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Letters to the editor are considered for publication if they have not been published elsewhere and are not simultaneously under consideration by any other publication. All accepted letters to the editor are subject to copyediting. On request, the corresponding author is responsible for providing the editor with photocopies of referenced material.

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Letter writers must include their full professional title(s) and affiliation(s), complete address, day and evening telephone numbers, fax number(s), and e-mail address(es). Letter writers are responsible for disclosing financial associations or other possible conflicts of interest.

Although JAOA cannot acknowledge the receipt of letters, we will notify authors whose letters have been accepted for publication. Rejected letters and illustrations will not be returned to their authors unless a self-addressed, stamped envelope accompanies the submission of these materials.

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Kudos on Electronic-Only COMLEX-USA

To the Editor:
I want to commend the National Board of Osteopathic Medical Examiners, Inc (NBOME) for taking a big step recently: deciding to administer the Comprehensive Osteopathic Medical Licensing Examination (COMLEX-USA) on computer only as of July 2005.

For years, osteopathic medical students and residents have been plagued by the cumbersome two-day, 800-question, written examinations—examinations that were only available in paper-and-pencil format and were only offered twice each year. Consequently, osteopathic medical students and residents were often forced to schedule rotations and vacations around NBOME’s examination schedule.

I remember taking the paper-and-pencil examination and being mentally and physically drained at the end of each block of questions. While students were trying to concentrate on the examination, there were always many other students around, walking by, coming and going for short breaks, making noise, and so forth.

It was therefore with great pleasure that I read the December 2004 announcement on NBOME’s Web site (http://www.nbome.org/) indicating that, starting this summer, all COMLEX-USA examinations will be offered electronically. Although some may argue against this change, I believe that it will make for a less tedious and better test-taking experience for osteopathic medical students and residents.

In fact, for several years, the National Board of Medical Examiners has offered a shorter, less cumbersome examination, the United States Medical Licensing Examination, in electronic format. Test-takers have been able to select the times and testing locations that best suited their schedules.

It will be interesting to see how this switch to electronic-only format works for NBOME this summer. Although the process will probably have a few small bugs that will need to be worked out, I commend NBOME and say “good job.” I hope all runs smoothly.

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“Hardship Exception” Is Necessary

To the Editor:
I have been reading JAOA—The Journal of the American Osteopathic Association these past few months with particular interest in the debate surrounding the current state and future direction of requirements for osteopathic internships. Frankly, it is time to stop the inefficient pedantic dogma being sent down from those DOs viciously defending a system that is simply not supported by those most important to the future of the profession: students.

In his January letter to the editor (“Rebuttal Regarding the ‘Hardship Exception.’” J Am Osteopath Assoc. 2005;105[1]:4–5), Dr Steier expresses disdain for the “routine granting of American Osteopathic Association (AOA) credit for non-AOA–approved internships and residencies under Resolution 42 (A/2000), the ‘hardship exception.’”

As a psychiatry resident reading this letter, I am first inclined to ask what the motivation behind such feelings and behavior might be.

The institution at which Dr Steier is a program director, Nassau University Medical Center in East Meadow, NY, requires that any osteopathic medical student applying for a second-year postgraduate residency position (PGY-2), including allopathic (MD) positions,
complete an AOA internship at his hospital (NYCOMEC, e-mail [policy statement], January 2005).

Of course, a hardship application requesting that credit be given for internships completed at other institutions is reportedly available. One wonders if Dr Steier is as opposed to this hardship application as well.

Considering the internship match rate at Nassau University Medical Center this year left 18 unfilled osteopathic internship slots,1 the motivation becomes more clear.

Such tactics serve only to artificially inflate the still-low osteopathic internship match rates while creating additional demands on newly graduated osteopathic medical students. Neither result fosters a love in osteopathic medical students and residents for osteopathic graduate medical education.

I would go so far as to say that Resolution 42, even as it now stands, fails to properly address the needs of many residents whose chosen specialties have very specific and very different requirements. For this reason, I argue that the hardship exception applications should rightfully have a high approval rate.

