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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. 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.

Electronic Health Records—at What Cost to Care?

To the Editor:

I was recently a patient at a leading teaching hospital in Philadelphia, Pa, where I underwent neurosurgery. Before my hospitalization, I was subjected to preadmission testing, which included a medical history and physical examination, electrocardiogram, chest radiograph, and laboratory tests. All of these procedures were conveniently

conducted during a single visit to a free-standing facility adjacent to the hospital. However, I found the history and physical examination sorely lacking in thoroughness.

When I was in osteopathic medical school, my fellow students and I had an excellent course in the taking of a patient's complete medical history and in the competent performance of a thorough physical examination. I was taught that in a properly taken history, the physician introduces him- or her-

self to the patient and engages the patient in discussion, helping to establish rapport and promote the bonding process between patient and physician. This discussion could also help guide the physician in establishing a working diagnosis even before the physical examination is conducted. I always incorporated these tenets into my practice as an osteopathic physician.

When I was undergoing these preadmission tests, the history taking consisted of a checklist of diseases for me to complete—independent of any personal interaction with a physician. The checklist also included blank spaces for me to list any drug allergies, previous surgeries, medical conditions, and current medications. After I completed this form, a nurse practitioner dutifully entered all the information into a computer. My attending surgeon played absolutely no role in this history-taking process. (I had filled out a similar history form at my initial visit to the surgeon's office.)

My physical examination, which was conducted by the same nurse practitioner, was a further extension of the impersonal electronic age of medicine. As in the history taking, all information that she obtained during the examination was entered into a computer. The actual examination that she performed was a joke. Several major body systems were completely ignored. Blood pressure was taken, but heart and breath sounds were auscultated through two layers of clothing, thereby eliciting excessive friction to the examiner's ears. The midabdomen was quickly palpated, but there were no examinations of the upper or lower abdomen. Did I have an enlarged liver, an inguinal hernia, point tenderness? There was no way to tell from this examination.

The examiner never checked my ears, nose, or throat. Nor did she perform even a cursory neurologic exam-

ination, such as checking my reflexes or checking my eyes for reaction to light or to the “follow my finger” test of ocular motility—despite the fact that I was being admitted for neurosurgery.

My thyroid gland was not palpated, and there were no checks for cervical or supraclavicular lymphadenopathy. Furthermore, my upper and lower extremities were ignored, with no checks for cyanosis of the nail beds or for dependent edema. My back was totally nonexistent to the examiner.

The nurse practitioner who took my medical history and conducted my physical examination spent about 45 minutes with me. She was entering data into the computer for approximately 35 minutes of that time, leaving only 10 minutes for any personal interaction.

Is this the future of medicine? Must personal interaction between patient and healthcare provider be so severely curtailed? Is storing relevant information into a computer database so paramount to patient care?

I agree that electronic storage of information improves the maintenance and availability of patients’ medical records and helps prevent errors by physicians and other hospital staff. A universal retrieval system for such records is certainly part of the future of medicine. However, I also believe that we should not abandon the time-tested model of the personal patient-physician relationship, which served us so well for so many years.

Perhaps it is time for the American Osteopathic Association to establish a task force to study this issue.

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Chronic Psoas Syndrome Caused by the Inappropriate Use of a Heel Lift

To the Editor:

I would like to thank Harold I. Magoun, Jr, DO¹ and Dale E. Alsager, DO, PhD^{2,3} for their careful attention to my September 2007 case report in

which I described a patient with chronic psoas syndrome.⁴

I am in agreement with Dr Magoun¹ that it is important, to correct pelvic dysfunctions before obtaining standing postural radiographs. This correction is, indeed, a necessary first step for postural radiographs to translate accurately a patient’s leg length discrepancy into the sacral base unleveling that is measured using this technique. It is for this reason that—as I described in the three paragraphs before “Radiographic Findings” in my case report⁴—I note that the patient’s pelvic dysfunction was corrected with restoration of pelvic symmetry before the postural radiographs were obtained.

I am fascinated by Dr Magoun’s disregard for standard postural radiographs, which he refers to as “an unnecessary technicality” after pointing out the importance of administering osteopathic manipulative treatment before obtaining them.¹ Although I congratulate Dr Magoun on his ability to prescribe heel lifts based solely on clinical evaluation, I will continue to use the quantitative measurement of sacral base unleveling to prescribe heel lifts, as described by Willman,⁵ Kuchera and Kuchera,⁶ and others.

