Letters to the Editor

The Journal welcomes letters to the editor. If found suitable, they will be published as space allows. Letters should be typed double-spaced, should not exceed 400 words, and are subject to abridgment and other editorial changes in accordance with Journal style. All letters that reference a recently published Journal article are sent to the original authors for their reply. If no reply is published, the authors have not responded by date of publication. Send letters to Paul M. Fischer, Editor, The Journal of Family Practice, Department of Family Medicine, Medical College of Georgia, Augusta, GA 30912, or Fax (706) 855-1107.

VITAMIN B_{12} DEFICIENCY

To the Editor:

In their study of cobalamin (Cbl) deficiency in geriatric outpatients (*Yao Y, et al. Prevalence of vitamin B_{12} deficiency among geriatric outpatients. J Fam Pract 1992;35:524–8*), the authors "suggest that serum Cbl screening be done for every person aged 65 or older." This recommendation does not appear to be justified, given the study's findings. The study showed that vitamin B_{12} deficiency was common in an unselected series of geriatric outpatients. A high prevalence is only one of several criteria necessary to indicate screening for a condition. Since disorders related to low serum cobalamin are reversible for at least a year after symptoms appear (as the authors note), one would have to demonstrate that detection of *asymptomatic* vitamin B_{12} deficiency ultimately improves clinical outcome to justify the expense of screening.

The study by Yao et al underscores the importance of considering vitamin B_{12} deficiency in the presence of certain signs and symptoms, including clouded consciousness, unexplained paresthesias, abnormal position or vibratory sense, and gait disorders. Recommending widespread screening for a condition solely on the basis of its prevalence, however, is unwarranted.

James T. Pacala, MD, MS
Program in Geriatrics
Department of Family Practice and Community Health
University of Minnesota
Minneapolis

To the Editor:

Some very important questions are raised in the article by Yao et al on B_{12} deficiency.[1] Should all patients 65 years and older be screened for B_{12} deficiency? What is the actual prevalence of B_{12} deficiency? What is the sensitivity and specificity of cobalamin, methylmalonic acid, and total homocysteine levels? And what is the cost-benefit ratio of screening all persons 65 years and older?

Although the authors bring up some very important issues, we are concerned about the methodology used in the study. The authors do not define B_{12} deficiency and thus determine its actual prevalence. The prevalence appears to be extrapolated without a comparison to a gold standard.

The sample consists predominantly of white people of upper socioeconomic class. Inclusion or exclusion criteria for the study sample selection are not specifically stated, and the baseline characteristics and health status for the sample are unclear. The study results are, therefore, exceedingly difficult to generalize to any other clinical settings.

If B_{12} deficiency, however defined, is as prevalent as the authors suggest, then one needs to question whether greater screening is needed in primary care practices. However, given the methodological errors in sample selection, it would be erroneous to make any changes in practice standards based on the results of this study.

A more recent reference article appears in the December issue of the *Journal of the American Geriatric Society*,[2] which addresses a number of these issues.

While we have a number of concerns in regard to the methodology, the authors should be commended for examining this clinical issue and for raising some important questions that should stimulate further study.

MAJ Margaret R. H. Nusbaum, MC, USA
CDR W. Robert Kiser, MC, USN
LTCOL David Ellis, MC, USA
MAJ Guy Runkle, MC, USA
LTCOL John P. Kugler, MC, USA
Department of Family Practice
Madigan Army Medical Center
Ft. Lewis, Washington

The views expressed in this letter are those of the authors and not necessarily those of the US Army or Madigan Army Medical Center.

References

1. Yao Y, Yao SL, Yao SS, Yao G, Lou W. Prevalence of vitamin B_{12} deficiency among geriatric outpatients. J Fam Pract 1992; 35:524–8.
2. Pennypacker LC, Allen RH, Kelly JP, et al. High prevalence of cobalamin deficiency in elderly outpatients. J Am Geriatr Soc 1992; 40:1197–1204.