Psychiatry, for example, requires 6 months of inpatient psychiatric unit care; 2 months of neurology; and 4 months of internal medicine, family practice, and/or pediatrics in the first year of residency (PGY-1).2 Some psychiatry residencies do not have accommodations for such requirements (eg, no pediatrics or family practice department). Considering the fact that there are only 4 osteopathic psychiatry residency programs in the United States (Michigan, 2; New Jersey, 1; Pennsylvania, 1) with a combined total of 28 positions,3 it is conceivable that many potential psychiatry residents would not be able to, or would not want to, go to any of these institutions for whatever personal reasons they may have.

When one combines this dearth of opportunity in osteopathic institutions with the fact that fiercely competitive fellowship positions often require residency training at prestigious institutions, it is no wonder many osteopathic medical students choose to attend the more plentiful and long-established Accreditation Council for Graduate Medical Education (ACGME) residency programs.

Resolution 42 demands that the resident “complete all AOA-approved traditional internship requirements within the ACGME program.”4 This requirement is often impossible to fulfill. Completion of these requirements would in some cases prevent residents from fulfilling the requirements for licensure application for their own specialties.

If this is not bad enough, the bylaws demand that these and other requirements be completed within the first year of postgraduate training.5 Some would argue that because psychiatry, for example, allows one to enter as a PGY-2, the osteopathic medical student should therefore complete an AOA internship and then apply to PGY-2 positions in psychiatry. This is extortionate. With the mounting debt that osteopathic medical students face,6 it is unreasonable to expect residents to feel comfortable tacking on an additional year of training, losing one year of salary equivalent to $50,000 to $250,000, with arguably minimal benefits.

Assertions like those made in the November 2004 edition of JAOA by Dr Clark (“Osteopathic Medical Training: Developing the Seasoned Osteopathic Physician.” J Am Osteopath Assoc. 2004;104[11]:452-454), that he had just as much knowledge (if not perhaps a little more) after completing his internship as those now completing full residencies, are preposterous and only signify an out-of-touch attitude that is sadly prevalent in the existing osteopathic guard.

In fact, Dr Clark begins his letter by berating Dr Smith for originally referring to himself as an “MS” (medical student), rather than an “OMS” (osteopathic medical student), making the false analogy that osteopathic medical school is akin to a business and that the designation OMS brings with it product recognition.

I say that if osteopathic medicine is a business, then it has largely failed in its marketing campaign. Despite more than 100 years of the existence of our profession, the vast majority of people in the United States still has no idea what a DO is.8 Insisting that osteopathic medical students refer to themselves as “OMS” will do nothing to improve this low level of awareness about osteopathic medicine among the public.

To take the business analogy a step further, a business must listen to its stockholders when they demand change. Osteopathic medical students in this scenario are the new stockholders. Results over the past few years show poor AOA internship match statistics.9 Basically, our “product” isn’t being bought. The truth is that those wishing to pursue ACGME residencies do so for a reason, and they should not be viewed as the enemy or ostracized from the osteopathic community.

The truth is that almost half of osteopathic medical students do not want to attend AOA internship programs, as evidenced by the recent 52% participation rate for osteopathic internship slots.9 In fact, even the term “internship” is now found to be degrading and old-fashioned and has, in fact, been eliminated from the ACGME lexicon. The term “intern” brings with it only the reminder that one is a subservient underling. In addition, in today’s common understanding of the word, it also often means “unpaid” or “marginally knowledgeable,” and possibly conjures images of morally questionable characters begging for recognition in “the real world.” Once again, the osteopathic profession seems reluctant to change or modernize in even this small matter.
Letters

It appears as though the current generation of osteopathic medical students and residents are choosing not to obsess over the differences between MDs and DOs, but rather focus on our similar yet distinct roles as leaders of the healthcare profession—choosing to be included rather than alienated from our allopathic colleagues. If this means training in an allopathic residency for whatever reason, that decision should be respected. Imposing unreasonable restrictions on osteopathic graduates will only further divide the profession, and that is something we truly cannot afford.

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References


Still Keeping the Faith

To the Editor:

I found meaningful the response of Dr Licciardone (J Am Osteopath Assoc. 2004;104[10]:406), to Dr Bledsoe’s letter to the editor (“The Elephant in the Room: Does OMT Have Proved Benefit? J Am Osteopath Assoc. 2004;104[10]:405). Dr Licciardone’s response reflects exactly what the majority of practicing DOs believe—and what they know.

The original teachings of A. T. Still, MD, DO, form the tenets of osteopathic philosophy and practice and support the foundations of osteopathic medicine today. Dr Licciardone notes that Dr Still’s work “suggest[s] that the body has the capacity to maintain health and that [osteopathic manipulative treatment] (OMT) may be useful in augmenting that capacity by preventing or healing disease.”

