

THE JOURNAL *of the* AMERICAN OSTEOPATHIC ASSOCIATION



The Journal of the American Osteopathic Association

(JAOA) 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 must be submitted online at <http://www.osteopathic.org/JAOAsubmit>. Letters to the editor are considered for publication in the JAOA with the understanding that 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 editing and abridgment.

Although the JAOA welcomes letters to the editor, these contributions have a lower publication priority than other submissions. As a consequence, letters are published only when space allows.

Updated Recommendations for HIV Screening

To The Editor:

Human immunodeficiency virus (HIV) continues to be a prevalent condition in the US population. According to the US Centers for Disease Control and Prevention, more than 1.1 million people in the United States have HIV, approximately 18% of whom are unaware of their condition.¹ To help combat HIV, the United States Preventive Services Task Force (USPSTF) recently updated its recommendations regarding HIV screening.

In the previous recommendations from 2005,² the USPSTF strongly recommended HIV screening in “all adolescents and adults at increased risk for HIV infection,” as well as in all pregnant women. The new recommendation ratifies these

previous recommendations and enlarges their scope.

The new recommendations,³ which were published in April 2013, state that all adolescents and adults aged 15 to 65 years be screened for HIV infection. As noted in the new guidelines,³ adolescents younger than 15 years and adults older than 65 years should be screened if they are at increased risk for the infection. Additionally, the new recommendation states that “all pregnant women, including those who present in labor,” should be screened for HIV if their HIV status is not known.^{3(p1)}

Although optimum screening intervals have yet to be determined, the USPSTF currently recommends that people between the ages of 15 and 65 years be tested for HIV at least once, while individuals at increased risk should be tested more often (eg, every 3 to 5 years).³ The USPSTF further recommends that individuals at

very high risk for HIV infection be tested at least annually.³

Using new evidence from studies that have taken place since 2005, the USPSTF substantiated its conclusions, specifically that “expanded HIV screening could identify a substantial number of persons with previously undiagnosed HIV infection, many of whom could benefit from the initiation of ART [antiretroviral therapy], behavioral counseling, and other interventions.”^{3(p8)} The recommendation relied on “new evidence that initiation of ART in HIV-infected persons with CD4 counts of less than 0.500×10^9 cells/L could improve clinical outcomes and reduce sexual transmission [of HIV].”^{3(p8)}

Visit <http://www.uspreventiveservicestaskforce.org> for more information regarding these recommendations. (doi:10.7556/jaoa.2013.001)

Susan C. Sevensma, DO

American Osteopathic Association Physician Representative to the USPSTF Partners; Metro Health Hospital, Wyoming, Michigan

References

1. HIV in the United States: at a glance. Centers for Disease Control and Prevention website. <http://www.cdc.gov/hiv/statistics/basics/ata glance.html>. Accessed June 12, 2013.
2. US Preventive Services Task Force. Screening for HIV: recommendation statement. *Ann Intern Med*. 2005;143(1):32-37.
3. Moyer VA. Screening for HIV: U.S. Preventive Services Task Force recommendation statement [published online ahead of print April 30, 2013]. *Ann Intern Med*. doi:10.7326/0003-4819-159-1-201307020-00645.

(continued)

Osteopathic Training for MDs

To the Editor:

In his letter¹ commenting on the September 2012 discussion^{2,3} in *The Journal of the American Osteopathic Association (JAOA)* about the common program requirements of the Accreditation Council of Continuing Medical Education, Stephen J. Noone, MS, CAE, asserts that “our profession should not fear that opening osteopathic GME [graduate medical education] programs to MDs [allopathic physicians] will have a deleterious effect on these programs.”¹ I take exception with Mr Noone’s assertion.

My reasons for disagreeing with Mr Noone stem from my experience as an osteopathic physician (ie, DO). For instance, I once heard an MD boldly proclaim during a staff meeting, “You cannot have a serious residency training program in an institution [with less than] 300 beds,” thereby seeming to question the legitimacy of many osteopathic GME programs. I think that Mr Noone may be naïve regarding the negative influence of such ignorant statements on large groups of residents. I have also witnessed the systematic deconstruction of several small osteopathic residency programs that were incorporated into larger allopathic residency programs as a result of either hospital buyouts or hospital failure and subsequent closure. As these osteopathic residency programs became more homogenized over time, the teaching of distinctive osteopathic philosophies and techniques in these programs ultimately

became meaningless. When residency training is conducted by physicians who did not receive training as DOs, it is entirely understandable that osteopathic manipulative medicine does not become an integral part of that training.