To the Editor:

The discussion of the prevalence of vitamin B_{12} deficiency by Yao et al (*Yao Y, et al. Prevalence of vitamin B_{12} deficiency among geriatric outpatients. J Fam Pract 1992; 35:524–8*) has confirmed what I have seen anecdotally and clinically in my practice. The study will help explain the clinical significance of vitamin B_{12} deficiency beyond the clinician's concerns with pernicious anemia.

I wish to point out that doing a Schilling test can be cumbersome and costly. A simple clinical maneuver using the oral administration of vitamin B_{12}, 250 to 500 μg per day, is often helpful in determining the best therapeutic approach. Have the patient with a vitamin B_{12} level below 200 μg/mL take vitamin B_{12} orally, 250 to 500 μg daily, for 2 to 4 weeks. Then have the patient's vitamin B_{12} level determined again. If a significant increase to a level above 300 μg has occurred, then the patient should be kept on oral vitamin B_{12} therapy and rechecked annually. If the patient does not respond to this therapy, then he or she is a candidate for intramuscular administration of vitamin B_{12}. This simple clinical maneuver is not very costly and quickly determines how vitamin B_{12} deficiency can be treated most effectively.

Joseph I. Golden, MD
Sophia, West Virginia

The preceding letters were referred to Dr Yao, who responds as follows:

A wide variety of neuropsychiatric disorders are seen in cobalamin (Cbl) deficiency. The window of opportunity for effective treatment of Cbl deficiency related to these disorders may be as short as 1 year from the onset of symptoms.[1] During this 1-year period, a patient with vitamin B_{12} deficiency may not seek a medical diagnosis.[2,3] If he or she does, a proper diagnosis of B_{12} deficiency may not be confirmed immediately.[2,3]

We estimate that the cost of B_{12} screening for 100 outpatients is around $5000. The prevalence of neuropsychiatric disorders from B_{12} deficiency among geriatric patients is approximately 5% to 10%. The cost for medical workups of 5 to 10 patients with neuropsychiatric dis-

continued on page 377

continued from page 373

orders is more than $5000, especially if these workups are done by neuropsychiatric consultants.

Several studies have suggested that oral administration of cobalamin (Cbl) without intrinsic factor (IF) for pernicious anemia is effective.[4–6] Cobalamin can be absorbed independently without IF, although this is inefficient.[7] The inefficiency can be compensated by a higher dose.[5,6] It is unclear why 94% of internists were not aware of the effective oral Cbl therapy for pernicious anemia.[5,6]

Elevated serum methylmalonic acid and/or homocysteine in a patient is indicative of intracellular Cbl deficiency if the patient does not have azotemia (azotemia can cause elevation of these metabolites without intracellular Cbl deficiency). Patients with intracellular Cbl deficiency can have serum Cbl levels above 400 pg/mL. They must be treated aggressively since the window of opportunity for effective treatment of Cbl deficiency may be as short as 1 year from the onset of neuropsychiatric abnormalities.

A 1-month trial of oral Cbl for the patient with elevated serum metabolites is contraindicated if the patient has had neuropsychiatric abnormalities for nearly 1 year because of the shortness of the window period and because the patient may not respond to oral Cbl therapy. Patients with low serum Cbl levels without elevation of these metabolites may be given oral Cbl as a preventive measure with adequate follow-up; monitoring of these metabolites is much more costly then taking oral Cbl.

Our unpublished data suggest that approximately 10% of patients with serum Cbl levels below 300 pg/mL do not respond to oral Cbl.

Yulin Yao, MD
Kingston, New York

References

1. Martin DC, Francis J, Protetch J, Huff J. Time dependency of cognitive recovery with cobalamin replacement: report of a pilot study. J Am Geriatr Soc 1992; 40: 168–72.
2. Yao Y, Yao SL, Yao SS, Yao G, Low W. Prevalence of vitamin B_{12} deficiency among geriatric outpatients. J Fam Pract 1992; 35:524–8.
3. Pennypacker LC, Allen RH, Kelly JP, et al. High prevalence of cobalamin deficiency in elderly outpatients. J Am Geriatr Soc 1992; 40:1197–1204.
4. Crosby WH. Oral cyanocobalamin without intrinsic factor for pernicious anemia. Arch Intern Med 1980; 140:1582.
5. Lederle FA. Oral cyanocobalamin for pernicious anemia: medicine's best kept secret? JAMA 1991; 265:95.
6. Oral cobalamin for treatment of pernicious anemia? [editorial]. JAMA 1991; 265:96.
7. Dorscherholmen A, Hagen PS, Liu M, Olin L. A dual mechanism of vitamin B-12 plasma absorption. J Clin Invest 1957; 36: 1551.

