JAOA LETTERS

JAOA—The Journal of the American Osteopathic Association encourages osteopathic physicians, faculty members and students at colleges of osteopathic medicine, and others within the health care 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.

All accepted letters to the editor are subject to editing and abridgment. 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.

Letters should be submitted online at http://mc04.manuscriptcentral.com/jaoa. 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.

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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 Manipulative Treatment: Much More Than Simply a "Hands-on" Phenomenon

To the Editor:

In his recent editorial, Michael M. Patterson, PhD, associate editor of *JAOA—The Journal of the American Osteopathic Association*, contends that the time has come to rethink the role of touch in osteopathic medical practice, particularly as it relates to osteopathic manipulative treatment (OMT).[1] He asks, "Is touch a peripheral factor in OMT, or does it play a more important role in the effectiveness of OMT?" He then argues that touch is one of the "active ingredients" of OMT. As support for this position, he cites our North Texas Clinical Trial results,[2] claiming that "a touch sham therapy can be as effective as an active OMT." However, there are 2 important factors that must be addressed to put this claim in proper perspective.

First, the sham OMT protocol used in the North Texas Clinical Trial included more than just a touch sham therapy.[2] In addition to light touch, range-of-motion activities and simulated OMT techniques were provided with this intervention. This comprehensive sham OMT protocol has now been adopted by others as a model for the delivery of sham manipulative techniques.[3] Another methodologic feature of the North Texas Clinical Trial was that both the active and the sham OMT protocols were delivered by third- and fourth-year osteopathic medical students rather than by experienced osteopathic physicians. Thus, it is unclear if the nonsuperiority of OMT to sham OMT in the study would have been generalizable to OMT provided by more seasoned clinicians.

Second, the OSTEOPAThic Health outcomes In Chronic low back pain (OSTEOPATHIC) Trial[4] was designed to overcome limitations of the North Texas Clinical Trial by increasing sample size and statistical power and by using predominantly licensed osteopathic physicians to provide OMT. The trial included a sham OMT protocol that was similar to that used in the North Texas Clinical Trial. Recent evidence from the OSTEOPATHIC Trial now clearly demonstrates that OMT is superior to sham OMT in reducing pain levels by 50% or more in patients with chronic low back pain.[5] The results, which were statistically significant, were also clinically relevant according to guidelines established by the Initiative on Methods, Measurement, and Pain Assessment in Clinical Trials[6] and the Cochrane Back Review Group.[7] Thus, because OMT provided substantially more low back pain relief than sham OMT, the specific effect of touch must have been correspondingly small in patients with chronic low back pain. Hence, these new data clearly refute Dr Patterson's contention that a touch sham therapy can be as effective as active OMT.

Nevertheless, the building of effective patient-physician relationships is integral to the practice of patient-centered medicine. The adjunctive use of OMT by osteopathic physicians to help manage a variety of musculoskeletal conditions and visceral disorders has long been a hallmark of the osteopathic approach to patient care. Indeed, osteopathic physicians often cite such "hands-on" care as an important difference in

practice style compared with that of allopathic physicians.[8] Many would argue that OMT training facilitates hands-on medical care and fosters better patient-physician relationships, even if OMT is not used during a patient encounter.

With an increased dependence on diagnostic tests and procedures in contemporary medicine, there is concern that physicians are abandoning their use of touch in interacting with and examining patients. Encouraging greater use of touch to enhance patient-physician relationships, improve diagnostic accuracy, and identify somatic dysfunction is certainly a worthwhile endeavor. However, the purported benefits of touch should not be extrapolated beyond the available data. At present, best evidence indicates that the effects of OMT are attributable to much more than simply a hands-on phenomenon. Why would we expect otherwise given the time and effort that are devoted to teaching OMT in our colleges of osteopathic medicine?

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Response

I very much appreciate the clarification made by John C. Licciardone, DO, MS, MBA, about his study[1] that I referenced in my August editorial[2] on touch and its effects in manipulative medicine.

As Dr Licciardone states, his 2003 study[1] illustrates the pitfalls of using well-intentioned but relatively inexperienced students as providers in studies of osteopathic manipulative treatment (OMT). That study did in fact show the sham OMT protocol to be statistically as effective as the OMT protocol. The reasons for this finding may be many, as Dr Licciardone points out. Of note, at least one other well-designed study[3] that used a sham control protocol found true treatment to have superior effects, but the study also demonstrated sham treatment to have an effect when compared with a no-treatment control protocol. These findings seem to show that touch and movements do have a positive effect on how a patient responds to treatment. Thus, a sham treatment must be evaluated carefully as to its effects and cannot be a priori considered a neutral, non–response-producing control.

