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.

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 (.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.

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. Mailed submissions and supporting materials will not be returned unless letter writers provide self-addressed, stamped envelopes with their submissions.

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.

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.

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**Importance of Early Exposure to Clinical Research for Osteopathic Medical Students**

To the Editor:

During the summer of 2009, an opportunity arose for two of us (A.M.P., K.J.W.)—osteopathic medical students at Kirksville College of Osteopathic Medicine–A.T. Still University (KCOM) in Missouri—to participate in a collaborative research project between KCOM and Pennsylvania State University–Her-}

shey College of Medicine. As a result of our lackluster experiences with high school and undergraduate laboratory research, we were both initially somewhat hesitant about the prospect of becoming involved in a clinical research project. Another reason we were tentative about pursuing research was that we both knew we wanted to spend our careers treating patients, and we did not envision much opportunity for patient care within a research-oriented career.

Despite our misgivings, we decided to accept the challenge to see how much we could learn about true clinical research. The research project was made possible by Grant No. 1 R25 AT003579-01 from the National Center for Complementary and Alternative Medicine of the United States National Institutes of Health.

The clinical research we encountered in the KCOM-Penn State summer elective was nothing like the type of research with which we were familiar, such as bench work involving measuring of solutions or running of reactions. Rather, we found ourselves in the clinic, following osteopathic physicians and interacting with patients. This clinical research model proved to be an active process in which the osteopathic physicians we observed used a practice-based research network (PBRN) for investigating the efficacy of patient care, including examination of the care of patients with diabetes mellitus.

Our responsibilities in this research project involved collecting data for a PBRN investigation of the use of various techniques of osteopathic manipulative treatment for different diagnoses and the subsequent extent of patient satisfaction. The mentors with whom we worked had investigative minds and strong passions for teaching, which impressed upon us the importance of current research within the osteopathic medicine paradigm.

We learned how well-planned research projects could improve clinical practice. One of the most important lessons that we brought away from the experience was learning how osteopathic physicians are able to integrate clinical research and clinical practice in a way that works—there was no conflict between these two aspects of medicine, and neither aspect suffered for the other to thrive. We discovered that research and practice could complement each other incredibly well.
Through our participation in the process of clinical osteopathic medical research, we came to realize that all the small pieces of medical training, protocol writing, and evidence gathering merge to form one big picture in clinical research. Such research is the keystone that holds the other pieces together and gives them value; it is the summit of evidence-based patient care.

The opportunity to participate in a clinical research project as first- and second-year osteopathic medical students proved to be a tremendous learning experience on many levels. Our research elective helped us realize more fully the connection between basic science studies and clinical decision making. It also stimulated our interest to pursue additional patient-oriented research training and influenced our consideration of future specialty options.

We recommend that osteopathic medical students at other institutions pursue similar research experiences early in their education should such opportunities be available. Participation in such a project would widen students’ perspectives to the plausibility of improving their future clinical practices by integrating research into their careers. It is essential that osteopathic medical students be encouraged to take advantage of more abundant research opportunities early in their training.

Reflecting upon our summer research experience, it is evident that this learning opportunity has prepared us as future osteopathic physicians to adopt a more scholarly and scientific approach to solving medical problems—an approach that we will use every day to guide our clinical decision-making processes for our patients.

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Understanding Insurance: Will a Public Option or Co-op Get Us Where We Want?

To the Editor:
I greatly appreciated Dr Debra A. Smith’s thoughts as presented in her editorial, “Understanding Insurance: Will a Public Option or Co-op Get Us Where We Want?,”1 published in the April issue. Her most salient comments are included in her conclusion, in which she stated:

It seems a violation of the current Medicare contract with Americans to take on additional public health plans when we do not have foreseeable means of paying for obligations already promised to the insured.

Dr Smith is correct. The US government simply does not have any possible means of paying its current healthcare obligations, including Medicare, for the projected number of Americans that will soon be seeking care. Indeed, a private entity that offered such a new medical insurance product without having the fiscal reserves to reasonably honor projected claims would, at best, fail in the market and, at worst, likely be subject to numerous prosecutions for felony law breaking.