HUMAN GENOME

To the Editor:

In his editorial on the human genome,[1] Dr Stein addresses a compelling problem of our society: the unwillingness to accept what is if there appears the remotest possibility for "improvement." Improvement is a form of secularized religion. We are charged with creating heaven on earth, a scientific divinity. Physicians have failed repeatedly in supporting compassion over improvement, whether the improvement is that of society or the individual, and at times whether the improvement was wanted.

"Medicine is playing an instrumental role in this movement, which tends to make health a supervalue, an end in itself. This means, according to the American sociologist I.K. Zola, that health is becoming life itself and that medical science now indicates the meaning of life."[2] The purpose of the American pursuit of fitness would seem to be having muscles, not moving mountains. Perfect blood pressure readings have been pursued despite the reduction in quality of life for those on some multiple drug regimens.

"Physicians," according to Dr Stein, "will need to serve as mediators, translators, and guides to help patients and families deal in new ways with their lives." Before the physician can understand the gene as metaphor, she or he must understand herself or himself as metaphor. Physicians, schooled in what they presume to be the hard facts of science, usually remain unaware of the assumptions upon which those facts rest. Doctors have been known to testify in court that hormones were the "cause" of a particular woman's violence. They have treated the "illness" of spontaneous abortion with hormones that later proved disastrous. They have been party to the mutilation of women in the pursuit of a faddish physical beauty. Doctors, as part of the hierarchy that defines and benefits from those definitions, may be unable to withdraw sufficiently to see the metaphor within the "science." Physicians are the very priests of "improvement." They continue to benefit socially, psychologically, and financially from their control of the definitions of well, ill, perfect and imperfect such that they may be unable to see their position within the problem.

Sandra F. Penn, MD
Albuquerque, New Mexico

References

1. Stein HF. The human genome as metaphor. J Fam Pract 1992; 35:256–8.
2. Zola IK. Healthism and disabling medicalization. In: Ivan Illich. Disabling professions. London: M. Boyers, 1987:177.

The preceding letter was referred to the author, who responds as follows:

With insight, eloquence, passion, and urgency, Dr Sandra Penn extends my essay on the human genome as metaphor. She cites *improvement* as metaphor, *health* as metaphor, *fitness* as metaphor, *physician* as metaphor, *science* as metaphor, *the human body* as metaphor, and *gender* as metaphor. Not bad for a mere three paragraphs!

Withdrawal from our cherished projections (and our sacred metaphors are just that, shared projections reified in social interaction) is always painful, unwelcomed, fought. For those of us in health care, these metaphors fulfill powerful wishes, fantasies, and protect us from overwhelming dreads; we have them because we need them—as defenses, as disguises, as buffers. And, as Dr Penn notes, both physicians and patients pay an enormous price for this protection.

What would it require for us in biomedicine to relinquish these metaphors? The beginning is Dr Penn's courage to relabel as "cultural" what many of us have willingly, willfully, mistaken for "reality." Journals, too, have their role in mystification and demystification of metaphors. Editors and editorial boards, as much as writers, encourage or censor the interpretation of metaphors. I am grateful to *The Journal of Family Practice* for creating a forum for this conversation. The history of science and medicine is full of enforced consensus, and of solitary voices. The Journal is helping us to break the silence over our assumptions.

Howard F. Stein, PhD
Health Sciences Center
The University of Oklahoma
Oklahoma City

PATIENT-PHYSICIAN RELATIONSHIP

To the Editor:

Dr Fischer's editorial in the January issue (*Fischer PM. Cards, cakes, and homegrown tomatoes. J Fam Pract 1993; 36: 21–2*) merits attention. His statements concerning the centrality of the patient's need for a personal relationship with a primary care physician are, indeed, pertinent, especially in these times when subservience to the developments of modern technology pervades our profession.

