The goal of such a program would be to strengthen existing efforts of the private sector to promote quality standards and the appropriate use of health services.

It is important that elected officials hear from concerned constituents before voting on any legislation reforming the US healthcare system. I strongly encourage readers of *JAOA—The Journal of the American Osteopathic Association* to write their senators and representatives and urge action on health system reform. In corresponding with congressional representatives on this matter, be sure to emphasize that any meaningful reform would include healthcare coverage that is retained regardless of employment, economic, or health status; freedom of choice in physicians and health insurance plans should be retained; medical decision-making is reserved for patient-physician interactions, rather than by government administrators or insurance clerks; and high-quality healthcare.

In conclusion, through the years, I have greatly appreciated the importance of ACOFP's political work on behalf of the osteopathic medical profession and the "mothership," the American Osteopathic Association. I am especially proud of efforts by Marcelino Oliva, DO, chair of the ACOFP's Committee on Federal Legislation, and Ray Quintero, the ACOFP's director of government relations. I urge *JAOA* readers to show their support for these efforts by thanking these hard-working individuals and by contributing to OPAC.

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Increase Efforts to Promote Primary Care

To the Editor:

In regard to the letter by Taras Lisowsky, DO,¹ titled "Pushing bodies through COMs," and the response by Diane N. Burkhardt, PhD,² in the March issue of *JAOA—The Journal of the American Osteopathic Association*, I would like to share my experiences and thoughts as a first-year osteopathic

medical student at Des Moines (Iowa) University—College of Osteopathic Medicine (DMU-COM). I am inclined to agree with Dr Lisowsky's intended point that osteopathic medical students are not being encouraged to pursue careers in primary care. In fact, my experience thus far has been more in the realm of, "You can do anything as a DO now. All specialties are open to you."

Of course, all specialties are open to DOs now, and this has happened as a result of the outstanding work and effort of so many osteopathic physicians during the past century. In addition, recent efforts of the osteopathic medical profession to focus on physician availability in underserved areas are to be commended. For example, last August, DMU (including DMU-COM) and the University of Iowa in Iowa City announced the formation of several health education centers in our state.³ These centers will serve as a network to recruit and retain healthcare professionals, including osteopathic physicians, in rural Iowa. My school also has loan repayment options available for students who decide to practice in state after residency training.^{4,5}

However, these efforts are indirect and somewhat ineffective. In the communications I have received as a student member of the American Osteopathic Association (AOA), American College of Osteopathic Family Physicians, and the Student Osteopathic Medical Association, it seems that the impetus behind any promotion of primary care is related to concurrent political efforts to improve Medicare reimbursements and student loan repayment programs for DOs. Although such political endeavors are necessary, they, again, fail to recruit students to primary care practice.

I do not doubt that the AOA and the COMs have considered how best to promote the fact that DOs can pursue any medical specialty while also promoting primary care as a noble, relevant, and economically feasible career

choice. I'm sure that balancing these two objectives is a difficult task. After all, our profession does need to address the problem of rising student loan debt coinciding with stagnant primary care physician income, especially in light of declining Medicare and Medicaid reimbursements.

More importantly, however, we need primary care DOs promoting their chosen career path one-on-one with students in the COMs—asking students to shadow them and discussing economics, lifestyle, and other aspects of primary care with them.

We also need directors of osteopathic primary care residency programs to promote their programs in the COMs. In addition, we need more of these residency programs in locations where students actually want to live during training.

For example, my home state of Colorado, considered to be a desirable location by many students, currently has no osteopathic medical residency programs in any specialty.⁶ I have already looked at which specialties have allopathic medical residency programs in Colorado, and I know from conversations with other students that residency location often plays a role in specialty selection.⁷

Combined, the actions taken to address these issues could turn the page and get more DOs into primary care.

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Eliminating Bad, Bad Medicine: Problems With P4P Initiatives

To the Editor:

The special communication by Robert G. Locke, DO, and Malathi Srinivasan, MD,¹ about pay-for-performance (P4P) initiatives, in the January issue of *JAOA—The Journal of the American Osteopathic Association* was thought-provoking. I believe, from a patient's perspective, that aspects of P4P initiatives may *seem* useful, but I question their application in actual clinical practice.