It is deeply disturbing that JAOA—The Journal of the American Osteopathic Association is not regular publishing clearly written articles describing the fundamental economic realities of US healthcare. As illustrated by a letter that I recently received from an osteopathic medical student who disagreed with comments I wrote in the December 2009 JAOA: that were critical of the economic fallacies in the Obama healthcare plan, some people in our profession have no idea how medical economics work. The student’s words were emotionally scathing but not grounded in mathematical reality.

Since I received that letter, new estimates by the Congressional Budget Office,3-5 released in March 2010, show that “Obamacare” will not be deficit neutral, as its supporters had claimed. In addition, if past performance of government-run programs is predictive, the healthcare bill signed by President Obama will end up costing Americans substantially greater amounts of money than originally projected.

We are training and graduating hundreds of new osteopathic physicians every year. Many of these DOs enter the market with little or no understanding of how healthcare is funded, how they are to be compensated for their services, what general health insurance products are available, or what it takes to operate the business of a medical office in the United States. There seems to be an idea in our profession that DOs will eventually pick up this information later in their careers. Based on my interactions with colleagues, however, many DOs continue to lack an adequate understanding of these economic and business issues. Frankly, this aspect of the osteopathic medical profession is unethical and embarrassing.

We owe our osteopathic medical students a clear education on American economics—writ large—with a special focus on medical economics. These students are facing a future in which available capital is likely to dry up. The United States will assume more debt in 2011 than the rest of the world’s nations combined, and the federal debt is projected to grow to 90% of the nation’s gross domestic product by 2020.4 At some point, inflation from trillions of printed dollars is going to hit the US economy, seriously eroding the basis of our currency.

None of this is good news, and it is even worse when one considers the unfunded mandates to which Dr Smith refers in her editorial.1

It is time for the American Osteopathic Association to assume the role of advocate for the education of osteopathic medical students and to demand that all osteopathic medical schools incorporate basic education about medical e-

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nomic and compensation of medical professionals. We specifically need education on profit and loss, overhead issues, insurance contracts, balancing payer mixes, and loan repayment strategies. Based on my experience working on a personal project involving curriculum development while I was at Ohio University College of Osteopathic Medicine in Athens, I believe that these topics could be adequately covered in 5 to 10 hours of instruction.

There is no valid excuse for not providing this kind of education, especially considering the economic demands that are growing every day on the osteopathic medical community.

Let us hope that Dr. Smith’s editorial marks the beginning of a focused effort on the part of the JAOA to provide the osteopathic medical profession with the skill sets it needs to survive the next 20 to 30 years of US economic uncertainty.

Todd R. Fredricks, DO
Ameville, Ohio

Response
I wholeheartedly agree with Dr. Fredericks that we need to train osteopathic medical students and physicians in the business of medicine. I have publicly advocated for this type of training.1 As a profession, we take intelligent, capable people and, in the course of their training, we essentially turn them into idiot savants in their respective specialties. It is all that many in our profession can do to run a successful and profitable practice in an increasingly challenging healthcare market—let alone lead positive change within physician groups, hospitals, and healthcare systems.

This deficit of business skills, political savvy, and “big-picture” economic knowledge even extends to our national organizations. As a result, our profession has the economic status of a market taker rather than a market maker—that is, we must take whatever price is offered for our services rather than receive the price we deserve. We have succeeded in making ourselves little more than a commodity at our own expense.

Traditionally, physicians have viewed the business of medicine with disdain, delegating it to someone else. In doing so, they have unwittingly delegated their voice and authority. Practitioners can no longer afford this attitude if they are going to meet their expenses, let alone get paid a decent wage.