Organized medicine in general has not recognized how important the lack of the personal relationship between a patient and a primary physician is in the scheme of modern medicine. Such a relationship has a value at least equal to any sophisticated diagnostic or therapeutic procedure that physicians feel a legal and medical imperative to utilize. We need to remind ourselves that a trusting relationship between a patient and his or her personal physician allows the physician to order only those tests, procedures, and therapies he or she deems necessary, bypassing expensive and inconvenient protocols dictated by the defensive medicine mentality. Such a mentality exists in direct proportion to the degree that the personal relationship is lacking.

It seems that for economic reasons alone America cannot support its health care system without honoring and encouraging the concept, as discussed by Dr Fischer, of all Americans having their own primary care physician.

Edward J. Volpintesta, MD
Bethel, Connecticut

CHIROPRACTIC

To the Editor:

Please allow me to raise a point of considerable concern in response to the special article[1] and the two accompanying editorials[2,3] extolling the value of manipulation in the treatment of back pain. Despite statements such as "The scientific evidence accumulated to date does not clearly indicate that spinal manipulation is beneficial . . . " the article and editorials unquestionably urge family physicians to refer patients to chiropractors.

Although many points raised in the articles and editorials are subject to rebuttal, let us for the moment accept all that has been proposed regarding chiropractic treatment for back pain. There is an essential point not even remotely addressed. Chiropractic does not limit itself to the treatment of uncomplicated back pain. Its uncritical acceptance of the basic chiropractic theory of subluxation leads its practitioners to urge, in person and in advertising, their patients to accept manipulation as therapy for a host of serious illnesses.

When a patient is referred to the chiropractor for back pain, the referring physician must realize that his patient will be exposed to suggestions that other diseases should be treated by chiropractic. The patient is often propagandized that drugs and surgery are harmful, and that chiropractic is "natural." While not applicable to every chiropractor, allow me several illustrative examples of what is being proposed as therapy within the chiropractic profession. Consider the Farrari technique of "neural organization therapy." The chiropractors involved propose to treat learning disabilities in children by manipulation of the skull. Craniosacral therapy claims ability to reverse the paralysis of cord transection by manipulation. In my community, within the past month, a prominent and personable chiropractor has sponsored a lecturer in his office purporting to cure malignancies by nutrition, acupuncture, and chiropractic.

Can you perceive the potential hazards that a physician's patient might be exposed to if referred to a chiropractor for back pain? That patient may be urged to accept manipulation as treatment for other concurrent medical problems. The family practice physician, in considering such a referral, must assess the entire range of chiropractic therapeutic claims. He must understand that his patient may be enticed into manipulative therapy for other serious diseases.

Edward H. Davis, MD
College of Medicine
State University of New York
at Brooklyn

References

1. Curtis P, Bove G. Family physicians, chiropractors, and back pain. J Fam Pract 1992; 35:551–5.
2. Cherkin DC. Family physicians and chiropractors: what's best for the patient? [editorial]. J Fam Pract 1992; 35:505–6.
3. Reis S, Borkan J, Hermoni D. Low back pain: more than anatomy [editorial]. J Fam Pract 1992; 35:509–10.

To the Editor:

In his editorial, Dr Cherkin (*Cherkin DC. Family physicians and chiropractors: what's best for the patient? J Fam Pract 1992; 35:505–6.*) cited "three perceptions among allopathic physicians that may perpetuate a distrust of chiropractors." While those three perceptions are, indeed, perceptions held by many allopathic physicians, he didn't mention a fourth perception: chiropractors have not always appropriately limited themselves to musculoskeletal conditions. I have had in my files advertisements recommending routine chiropractic treatment of newborns to prevent sudden infant death syndrome, and recommending chiropractic for asthma, heart disease, and a variety of other problems. I know of chiropractors in this area who have used megavitamin therapy and high colonic enemas. I personally have seen one case of meningitis treated by a chiropractor with manipulation, know of another case of meningitis-related death, and have recently had a patient who suffered a vertebral artery cerebrovascular accident as a result of chiropractor manipulation for benign neck pain. There was no informed consent in the latter case.