For example, the P4P initiatives, on paper at least, may seem helpful for certain practices, such as those with clinics that are operated as "cattle calls" (ie, "fast-food medicine"); those with physicians who have terrible people skills (ie, bad bedside manner); those that re-use syringes;² and those with physicians and other healthcare providers who fail to wash their hands before and after patient interactions.

In reality, however, the P4P initiatives are not going to make "non-hand-washers" suddenly start washing their hands. Hand-washing is something you learn as a student in elementary school—not as a practicing physician. Neither will the P4P initiatives make those physicians with bad bedside manner develop better people skills; these are skills that you either have or do not have prior to matriculation.

In short, the P4P initiatives are not going to prevent bad physicians from practicing fast-food medicine, re-using syringes, or transporting patients when not medically necessary in an effort to increase "billable hours." All those real-world situations encompass ethical

issues that are learned prior to medical school.

Furthermore, taking a yearly ethics examination before obtaining a state medical license will not change poor medical behaviors either. Efforts to eliminate "bad medicine" need to begin with recruiting efforts—and factors beyond Medical College Admission Test scores need to be considered. A written examination with the question, "True or False: Can washing your hands prior to and after seeing a patient reduce microbial spread?" is useless. That question would never weed out the non-handwasher because even a 5-year-old child would know how to answer it correctly.

Rather than improve the behaviors of bad physicians, the P4P initiatives have the potential to create serious problems for good physicians. As a patient, I see the P4P initiatives taking away a good physician's ability to practice medicine because the initiatives may have the effect of turning practitioners into administrators—administrators who follow rules, regulations, and by-laws to the detriment of a patient's unique medical issues, or who use a one-medicine-fits-all approach.

It is true that checklists can be very useful in any profession. For example, a report presented at the annual meeting of the American Society for Microbiology in New Orleans, La, in May 2004, showed that 46% of the neckties worn by physicians at the New York Hospital Medical Center of Queens contained large quantities of *Staphylococcus aureus* and other infectious microorganisms.³ Thus, one item on a useful checklist in hospitals and clinics would prevent physicians from wearing neckties. However, checklists and similar quality-improvement initiatives can be overly complicated, resulting in possible adverse effects on the quality of patient care.⁴

If the P4P initiatives are intended to establish a new standard of care (as mandated checklists), why not just use a software program to fulfill the pur-

pose of the initiatives and determine the medical necessities for each patient?

In computerized medical assessments, patients would answer questions about their medical needs, and—based on patient responses...and the assumption that the questions were answered truthfully—the software would produce a clinical diagnosis and appropriate prescription.

If the P4P initiatives could truly assess clinical observations, the US Food and Drug Administration (FDA) would not need expert committees to analyze preclinical, clinical, and postmarketing data on drugs and medical devices. Instead, the FDA would rely on a software program like the one described to accurately evaluate a drug or medical device based on inputted data. This hypothetical scenario, of course, is not realistic because no software program could adequately substitute for the years of practical experience represented by physicians in their clinics or on FDA expert committees.

I agree with the majority of the DO survey respondents that P4P initiatives would not appropriately capture the quality of their work.¹ Medicine is referred to as being “practiced” for a reason, and practicing medicine does not mean that every patient’s medical needs are the same. In addition, the statistical significance found in an academic study may not translate usefully into a physician’s private clinical practice. Conversely, an excellent patient-physician relationship will not translate into a checklist item that can be given to a poor physician to automatically change his or her terrible skills (whatever they might be) into the skills of a great physician. No P4P initiatives will change the behaviors of those physicians with questionable ethics or poor medical-business practices.

