JAOA LETTERS

JAOA—The Journal of the American Osteopathic Association encourages osteopathic physicians, faculty members and students at colleges of osteopathic medicine, and others within the health care professions to submit comments related to articles published in the *JAOA* and the mission of the osteopathic medical profession. The *JAOA*'s editors are particularly interested in letters that discuss recently published original research.

Letters to the editor are considered for publication in the *JAOA* with the understanding that they have not been published elsewhere and that they are not simultaneously under consideration by any other publication.

All accepted letters to the editor are subject to editing and abridgment. Letter writers may be asked to provide *JAOA* staff with photocopies of referenced material so that the references themselves and statements cited may be verified.

Letters should be submitted online at http://mc04.manuscriptcentral.com/jaoa. Letter writers must include their full professional titles and affiliations, complete preferred mailing address, day and evening telephone numbers, fax numbers, and e-mail address. In addition, writers are responsible for disclosing financial associations and other conflicts of interest.

Although the *JAOA* cannot acknowledge the receipt of letters, a *JAOA* staff member will notify writers whose letters have been accepted for publication.

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 AOA Category 1-B CME credits. Authors of published articles who respond to letters about their research receive 3 Category 1-B CME credits 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.

OCC: Will It Never End?

To the Editor:

For the past 20 years, my wife, Karen A. Sylvara, DO, and I have had the distinct privilege of providing competent and compassionate care to a rural, underserved population in northern Missouri. Thanks in large part to the excellent osteopathic medical education I received and the clinical mentors who advised me along my career path, my life's work and mission of providing rural primary care has been successful.

However, I have grave concerns about the continued survival and success of this endeavor. Ever-increasing overhead, flat or declining reimbursement, greater and greater intrusions, demands from insurance and governments, and the constant threat of malpractice suits are just a few of my concerns. Dark clouds on the horizon are many, and I hope the country doctor can survive.

I certainly hope that implementation of Osteopathic Continuous Certification (OCC) is not so onerous that it results in lost time, extra travel, missed work, and emotionally stressful, constant test-taking, all so that I can comply and maintain my certification with the American College of Osteopathic Family Physicians (ACOFP).

I cannot speak for my family practice brothers and sisters across the country. In the trenches in this section of flyover country, however, my peers and I taking care of patients and business here feel pretty squeezed, pressured, and stressed. We are growing weary of complying with mandate after mandate, great ideas from people who, for the most part, have no idea what we do. I have serious concerns about the primary care work force, especially in rural areas.

As ever, I strive to stay up to date with continuing medical education, audio digests, journals, and board recertification criteria. I feel these things have been sufficient up to this point.

At age 50 years, I am exactly the mean age of a typical family physician, to my knowledge. Obviously, that means half of the family physicians are older than I am.

Would you like to venture a guess at what most of them think about a bunch of new mandates to maintain board certification? More and more demands are being placed on an understaffed and aging family practice workforce.

Has board certification been beneficial to me up to this point? Here are a few of my thoughts on the matter:

- I have not had a patient ask me if I was board certified.
- I have not received higher reimbursement from insurance, government, or private payers because of current board certification.
- Board certification was not required to staff the various rural emergency departments and clinics I have worked, nor was it required in my private practice.
- Being board certified does little to protect against malpractice suits (an unfortunate event that, thankfully, I have never faced).

There is an ever-increasing demand for primary care services, coupled with a work force shortage. The primary care population includes many licensed, practicing physicians

who are not board certified or eligible. In this context, why would states worsen the primary care workforce shortage by tying board certification to state licensure?

Removing thousands of practicing noncertified family physicians from inner city and rural communities that desperately need their services would be tragic.

To the ACOFP certification board, some friendly, collegial, and unsolicited advice: When formulating new mandated hoops for the rest of us to jump through to maintain board certification, please do not overestimate the perceived value of board certification to the primary care workforce, especially in the context of even greater costs, mandates, time, and stress.

J. Tod Sylvara, DO
La Plata, Missouri

Response

I thank Dr Sylvara for his thoughtful letter expressing concern about Osteopathic Continuous Certification (OCC) and the way in which it may negatively impact his rural primary care practice.

Board certification is an ever-changing process. American Osteopathic Association (AOA) board certification was first offered in 1939, when diplomates were awarded a certificate upon achieving AOA board certification. Certificates were initially granted with no expiration dates, as there was no expectation of certification expiration from stakeholders such as employers, government agencies, or patients.