The argument is not with spinal manipulation as a therapy, particularly for low back pain (in fact, many of us feel it is a useful modality). The argument is with the recommendations made by chiropractors for chiropractic treatment of conditions for which there is no evidence whatsoever that chiropractic will be helpful, when it may, indeed, delay the appropriate diagnosis and treatment of serious conditions.

Until chiropractors are willing to abandon therapies that have no (even empiric!) scientific basis for utilization, I for one will refer my patients to them only if required by law.

John W. Beasley, MD
Department of Family Medicine and Practice
University of Wisconsin Medical School
Madison

To the Editor:

The special article by Curtis and Bove[1] and the editorial by Cherkin[2] seem to encourage the reader to embrace chiropractic as an acceptable health care field. The authors of both articles pointed out the roadblocks to cooperation, which they felt represented the major obstacles between the fields of chiropractic and

allopathic medicine. These may be valid assessments, but there is a bigger concern that, I feel, may represent greater obstacles to cooperation. This greater problem is the representation by a sizable portion of the chiropractic community that the manipulation of the spine is appropriate therapy for a wide range of medical problems beyond musculoskeletal complaints.

Students at the local chiropractic educational facility are taught that spinal manipulation can somehow affect the course of diseases ranging from immune deficiency to diabetes to bacterial infection. There was a chiropractic student locally who became unnerved when it was suggested that antibiotics would be the best treatment for his pregnant wife, who had pyelonephritis.[3] My own patients have been dissuaded by chiropractors from taking medications for diabetes and congestive heart failure. The most memorable case was an elderly woman whose condition was well controlled by furosemide and captopril therapy who presented to the emergency department in florid pulmonary edema because she had been talked into controlling her congestive heart failure with vitamins and regular chiropractic manipulation.

That back pain is difficult to treat effectively makes this particular condition open to a lot of options, some good and some bad. If the chiropractors would stick to their high-teeh back rubs for the treatment of back pain, I would have no axe to grind. In the meantime, you won't see me hopping on the bandwagon.

Michael J. Kelly, MD
Buffalo, Iowa

References

1. Curtis P, Bove G. Family physicians, chiropractors, and back pain. J Fam Pract 1992; 551–5.
2. Cherkin D. Family physicians and chiropractors: what's best for the patient? J Fam Pract 1992; 505–6.
3. Camp D. Letter. The Palmer Beacon, Palmer College of Chiropractic, Sept 1992.

To the Editor:

It is indeed a shame that in the year of the centennial of the osteopathic medical profession a major journal in family practice has published an article[1] and an editorial[2] extolling the virtues of referrals to chiropractors by family physicians for patients complaining of back pain and other seemingly benign musculoskeletal ailments. With all due respect to the authors, their writings appear to reflect the continued media bias toward chiropractic. They are either ignorant of, or lack interest in giving equal time to or sharing information concerning, the advantages of referring such patients to an osteopathic physician, or DO, who uses osteopathic manipulative treatment (OMT) in conjunction with family medical practice. Osteopathic physicians have provided the majority of the family and primary care for a century in this country. Drs Curtis and Bove used the archaic term "osteopath" in a few sentences to refer to the osteopathic physicians who use osteopathic manipulative skills.

The osteopathic profession was founded about 21 years *before* chiropractic, and its manipulative principles are a major foundation on which chiropractic theory was and is based. Osteopathic physicians are taught to integrate OMT into traditional medicine and surgery. They have been accepted by MDs and the public as competent family physicians. There are many osteopathic physicians, such as myself, who have very active and thriving board-certified family practices, owing in part to our holistic and hands-on approach to medicine. I use my hands both in the office in an outpatient setting *and* in the hospital whenever clinically applicable. *Touch* is the key word here, and patients appreciate it, often interpreting it as a wonderful bedside manner in which the osteopathic physician must be specially trained.