The P4P initiatives are not grounded in the realities of clinical practice. Many physicians who practice good medicine and many hospitals that use quality-assurance checklists still have patients who test positive for infec-

tious microorganisms, such as methicillin-resistant *S. aureus* (MRSA). Medicare officials recently announced that they plan to stop paying for 13 common conditions typically caused by hospital errors.⁵ Some of these errors can obviously be prevented, but others, such as MRSA infections, cannot. As with the P4P initiatives, Medicare’s “Hospital 13” plan⁵ ignores the realities of clinical practice. The Medicare plan implies that all microbial infections are hospital-acquired or hospital-generated. However, this is misleading because one-third of MRSA infections are community-acquired.⁶ Does hospital protocol now need to dictate that all patients head toward the laboratory to get tested for MRSA before treatment—similar to the way some hospitals screen every pregnant patient for drug use?

I also take issue with the value of the patient satisfaction scale reported in the article by Drs Locke and Srinivasan.¹ Is the patient satisfaction scale, which is likely to become the cornerstone of P4P evaluations, really a true measurement of medical care quality?

For example, how is a physician supposed to help a patient who has been diagnosed with chronic obstructive pulmonary disease but refuses to stop smoking? What about those patients who are not proactive with their healthcare, yet expect the physician to fix their problem(s) quickly with a pill?

Presuming the physician does not “cave in” to a patient’s medically irresponsible requests, the smokers and pill seekers will undoubtedly rate the physician poorly—thus skewing the results of that physician’s patient satisfaction scale rating—and seek a second opinion. Obtaining a second medical opinion is not inherently bad, but seeking a second medical opinion for the wrong reasons is dangerous.

It has been stated anecdotally that about 80% of the US healthcare budget is consumed by the effects of five behavioral issues: smoking, alcohol consumption, lack of exercise, poor nutrition, and stress.⁷ No P4P initiatives or Medicare-

mandated payment refusals will change unhealthy patient behaviors.

Should there then exist a report card for patient healthcare performance in which a patient’s efforts at good self-care determines his or her costs for healthcare? Should this report card include factors such as how well a patient manages diseases with a genetic basis, such as type 1 diabetes mellitus?

It needs to be kept in mind that a successful medical healthcare system consists of approximately 10% medical guidance and 90% patient effort—not the other way around. Consequently, the P4P rating system makes a huge and erroneous assumption that medical soundness takes a back seat to a patient’s whims.

Another issue highlighting the inadequacy of the P4P initiatives is related to lack of patient options. For example, there are clinics in some areas of the United States that are the only ones in town—and thus the only healthcare option for patients. Yet, some of these clinics may provide terrible healthcare. How would the P4P initiatives improve the care of patients in such clinics?

Years ago, I went to a physician whose arrogance created a poor patient-physician relationship. As a patient, I decided to never return to that physician, regardless of the degrees and certifications displayed in his office. I now have a primary care physician—an osteopathic physician in family practice—who, from my perspective, is excellent in all aspects of clinical practice. I plan to keep her as my primary care physician even if she changes her practice location (provided that she agrees to still be my physician, of course), regardless of P4P initiatives or her patient satisfaction scale scores.

I follow (as in the 90% patient-effort part referred to above) my physician’s medical recommendations and advice (the 10% medical-guidance part) to ensure that my healthcare path is proceeding according to our plan (encompassing 100% medical healthcare).

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A mutually respectful relationship between a competent physician and a responsible patient is ultimately the only way to achieve quality healthcare. The P4P initiatives will never replace that, as they place all the responsibility on physicians and none on patients.

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Spirituality is Fundamental to Osteopathic Medicine

To the Editor:

In the April issue of *JAOA—The Journal of the American Osteopathic Association*, Elizabeth K. McClain, EdS, and colleagues¹ reported that osteopathic medical students generally receive 2 to 20 hours of instruction on spirituality and religion, and that approximately 55% of all colleges of osteopathic medicine (COMs) have some form of spirituality-in-medicine program in place. The authors concluded that it is important that more information regarding methods of medical schools'

spirituality curriculum development and program evaluation become available.¹ We strongly agree with their conclusion. In addition, we believe it could be argued that spiritual aspects of patient care are a fundamental part of osteopathic medical care.