Dr Licciardone acknowledges that active and rigorous research in osteopathic medicine is still needed and remains ongoing, noting that “evidence . . . exists to suggest that the benefits of OMT for patients with chronic low back pain are substantially greater than can be attributed to the placebo effect.”

I fail to see the correlation Dr Bledsoe attempts to draw between OMT as an osteopathic treatment modality for acute and chronic low back pain and the efficacy (or lack thereof) of OMT following knee and hip arthroplasty. Osteopathic manipulative treatment is not a panacea—not for that matter are medications.

I would like to suggest that Dr Bledsoe might want to look into the research of Drs Korr, Denslow, and Hicks of Kirksville College of Osteopathic Medicine of A.T. Still University of Health Sciences.

It may be that Dr Bledsoe has never used OMT as a treatment modality. In fact, although he says he “received an excellent . . . medical education” at a college of osteopathic medicine and is “proud” to be a DO, it is unfortunate and saddens me that he now appears to be quite cynical about the experience.

Dr Bledsoe, in his cynicism, quotes Mark Twain’s Following the Equator: “Faith is believing what you know ain’t so.” Faith, according to Webster’s dictionary, is “confidence and trust in a person or thing.” I know I speak for myself and many other DOs who are proud to count ourselves as one with active and rigorous researchers like Dr Licciardone in keeping our faith in osteopathic medicine.

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Faith versus Evidence: The Real Question in Osteopathic Medicine?

To the Editor:

We were saddened to read a recent letter to the editor by Dr Bledsoe (“The Elephant in the Room: Does OMT Have Proved Benefit? J Am Osteopath Assoc. 2004;104[10]:405). The sadness we felt came not so much from the writer’s cogently expressed anger, but from an awareness that many osteopathic physicians arrived at their first day of osteopathic medical school at least agnostic in their attitudes toward osteopathic philosophy—and later graduated feeling betrayed and angry.

Having passed our twelfth and twenty-eighth years in practice, respectively, we find it increasingly difficult to blame earlier generations of DOs for the failure of the colleges of osteopathic medicine (COMs) to convert their students more successfully to osteopathic principles and practice (OPP). If such “conversions” were easy, they would not be so deeply felt as we have experienced them.
At the core of the debate is one question: Is osteopathy simply a metaphysical paradigm requiring faith, or is it a scientific paradigm supported by evidence?

A cursory examination of the literature yields successive generations of osteopathic physicians and researchers providing scientifically validated evidence of the effectiveness of OPP—all of which were appropriate and suitable to their time.

In the early decades of the 20th century, Louisa Burns, DO, DScO, published extensively.1–4 The scientific papers of Irvin M. Korr, PhD, spanned three decades.5 In the 2004 Scott Memorial Lecture, Dennis J. Dowling, DO, summarized the scientific papers of the last 20 years that have each met the evolving requirements of evidence-based medicine.6 In the November 2004 Supplement to JAOA, another article by John C. Licciardone, DO—the same author who prompted Dr Bledsoe’s October letter—presents further pertinent references (“The Unique Role of Osteopathic Physicians in Treating Patients With Low Back Pain [review].” J Am Osteopath Assoc. 2004;104[11 Suppl 8]:S13-S18).

From 1992 to 1996, the Agency for Health Care Policy and Research (now the Agency for Healthcare Research and Quality) issued several well-known clinical practice guidelines using an evidence-based format. In the clinical practice guideline Acute Lower Back Problems in Adults, a preponderance of evidence supported manual treatment for acute low back pain.7 Because of the process the Agency used for selecting evidence, however, their researchers arrived at this conclusion with only one of their 360 sources cited referencing osteopathic medicine8 and only four sources referencing chiropractic treatment modalities.

During the last decade, as DOs have increasingly disconnected from their heritage of OPP, allopathic groups are offering more manual medicine courses. Michael A. Seffinger, DO; R. Todd Dombroski, DO; and Carl W. Steele, DO, presented a workshop at a national meeting for the American Academy of Family Physicians (see http://www.aafp.org/PreBuilt/assembly_extracontent_pdf#search=’michael%20seffinger,%20DO%20aafp’). In addition, S. Noone, Executive Director of the American Academy of Osteopathy, indicated that in August 2004, Jerel H. Glassman, DO, MPH, presented a manual medicine workshop at Harvard Medical School in Cambridge, Mass, that was sold out (oral communication, March 2005). Finally, the Association of American Medical Colleges will convene a special panel to write a Medical School Objectives Project special report regarding the importance of musculoskeletal education as part of the predoctoral curriculum at the nation’s medical schools (S. Noone, oral communication, March 2005).

