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.

Osteopathic Graduate Medical Education: A Way Forward

To the Editor:

The July 2013 refusal of the Board of Trustees of the American Osteopathic Association (AOA) to accept unification under the proposed memorandum of understanding from the Accreditation Council for Graduate Medical Education (ACGME) is the best outcome the osteopathic medical profession could have hoped for. As I described in a March 2013 letter to the editor,[1] the underlying premise of relinquishing our accreditation process to the ACGME was flawed from the beginning. This line of inconsistent thinking is outlined by Thomas J. Nasca, MD, in his July 2013 letter in response to the AOA's refusal to ratify the ACGME's proposed memorandum of understanding.[2] His implication is that quality in graduate medical education (GME) is somehow bestowed by the accrediting body; it is not. If this were indeed true, then our current US hospital accreditation process, in which hospitals independently choose their accrediting body, should be questioned as well.[3] If the ACGME and Dr Nasca were fully committed to fostering an environment that is diverse, welcoming, and inclusive of the osteopathic medical profession, then they would not hold the continued participation of osteopathic residents in ACGME fellowship positions in contention.

Improving quality and safety in the arduous task of training physicians knows no arbitrary time limit nor requires 1 single accrediting board. There is no reason both the AOA and the ACGME cannot coexist as separate accrediting bodies while collaborating on innovations such as the ACGME's new accreditation system and other outcome measures that improve training.

Unified accreditation with the ACGME is not the answer. The osteopathic medical profession has a long history of resiliency, and with our new adversities we will continue to persevere. We must define our own destiny, beginning with a cogent strategy on how to avert the impending crisis in osteopathic GME. Although there are no simple solutions to the challenges we face, the following suggestions are a start:

- Colleges of osteopathic medicine (COMs) must work together in an environment of collaboration to create more osteopathic GME opportunities. This collaboration can be accomplished by working hand in hand with nonteaching hospitals and alternative sites such as teaching health centers and large medical groups. Our COMs need to be aggressive and held accountable in developing new opportunities for our graduates. According to my estimates (based on the number of graduates and the percentage typically enrolling in the ACGME match), we need at least a 20% increase in first-year positions annually (580 new positions per year) from our current number of 2900 over the next 5 years.
- Each COM must have its own osteopathic postdoctoral training institution (OPTI). With 29 COMs operating in 37 sites[4] but only 21 OPTIs,[5] we must be smarter about how we allocate resources and define who we are. The comparatively small number of OPTIs has enabled multiple COMs to claim the same GME spots as their own. In some

cases, according to my observations, this set-up has led programs to double and even triple dip into another OPTI's spots. Each COM's OPTI must be responsible for its own COM's graduates and should not be allowed to join a different OPTI.

- The AOA must aggressively pursue osteopathic accreditation of ACGME fellowships that have historically accepted COM graduates. A facilitated accreditation process must be developed toward "osteopathic friendly" allopathic fellowships without additional costs to the program. These programs want our graduates because of their high quality. This relationship will mitigate the loss of any fellowship opportunities as a result of the ACGME's discriminatory proposal not to accept graduates from osteopathic residency programs to their fellowships.
- In addition, the osteopathic medical profession must support legal action against the ACGME in any and all instances of discrimination against residents trained in AOA-accredited programs who are denied acceptance into ACGME residencies or fellowship training programs.
- As a profession, we must promote our strengths to the government. Osteopathic physicians already play a significant role in providing primary care in the United States, and with our continued growth, our position will only increase. The Affordable Care Act, with its emphasis on cost savings and preventive medicine, is a gift to the osteopathic medical profession. More than 60% of osteopathic physicians are in primary care,[6] a percentage that is no doubt higher than that of allopathic physicians. This status provides osteopathic physicians leverage with Congress. I believe that osteopathic medicine is in line with the health care needs of this country,[7] whereas our allopathic counterparts continue to produce an excess of specialist physicians that drives health care costs higher and does nothing to alleviate the access to care issue.

Osteopathic GME is at a critical juncture. Unless there is a concerted effort to substantially grow osteopathic GME and strategic planning to further expand, our profession will soon face the grim reality of not having enough opportunities for our graduates and the possible extinction of the osteopathic medical profession as we know it. (doi:10.7556/jaoa.2013.064)

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Editor's Note: For more information regarding this topic, visit http://www.osteopathic.org/acgme.