I must respectfully disagree with Dr. Fredericks’ estimation of 5 to 10 hours of instruction being adequate for learning the business of healthcare. Acknowledging the age-old struggle to find time in the curriculum and considering that a number of medical schools are moving toward a 3-year program,2-4 I believe that the ABQAURP CBK covers only the bare minimum of what schools should have taught young physicians about the business of medicine 20 years ago—if they wanted their student-customers to have a basic understanding of the system. This curriculum is a gross underestimation of what is needed for physicians to acquire the needed skill set for the 21st century.

Solving the Problem
It has become fashionable for physicians to enter executive education masters programs in business administration, public health, or medical management in hopes of attaining the needed business skills. In surveys of physicians conducted by Sermo, Inc, an online physicians’ community, many respondents expressed disappointment in such programs.6 I believe the reason for this disappointment is that unlike medical school, where societal necessity and board examinations dictate the creation of a fairly uniform product (ie, the physician), business school does not require such a product. Thus, there is a huge difference between top-tiered business schools and lower-ranked institutions. Unfortunately, many physician-oriented programs “dumb down” management classes to the level of psychology 101, and the requirements for accounting and finance classes are equivalent to a financial statement reading class.

In medicine, there are a limited number of conditions that have a given symptom or complaint. We proceed to create a differential diagnosis, given the symptoms and considering that a number of medical schools are moving toward a 3-year program,2-4 I believe that we need to reexamine curriculum design and integrate the business of medicine into it. The American Board of Quality Assurance and Utilization Review Physicians (ABQAURP) has assembled a core body of knowledge (CBK) that lays out the basic rules of “the game” in which we have been engaged. The ABQAURP has collaborated with the National Board of Medical Examiners to plan, develop, and administer examinations for demonstrating mastery of that CBK.5 However, the ABQAURP CBK covers only the bare minimum of what schools should have taught young physicians about the business of medicine 20 years ago—if they wanted their student-customers to have a basic understanding of the system.

References

LETTERS

Letters

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policy, the regulatory environment, the behavior of competitors (both domestic and foreign), and paradigm shifts in technology. We then need to apply our knowledge and understanding of those interrelating factors to solve problems at hand. The top schools do not merely teach facts, which may soon become obsolete, but they also teach students how to critically analyze; how to develop strategies that properly account for, weigh, and mitigate risk; and how to collaborate with colleagues to carry out the objectives set forth.

One area that physicians need to understand is how to approach entrepreneurship. Whether starting a practice, seeking venture capital to produce or commercialize a modification to a piece of equipment, or effectively lobbying the local hospital to purchase a new piece of expensive equipment, the same skills are required. These skills are related to analyzing market demographics, competition, payor mix, reimbursement levels, time frames for plan implementation and return on investment, opportunity costs, and continued sustainability.

As a profession, we must have the skills needed to address the systemic problems in healthcare, especially costs, rather than simply shift those responsibilities to someone else or to another place or time. As a former chief medical officer who has medically underwritten catastrophic care cases, I must vehemently disagree with Don Berwick MD, the new administrator of the Centers for Medicare & Medicaid Services, who said the following:

...any health care funding plan that is just, equitable, civilized and humane must—must—redistribute wealth from the richer among us to the poorer and the less fortunate. Excellent health care is by definition redistributional.

I would like to point out that insurance by definition is risk-sharing, not wealth redistributing.

As a physician, economist, and health administrator, I felt an obligation during this past year to my profession and the American people to help see that healthcare is reformed in a responsible manner—saving money and improving quality and efficiency, rather than just shifting costs. As a starting point, I published a plan and contacted three major physician organizations about assembling a team of leading physician administrators (including many DOs) from major employer groups, insurers, pharmaceutical companies, medical device manufacturers, hospitals, and government agencies to collaborate on developing a comprehensive physician-led reform proposal.

One of the physician organizations that I contacted replied that it had already decided in favor of the healthcare legislation then being considered by Congress, stating that the legislation wasn't perfect but it was better than nothing. Another organization said that it planned to wait to see the content of the final bill and then lobby for changes accordingly. The third organization said that it was afraid to get "political" for fear of losing its section 501(c)3 tax-exempt status. I found this latter response to be especially perplexing. We all would get patients better in a faster and cheaper manner. Advocating that is not political; it is just logical and practical.

