JAOA LETTERS

As the premier scholarly publication of the osteopathic medical profession, *JAOA—The Journal of the American Osteopathic Association* encourages osteopathic physicians, faculty members and students at colleges of osteopathic medicine, and others within the healthcare professions to submit comments related to articles published in the *JAOA* and the mission of the osteopathic medical profession. The *JAOA*'s editors are particularly interested in letters that discuss recently published original research.

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. 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.

All accepted letters to the editor are subject to editing and abridgement. Letter writers may be asked to provide *JAOA* staff with photocopies of referenced material so that the references themselves and statements cited may be verified.

Readers are encouraged to prepare letters electronically in Microsoft Word for Windows (.doc) or in plain (.txt) or rich text (.rtf) format. The *JAOA* prefers that readers e-mail letters to jaoa@osteopathic.org. Mailed letters should be addressed to Gilbert E. D'Alonzo, Jr, DO, Editor in Chief, American Osteopathic Association, 142 E Ontario St, Chicago, IL 60611-2864. Mailed submissions and supporting materials will not be returned unless letter writers provide self-addressed, stamped envelopes with their submissions.

Letter writers must include their full professional title(s) and affiliation(s), complete preferred mailing address, day and evening telephone numbers, and preferred fax number and e-mail address. In addition, writers are responsible for disclosing financial associations and other conflicts of interest. No unsigned letters will be considered for publication.

Although the *JAOA* cannot acknowledge the receipt of letters, a *JAOA* staff member will notify writers whose letters have been accepted for publication.

All osteopathic physicians who have letters published in the *JAOA* receive continuing medical education (CME) credit for their contributions. Writers of original letters receive 5 hours of AOA Category 1-B CME credit. Authors of published articles who respond to letters about their research receive 3 hours of Category 1-B CME credit for their responses.

Alpha-Adrenergic Receptor Antagonists in Older Patients With Benign Prostatic Hyperplasia: Issues and Potential Complications

To the Editor:

In the July 2008 review article by Shari R. Fine, DO, and Phillip Ginsberg, DO, JD,[1] an important point regarding α-adrenergic receptor antagonists is not identified or addressed. Since the widespread use of tamsulosin for treating patients with benign prostatic hyperplasia (BPH), adverse effects during cataract surgery associated with the use of these vasoconstrictors have become a serious problem.

Based on studies published in 2005 and 2006, Drs Fine and Ginsberg[1] note that, "in some patients...intraoperative floppy iris syndrome [IFIS] has been observed during phacoemulsification cataract surgery." However, more recent research,[2] indicates that IFIS occurs frequently with the use of tamsulosin (a selective α-adrenergic receptor antagonist) and sporadically with the use of alfuzosin, doxazosin, and terazosin (nonselective α-adrenergic receptor antagonists).

A recent survey of primary care physicians conducted in the United Kingdom showed that 97% of respondents who prescribed α-adrenergic receptor antagonists were unfamiliar with IFIS.[3] Nevertheless, four of five surveyed physicians wrote at least five new prescriptions for tamsulosin each month.[3]

Ophthalmologists have been slow in educating their colleagues in urology and primary care regarding this matter. Fortunately, a concerted effort is now under way by the American Academy of Ophthalmology and the American Society of Cataract and Refractive Surgery to emphasize to the importance of screening patients for cataracts before initiating treatment for BPH with α-adrenergic receptor antagonists.[4]

Although Drs Fine and Ginsberg[1] do an excellent job of identifying and describing IFIS, they leave unaddressed the matter of cataract screening before initiating treatment for BPH. Therefore, I wish to encourage physicians to ask patients about their visual acuity before treatment with systemic α-adrenergic receptor antagonists is initiated.

More specifically, in addition to inquiring about any history of cataracts or cataract surgery, physicians should routinely assess patient risk for cataracts (eg, family history, medication use, impaired vision).

It is important to educate patients who have cataracts about IFIS before starting chronic nonemergent treatment with systemic α-adrenergic receptor antagonists, such as tamsulosin. As one might infer from the article by Drs Fine and Ginsberg,[1] clinical evidence shows that even after discontinuation of α-adrenergic receptor antagonists, permanent effects on the iris may occur—effects that may complicate future cataract surgery.

Many patients do not remember the names of medications they used in the

past. This fact creates a potential "ticking time bomb" for eye surgeons, especially if their patients need cataract surgery but do not recall whether they have previously used systemic α-adrenergic receptor antagonists.