A number of studies have demonstrated the value of religion and spirituality to the physical and mental health of patients,²⁻⁴ making it clear that a high proportion of patients rely on religious beliefs to help them cope with their health problems. In fact, more than 60 studies have examined the role that religion plays in helping people deal with such diverse conditions as diseases of the heart, lungs, and kidneys, as well as AIDS, amyotrophic lateral sclerosis, arthritis, cancer, chronic pain, diabetes mellitus, and other illnesses.²

According to Harold G. Koenig, MD, MHS,³ codirector of the Center for Spirituality, Theology, and Health at Duke University Medical Center, among 445 patients who were consecutively admitted to general medicine cardiology and neurology services at Duke, nearly 90% reported using religion to some degree to cope with their conditions. Similarly, more than 40% indicated that religion was the most important factor that kept them going.³

Koenig and McCullough⁴ note that more than 700 studies have examined the relationship between patients' religious beliefs, well-being, and mental health—with nearly 500 of these studies demonstrating a beneficial association between religion and better mental health, greater well-being, and lower levels of substance abuse. Koenig and McCullough⁴ also summarize research from numerous investigations that found beneficial effects of religion/spirituality on patients' physical health outcomes.

Among the findings of these investigations, religious beliefs and activities were associated with improved immune functioning in 5 of 5 studies; reduced death rates from cancer in 5 of

7 studies; less heart disease and better cardiac outcomes in 7 of 11 studies; reduced blood pressure in 14 of 23 studies; lower cholesterol levels in 3 of 3 studies; reduced cigarette smoking in 23 of 25 studies; increased exercise in 3 of 5 studies; and improved sleep in 2 of 2 studies.⁴

In addition to being a growing area of research, religion/spirituality is becoming a crucial part of modern medical practice. Increasing evidence suggests that religious beliefs influence patients' medical decisions and that religion/spirituality becomes even more important to patients as they face the specter of serious illness.⁵

Many patients desire their physicians to consider their spiritual needs on an equal basis with their physical health,⁶ and many want clinicians to ask about their religious beliefs in times of serious illness.⁷ The Joint Commission on Accreditation of Healthcare Organizations now requires that certain patients in inpatient behavioral healthcare programs be given an assessment that "includes the client's religion and spiritual orientation."⁸

The proposed tenets of osteopathic medicine offered by Rogers and colleagues⁹ indicate that spirituality should be an important part of the osteopathic approach to treatment. The first tenet states the following:

A person is the product of dynamic interaction between body, mind, and *spirit*. The human body functions as a unit, integrated such that no part truly operates independently. Alterations in the structure or function of any one area of the body influence the integrated function of the network as a whole. A comprehensive approach recognizes the integral roles of body, mind, and *spirit* in health and disease. [emphasis added]

In view of this tenet, it would seem that there is little question that addressing spiritual issues related to a patient's illness should be an essential part of the osteopathic approach to treatment.

In describing why physicians should consider spirituality to be an integral part of the practice of medicine, Dr Koenig⁵ stated, "...because doing so is part of whole person health care. Simply treating a medical diagnosis or a disease, without considering the person with the disease, is no longer acceptable."

The need for additional education regarding religion/spirituality for trainees in osteopathic medicine is evident. We believe that the 2 to 20 hours of didactics currently provided at COMs may not be sufficient to address this topic. However, we acknowledge that it may be problematic to fit additional training into the extensive curriculum already in place at COMs. Thus, we encourage further dialogue on religion and spirituality among members of the osteopathic medical profession.

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Rise and Shine, Rhinorrhea

To the Editor:

The article by Nicholas L. Rider, DO, and Timothy J. Craig, DO,¹ in the September 2006 issue of *JAOA—The Journal of the American Osteopathic Association*, about long-acting β_2 -agonists and inhaled corticosteroids, shows the benefits of standard therapy in the treatment of patients with asthma. At the same time, however, the article raises questions in my osteopathic-oriented mind about the wisdom of using intranasal steroids to put the immune system "to sleep."