Benjamin Asher, MD, is a surgeon and board-certified otolaryngologist who served as chief resident at the University of Iowa in Iowa City, after which he completed a fellowship in pediatric otolaryngology at Children’s Hospital Boston. After serving as an assistant professor at Harvard Medical School and Dartmouth Medical School in Cambridge, Mass, and Hanover, NH, respectively, he went on to private practice. When Dr Asher’s son needed tympanoplasty, however, this physician and surgeon was “open minded enough to visit an osteopath who was well trained in cranial work.” After a few treatments, his son no longer required surgery. In addition, the DO gave up surgery and has now become dedicated to applying OPP to a wide variety of ear, nose, and throat problems (B. Asher, MD, oral communication, January 2005).

Scientific peer-reviewed papers on the applications of OPP cumulatively present a crushing preponderance of evidence in support of osteopathic medicine—yet there remains a disconnect between book evidence and its translation into practical medical expertise.

It is perhaps unrealistic to expect COMs to select out candidates with a natural proclivity for OPP; the pool includes too many bright students whose primary goal is to acquire a medical education. The challenge remains for the COMs to provide their students with scientific evidence and validation of core OPP in action by personal example.

We further propose that the dichotomy between scientific and metaphysical is an arbitrary one; scientific evidence will continue to provide proof sufficient for those with “ears to hear and eyes to see,” and those with a faith-based leaning will continue to find deeper meaning in the personal exploration of OPP. Perhaps if Dr Bledsoe is not able to find practical value in OPP,
he should turn his energies toward providing practical proofs in the allopathic paradigms, where only 10% to 20% of all procedures currently used in medical practice have been proven efficacious in controlled trials.\textsuperscript{9}

The process will never be perfect. The center of osteopathic evolution may pass from its point of origin to different continents. In the meantime, the current generation of DOs should continue to ask the difficult questions, forge new tools and methods, and deepen our understanding of the practice of medicine.

If there is any “historic dogma of OMT,” to borrow the words of Dr Bledsoe, it is dig \textit{on}—continue to apply OPP to the practice of medicine in an evidence-based fashion. It may well be that core osteopathic principles will continue to be relevant to the osteopathic physicians of tomorrow.

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References

Same As It Ever Was

To the Editor:

I just returned from an extended vacation in India. Although I was in the areas that were hit by the tsunami, I was fortunate to have missed the tragedy by a couple of hours.


This argument has been ongoing in the profession for probably a hundred years. There are and always will be osteopathic “purists” who will adhere to osteopathic principles and practice (OPP) exactly as laid down by A. T. Still, MD, DO. And there are and always will be young osteopathic physicians with progressive thinking who want to enhance the depth of our knowledge and the depth of our caring. These young DOs will also argue that we must keep up with the advances in modern medicine as well as the use of complementary and alternative medicine and further develop the osteopathic approach.

As a result of the elaborate system, insurance carriers now use to reimburse physicians for patient care, the days of the “ten-finger osteopath” are gone. There are no more 10- or 20-bed osteopathic hospitals. Hospitals are no longer owned and run by osteopathic families.

And because we no longer have our own Detroit Osteopathic Hospital (closed in 1992 and formerly located in Highland Park, Mich), the Osteopathic Medical Center of Texas (closed in 2004 and formerly located in Fort Worth), or similarly superb—and exclusively osteopathic—environments at which our students and residents can continue their clinical education, we have to prepare our young professionals for this new world of healing and caring that does not fall under the osteopathic umbrella.

So, if we want to send our young osteopathic physicians to Yale University, Stanford University, Harvard University, Mayo Clinic, and the Cleveland Clinic, we have to adopt a broader view of our education and residency years in the osteopathic institutions of learning.

It is true that, in the past, some of us came to the osteopathic medical profession because we could not get accepted for admission at the “other” schools. Initially, we were all rebellious and extremely critical of our system of learning—and critical of our clinical trainers who were at times ill-prepared to be good teachers but were very intelligent, kind, compassionate, and helpful.

