JAOA LETTERS

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 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.

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 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.

EHR Boat Not Ready to Sail in United States

To the Editor:

According to a survey of 3700 physicians in 8 countries reported in *InformationWeek*,[1] only 47% of US physicians agreed that health care information technology (IT) has helped to improve the quality of their treatment decisions, compared with 61% of the other physicians surveyed. The other countries, not surprisingly, were Australia, Canada, England, France, Germany, Singapore, and Spain—all or most of which have coherent, efficacious national medical systems. The United States does not have such a system.

The main obstacle to US physician acceptance of electronic health records (EHRs) is high cost, due in no small part to the multitude of insurance forms, unique electronic access needs, and various other requirements of the US system. Who in their right mind would want to gamble $20,000 to $40,000 of their own money for a computer program that might not interface with the many different programs used by their vendors—today or next week?

Patients' acceptance of EHRs is also hindered by certain obstacles. For example, some patients with high health risks will not accept EHRs if they feel that their use will lead to greater medical costs, increased life insurance rates, and reduced job security. (Some companies may "let go" employees who have a larger apparent medical risk.)

Another patient concern with EHRs is identity theft. In the event of a data breach in your EHR system, are you prepared to pay the average $200 cost per patient medical record for patient notification, restitution, and credit monitoring?[2] Are you comforted by the fact that the US Department of Health and Human Services does not require the reporting of breaches affecting fewer than 500 people?[2] The "external chart reviews" and "clinical support systems" required for EHRs by the laws of federal and state governments and the guidelines of professional organizations add layers of cost for physicians.

The contribution of EHRs to improvement of patient safety is primarily dependent on their ability to improve the extraction of outcome data on populations using various drugs, procedures, medical devices, and other treatments. Thus, EHRs will be resisted by various economic interests threatened by this improved ability.

For myself, an acceptable EHR system would include the following features:

- ☐ ability to import my office visit templates onto an electronic tablet
- ☐ ability to carry forward patients' previous medical and surgical histories, medications, and hypersensitivities to new office visits

- a laser pencil attachment to the headpiece microphone that, when shined on a particular blank space on the office visit template, will insert spoken words in written form (This capability presumes a more highly functional voice-to-writing feature than the previous 2 versions of Dragon NaturallySpeaking [Nuance Communications Inc, Burlington, Massachusetts] that we have tried.[3])
- a program that keeps score of inputted data for the day's office visits to tally whether enough "bullets" have been documented to satisfy evaluation and management, or E/M, level-of-care codes (eg, 99213, 99214, 99215)
- a feedback mechanism at the end of the office visit template that automatically tells you how many more "bullets" you need for a particular level of service
- an updateable library of *International Statistical Classification of Diseases and Related Health Problems* codes
- ability to automatically extract billing information to be sent to the appropriate insurance vendor after appropriate review
- ability to interface with EHR systems of all insurance carriers. This is a major stumbling block for EHRs in the fractured, disjointed US health insurance system
- ability to easily interface with systems of all laboratories
- data encryption that does not require "a full-time nanny" (ie, IT specialist)
- ability to transfer a patient's medical summary, laboratory test results, and procedure reports to a personal database the size of a credit card
- meeting of all Health Insurance Portability and Accountability Act requirements
- patients' medical data in a searchable matrix form, so that office, community, and national outcome studies can be performed
- not being cost-prohibitive in terms of either time or money

The reason that US physicians are hesitant to accept EHRs has nothing to do with whether they know how to use their personal computers, tablets, and smartphones. Rather, US physicians sense that this EHR boat is not yet ready to sail, except for large organizations that have their own on-site IT staffs.

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2. Dolan PL. Small medical practices are greatly at risk for data breaches. *American Medical News*. January 16, 2012. http://www.ama-assn.org/amednews/2012/01/16/bil20116.htm. Accessed March 30, 2012.

3. Singer N. The human voice as game changer. *New York Times*. March 31, 2012. http://www.nytimes.com/2012/04/01/technology/nuance-communications-wants-a-world-of-voice-recognition.html. Accessed March 31, 2012.

Osteopathic Medical Students' Beliefs About Osteopathic Manipulative Treatment at 4 Colleges of Osteopathic Medicine

To the Editor:

I just finished reading the interesting medical education article by Brian B. Draper, DO, and colleagues in the November 2011 issue of *JAOA—The Journal of the American Osteopathic Association* ("Osteopathic Medical Students' Beliefs About Osteopathic Manipulative Treatment at 4 Colleges of Osteopathic Medicine." 2011;111[11]:615-630). The results of the authors' survey on osteopathic medical students' attitudes toward osteopathic manipulative treatment (OMT) were depressing indeed. Although Dr Draper and his coauthors present several conclusions as to why a growing number of graduates of colleges of osteopathic medicine (COMs) may not be using OMT in their clinical practices, at least 1 important factor was not assessed in their survey—namely, the type and quality of the OMT currently being taught in COMs. The authors assume that all forms, techniques, and theories of OMT being taught in COMs are of equal value and, hence, equally valid. I contend that this assumption is not necessarily correct. Furthermore, I suspect that much of what is being taught to first- and second-year osteopathic medical students may actually have a detrimental impact on their decisions regarding whether to use OMT in their clinical practices after graduation.

