As the scholarly publication of the osteopathic medical profession, JAOA—The Journal of the American Osteopathic Association encourages osteopathic physicians, faculty members at osteopathic medical colleges, students, and others—as consistent with the mission of the JAOA—to submit their comments to the JAOA.

Letters to the editor are considered for publication if 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 copyediting. On request, the corresponding author is responsible for providing the editor with photocopies of referenced material.

JAOA encourages its readers to submit letters electronically to jaoa@osteopathic.org. When sent by mail or fax, letters must be typewritten and double-spaced. Except in rare instances, the text of a letter should not exceed 500 words and should not include any more than five references and two tables or illustrations.

Letter writers must include their full professional title(s) and affiliation(s), complete address, day and evening telephone numbers, fax number(s), and e-mail address(es). Letter writers are responsible for disclosing financial associations or other possible conflicts of interest.

Although JAOA cannot acknowledge the receipt of your letter, we will notify you if the letter has been accepted for publication. Rejected letters and illustrations will not be returned unless accompanied by a self-addressed stamped envelope.

Address letters to: Gilbert E. D’Alonzo, Jr, DO, Editor in Chief, JAOA, American Osteopathic Association, 142 E Ontario St, Chicago, IL 60611-2864. E-mail: jaoa@osteopathic.org. Fax: (312) 202-8204 or (312) 202-8466.

In Opposition to Resolution 42

To the Editor:

Resolution 42 (A/2000), also known as the “hardship resolution,” was enacted in 2000, allowing DO graduates to apply for credit from the American Osteopathic Association (AOA) during or after completing a non–AOA-approved internship or residency. To qualify, graduates are required to demonstrate a significant hardship due to “unusual or exceptional circumstances.” Specific eligibility criteria include physical or mental disability, legal restrictions tying a DO to a certain geographic area, and service in a federally designated health profession shortage area or in a specialty for which no AOA programs exist.

The spirit of this resolution is to allow DO graduates to remain “part of the osteopathic family” if, for legitimate reasons, the student had no choice but to select allopathic over osteopathic residency training. Applications for approval are submitted to the AOA Division of Postdoctoral Training. Final AOA approval of an application under this resolution satisfies the requirement for an AOA-approved internship and for eligibility for osteopathic specialty certification eligibility.

Unfortunately, there is ongoing widespread abuse of this hardship exception. According to AOA records, since 2000, only 4 of 400 applicants for this exception have been turned down, a mere 1% of all applicants. This is despite opposition from Osteopathic Postdoctoral Training Institute (OPTI) leadership, at least in New York and Pennsylvania, to many of these applications, as “groundless” (verbal communication-OPTI leadership). In states where there is a multitude of quality AOA-approved training programs, the routine granting of hardship exceptions is alarming and particularly difficult to understand.

According to osteopathic medical school students, one allopathic hospital in New York reportedly informs DO applicants to their internal medicine residency that Resolution 42 is always available to them and that “all 11 of their DO residents” that applied for the exception have received it. This is despite several competing, fully accredited AOA-approved internal medicine residencies available within miles from this community hospital. Interestingly, this particular facility does not accept DO students for third-year clerkships, while readily accepting allopathic medical students.

A Pennsylvania hospital has even reported that a DO received the hardship exception, though he was offered an AOA-approved fast-track internship position, in the same discipline, at the same hospital! Certainly, this is not what anyone had in mind when Resolution 42 was implemented.

Olive Hayes III, DO, MHSA, at the Michigan State University College of Osteopathic Medicine, East Lansing, has reported that DO graduates who participate in dually certified AOA/ACGME (Accreditation Council on Graduate Medical Education) programs are as likely as those in AOA-only programs to become AOA certified and AOA members. (J Am Osteopath Assoc. 2004;104:82-86) This important study points out the importance of keeping DOs in AOA-approved training programs, including those that are dually approved.

The blatant abuse of Resolution 42 is a threat to AOA– and dual–approved programs. We are providing ACGME-only programs a recruitment weapon to use against our approved programs. This is tantamount to handing a burglar a weapon, knowing he will use it against you. There are no data that DO graduates granted the Resolution 42 hardship are any more likely to become AOA board-certified, or to become long-term AOA members, than if they were not granted this exception. To the contrary, given this free pass, DO graduates may be even more likely to turn their backs on osteopathic medicine.