The responses I received were nothing short of astonishing. Perhaps an explanation for these attitudes lies in the following statement by Jean-Marc C. Haeusler, MD, regarding medical leadership:

Identifying and changing problematic values, habits and structures in the medical community requires collective learning and causes uncertainty and loss. That is why the allure of a technical solution is high.

**Practical Measures to Initiate**

Because we know that continuing the present course will doom physicians to being the proverbial cog in the healthcare wheel and to experiencing ever greater frustration, I propose that we initiate the following four measures:

1. **Grant Category 1-A continuing medical education credit for osteopathic physicians to learn the business of medicine.** (These credits fall under the core competencies of the specialty of public health.)
2. **Integrate the business of medicine into curriculum design.**
3. **Use the premier peer-reviewed journal of our profession—JAOA—The Journal of the American Osteopathic Association—as a vehicle for explaining the healthcare issues of the day, as well as for analyzing policies that have proven effective and sustainable both here and in other industrialized countries.**
4. **Move our national organizations from developing only talking points to writing legislation for sustainable policies that improve delivery of healthcare.** It is important to recognize that in the current political climate, politicians do not write the bills. At most, they merely sponsor and tweak them.

Working through the specific mechanics of these initiatives may not be easy, but that should not hinder us. It is essential that we dispense with the fatalism that has plagued the medical profession and focus on pursuing the steps that will allow us to credibly lead healthcare management from a cost and administrative standpoint, as well as from a clinical standpoint, at local, regional, national, and international levels. Such leadership will help osteopathic and allopathic physicians regain a strong moral, political, and economic position.

I have spoken with representatives from one of the world’s leading business schools to develop a program that teaches physicians the critical thinking skills required in business. Personally, I would be willing to serve as a curriculum development consultant for
medical schools that are anxious to reform the educational process for physicians now in training.

Is This Still Osteopathic Medicine?
Osteopathic medical tradition continues to focus on the interrelatedness of the body’s systems and the mind-body-spirit connection as related to the patient’s state of health. The 20th century brought new ideas and directions for the profession. As the last century ended, osteopathic physicians and the medical profession as a whole became entangled in the great healthcare debate and the need for reform, though no real solutions were brought to light.

A.T. Still, MD, DO, said that we need to treat the disease, not just the symptoms. By applying this logic to our current national healthcare problems, we can see that skyrocketing costs are mere symptoms of a sickly healthcare system. The focal point must be finding a better method of delivering healthcare and implementing that method.

By right of heritage, the osteopathic medical profession should take the lead in this noble endeavor. And so, the legacy Still lives!

Debra A. Smith, DO, MIHM, MBA
President-elect, American Osteopathic College of Occupational and Preventive Medicine

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Editor’s Note: Dr Smith is conducting an online survey to gauge osteopathic physicians’ interest in learning the business of medicine. Osteopathic physicians can participate in the survey at http://www.drdebrasmith.com/. The survey is designed to investigate the demand for courses in the business of medicine and to gather information on survey participants’ preferences for the format and forum of such courses. In addition, Dr Smith invites osteopathic physicians who already have the necessary skills and experience and who have an interest in teaching the business of medicine to also participate in the survey.

Importance of Obtaining a Detailed Medical History in Diagnosing Emphysematous Cystitis

To the Editor:
In the February case report by Jeremy K. Selley, DO, and colleagues1 regarding emphysematous cystitis, the authors state that pneumaturia is “the characteristic pathognomonic finding in emphysematous cystitis.” However, I would like to point out that pneumaturia is more commonly associated with a colovesical fistula—in 52% to 77% of cases, often as a result of Crohn’s disease or diverticulitis2—than with emphysematous cystitis. Thus, a finding of pneumaturia in a patient’s medical history would not necessarily be indicative of emphysematous cystitis, as Selley et al1 imply.