When an ophthalmologist receives a complete medical history from a patient and knows that he or she has used these vasoconstrictors, the ophthalmologist is better able to prepare treatment with intraocular surgical devices, intraocular pharmaceuticals, or both. Such preparation is far preferable to dealing with unknown variables during what should be a standard surgical procedure.

Thus, a thoroughly prepared ophthalmologist should routinely ask his or her patients about the use of systemic α-adrenergic receptor antagonists before recommending or performing cataract surgery.

A recent survey of ophthalmologists[3] showed that—based on their own intraoperative experiences of IFIS—the vast majority of respondents who encountered a known personal history of BPH and early cataract would choose a nonspecific α-adrenergic receptor antagonist, avoid α-adrenergic receptor antagonists altogether, or consider cataract surgery before treatment for BPH with α-adrenergic receptor antagonists.

This finding further highlights the need for urologists and primary care physicians to be proactive in identifying patients who are at risk for future cataract surgery if α-adrenergic receptor antagonists are being considered in treatment plans. Other treatment options may be more appropriate when patients require future cataract surgery.

There may come a time, as a matter of standard care, when patients with BPH will be required to seek an ophthalmology consultation before therapeutic use of systemic α-adrenergic receptor antagonists is initiated.

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2. Chang DF, Osher RH, Wang L, Koch DD. Prospective multicenter evaluation of cataract surgery in patients taking tamsulosin (Flomax). *Ophthalmology*. 2007;114:957-964.

3. Chang DF, Braga-Mele R, Mamalis N, Masket S, Miller KM, Nichamin LD, et al. Clinical experience with intraoperative floppy-iris syndrome. Results of the 2008 ASCRS member survey. *J Cataract Refract Surg*. 2008;34:1201-1209.

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General Pediatrics in Its Death Throes?

For the times they are a-changin'.
Bob Dylan (1964)

To the Editor:

A staggering number of sociopolitical, demographic, and economic forces are currently converging on the profession of medicine, substantially impacting the healthcare of children in the United States.

An increasing number of physicians are rightly seeking to achieve a more healthy balance between their personal and professional lives than did previous generations. More and more medical school graduates find themselves in debt. Heavy administrative burdens are being borne by all licensed practicing physicians.

Moreover, a complex, fragmented, and difficult situation has been created for the noble medical profession by the combination of state and federal unfunded mandates, continuing medical education requirements, maintenance of board certification requirements, and an insurance industry that engages in a cat-and-mouse game with physicians by requiring large administrative overhead to yield low reimbursements.

As a result, physicians find themselves working harder than ever to maintain their economic status.

In addition to these forces, which affect all physicians, those in general pediatrics face numerous challenges specific to our specialty, that continue to erode the desirability of our profession as a viable and rewarding career choice for young medical school graduates.

The remainder of this letter describes some of my ongoing observations of the many challenges that lie before us.

The types of preventive care provided for children are changing. The traditional "checkup"—a relationship-based source of joy for both patient and physician—is increasingly being provided by midlevel practitioners (eg, physician assistants, nurse practitioners) who may gladly perform this service at lower costs than physicians.

In addition, numerous other professions (eg, naturopathic physicians, chiropractors, nurses) are donning the cloak of "doctor" by promoting themselves as providers of primary care services.

The provision of immunizations has long been an essential part of patient services for the pediatrician. However, this service is increasingly being provided outside of the pediatric office. Government health department clinics, schools, and even pharmacies have begun to administer immunizations. Although this development may be of some public health benefit, it may also lead to decreases in the number of children being seen in the general pediatric medical home model.

The number of children with special healthcare needs that are the result of complex multisystem problems is increasing. These patients require coordination of care among a variety of medical specialists. Will the role of generalist pediatricians evolve into one that mainly involves completion of administrative forms, such as referrals to such specialists, prescriptions, and orders for medical testing? Will generalists be able to continue functioning as vital, thinking members of the healthcare team—or will the growing prominence of subspecialty care render generalists unnec-

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essary, except for providing administrative support?

Hospitalists are also growing in prominence. The time involved in visiting hospitalized patients and the challenges of maintaining hospital skills have spawned hospitalist medicine as a popular new career choice for young medical school graduates. As the hospitalist approach to children's healthcare becomes the norm, most generalist pediatricians of the future are likely to provide limited or no inpatient care.