The real pioneers of manipulation in the United States, osteopathic physicians, have been ignored. This is not without fault of the osteopathic medical profession itself. Over the years, the osteopathic medical profession has become complacent, and its unique hands-on approach has diminished, giving way to a "medical mainstreaming" attitude. The information published in your journal will simply add to the misconceptions surrounding osteopathic medicine.

David S. Abend, DO
Emerson, New Jersey

References

1. Curtis P, Bove G. Family physicians, chiropractors, and back pain. J Fam Pract 1992; 35:551–5.
2. Cherkin DC. Family physicians and chiropractors: what's best for the patient? J Fam Pract 1992; 35:505–6.

The preceding letters were referred to the authors, who respond as follows:

Dr Abend is correct in pointing out that osteopathic physicians make important contributions to patient care. Many, however, do not use spinal manipulation. In this country, 94% of manipulative therapy is delivered by chiropractors and less than 6% by osteopathic physicians.[1]

Drs Davis, Beasley, Kelly, and Abend express valid concerns about chiropractic treatment of serious medical problems that are nonmusculoskeletal in origin. Although there is substantial evidence that spinal manipulation can hasten the recovery of patients with uncomplicated back pain,[1] there is little scientific support for the efficacy of spinal manipulation for heart disease, asthma, diabetes mellitus, or other nonmusculoskeletal disorders. In the absence of efficacy studies, the use of spinal manipulation for such problems is a cause for concern. It should be pointed out, however, that the use of unproven treatments for serious illnesses is not a phenomenon unique to the chiropractic profession.

The reality is that millions of Americans self-refer to chiropractors each year, and many more are encouraged by their family physicians to see chiropractors.[2] By dismissing chiropractors as quacks, the medical profession has diminished its credibility with the millions of Americans who have found from personal experience that chiropractors can relieve back and neck pain. As a result, patients may dismiss warnings from medical doctors that chiropractic treatments for serious diseases are inappropriate.

Family physicians should attempt to establish working relationships with chiropractors who avoid inappropriate or excessive treatments. By doing so, they will provide their patients with back pain access to the potential benefits of spinal manipulation while minimizing the risk that these patients will receive unproven treatments for serious medical problems.

Dan Cherkin, PhD
Center for Health Studies
Group Health Cooperative
of Puget Sound
Seattle, Washington

References

1. Shekelle PG, Adams AH, Chassin MR, Hurwitz EL, Brook RH. Spinal manipulation for low-back pain. Ann Intern Med 1992; 117:590–8.

2. Cherkin DC, Deyo RA, Berg AO. Family physician's views of chiropractors: hostile or hospitable? Am J Public Health 1989; 79:636–7.

The correspondence resulting from our article[1] raises important and interesting issues. Most of the letters expressed concern, and some outright rejected the idea of referral between the two groups of providers. In our article we attempted to provide a balanced view of the value of spinal manipulative therapy with particular reference to chiropractic. The reason for doing this was to acknowledge that the discipline of chiropractic is growing steadily and that chiropractors care for many patients who have personal family physicians. Our aim was to provide information and guidance for clinicians whose patients may say, "I want to see a chiropractor. My back isn't any better!" We would like to address several points raised in the correspondence.

There is no doubt that some chiropractors make unrealistic and sometimes outrageous claims and advertise aggressively. These kinds of claims reported by Dr Davis should be reported to the State Chiropractic Board or other regulatory agencies. Claims to treat systemic disease such as hypertension and peptic ulcer disease are unsupported by clinical trials, though articular neurologic research has demonstrated effects of spinal manipulation on blood pressure and acid secretion. It is also possible that chiropractors may try to "steal" patients from osteopathic physicians, but we would suggest from our own experience that a formal referral process from the family physician (by phone or letter) is an excellent way to prevent this happening. It should be noted that treatment of many of our patients' diseases get stolen by our allopathic colleagues as well.