In the September 2006 edition of *The DO*, the late John A. Strosnider, DO,² (2006-2007 President of the American Osteopathic Association) encouraged us to remember our roots. One of the issues that helped me decide to pursue osteopathic medicine as a career was the success rate of osteopathic physicians in treating patients with influenza after World War I. According to the United States Centers for Disease Control and Prevention,³ the mortality rate of patients with "Spanish flu" who were treated with conventional medical therapy was more than 2.5%, while records reported at the time suggest that the mortality rate of patients who were treated by osteopathic physicians may have been as low as 0.25%.⁴

Even if the statistics then reported in the *JAOA*⁴ were not entirely accurate, the difference in outcomes for osteopathically treated patients versus allopathically treated patients was still likely to have been significant.

As Harold I. Magoun, Jr, DO,⁵ pointed out in a letter in the October 2004 *JAOA*, this difference in outcomes probably centered on the real-

ization by osteopathic physicians that the symptoms of fever and cough exhibited by patients with influenza—symptoms that MDs addressed pharmaceutically with aspirin and cough suppressants—were actually the immune system's protective responses to illness. In the language of evolutionary biology, those symptoms were defenses that were expressed because they conveyed a survival benefit that was lost when they were suppressed. In the language of sports, hobbling your defense means the other side scores.

Most triggers for asthma are recognized in the nose. The "one airway hypothesis" posits that when the immune system recognizes a substance in the nose (ie, upper airway) that could cause greater problems in the lungs (ie, lower airway)—where the body's defenses are less robust—the system protects the lungs by constricting the connection between the two airways.⁶ This constriction is one of the actions of histamine as it triggers the washing defense that is rhinorrhea. Both common sense and ultramicrographic studies point to the fact that histamine's action in triggering rhinorrhea is just as much of a defense as is a fever or a cough.⁷

Just as blocking other evolutionary defenses handicaps our ability to deal with threats, stopping rhinorrhea risks an increase to nasal-related problems. The up to 20-fold increases that have been reported in hospitalizations for asthma stem from the early 1970s.⁸ That was the same time at which antihistamines and decongestants were made available on an over-the-counter basis—and the same time at which these medications were advertised on television and supplied in bulk for physicians to give to needy patients. Although this sequence of events does not satisfy the logic of causality, it should at least raise the question of causality.

If the osteopathic medical profession is serious about looking to its roots, we ought to look at treatments that honor the natural defenses of the

immune system and observe how doing so would impact the incidence and severity of asthma. Then, it is likely, we would not have to put our immune systems to sleep with steroids.

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More on Benzocaine-Induced Methemoglobinemia

To the Editor:

I am writing in response to the case report by Sandra Kaye Birchem, DO,¹ published in the August 2005 edition of *JAOA—The Journal of the American Osteopathic Association*.

Situations of benzocaine-induced methemoglobinemia, similar to the one described by Dr Birchem,¹ arose in 2001 at York Hospital (York, Pa) in several patient-care areas, mainly related to endoscopy cases in the emergency department.

Instead of immediately removing the medication from the formulary, an aggressive program of education for

the house staff occurred, and each canister of Hurricaine (20% benzocaine) (Beutlich LP Pharmaceuticals, Waukegan, Ill) topical anesthetic aerosol spray was tagged with a fluorescent pink sticker that displayed the following text:

Excessive doses can cause methemoglobinemia. Only one half-second spray is recommended with one repeat if necessary. Not recommended for use for pharyngitis or tonsillitis.

Both Hurricaine and Cetacaine (14% benzocaine) (Cetylite Industries, Pennsauken, NJ) topical anesthetic aerosol spray formulations are safe when used appropriately. However, overdosing with Hurricaine and Cetacaine may occur when house staff expose patients to these topical anesthetics for a longer time than recommended by the manufacturers.

