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.

Evidence-Based Medicine and Osteopathic Medicine: No Paradox

To the Editor:

Parker puts forth some interesting ideas in his November 2014 editorial, titled "Reversing the Paradox: Evidence-Based Medicine and Osteopathic Medicine."[1] He asserts that evidence-based medicine is a particular way of using data to determine clinical care, it is a normative system, and it is a conscious decision to choose the benefit of many over time at the cost of the individual. He also asserts that the risk-benefit of a large population is at the heart of the evidence-based model of clinical decision making. In contrast, osteopathic medicine traditionally puts the individual patient at the heart of clinical decision making. By continuing to embrace our focus on the individual patient, osteopathic medicine can reverse Howell's so called paradox of osteopathy.[2]

The primary weakness of Parker's editorial is that he does not define *evidence-based medicine*. The description explored in the original 1992 article[3] is not exactly congruent with Parker's version. For a clear definition of evidence-based medicine, I highly recommend an 1996 editorial published in the *British Medical Journal*,[4] which includes the following statements:

- "Evidence based medicine is the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients."
- "Good doctors use both individual clinical expertise and the best available external evidence, and neither alone is enough."
- "External clinical evidence can inform, but can never replace, individual clinical expertise, and it is this expertise that decides whether the external evidence applies to the individual patient at all, and if so, how it should be integrated into a clinical decision."
- "Evidence based medicine is not restricted to randomised trials and meta-analyses."

I have previously made the case that the axiom "You treat what you find" from osteopathic medicine's founder, Andrew Taylor Still, MD, DO, is compatible with modern evidence-based medicine.[5] What Still and evidence-based medicine have in common is a critical attitude toward interpreting published reports and applying what works to the individual. In other words, evidence-based medicine as originally conceived is not in conflict with individualized care, nor is it in conflict with the practice of osteopathic medicine.

However, I must concede some ground to Parker and admit that how evidence-based medicine is often applied these days gives validity to his argument. I remember discussing patient care with an accomplished internal medicine resident near the end of his training. The conversation wandered into evidence-based medicine, and I started talking about the definition of the term and the ideas cited above. He looked me in the eye and said, "I have never heard of that before."

Although I don't believe in Howell's paradox,[2] I pretty much agree with Parker's

prescription. According to Howell,[2] the paradox is as follows:

> If osteopathy has become the functional equivalent of allopathy then what is the justification for its continued existence? If there is value in a therapy that is uniquely osteopathic (osteopathic manipulation), then why should it be limited to osteopaths?

I suppose if we as osteopathic physicians all abandoned our heritage, principles, and drive for excellence, then the paradox has validity. However, I do not see either Coca-Cola or Pepsi throwing in the towel anytime soon because they have similar products. Both Wendy's and McDonald's make hamburgers, but I believe there is a difference in their products. The United States Marine Corps maintains its distinctiveness, even though their equipment and mission overlap with other service branches. Entities such as these maintain their distinctiveness through competition, by making a better product, and by cultivating a heritage of excellence.

I hope others learn to use osteopathic techniques to help patients. This would enhance the prestige of the profession. A person is distinctive when he or she does something better than everyone else. One thing I learned from Gevitz's recent series tracing the development of the DO degree is that it is the value we put into the degree that makes the profession strong and unified.[6,7] So, although I do not believe in the paradox, I do agree with Parker that we should do more to embrace and cultivate our tradition of focusing on the individual patient.

Parker also says there is overwhelming evidence that osteopathic manipulative medicine (OMM) helps patients. I assume he means there is an abundance of anecdotal evidence. But this is the weakest evidence in the evidence-based hierarchy. In my opinion, OMM will never be widely used with this kind of evidence for a foundation. I do not believe OMM falls victim to evidence-based medicine's strict standards—it falls victim to inadequate funding. Historically, the American Osteopathic Association (AOA) awarded approximately $300,000 annually for research projects, which typically goes to OMM or osteopathic manipulative treatment studies. Because of inadequate funding we lack adequate fermentation and career researchers to change the paradigm.

At present, the AOA is currently reevaluating its research program and expects to have new funding opportunities available later this year. However, to change our current state of research will require a dramatic increase in funding by the AOA. We need enough funds to support a critical mass of career-oriented researchers at multiple institutions. By this I mean, enough money to fund a $100,000 project at each of the 30 colleges of osteopathic medicine yearly, or about $3 million per year. These grants should be merit based, not necessarily distributed evenly among the colleges or other qualified institutions. These grants should also be focused on projects exploring applications of osteopathic philosophy or practice. If we spend these funds on other worthy research topics, then we will not reach the critical mass needed to change the current paradigm. The American Cancer Society focuses on cancer research and the Michael J. Fox Foundation focuses on Parkinson disease research, so it makes sense for the AOA to focus on things related to osteopathic principles and practice. It will require this level of investment for funding agencies external to the profession to take notice of and support OMM-related research on a larger scale. (doi:10.7556/jaoa.2015.024)

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Professionalism Score and Academic Performance: With Objective Measures of Professionalism, Do We Measure What We Want to Measure?

To the Editor:

In the November 2014 issue of *The Journal of the American Osteopathic Association*, Snider and Johnson[1] described the correlations between an objective professionalism score and academic performance in first- and second-year osteopathic medical students. These correlations are of grave importance, as lack of professionalism may be a predictor for future unprofessional performance.[2] These correlations give us as educators the means to identify "problem learners" as soon as possible in their careers and facilitate corrective actions in due time.

However, we need to be humble, gentle, and patient with our students. The threat of pigeonholing exists, especially when it concerns objective professionalism scores. We have to ask ourselves whether we measure what we want to measure. Do we measure professionalism in objective professionalism scores? And do we measure it objectively?

Words are important. First, the items in the professionalism score described by Snider and Johnson[1] all cover behavior. When students do not arrive on time or do not dress in appropriate attire, they demonstrate unprofessional behavior. However, this behavior does not necessarily mean unprofessional inner virtues and attitudes. Professionalism and professional behavior may be 2 sides of the same coin, but they are not synonymous. I believe the extent to which these 2 concepts relate to one another requires further research.

Second, can we measure professional behavior or even professionalism objectively? I have reservations with the term *objective*. Professionalism is not something absolute, and behavior is always open to a number of different interpretations. In one context, behavior may be seen as professional, and in a different context, the same behavior may be assessed as unprofessional.

I thank Snider and Johnson[1] for showing the correlation between unprofessional behavior and academic performance. However, I caution us to be humble in what we think we measure in our students. (doi:10.7556/jaoa.2015.025)

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