Certification has since evolved into periodic requirements for recertification. All AOA board certifications awarded since 2004 (and many of the specialty boards prior to that date) require a periodic recertification process, including reexamination, continuing medical education, and AOA membership.

More recently, concerns about medical errors, patient safety, and the quality of health care have been noted in numerous reports from the Institute of Medicine. In particular, a report published in 2000, *To Err Is Human: Building a Safer Health System*[1] prompted a number of influential groups from government, medicine, the public, and industry to address the quality of the nation's health care system by supporting a reduction in the number of medical errors. This coalition led the medical community to implement various initiatives designed to improve the quality of patient care, one of which is continuous certification.

The only new requirement for maintaining AOA board certification under OCC is Component 4: Practice Performance Assessment and Improvement, in which an osteopathic physician engages in continuous quality improvement through comparison of personal practice performance measured against national standards for the physician's medical specialty.[2] All AOA specialty certifying boards are working to make sure that the projects are meaningful and will help osteopathic physicians identify areas of excellence in their practice as well as ways in which improvement may be indicated. Many of the Component 4 activities will be available on the Internet.

State medical licensing boards are actively pursuing maintenance of licensure, which will require practice performance measurement, similar to the OCC Component 4 requirement. The AOA is actively working with the Federation of State Medical Boards to ensure that participation in OCC will meet all requirements for maintenance of licensure in Missouri and all other states.

Obviously, the AOA strives to ensure value in maintaining AOA board certification, but the decision to maintain certification is a personal one. Many hospitals and insurers require recognized board certification in granting privileges or allowing for reimbursement.

I truly appreciate Dr Sylvara's concerns and his and others' dedication to the osteopathic medical profession, and I encourage Dr Sylvara and other family physicians to visit the American Osteopathic Board of Family Physician's Web site regularly for additional details about its plan for OCC.

Martin S. Levine, DO, MPH
AOA Immediate Past President

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Touch—More Than a Basic Science

To the Editor:

Modern technology—whether exemplified by smartphones, tablet computers, or desktop computers—is rapidly consuming a greater share of our lives. So too is technology redefining the way that physicians and patients interact.[1-3] It can be helpful in the health care setting in many ways: assisting in prescribing medication, reviewing and updating medical records, and connecting patients with specialists. However, I fear there may come a day when a physician performs a full online assessment of a patient. When physical contact ends, I am convinced that the patient-physician relationship will end, too. Osteopathic

physicians seem immune to this development; after all, assessing somatic dysfunction will always require touch.

The article "Touch—More Than a Basic Science"[4] by Elkiss and Jerome reflects on the importance of the art and science of touch in osteopathic medicine (and, by extension, in allopathic medicine). Relating to the whole body, the MINE (musculoskeletal, immune, nervous, endocrine) system underscores the complex network of the healing touch. I would add that beyond touching, a physician's demeanor, too, contributes tremendously to the relationship with a patient.[5] Ideally, a physician should be positive and calm because a physician's touch can transmit stress as well as it can healing. A warm, relaxed, and joyful demeanor optimizes treatment and healing. Perhaps this attitude defines the osteopathic difference?

As a DOMP—an osteopathic manipulative practitioner—in Québec, Canada, I work exclusively with osteopathic manipulative therapy (OMTh).[6] Day after day, I feel my touch emanating through the different layers of my patients' bodies in the manner described by Elkiss and Jerome.[1] When I suspect that something is wrong (other than somatic dysfunction) in my patient, I immediately refer him or her to an allopathic physician (MD) for a full physical examination, which may include magnetic resonance imaging or radiography. (Whereas legally, US-trained osteopathic physicians can practice in Québec, none to my knowledge do. Maybe having to take a French examination was too much of a hurdle?)[7,8] In contrast, MDs often refer to DOMPs when they feel that their patients need OMTh. I believe that osteopathic medicine as practiced in the United States allows osteopathic physicians to have the best of both worlds: osteopathic and allopathic medicine. And the link between these worlds? Touch.

It is important to preserve touch, the jewel that defines osteopathy and osteopathic medicine, as one of the building blocks of better patient-physician relationships. As Patterson captured in his editorial, "Touch: Vital to Patient-Physician Relationships,"[9] it is time to rethink the role of touch in OMTh and osteopathic manipulative treatment. And, as ever, more research on OMTh and osteopathic manipulative treatment will prove vital if osteopathic medicine is to maintain its historical distinction from allopathic practice.

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