I am a 1975 graduate of A.T. Still University-Kirksville College of Osteopathic Medicine (known simply as Kirksville College of Osteopathic Medicine [KCOM] back then). The primary focus of my OMT classes at KCOM concerned structural diagnosis and treatment using high-velocity, low-amplitude (HVLA) techniques. To be sure, other forms of OMT were also taught, including such esoteric and pseudoscientific treatment regimens as "cranial manipulation," but the main emphasis during my 2 years of OMT classes at KCOM was HVLA and other direct OMT techniques. Moreover, after I graduated, I continued honing my manipulative skills through informal mentoring with a number of osteopathic family physicians who were highly proficient in structural diagnosis and HVLA techniques. Needless to say, I used OMT regularly and effectively in my own family practice during the next 3 decades.

In 1980, I joined the faculty of 1 of our Midwestern COMs. Being a strong believer in and user of OMT in my own practice, I was immediately assigned to the OMT teaching team. I continued in that role during most of my tenure at the college. Initially, our OMT curriculum consisted of the classic direct techniques, including HVLA, muscle energy technique, and soft-tissue technique—pro-

cedures that would have been familiar to A.T. Still himself. (The scientifically questionable cranial manipulation was offered as an adjunct course to interested students, but it was not part of the college's standard OMT curriculum.)

Sometime in the mid-1990s, more and more unorthodox theories and practices began working their way into our college's OMT curriculum. Such suspect and pseudoscientific manipulative techniques as Chapman reflex, other reflexology techniques, and visceral manipulation eventually became part of our standard curriculum. One faculty member was allegedly even telling students how to "manipulate energy auras"! Along with these questionable techniques, our faculty also began teaching some rather unpleasant manipulative procedures, such as "intraoral muscle energy," "intra-anal coccyx manipulation," and "pelvic spread."

I write all this only to ask a single question: Could the *primary factor* driving our osteopathic medical students further and further away from OMT be our teaching of scientifically questionable and controversial manipulative techniques under the rubric of osteopathic principles and practice? Students choose to study and practice osteopathic medicine for a variety of reasons. However, 1 thing that all students have in common is that they have been steeped in the scientific method and they recognize good ol' *bovine scatology* when they see it.

If the statistics reported by Dr Draper and colleagues are accurate reflections of osteopathic medical students' feelings concerning OMT in all of our COMs—and I fear that they may well be—we as a distinct profession of health care providers will soon be going the way of the snake-oil salesmen and the phrenologists of yore.

William F. Duerfeldt, DO (retired)
Asheville, North Carolina

Thanks, but No Thanks: How Denial of Osteopathic Service in the World Wars Shaped the Profession

To the Editor:

I would like to congratulate Shawn A. Silver, OMS I, on his excellent article on an important but often neglected subject: the history of the osteopathic medical profession ("Thanks, but No Thanks: How Denial of Osteopathic Service in World War I and World War II Shaped the Profession." *J Am Osteopath Assoc*. 2012;112[2]:93-97). His discussion of the struggle of the profession to gain the recognition of the US Military reflected some diligent research.

During World War II, with a mass exodus of allopathic physicians to the military, osteopathic physicians had a golden opportunity to step up to the plate and demonstrate that they did have the "right stuff."

In studying the history of the osteopathic medical profession in Oregon, I have interviewed and written biographies of several retired osteopathic physicians who practiced in small towns during those war years. Their stories of self-sacrifice and devotion to their patients are truly inspirational.

We can justly be proud of our osteopathic heritage, and it warms my heart that students like Mr Silver and others are telling the story. Keep up the good work!

John Stiger, DO
Milwaukie, Oregon

Editor's Note: Dr Stiger's biographies of retired osteopathic physicians in Oregon are available at http://www.opso.org/ under the tab "Stories of Osteopathic Medicine in Oregon."

To the Editor:

I want to congratulate Shawn A. Silver, OMS I, on his outstanding article *Thanks, But No Thanks*, a history of DOs and military service, in the February issue of *JAOA—The Journal of the American Osteopathic Association*.[1] It is right on target, and it is good to see this type of material in print.

Perhaps the viewpoint of someone "who was there" can add emphasis to Mr Silver's thesis. I entered the Philadelphia College of Osteopathy (now the Philadelphia College of Osteopathic Medicine) in 1942, at which time 3 to 4 years of undergraduate study were required for admission. I graduated in the fall of 1945, a course compressed because of the war from 4 years into 3. Up front, admittedly, specific memories alone of more than 70 years can be faded or jaded, but generally overall impressions can persist.