Provision of care for illness visits has also become a challenging issue. With both parents commonly employed outside the home, families require access to office visits 7 days per week, 18 hours per day. Time constraints imposed by the demand side create an additional challenge for those on the supply side of this healthcare model; pediatricians who wish to balance work commitments with personal life and still make enough money to pay the bills find increasing challenges in the new healthcare marketplace.

Many families find retail clinics (such as those in shopping malls) to be more convenient than the traditional doctor's office because such clinics provide the parent ready access to healthcare services. Waiting time can be used for shopping time or for some other multitasking activity. The market-based, consumer-oriented model of retail clinics may continue to erode the traditional general pediatrics medical home model.

Given these many challenges, one may wonder why any young medical school graduate would choose general pediatrics as a profession.

And yet, the role of providing nurturant support and hope for the future continues to call to the hearts of idealistic young people who wish to make a difference in this world. Fulfilling this role, which is expressed in the event of a new birth and the creation of a new family, will always be intrinsically noble and satisfying work.

As general pediatrics changes, we are increasingly challenged to adapt and preserve our profession, giving young people a reason to be satisfied with general pediatrics as a career choice.

Without effectively addressing the challenges described in this letter, general pediatrics will likely become a quaint memory of "the good old days."

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Editor's Note: Dr Marino serves as a member of the Editorial Advisory Board for *JAOA—The Journal of the American Osteopathic Association*.

Intent to "Teach" and Pay to Play in Osteopathic Medical Education?

To the Editor:

What is happening to my profession?

Have our educators in the colleges of osteopathic medicine (COMs) caught the "modern medicine bug"—teaching that osteopathic physicians should base patient treatment on the use of "magic" machines and a pill for every problem?

After many years as an osteopathic medical educator, I shudder when I overhear first- and second-year students ask each other, "What specialty are you going into?"

Likewise, I remain surprised to hear our graduates sigh, "OMT [osteopathic manipulative treatment]...I just don't have time for it." An osteopathic physician even recently said to my daughter in Georgia, "Manipulation? They showed us that in school, but I don't use it."

While attending an "osteopathic" continuing medical education program last year, I was mortified to realize that during the first 8 hours of lectures, only one speaker mentioned OMT. It was gratifying, however, to hear that internist also say that he is a member of the American Academy of Osteopathy.

It is apparent that some osteopathic medical students have no interest in manipulation and do not intend to use it in practice. However, isn't this exactly why COMs have committees to interview prospective students? It is beyond my ken why students who have no interest in manual treatment apply to osteopathic medical schools in the first place—and why we accept them.

Our COMs are clearly benefiting from increases in tuition and class size, and they are producing more and more graduates. Yet, perhaps we should ask if this growth is diluting our unique mission in healthcare—and, in fact, endangering the future of the osteopathic medical profession. When will we realize that our profession's phenomenal growth has been the result of our *difference* from our allopathic counterparts rather than a result of copying their methods?

My first contact with the profession was in 1955, after my service in the United States Marine Corps. Today, 54 years later, I still feel that ours is the *complete* healing arts profession, and I pray that we do not give it away in a mistaken effort to become "real doctors."

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Corrections

The *JAOA* regrets several errors that appeared in the November issue:

- **Timoshkin EM, Sandhouse M. Retrospective study of cranial strain pattern prevalence in a health population. *J Am Osteopath Assoc*. 2008;108(11):652-656.**

On page 654, reference 4 should not have been used to support the statements made in the first paragraph under "Comment." Reference 6 should have been used instead. This change was made to the full text (http://www.jaoa.org/cgi/content/full/108/11/652) and Adobe Portable Document Format (http://www.jaoa.org/cgi/reprint/108/11/652) versions of this article online.

- **Ho MK. Pathos [poem]. *J Am Osteopath Assoc*. 2008;108(11):669.**

The photograph credit for the image that accompanied this poem appeared incorrectly as follows: "Photo of A.T. Still © Still National Osteopathic Museum, Kirksville, KY." Instead, the credit line should have appeared as follows: "Photo of Andrew Taylor Still, MD, DO © Still National Osteopathic Museum, Kirksville, Mo." This change was made to the full text (http://www.jaoa.org/cgi/content/full/108/11/669) and Adobe Portable Document Format (http://www.jaoa.org/cgi/reprint/108/11/669) versions of this contribution online. ♦