In early 2007, York Hospital switched from Hurricaine to Exactacain (14% benzocaine) (Healthpoint Ltd, Fort Worth, Tex) topical anesthetic aerosol spray (G.D. Moffett, JD, written communication, August 2007). Because of the lower concentration of benzocaine in Exactacain versus Hurricaine, this switch further reduced the risk of methemoglobinemia in patients. Each canister of Exactacain features a fluorescent pink sticker with the following text:

WARNING!!! Excessive doses of benzocaine from Exactacain Spray may lead to methemoglobinemia. DO NOT exceed the recommended dose of three metered sprays, with one repeated application as necessary. This product is not intended for use in the treatment of sore throat!

The *JAOA* has performed a useful service in making its readers aware that Hurricaine and Cetacaine must be used with great care. However, it is important that readers understand that it is the duration of application with these topical anesthetics that often creates the

severe reaction noted in Dr Birchem's case report.¹

In addition, research suggests that even if the duration of spray is consistent, there can be considerable variability in the delivery of the active ingredient in Hurricaine depending on the orientation of the canister (ie, vertical vs horizontal) and the degree of fullness of the canister.² Because Exactacain dispenses a metered dose, the possibility of overdosage is lessened with this medication.

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ED Physicians Beware When Using OMT for Patients With Motor Vehicle Injuries

To the Editor:

I read the original contribution by Tamara M. McReynolds, DO, and Barry J. Sheridan, DO, titled "Intramuscular ketorolac versus osteopathic manipulative treatment in the management of acute neck pain in the emergency department: a randomized clinical trial" in the February 2005 issue of *JAOA—The Journal of the American Osteopathic Association* (2005;105:57-68) with a bit of apprehension. After rereading this study, I believe a few comments are in order.

First, I congratulate the authors for undertaking the challenge of finding a better treatment for patients who have a problem that is "a real nuisance" to the emergency department (ED) physician—spinal pain, manifested in this particular setting as neck pain.

My main concern with the study by Drs McReynolds and Sheridan, however, relates to the statement, "The majority of patients (58%) had cervical strain resulting from a motor vehicle collision." In the study group receiving osteopathic manipulative treatment (OMT), there were 18 (62%) subjects with injuries caused by motor vehicle accidents. In the study group receiving ketorolac tromethamine, there were 16 (55%) subjects with this type of injury.

Depending on the exact mechanism of injury, a small subset of patients in motor vehicle accidents may harbor injuries to the neck that are not readily apparent in plain film radiographs. Even if the findings of a patient's physical examination are normal and there is no neurologic complaint (eg, radiculopathy), there may still be structural problems that could be a contraindication to OMT. Facet joint fractures of the cervical spine may be so subtle that they are diagnosable only after imaging using computed tomography. In such cases, there could also be an associated laminar fracture. Furthermore, some ligamentous injuries may not be apparent in lateral cervical films. Such injuries may be noticed only with the assistance of magnetic resonance imaging. Days or weeks after the initial trauma, patients with these injuries may describe only "neck pain."

The diagnostic complexities associated with patients who were in motor vehicle accidents raise a number of questions. For example, should patients involved in motor vehicle accidents be excluded from clinical studies of OMT because of possible legal ramifications to the investigating physicians? Also, why add the ED physician to the list of candidates for possible future litigation in these situations, which are already primed for legal action?

Some readers of the article by Drs McReynolds and Sheridan may have been left with the impression that OMT is broadly applicable in the ED setting. Such an impression has the potential to throw the door wide open

for serious legal and financial consequences to osteopathic physicians in this setting. For those osteopathic physicians practicing in a clinical setting similar to that of Drs McReynolds and Sheridan (ie, an ED teaching hospital), the level of physician awareness of legal consequences is always high. Thus, OMT is likely to be used for only select patients, and the odds of an adverse outcome from OMT would be small, as the authors point out. This might not be the case, however, in other kinds of ED settings.

The concept of using OMT in the ED setting is worthy of further study. However, obtaining a computed tomographic scan or magnetic resonance imaging of the patient's spine prior to the use of OMT would be a wise diagnostic adjunct and safeguard.

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Response

We thank Dr Fletcher for his letter in response to our article in *JAOA—The Journal of the American Osteopathic Association*¹ regarding the use of osteopathic manipulative treatment (OMT) in the emergency department (ED) setting.