(continued)

On the Oft-Debated Question of What It Means to Be an Osteopathic Physician

To the Editor:

I am an emergency physician in active practice. I graduated from Des Moines College of Osteopathic Medicine and Surgery (now Des Moines University College of Osteopathic Medicine) in 1983. I have been a preceptor for osteopathic medical students for many years. I have heard their laments and complaints. They work with me at all of the odd hours, including the wee morning ones when everyone else is sleeping. They learn that the emergency department is a safe place to ask uncomfortable questions. So they ask and I echo their existential question: DO? So what?

They ask me what it really means to be an osteopathic physician. I would like to re-ask that question, providing them cover. So let's start with heresy.

Being a DO is not about skeletal manipulation. I will repeat myself, taking the coward's cover of opinion: osteopathic manipulative medicine (OMM) is not primary.

There, I have said it and am a heretic. And I am certain I will have a lot of company.

Let's visit the negative aspects first; that is easiest. If we are all about manipulation as a primary identity, then we are osteopath-chiropractors. If manipulation is our primary identity, then we are not "physicians trained in the osteopathic philosophy," and we give our patients less than they deserve.

Let's review some admittedly revisionist history to understand where we are. Andrew Taylor Still, MD, DO, the founder of our profession, had some problems with then-conventional medicine.[1,2] After the Civil War, he sought the cause of the death he witnessed and determined it to be "the ignorance of our 'Schools of Medicine.'"[2(p92)] He taught his students his own philosophy of medicine and, recognizing that his system was "different and better that the traditional practice of medicine," selected the DO degree.[1(p7)] This branding—DO instead of MD—served at the time as a beacon for medical care that, by current standards, might not help, but at least it would not harm!

In this setting, with an oath to do no harm, providing patients comfort was the least the DO could do. And here the development of OMM made perfect sense: we may not always cure but we can always provide care and comfort.

A good half century later, Abraham Flexner rightly castigated virtually all medical education.[3] Osteopathic and allopathic schools had to change, and although most did, some died. The central tenets of osteopathic medicine kept an occasionally anemic flame alight; today it glows strong.

And that brings us to the positive aspects. The concept of a holistic approach, long a central osteopathic but controversial allopathic concept, has clearly come to fore. A wariness of drugs, likely the fulcrum of Still's revolution, is now de rigueur. Viewing the patient within the framework of his or her family and environment rather than as an isolated diseased organ is so accepted as to beggar discussion. Within my memory, these were not well-accepted allopathic concepts, yet they were ever accepted osteopathically.

And so, today we face a new challenge: managing success and assuring our students that they have a unique, valuable identity and contribution. And here is where I submit that osteopathic philosophy is the winner of our identity. We must figure out how to leverage our philosophy, especially for our students, who are our professional future.

As I close my third decade as a DO, I would like to see a wider conversation on what it takes to be a DO in the modern world. I submit the following, not nearly exhaustive, not nearly rank prioritized list:

- excellence in patient care
  - primacy of the patient-physician relationship
- excellence in medicine
  - always an awareness of the patient's wishes and life philosophy
- excellence in the use of diagnostics, always having a relevant question before ordering an answer (ie, test)
  - respect for borders—personal, professional, and societal
- excellence in anatomy and physiology, keeping in mind the inherent healing ability of the body
  - awareness that the patient cures himself or herself and that physicians just help
- excellence in the use of chemicals, making no excuses for sloppiness and avoiding nocebos

- constant advocacy for our patients, speaking ever truth to power
- excellence in choosing therapeutic modalities, including the use of OMM when indicated
- ensuring that modalities chosen, including medications, are appropriate for this patient at this period of his or her life
- excellence in caring—always

If there appears to be a theme—that of excellence—that perception is correct.

The 1 consistent lament I hear from the students I have been privileged to precept these many years is despair at poor diagnostic skills and impoverished logic they witness in training in the therapeutic selections made by preceptors, whether DOs or MDs. I think we can do better; we owe this much to our future. I was the beneficiary of such teaching early on.

The primacy of good science and patient care was and is and should be the central guiding principle of medicine, especially osteopathic medicine. (doi: 10.7556/jaoa.2013.065)

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Correction

The authors regret an error that appeared in the following 2013 American Osteopathic Association Research Conference abstract:

Qureshi Y, Song W, McInnis R, et al. Reliability of the diagnosis of thoracic outlet syndrome [abstract P6]. *J Am Osteopath Assoc*. 2013;113(8):e6-e7.

The last name of the fifth author incorrectly appeared as Nowhaktar. The fifth author's name is Tara Nowakhtar, BS. This change has been made to the full text version of the abstract online.