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.

A Single, Unified Graduate Medical Education Accreditation System

To the Editor:

In October 2012, the American Osteopathic Association (AOA), together with the Accreditation Council for Graduate Medical Education (ACGME) and the American Association of Colleges of Osteopathic Medicine, announced the proposed unification of osteopathic and allopathic graduate medical education (GME) program accreditation.[1] Some have touted this change as "saving" the profession. However, I fear this merger will cause irreparable harm and will ultimately destroy the osteopathic medical profession for the following reasons:

- I believe many osteopathic GME programs (quality programs) may not meet all of the ACGME standards and will close. We can ill afford to lose even 1 osteopathic GME spot.
- It is my understanding that a number of AOA-accredited teaching hospitals cannot fiscally support ACGME-accredited programs, but they are able to support AOA-accredited programs.
- I believe that starting new programs with ACGME standards will prove more difficult and that fewer programs will be created, especially in non–primary care specialties.
- Accepting MD graduates into AOA-accredited programs takes potential spots from DO graduates.
- Osteopathic GME offers an osteopathic perspective that makes DOs distinctive, and I believe this distinctiveness will be completely lost if the unified GME accreditation system comes to fruition.
- It is my understanding that ACGME-accredited programs do not guarantee more spots for DO graduates (many ACGME programs currently limit the number of DOs or do not accept DOs altogether).[2]
- Accreditation of our programs by the ACGME negates the need for AOA specialty certification, and I believe it will cause a "death spiral" for osteopathic specialty colleges and will ultimately destroy allegiance to the AOA.

It is sadly ironic that the osteopathic medical profession fights vigorously to maintain the DO degree in Texas, yet it is ready to relinquish control of osteopathic GME accreditation to the ACGME.

Richard Terry, DO, MBA

Lake Erie College of Osteopathic Medicine, Erie, Pennsylvania; ArnotHealth, St. Joseph's Hospital, Elmira, New York

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To the Editor:

In October 2012, the American Osteopathic Association (AOA) announced an agreement with the Accreditation Council for Graduate Medical Education and the American Association of Colleges of Osteopathic Medicine to "pursue a single, unified accreditation system for graduate medical education programs in the United States beginning in July 2015."[1] Although I think that this change is necessary, I would like to voice some of my concerns for consideration as this process moves forward.

The biggest concern that I have is that we cannot lose our identity as a profession. Although it may benefit the osteopathic medical profession to have a unified accreditation system for residency programs, I think it is vital and crucial that we maintain our board certification process. We are osteopathic physicians who have a unique philosophy and skill—osteopathic manipulative treatment. We should not lose that identity; it is part of what makes us unique.

If we have a unified accreditation system for residency training, what is the incentive to take the osteopathic board certification examinations? Although I see the necessity of having the unified accreditation system, we still need to maintain our uniqueness as a profession. If we don't maintain our boards or even require osteopathic physicians to take our boards, I fear we will lose our identity. If we give up the right to police ourselves, where will this madness stop?

I ask that the leadership of the AOA strongly consider these concerns as we move ahead. Requiring osteopathic physicians to take osteopathic certification examinations is crucial to maintaining the language, culture, and ultimately the identity of our profession.

Carl Hoegerl, DO, MSc

Geisinger Medical Center, Danville, Pennsylvania

Reference

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Response

The American Osteopathic Association (AOA) is dedicated to advancing osteopathic medicine and promoting the distinctiveness of osteopathic physicians (ie, DOs). Discussions with the Accreditation Council on Graduate Medical Education (ACGME) are limited to a unified graduate medical education system, including maintaining core competencies for DOs in osteopathic manipulative medicine and osteopathic principles and practice. Losing the distinctiveness of the DO degree through a unified system is contrary to the AOA's mission, vision, and purpose.

The number of DO graduates has exceeded the number of available osteopathic graduate medical education (OGME) positions for many years.[1-3] Today there are more DOs training in ACGME residencies than in AOA programs.[4] The proposed unified accreditation system will preserve access to ACGME residency and fellowship training programs for DOs. It will not necessarily guarantee us more spots, but it will ensure that our DOs will continue to have the opportunity to train in allopathic programs, particularly in those specialty areas in which there are few OGME programs. With the continued growth in numbers of both DO and MD graduates, neither the AOA nor the ACGME entered into these discussions to lose training programs.

Our goal is to continue to work with the Bureau of OGME Development and the ACGME to increase the number of osteopathic-focused training programs and to ensure that current OGME programs meet ACGME standards.

If and when the proposed unified system goes into effect, there will be a transition phase. It is envisioned that OGME programs would undergo inspection within 3 years. Both AOA and ACGME leadership believe that the vast majority of programs will meet the requirements on the first attempt, and those that do not would have an opportunity to achieve compliance. Indeed, 30% of osteopathic internal medicine programs and half of osteopathic family medicine programs are already dually accredited.[4,5]

We anticipate the specialty colleges will play an important role in the ongoing evolution of educational standards and milestones for osteopathic-focused residency programs. Furthermore, osteopathic specialty colleges will always provide valuable services, including continuing medical education, communications, professional networking, and advocacy.