As we progressed, succeeded, and eventually won the respect of our patients and then the fellows on the other side of the fence, we were filled with a sense of gratitude for the osteopathic medical profession and those who taught us—regardless of the quality of our initial training. We came to recognize that the solid foundation we received in our residency years and at those osteopathic institutions of learning had indeed helped us pull through successfully at the Yales, Stanfords, and Harvards.

We must continue to provide our graduates with a solid medical background and instruction in OPP so that they can compete successfully with other physicians within the United States and abroad.

I believe that we should do as we have always done: if young DOs have new ideas, criticisms, and different outlooks, our profession should take a crit-
To the Editor:

I would like to thank Dr Smith and Dr Bledsoe for using this forum to boldly address some controversial issues within the osteopathic medical profession (J Am Osteopath Assoc. 2004;104[6]:230–231, and J Am Osteopath Assoc. 2004;104[10]:405–406, respectively).

When I began medical school, I was excited about using osteopathic manipulative treatment (OMT) as a treatment modality. However, over the past 3 years, I’ve been underwhelmed by its clinical applicability and unimpressed with the science and research used to support its use among those in the profession.

As a scientist and future osteopathic physician, I have been trained to evaluate all the options for my patients critically and to utilize the most appropriate and effective treatment available.

Because I generally have neither the data to support the use of OMT in the clinical setting nor the ability to explain its mechanisms, I feel ethically compelled to limit my use of this treatment modality. In fact, I cannot even say with confidence that it “does no harm,” as a recent study by Licciardone et al demonstrated.1

Other researchers have concluded that the majority of DOs rarely or never use OMT.2 Although the reasons for this are multifactorial, a serious disconnect seems to exist between what DOs are “supposed” to do, and how we actually practice medicine.

Juxtapose these research findings with the examination questions used in the second part of the Comprehensive Osteopathic Medical Licensing Examination, which I recently completed. The emphasis on OMT-specific questions—such as Chapman reflex points, craniosacral manipulation, and assorted viscerosomatic reflexes—surprised me. I found it troubling that a substantial portion of my medical licensing examination was dedicated to concepts lacking broad-based support even among osteopathic physicians, let alone the rest of the medical community. I think this disconnect is part of the “elephant in the room” syndrome that Dr Bledsoe was referring to in his aforementioned letter to the editor.

Dr Clark, in his November 2004 response to Dr Smith (“Osteopathic Medical Training: Developing the Seasoned Osteopathic Physician.” J Am Osteopath Assoc. 2004;104[11]:452–454), made a reasonable suggestion when he proposed that osteopathic medical students and residents who have concerns gain more experience and clinical competence before proposing changes to the profession they have just joined.

The main problem I see in following Dr Clark’s well-intentioned advice is that those with concerns might just become exasperated—or worse, apathetic—while waiting for “their turn” to speak up. In fact, they may begin looking for satisfaction in Accreditation Council for Graduate Medical Education (ACGME) residency programs, curtailing all future participation and discussion within the osteopathic community.

With the majority of new DOs currently accepting ACGME residencies, it is not plausible that only the “unconcerned” DOs might remain in the system to eventually assume positions of influence within the profession? I doubt this self-selected body would have any strong motivation to examine more closely a system that has worked just fine for them. Surrounded only by fellow osteopathic patriots, one could well imagine that they would feel no compelling reason to change anything at all.

I’ve worked hard during my medical training. I feel confident I’ve prepared myself to become a competent, caring, “people-not-just-symptoms”—treating resident and physician. However, I’ll be truthful and admit that, like the majority of current DOs, OMT is not likely to be a meaningful part of my clinical practice.

My future participation as an active member of the American Osteopathic Association (AOA) is less clear. As proud as I am of my medical training and pending degree, I am not sure that the AOA adequately represents who I want to be as a physician. I believe the AOA is most concerned with its own survival. The AOA adamantly maintains that osteopathic medicine is distinct from allopathic medicine, but it seems far less interested in the research and training programs necessary to justify that distinction.

As evidenced by the increasing numbers of osteopathic medical students selecting ACGME residency training, until the osteopathic profession and the AOA tackle some issues soberly and head on, I am afraid that the elephants in the room will continue to crowd many of us out of the tent.

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References