We hope the *JAOA*'s readers were not left with the misimpression that OMT is broadly applicable in the ED setting—particularly with respect to patients who were in motor vehicle accidents (MVAs), as was Dr Fletcher's concern.

We used an extensive list of exclusion criteria in our study.¹ For trauma patients (including patients in MVAs), we excluded those with individuals who had substantial trauma, distracting injuries, neurologic deficits, alcohol intoxication, or other factors that precluded a reliable physical examination. Average "fender-bender" MVAs were not considered "substantial trauma" in our study.² Cervical radiographs were obtained if there was a history of trauma and the patient could not be cleared clinically.

Although not specifically stated in the discussion of methods used in our study,¹ we used the criteria of the National Emergency X-Radiography Utilization Study (NEXUS)^{3,4} to clinically clear the cervical spine. These criteria are: absence of tenderness at the posterior midline of the cervical spine; absence of a focal neurologic deficit; a normal level of alertness; no evidence of intoxication; and absence of a distracting injury.^{3,4}

In NEXUS,^{3,4} 34,000 blunt trauma patients were evaluated by cervical spine imaging in 21 EDs nationwide. Of these patients, 818 (2.4%) had cervical spine injuries. The study's criteria were 99.0% sensitive for identifying all cervical spine injuries and 99.6% sensitive for identifying clinically significant cervical spine injuries.⁴

It is with such low-risk patients that we believe OMT can be provided safely without the need of cervical computed tomography (CT). We do not consider our study results to be "broadly applicable," but rather applicable to only a carefully selected population of patients in the ED.

We acknowledge that plain film radiography does not allow visualization of every cervical spine injury sustained as a result of blunt trauma. The risk of neurologic disability and potential litigation from missing an occult unstable cervical spine fracture exists—regardless of whether OMT, medication, or no treatment is provided to the patient. A prospective observational study by Mower et al⁵ found that occult unstable injuries (ie, injuries that were not identified on plain radiographs) were missed infrequently with the use of plain film radiography. These missed injuries represented only 0.4% of all injuries and occurred in only 0.015% of all blunt trauma presentations (ie, fewer than 1 in every 6500 screening evaluations) in that study.⁵

Patients in EDs who are at high risk (eg, with altered mental status, multi-system injuries, neurologic deficits, or intoxication) should be evaluated by

CT. Computed tomography should also be used if a patient's plain film radiographs are deemed to be inadequate, suspicious, or definitely abnormal—or if clinical suspicion of injury continues despite a normal radiograph result.

In cases where ligamentous injuries are suspected, we agree with Dr Fletcher that the use of magnetic resonance imaging (MRI) and/or flexion-extension films should be considered. Unfortunately, routinely obtaining an MRI in the ED is not currently feasible at most institutions. As MRI becomes faster and more readily available, however, its use may become commonplace in the ED setting.

Because of high direct medical costs and potential risks to patients of radiation-induced malignant thyroid cancer, a CT scan should be used only when it can be fully justified after appropriate clinical stratification with decision rules. The thyroid gland is exposed to approximately 14 times more radiation during cervical CT scanning (26 mGy) than during plain film radiography (1.8 mGy).⁶

It is important to keep in mind, however, that decision rules are only guidelines, not absolute requirements. If necessary, physicians—drawing on their own clinical acumen and experi-

ence—should make exceptions to such guidelines for individual patients. No decision-making tool should replace the clinical judgment of a physician in the care of individual patients.

We are unaware of any studies suggesting—as Dr Fletcher implies—that physicians who practice in ED teaching hospitals have higher levels of awareness of legal consequences than do physicians who practice in other ED settings. All physicians should realize that safety is of paramount importance for all patients—regardless of the clinical setting in which that care is provided.

We believe that the use of OMT in the ED provides physicians with another powerful therapeutic tool that can and should be used in the correct clinical setting. Patients in EDs with acute neck pain should be given (or not given) OMT based on clinical criteria and evidence-based medicine—not on physicians' fears of litigation.

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