Most importantly, the AOA has always believed that osteopathic board certification measures the competence of our DO graduates, particularly with respect to the application of osteopathic principles and practice within each specialty. That is why

ACGME discussions are limited to graduate medical education and do not include AOA board certification. The ACGME is aware of the AOA's position on this matter and knows that the AOA will continue to encourage all DO graduates to take AOA board certification examinations, both now and in the future.

For the most recent updates on the proposed accreditation system, please visit http://www.osteopathic.org/ACGME.

Ray E. Stowers, DO
AOA President

Boyd R. Buser, DO
AOA Board of Trustees; AOA-ACGME-AACOM (American Association of Colleges of Osteopathic Medicine) Joint Task Force

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Doctors Need Hollywood

To the Editor:

Celebrity sells. *US Weekly* and *People* fly off the shelves with the latest celebrity gossip and reality star drama, with print circulations of nearly 2 million and 3.5 million, respectively.[1,2] Unfortunately, the same cannot be said of magazines filled with the latest news on the diseases running rampant in today's society. Is there a solution to making such diseases a bigger part of our conversations? I would like to say yes, to some degree, but the answer remains to be seen. After my 4 years of undergraduate work and 4 more years of osteopathic medical school, I am confident that there are myriad professionals in the medical field dedicated and committed to finding cures for these diseases. The problem comes when these investigators ask for dollars to fund their research.

Why not use celebrity status? Hollywood has the power to sell a product or idea. Give Kim Kardashian a product and I am nearly positive it will sell. Whether it is a cleaning substance, food chopper, or piece of jewelry, those who put their faces on television and the silver screen have an innate ability to get the general population to take an action. These celebrities, whether talented actors or reality television stars, are gifted with talents that allow them access to households across the globe and outlets that members of society cannot hide from.

Why not put these gifts to use for the greater good? We need celebrities to advocate for funding and finding cures for these diseases. Just think of how much coverage Stand Up to Cancer has gotten over the past several years through celebrity telecast events such as the one held this past September with prominent celebrities such as Tom Hanks, Halle Berry, and Justin Timberlake.[3] Consider also the National Football League's A Crucial Catch campaign, which aims to increase awareness of the importance of annual breast cancer screening through pink apparel, ribbons, and other programs every October.[4] A single celebrity can make a big difference, too—for example, The Michael J. Fox Foundation for Parkinson's Research funded $57 million in research for Parkinson disease in 2011 alone.[5]

So yes, nobody really cares that your average Joe has diabetes mellitus, cancer, heart failure, or polycystic kidney disease, but if a celebrity talks about it, especially if he or she has the disease, I am sure the attention would change. Media outlets would cover it, and people would care. People would become interested in helping out and funding would increase.

I ask you, Hollywood and sports celebrities, for your courage in stepping forward and helping us get the help we need to pay it forward to our patients. One small act could have a big impact on someone's life. Borrowing a line from one of my favorite movies, *Field of Dreams*, "If you build it, he will come." I truly believe that if celebrities talk about it, more funding and support will follow.

Adam Bitterman, DO
Orthopedic surgery resident,
North Shore-Long Island Jewish Health System, Plainview Hospital, New York

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Corrections

The *JAOA* regrets an error that appeared in the following article:

Radnovich R. Heated lidocaine-tetracaine patch for management of shoulder impingement syndrome. *J Am Osteopath Assoc*. 2013;113(1):58-64.

On page 59, in the fourth paragraph of the "Report of Cases" section, the dosing schedule for the heated lidocaine 70 mg-tetracaine 70 mg topical patch administered to patient 1 was incorrectly stated as "initially twice per day, applied to the most palpably painful area on her shoulder for 3 to 4 hours per week and then tapered to as-needed use during the course of 4 weeks." Instead, this line should have stated that the patch was applied "to the most palpably painful area on her shoulder 3 to 4 hours twice daily for 1 week, and the dose was subsequently tapered over the course of the following 4 weeks to as-needed use."

In addition, the *JAOA* and the authors regret an error that appeared in the following article:

LaSalle JR, Berria R. Insulin therapy in type 2 diabetes mellitus: a practical approach for primary care physicians and other health care professionals. *J Am Osteopath Assoc*. 2013;113(2):152-162.

On page 159, in the paragraph immediately before the "Conclusion" section, the number *.087* was incorrectly identified as a *P* value. The number should have appeared as an adjusted mean difference from analysis of covariance. The sentence should have appeared as, "Statistical noninferiority for the adjusted difference in HbA_{1c} levels at the study completion, however, was observed in a subgroup analysis of covariance of patients with a HbA_{1c} level of 8% or less at randomization (0.087: 95% confidence interval, −0.175 to 0.349)."

These corrections will be made to both the full text and PDF versions of the articles online.