The threat of DOs losing their distinctive identity as hands-on physicians is another reason why I am against opening osteopathic GME programs to MDs. In the current health care environment, patient care is of secondary importance to completing 30 to 40 patient visits a day, meeting the unceasing call to improve metrics (such as relative value units), and implementing whatever plans “the best and the brightest” come up with to meet “customer” demand. In his efforts to find alternative methods of treating patients without using dangerous medications, Andrew Taylor Still, MD, DO, was a pioneer in responding to polypharmacy,⁴ which, along with unnecessary prescribing,⁵ has become rampant in modern medical practice in the United States.⁶ As a DO in the latter half of my clinical career, I have watched the transformation of physicians into commodities who are expected to lose their dynamic individualism for the sake of promoting corporate ethos. In my experience, health care corporations tend to be run by nonphysicians or, even worse, physicians who have rejected the distinctive philosophies of the osteopathic medical profession in favor of adopting an administrative mindset. The survival, identity, and autonomy of the osteopathic medical profession depend on a rigorous and regular revisiting of the fundamental principles

of osteopathic medicine outlined by Dr Still. Such principles include the furtherance of osteopathic manipulative medicine and physician-patient autonomy and the protection of osteopathic beliefs. Unique and distinctive osteopathic GME programs serve to strengthen these principles in students who have already received indoctrination in these beliefs during their predoctoral education. I shudder when I hear someone state that “DOs are the same or just as good as MDs.” Such a statement should be seen as a sign that Dr Still’s efforts have failed, because Dr Still founded osteopathy and osteopathic medicine in response to the deficiencies he identified in the American medical system of his era, including its inability to meet patient needs. As DOs, we would be foolish to ignore this trend toward diluting the distinctiveness of osteopathic medicine.

There is an old saying about camels “poking their noses under the tent wall.” Although I support a vibrant outreach to MDs by the osteopathic medical profession, I would no more expect MDs to become adherents of the core principles of osteopathic medicine than I would expect any other philosophically distinctive group to become integrated into a group of peers with whom they are competitive. The inertia of the majority will always drive the creation of a new group dynamic when 2 disparate philosophies are present. If the culture of allopathic medicine (with its notable absence of osteopathic manipulative medicine) is integrated into osteopathic GME programs, a shift toward allopathic models of thinking will occur.

It is simply a matter of physics and human dynamics.

I am not in favor of opening osteopathic GME programs to MDs. As a DO, I was trained to approach medical problems in a uniquely osteopathic fashion. I respect those DOs who, throughout history, have fought so hard to create a unique and vibrant identity for our profession, which is recognized as having a scientific foundation and which offers effective treatment to wounded, sick, and infirm patients. Osteopathic medicine is not just “allopathy with some manipulation thrown in.” When practiced from day 1 of training as envisioned by Dr Still, osteopathic medicine is an entirely unique medical approach. Dr Still did not abandon effective and useful aspects of standards of care. Instead, he “rebelliously” rejected those elements that he believed caused harm to patients, incorporating an entirely new approach into conventional medical practices to make “good medicine” even better. The unique philosophy, principles, and skills associated with osteopathic manipulative medicine and whole patient care may be what helps preserve our profession’s investment and professional freedoms in a world where generic approaches are the latest trend.

I respect Mr Noone’s opinions, but he says that osteopathic medicine is “our” profession.¹ If I am not mistaken, because Mr Noone lacks a DO degree his use of the word “our” is incorrect. Osteopathic medicine is, in fact, “my” profession, and I would like it to remain unique and distinctive. (doi:10.7556/jaoa.2013.002)

Todd Robert Fredericks, DO

Department of Family Medicine, Ohio University Heritage College of Osteopathic Medicine

References

1. Noone SJ. Osteopathic training of MDs [letter]. *J Am Osteopath Assoc.* 2013;113(4):270-271.
2. Zeichner SB. Need to oppose proposed ACGME common program requirements [letter]. *J Am Osteopath Assoc.* 2012;112(9):586-587.
3. Buser BR, Bulger J, Watson DK, Crosby JB, Swartwout JE. Response [letter]. *J Am Osteopath Assoc.* 2012;112(9):587-588.
4. Our founder. A. T. Still University website. http://www.atsu.edu/about/our_founder.htm. Accessed April 29, 2013.
5. Hersh A, Shapiro DJ, Pavia AT, Shah SS. Antibiotic prescribing in ambulatory pediatrics in the United States. *Pediatrics.* 2011;128(6):1053-1061.
6. Multiple medications: growing “polypharmacy” problem [video]. CBS Evening News website. http://www.cbsnews.com/8301-18563_162-57402912/multiple-medications-growing-polypharmacy-problem. Accessed April 29, 2013.

© 2013 American Osteopathic Association

Corrections

The *JAOA* regrets 2 errors that appeared in the following article:

Petznick AM. Identifying and addressing barriers to insulin acceptance and adherence in patients with type 2 diabetes mellitus. *J Am Osteopath Assoc.* 2013;113(4 suppl 2):S6-S16.

In the first column on page S11, reference 26 was incorrectly cited for the quotation “In newly diagnosed type 2 diabetic patients with markedly symptomatic and/or elevated blood glucose levels or HbA_{1c}, consider insulin therapy, with or without additional agents, from the outset.” Reference 11 should have been cited.

In the second box of Figure 8, a greater than symbol was missing from the last line. The item should have read as follows: “Can increase dose by 4 units every 3 days if blood glucose level is >180 mg/dL.”

In addition, the *JAOA* regrets an error that appeared in the following article:

Shubrook JH. Insulin therapy for challenging patient cases. *J Am Osteopath Assoc.* 2013;113(4 suppl 2):S17-S28.

In the last paragraph on page S26, William’s insulin dosage incorrectly appeared as “18 U before breakfast and 18 U before dinner.” This dosage should have appeared as “22 U before breakfast and 14 U before dinner.”

These changes have been made to the full text versions of the articles online.