In addition, the point made in my editorial[2] was that touch is an integral and active part of OMT that in itself has real physiologic effects on function. This point was also made in the article[4] referred to in my editorial; the article cites several mechanistic studies on the effects of touch on function. Touch must be considered as an active ingredient within the totality of OMT and not relegated to the status of a paraphenomenon, the effects of which are only psychological.

Certainly, studies can be designed to evaluate the effects of various aspects of OMT. However, researchers should evaluate the total treatment before trying to tease apart such factors as touch and physician presence. As Dr Licciardone points out in his letter,[5] touch is being used less and less in the patient-physician relationship, which should be of concern to the profession. The possibility remains that touch and physician presence, among other things, reasonably contribute to all manual medicine and that they actively add to the effects of the actual movements administered.

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Oral Histories—Get Them Live!

To the Editor:

In fall 2011, I had the privilege of assisting in the interview process of selecting the class of 2016 at the new

Western University of Health Sciences College of Osteopathic Medicine of the Pacific-Northwest in Lebanon, Oregon. As might be expected, many of the candidates had little or no understanding of what the term *osteopathic* meant. It was also evident that the candidates did not have a very clear understanding of the rich history of osteopathic medicine in the state of Oregon. In fairness, it is also evident that most of the DOs practicing in the state have, at best, a very vague idea of the history of the profession in the state. Until recently, I was in the same group.

As a recently retired general practitioner searching for some new way to be useful, I realized that now was a great time to satisfy my curiosity regarding the history of the osteopathic medical profession in Oregon. I started my search by reading what I could find on the subject only to learn that very little had been written on the topic here and seemingly throughout the United States. It became clear that I would have to begin at the source: I contacted DOs who had retired before me, and I asked if they would be willing to tell me their stories. These were physicians with whom I had associated at Eastmoreland Hospital and other hospitals accredited by the American Osteopathic Association in the surrounding area. I found that these DOs were a rich source of information and that they were more than willing to tell their stories. (Alas, many are getting on in years, and all too often they disappear from the radar before they can be interviewed. This has been especially true of the physicians who started practice during or shortly after World War II.)

These initial interviews provided me with names of other DOs who have practiced in the area in earlier times. I also found other information through online sources and in interviews with relatives and friends of DOs who are no longer with us.

With each interview, I have become more and more appreciative of the wonderful contributions these physicians have made to their patients, to their communities, and to the osteopathic medical profession, as well as to the future of the profession by working with students. Often these DOs practiced in small towns where they were the only physician, where they were allowed to practice osteopathic medicine in its fullest scope. The people of these towns were not interested in what sort of physician they had but whether the physician had what it took to take care of them and their families. That meant that the DOs were on call most of the time to deliver babies, make house calls, and attend to emergencies, surgeries, and all the medical care responsibilities of the folks in the area. Some of the stories of the feats of these DOs are amazing. It is little wonder that several of these towns have museum spaces dedicated to a DO or a park named in honor of a DO.

My state organization, the Osteopathic Physicians & Surgeons of Oregon, has supported my project to document the history of osteopathic medicine in Oregon, with David Walls, the executive director, assisting in some editing. What we have written so far can be found on the association's Web site (http://www.opso.org/) under "Stories of Osteopathic Medicine in Oregon."

Throughout this process, I have learned a few lessons that I would like to share with others interested in pursuing such an endeavor:

- Prepare a list of topics that will be discussed, and then e-mail the questions to the interviewee in advance (this allows the interviewee time to organize his or her memories).
- Try to conduct the interview in a quiet, comfortable location; the interviewee's home is usually best.
- For a physician still in practice, budget an hour or so in his or her office at his or her convenience.
- Include the spouse in the interview, as I have found that he or she usually played a very important role in the DO's career.
- Keep the interview on track by following the list sent by e-mail.
- Take notes and always record the conversations.
- Type a version of the interview and send it to the interviewee for his or her approval or edits.

In Oregon, and I suspect in many other states, the contribution of the osteopathic medical profession to the well-being and health care of communities has not been adequately documented or appreciated. It is my hope that my efforts and those of others will once and for all document the importance of the osteopathic medical profession and the philosophy of patient care that we as DOs embody.

I urge fellow DOs and osteopathic medical students to interview these retirees and learn their stories. We must not let this history disappear!

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