Dr Alsager^{2,3} noted in his letters that, for postural radiographs to be valid, sacral base unleveling must be measured in reference to a vertical plumb line. The use of such a plumb line is an extremely important part of this technique. In my clinical practice, I use lead wire (like that used for tying flies for fishing), with a lead weight at the end, suspended from the ceiling, allowing gravity to provide a true vertical reference. Dr Alsager³ also expressed concern about the lack of a plumb line in the radiographic images shown in my case report.⁴ I would like to note that these radiographs were taken using a leveled bucky, and the markings and measurements in the radiographic images are merely representations of the actual markings and measurements used during evaluation of the patient.

Another concern expressed by Dr Alsager³ is important to discuss: where does the clinician draw the horizontal reference lines for femoral head height on a radiographic image when there is an artificial hip? And perhaps a more important, related question might also be asked: where does the clinician draw the vertical reference lines off the femoral heads when there is an artificial hip in the radiographic image? These are two conundrums to which I believe my case report⁴ provides ready solutions.

The horizontal reference lines (lines 1 and 2 in Figure 2, 2007;107:417) are usually drawn across the highest point of the natural femoral head. An artificial femoral head is smaller, however, and therefore lower, when compared to the natural femoral head. Should the horizontal lines incorporate the artificial acetabular component, or should they be across the artificial femoral head, as suggested by Dr Alsager?³ I believe this question is redundant, because the horizontal lines do not come into play with the measurements used. In fact, regardless of the femoral head heights, the only actual concern in evaluating a leg length discrepancy is how the discrepancy affects the rest of the body—and this is determined by measuring the amount of sacral base unleveling created by the discrepancy. Thus, the only relevant measurement is the angle created by the unlevelled sacral base against the vertical plumb lines drawn off of the femoral heads.

It is crucial to determine the correct placement of the vertical plumb lines off of the femoral heads (lines 3 and 4 in Figure 2), generally drawn in this technique from the tallest points of natural femoral heads. These lines and the line that is drawn across the unlevelled sacral base (line 7 in Figure 2) are used to calculate the proper-sized heel lift to prescribe. With an artificial hip, I believe that the ideal position to place the vertical plumb line from the artificial femoral head is at the same distance

medial to the greater trochanter as is the contralateral plumb line from the natural femoral head.

Again, I am grateful for the interest generated by my case report.⁴ I hope that other osteopathic physicians and their patients may benefit from the details of this discussion.

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References

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Editor's Note: JAOA readers may recall the extensive series of letters to the editor published last year on the topic of **student debt loads** (2008;108:53,81,231-233,264-265,321,350,483-484). At the American Osteopathic Association, the Department of Government Relations has been redoubling their advocacy efforts on behalf of medical students to ensure access to student loan hardship deferments.

Recently, Senators Richard Burr (R-NC) and Christopher Dodd (D-CT) and Representatives Vern Ehlers (R-MI) and Mike Honda (D-CA) introduced the "Medical Economic Deferment for Students (MEDS) Act" (S 646/HR 1615) to reinstate the debt-to-income ratio pathway ("20/220 pathway") used by many medical residents to qualify for economic hardship loan deferment.

The American Osteopathic Association believes that high debt loads discourage students from seeking careers in public health service, practicing in underserved areas, and seeking careers in primary care specialties. Loan deferment programs, like the 20/220 pathway, allow medical school graduates to pursue training in medical specialties based on career interests and talents rather than financial obligations alone.

The Department of Government Relations encourages interested readers to send a letter to Congress in support of this legislation. A variety of online tools are available at the DO Advocacy Action Center on DO-Online to assist members of the osteopathic medical profession in these efforts. Please see <http://capviz.com/aoa-aoia> for more information.

Corrections

The JAOA and the author regret several errors that appeared in the following article:

Rodgers DJ. AOA continuing medical education. *J Am Osteopath Assoc.* 2009;109:160-179. Available at: <http://www.jaoa.org/cgi/content/full/109/3/160>. Accessed April 22, 2009.

In the last sentence of the first paragraph on page 160, the data were incorrect. The sentence should have read, "Currently, 77% of all AOA members have a CME requirement" instead of reporting this number as 84%.

Also, for the fourth item on page 162 in Figure 3, the item "Passing an American Board of Medical Specialties recertification examination or a Certification of Added Qualifications examination (maximum: 15 hours)" was incorrect. The term "American Board of Medical Specialties" should have been replaced with "American Osteopathic Association."

These changes were made to the full text (<http://www.jaoa.org/cgi/content/full/109/3/160>) and Adobe Portable Document Format (<http://www.jaoa.org/cgi/reprint/109/3/160>) versions of this article online. ♦