By 1942, the Flexner Report[2] had already wielded its influence on medical education and many changes were evident. The osteopathic profession, in its way, always followed the accepted mode of medical education, and so the training I had was very similar to that of MD schools and prepared me well for medical practice. But it must be remembered that a medical school curriculum is not a medical school curriculum is not a medical school curriculum. Many surveys have shown that allopathic schools, all giving good training, had divergent emphases and variable assignment of hours for specific subjects. For example, the American Academy of Pediatrics in the late 1940s did a survey that showed that the number of hours of pediatrics taught varied from just a few to many—often depending on the specialty of the dean. So great variations abound between schools, and between MD and DO schools, without impinging on the quality of education. But my medical education in the 1940s was comparable to that of allopathic schools of that day.

Unfortunately, Mr Silver includes in a section centering on the 1940s sev-

eral quotations from Flexner about the poor quality of osteopathic education—comments that Flexner made around 1910, when he did his survey. Our schools were different in 1942.

However, the greatest deficiency, to my mind, was in graduate medical education, especially in osteopathic residency training programs. For example, the Philadelphia College of Osteopathy, which was one of the major osteopathic institutions in the country, had in 1945 one surgical residency but not even one internal medicine residency. This situation was similar across the country. I sought training in pediatrics, and there were just 2 residencies, both in California. Perhaps this is the educational deficiency alluded to by Mr Silver, and it is correct.

This deficiency is important in this issue because, as a result of the lack of specialty training, most of our graduates became general practitioners and went directly into practice. Here is where the failure of the armed forces to accept DOs as physicians becomes an important causative factor in the growth—and ultimate acceptance—of osteopathic medicine. As Mr Silver stated, the rejection of DOs had "unwittingly created the perfect situation for osteopathic medicine to grow exponentially."[1] Many neighborhoods in both cities and rural communities were bereft of MD-physician availability. People then went to "those osteopaths," not because they wanted osteopathic care or because DOs were better physicians, but because there was no other physician available. Some DOs went into practice the day after graduation, others the day after a 1-year internship. And most were flooded with patients—the only doctor sign in the area, friends' recommendations, or a neighbor's reluctant suggestion. So great was the flood that at the universal rate of $2 for an office visit, many "freshman" doctors were reputed to be making $25,000 a year (a lot for those times).

Well, what did they find at these "new doctors"? Mostly competent, mostly friendly, mostly willing practitioners—and with all due praise and honor to these great pioneers, whom we do not thank enough—eventually a satisfactory substitute for their "old family Doc." Thus, osteopathic medicine built up a large and impressive following. To me, that was the most important cause of the booming and explosion of the osteopathic profession, and Mr Silver had it right.

Simultaneously, the osteopathic profession had begun before World War II to follow the lead of allopathic medicine in educating its physicians. This improvement, as pointed out by Mr Silver, was a perfect accompaniment to the huge patient surge, but it was not the cause of it.

I am of the opinion that this discriminatory act of the armed forces—as painful as it was at the time—was almost totally responsible for the growth and success of the osteopathic profession—something that might have come later anyway, but only after more prolonged struggles. And the tremendous spurt in the number of osteopathic patients—and satisfied patients—provided added public support. As they say, "It's an ill wind that blows nobody any good."

At times, I have postulated—as have others—that if the allopathic profession had acted differently, the armed forces could have "devoured" us and either destroyed us or slowed our growth down a considerable number of years.

So, thanks, Shawn, for reminding us of the keystone of our growth and our progress, and for emphasizing this major factor in our lives. Great job!

Arnold Melnick, DO
Aventura, Florida

P.S. Sorry, I cannot verify the World War I factors—I wasn't around.

References

1. Silver SA. Thanks, but no thanks: how denial of osteopathic service in World War I and World War II shaped the profession. *J Am Osteopath Assoc*. 2012;112(2):93-97.

2. Flexner A. *Medical Education in the United States and Canada*. New York, NY: Carnegie Foundation for the Advancement of Teaching: 1910.

Correction

The AOA Division of International Affairs and the *JAOA* regret an error that appeared in the following abstract:

> **Lui M, Lin Y, Chiu B, et al. Comparison of OMM and TCM Tui-Na diagnostic methodology [published correction appears in *J Am Osteopath Assoc*. 2012;112(3):108]. *J Am Osteopath Assoc*. 2012;112(1):53-54. Abstract 843.**

Yen-Yi Ho, CMD, was mistakenly associated with Touro University California, College of Osteopathic Medicine in Vallejo, which is where his coauthors are affiliated. His affiliation should have appeared as the Department of Health at Taipei Hospital in Hsin-Chuang District, New Taipei City, Taiwan.

This correction will be made to both the full text and PDF versions of the abstract online.