Furthermore, the statement by Selley et al1 that emphysematous cystitis has a 20% mortality rate is erroneous, as suggested by the fact that this condition rarely calls for surgical debridement. By contrast, the similarly named but very different entity of emphysematous pyelonephritis, which has a reported mortality rate of 19% to 43%,7 often calls for emergency surgical debridement to save lives.

Adam W. Ylitalo, DO
Urological Surgery Resident, Detroit Medical Center, Michigan

References

Response
We would like to respond to Dr Ylitalo’s letter about the case report1 that we wrote in the February issue of JAOA—The Journal of the American Osteopathic Association. Dr Ylitalo raised two issues—one regarding whether pneumaturia is pathognomonic for emphysematous cystitis, and the other regarding the mortality rate associated with the disease.

Pathognomonic is defined by the Bantam Medical Dictionary as, “describing a symptom or sign that is characteristic of or unique to a particular disease.”2 We concede that pneumaturia is also frequently encountered in cases of colovesical fistula caused by Crohn’s disease or diverticulitis3 because of the limited amount of available information on emphysematous...
cystitis alone, it is difficult to calculate the true frequency of pneumaturia in this condition. Nevertheless, emphysematous cystitis is, by definition, a gas-forming infection—albeit sometimes only a small volume of gas is formed. Thus, it could be theorized that the frequency of pneumaturia approaches 100% in emphysematous cystitis, making pneumaturia truly pathognomonic for emphysematous cystitis. Pneumaturia in the suspected presence of a urinary tract infection should lead physicians to strongly consider emphysematous cystitis.

Little information was available in the literature regarding the mortality rate of emphysematous cystitis. Among the literature that we reviewed, most of the published sources combined mortality data for emphysematous cystitis, emphysematous pyelitis, and emphysematous pyelonephritis—if the sources listed mortality data at all.

In a review of 135 cases, Thomas et al suggested that emphysematous cystitis alone had a mortality rate of 7%, and the mortality rate for all emphysematous diseases approached 14%. Mokabberi et al and Grupper et al reported that the mortality rate of emphysematous cystitis alone is about 20%, as we mentioned in our case report. However, as a result of the rarity of this condition, we acknowledge that 20% mortality is only an estimate. As pointed out by Dr Ylitalo, Schaeffer and Schaeffer reported that emphysematous pyelonephritis is the more severe form of emphysematous, with a reported mortality rate of 19% to 43%, and that emphysematous pyelonephritis calls for surgical debridement more frequently then does emphysematous cystitis.

As to the manner of intervention, Thomas et al suggested that in 90% of the reviewed emphysematous cystitis cases, patients were treated with medicines, and in the remaining 10% of cases, patients received a combination of medicinal and surgical treatment. Although surgery is rarely required for patients with emphysematous cystitis, it is one treatment option after medicinal treatment has failed, as indicated by our case report. We would respectfully disagree with Dr Ylitalo’s assertion that disease mortality is related to the need for surgical intervention.

Our case report focused on the opportunity to make a diagnosis with a complete and detailed medical history and physical examination—while understanding that immunocompromised patients are at higher risk for emphysematous infections. The ability to obtain crucial diagnostic information from a patient’s medical history may be limited by the patient’s degree of comfort in providing potentially vital information.

Nevertheless, obtaining such information begins with physicians understanding the need to ask.

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References

Correction
The American Osteopathic Association’s Department of Quality and Research regrets errors that appeared in the following contribution:


Drs Sigar, Ramsey, and Laddaga were incorrectly designated as osteopathic medical students. The authors’ names should have appeared as Ira M. Sigar, PhD, Kyle H. Ramsey, PhD, and Richard A. Laddaga, PhD.

These changes will be made to the full text (http://www.jaoa.org/cgi/content/full/109/8/425) and PDF (http://www.jaoa.org/cgi/reprint/109/8/425) versions of this contribution online.