One of us, G.B., was trained in chiropractic at the Canadian Memorial Chiropractic College in Toronto, Canada, and is completing a PhD degree in anatomy and neurophysiology here. During the 3 years of academic study at this university he has also "moonlighted" in 18 different chiropractic offices. He estimates that good care was provided by colleagues in 16 offices, as evidenced by the use of accepted standard manual techniques, good history-taking and evaluation, and subjective improvement of patients. However, in 9 of 18 offices, some type of "overutilization" in the form of unnecessary x-ray examinations and recall visits was found. (These are problems that are currently being addressed by the publication of practice guidelines.[2]) G.B. noted no reluctance on the part of the chiropractor to refer to allopathic physicians for medical problems.

The dangers of spinal manipulation itself are very rare, but serious, the most common of which is a cerebrovascular accident following neck manipulation. This is usually not due to faulty technique but to vascular anomalies of the vertebral artery and cannot be predicted. It is important to remember that our paper addressed back pain, not neck pain.

The suggestion that informed consent be obtained is a good one but creates a situation where anxiety induced by discussion of the rare adverse event will probably inhibit the effectiveness of manipulation. A similar situation would be if a clinician was expected to inform a woman in labor that her baby has a 12 per 1000 chance of dying during delivery. The sad history of mortality and morbidity from excessive tonsillectomy and hysterectomy (some of it fueled by financial incentives) and the rise and fall of chymopapain therapy for prolapsed intervertebral discs (mortality rate 700 per million)[3] indicate that our own house is not necessarily in order. Did we refrain from referring our patients to surgeons and gynecologists in those days because of those adverse risks?

Also, we are not sure whether the dangers of spinal manipulation therapy (SMT) and the need for informed consent have been considered by the Congress of Delegates of the AAFP, which recently approved CME credit for courses in manipulation.[4] This step suggests that our academy now believes in the efficacy of the modality, but there has been little discussion of the adequacy of the type of CME training compared with the intensity and length of training required for chiropractors and osteopaths. This plan provides cause for concern. In the United Kingdom and Germany, many family physicians have been trained in SMT, not because it has been scientifically validated, but because they realize its great usefulness in practice. The effectiveness and adequacy of this training have not been established.

Osteopathic physicians are positioned to provide an ideal meld of musculoskeletal skills and traditional clinical education. Certainly, in North Carolina, there seem to be very few of them in practice, and many seem to discard their musculoskeletal expertise in favor of the traditional practice model or subspecialization. In fact, many osteopathic schools no longer offer full training in spinal manipulative therapy.[5,6]

Spinal manipulation is a skill that is not the property of any one discipline (just as ultrasound and colposcopy are not).[7] The growth of chiropractic would not be taking place, however, if there were no significant need indicated by the public.

Finally, preliminary data from a current large study on low back pain funded by the Agency for Health Care Policy and Research show that 179 patients (in a stratified random sample of 8067 North Carolina adults) had acute, impairing low back pain in 1991. Of those, 37% sought initial care from a chiropractor, the remainder from physicians. Satisfaction with care was reported by 95% of patients seeing a chiropractor and by 80% of those seeing physicians.

Peter Curtis, MD
Geoffrey Bove, DC
Department of Family Medicine
School of Medicine
University of North Carolina
at Chapel Hill

References

1. Curtis P, Bove G. Family physicians, chiropractors, and back pain. J Fam Pract 1992; 35:551–5.
2. Haldeman S, Chapman-Smith D, Petersen DM. Guidelines for chiropractic quality assurance and practice parameters. Proceedings of the Mercy Consensus Conference, Gaithersburg, Md: Aspen Publishers, 1992.
3. Metz B. The honeymoon is over. Spinal surgeons begin to divorce themselves from chemonucleolysis. JAMA 1986; 256: 317–8.
4. Academy seeks CME credit for osteopathic manipulation courses. Fam Pract News 1992; December:28.
5. Eckberg DL. The dilemma of osteopathic physicians and the rationalization of medical practice. Soc Sci Med 1989; 25:1111–20.
6. Cummings JM. The pull toward the vacuum: osteopathic medical education in the 1980's. JAMA 1990; 90:353–62.
7. De Fabio R. Efficacy of manual therapy. Phys Therapy 1992; 72:853–64.