The assumption by some that ACGME-accredited programs are uniformly superior is unfounded, especially as many ACGME-accredited programs are based at the same hospital as AOA-approved programs. American Osteopathic Association-approved (or ACGME-accredited) programs with quality issues need to be beefed up or closed. Resolution 42 neither addresses nor solves that problem.

In conclusion, though well-intentioned, Resolution 42 is being grossly overused. Its policy is counterproductive for the osteo-
pathic medical profession and our graduate medical education programs. To build more programs, including dually approved AOA/ACGME programs, with willing partners, this resolution should become more the exception and less the rule. We should immediately suspend this resolution and the process by which AOA credit is granted until this can be studied further and the standards properly enforced. The future of our osteopathic training programs may depend on it.

Kenneth J. Steier, DO, FACOI, FCCP
Corporate Safety Officer
Associate Professor
Director of Pulmonary Care Unit
Director of Medical Education
Program Director, Dual-Approved Internal Medicine Residency
Nassau University Medical Center
East Meadow, New York
Clinical Assistant Dean
New York College of Osteopathic Medicine
Old Westbury, New York

Response
Resolution 42 (A/2000), Approval of ACGME Training as an AOA-Approved Internship, was approved by the American Osteopathic Association (AOA) Board of Trustees in July 2000. Currently, 486 applications have been reviewed and acted on by the Executive Committee of the Council on Postdoctoral Training and recently by the Program and Trainee Review Committee. This equates to approximately 122 applications reviewed annually since adoption of Resolution 42 by the AOA Board.

Dr Steier is correct in describing Resolution 42 as intending to deal with such issues as students’ financial hardships, family situations, and geographic issues due to lack of availability of AOA-approved internship programs. Each application is reviewed separately based on such parameters. Documentation is provided by applicants, though personal documentation of this sort is uncomfortable to request and review. However, the committee has attempted to adhere to this policy. In addition, applicants are required to follow the correct rotational requirements of the AOA-approved internship.

In reviewing the data, we find that 374 applicants for Resolution 42 remain in an internship or residency and therefore are not yet eligible to be included in data regarding AOA board certification. In addition, of 243 approved applicants, 189 maintained AOA membership, and of 108 applicants who completed training, 10 are AOA board certified.

Dr Steier writes that Resolution 42 is “grossly overused, counterproductive for the osteopathic medical profession and our graduate medical education programs, and tantamount to handing a burglar your weapon, only to have him use it against you.” Let us examine more closely the data regarding DO graduates in the two states mentioned in his letter (New York and Pennsylvania). During this 2003–2004 training year, New York has 712 DOs currently in programs accredited by the Accreditation Council on Graduate Medical Education (ACGME), while Pennsylvania has 713 DOs currently in ACGME-accredited programs. During all 4 years of Resolution 42 activity, 34 applications from students in New York in ACGME-accredited programs were reviewed and 32 were approved. During the same 4-year period, 41 applications from students in Pennsylvania were reviewed and 39 were approved. Thus, those states registered 1425 DOs in ACGME-accredited positions, of which 71 were approved. It appears that these students made a choice to enter ACGME-accredited programs, as only 5% of them requested AOA approval and the option to remain within the osteopathic family with osteopathic-related options in the future. Should those 5% be criticized and refused consideration over the 95% of osteopathic medical students who never so much as requested AOA approval or presumed to care?

I do not believe Resolution 42 to be counterproductive, and therefore, I do not support suspension of the resolution. While we continue to study further, our students continue to speak and act.

Michael I. Opipari, DO
Chairman
Council on Postdoctoral Training
American Osteopathic Association

Conclusion of Frequently Used Unsupported by Data

To the Editor:
I question the conclusion cited by Boyd R. Buser, DO, et al in the article “Osteopathic Emergency Physician Training and Use of Osteopathic Manipulative Treatment” (J Am Osteopath Assoc. 2004;104:15-21). The authors conclude that osteopathic emergency physicians frequently use osteopathic manipulative treatment (OMT). Table 3 of the same article cites frequency of use among the 944 respondents as daily, 11.4%; weekly, 16.8%; monthly/rarely, 26.7%; and never, 45%. It seems to me that the rarely-never group cited at 71.7% is the dominant number and thus the conclusion should state that most osteopathic emergency physicians rarely or never use OMT.

I wonder whether the authors’ conclusions are nothing more than wishful thinking, for certainly the conclusion they drew is not supported by their own statistics.

Robert M. Smith, DO, FACOI, FACC
Brentwood, Tennessee

LETTERS