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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 the *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.

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**The Hospitalist: A Patient-focused Paradigm?**

To the Editor:

To be American means to long for a past that never occurred and to yearn for a homecoming to a place that never existed. There was never a time when every household was a variation of Huckleberry Finn’s, every family lived in a rambling Victorian house, a mother’s biggest problem was whether to serve ham or roast beef at the family’s Sunday dinner, and going to work meant strolling down the block to open a shop on Main Street. There were Americans who had some part of these scenarios in their lives, but for every one of them, there were a million others who did not dare dream of such things.

Part of our collective fictive memory as Americans is the image of the family physician: Born at about 60 years of age but never reaching 61; plain-speaking and always in good humor but secretly passionate about his patients; possessing “aw-shucks” simplicity, yet a veritable medical genius; never sleeping (there were babies to be delivered at 2 AM in every heavy storm); never taking a vacation, never taking a fee (“Why, Mrs. Smith, that apple pie will be just fine as payment for Tommy’s brain tumor operation.”); a surgeon, neurologist, cardiologist, podiatrist, obstetrician (women had no need of gynecologists in those days); a psychiatrist, psychologist, philosopher, and conscience; as adept at curing a cow as he was at healing a headache; who knew his patients better than they knew themselves (“Don’t you worry about new Baby Sally. Now, Joe, don’t forget, I delivered you’re great-grandmother on just such a night as this.”).

The old family doctor never existed, of course, but as with all the great myths of mankind, this myth does reflect some bits of reality, some nuggets of fact around which the yarn is skeined.

The truth is that although physicians did not and could not live up to this image, they wanted to, and their patients wanted it of them. This ideal drove many young men and women to medical school in the first place, and, believing that their doctor could be all this, many patients trusted their family physician without question in matters they might trust otherwise only to a spiritual adviser.

The practice of medicine has changed significantly through the years, and physicians and patients have changed their expectations of each other. We now live in an age of signs and wonders; promising patients a diagnosis and treatment before there is a disease; patients’ expectation to be preserved from mortality. Physicians, straining to keep up with the rising tide of medical information now available, expect patients to trust their judgment, while patients having far greater access to medical information than ever before, expect physicians to provide the latest and greatest in treatment, and sometimes fades.

One aspect remains the same, however: As in the Ol’ Doc’s day, patients still want to be cared about, not just cared for, and caring physicians want to serve their patients, not just provide a service for pay. This has always been and continues to be the particular concern and strength of the osteopathic approach to patient care.

Enter the hospitalist.

The hospitalist practices a specialty that is now approximately 8 years old and that is becoming increasingly prominent in clinical circles. Broadly speaking, a hospitalist is a physician who specializes in supervising patient care during a hospital stay: he or she receives the patient from the family physician, becomes that patient’s personal care physician as that patient’s primary care physician for the duration of hospitalization, and returns the patient to the care of the family physician on the patient’s release. In other words, the concept of a patient’s primary care physician as that patient’s personal medical adviser and the manager of his or her total health program has received another blow. Primary care has been redefined once again. These physicians’ ever-diminishing circle of care will soon dis-
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Second, the trend to hospitalists seems part of the movement away from the holistic big-picture approach to care of the patient that led to a crisis in the ranks of primary care physicians. Lisa Sanders, MD, has noted that although one third of her medical school class (1996) had planned to go into primary care, that number has been cut by one third.1

“Some doctors and other critics say that primary care is just a remnant of an earlier time in medicine and that we are simply witnessing the end of a type of doctoring, like bloodletting or cupping, whose time is over,” she wrote. Maybe. But there is some evidence that this is not the case. In the United States, people with means are willing to pay for what they want in healthcare, and a recent trend suggests that what people want is my Ol’ Doc James. In today’s healthcare system, a patient may pay an annual fee of between $1,000 and $10,000 to retain a physician who is available as needed. Sound familiar? It’s television’s Marcus Welby repackaged as luxury primary care.

Hospital rounds, requiring travel, extended time, and the annoyances involved in overseeing patients in the hospital setting, cannot compare with having patients file into an examining room all day. Further, though we walk about with videophones strapped to our belts like Buck Rogers able to summon up files, charts, and other information with a touch of a button, we still must ask how a hospitalist—the way a car mechanic might send an alternator off to be rebuilt and returned—doesn’t seem to fit comfortably into our notion of care for a person’s wellness.”

Americans are a nostalgic lot. We long for a time that was more humane, more personal, a time when each person mattered, relationships meant something, and people trusted, more, believed in their physician. The hospitalist model, as convenient as it is for the family physician in his or her office and the accountant in the boardroom, leaves the patient dependent on the kindness of strangers.

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Bridging Perspectives,
but Regretting Demise of Internship

To the Editor:

I read with interest the letter by Adam B. Smith, MSIV, and the response by Michael I. Opipari, DO, reflecting on the philosophy of internship (J Am Osteopath Assoc. 2004;104:230, 231, respectively). I agree with the authors that the vagaries of state licensure prevent the medical profession from exerting control in the type of licenses issued, as well as how and where issuing occurs. The medical student, Adam Smith, makes a good point when he notes that an internship at that stage of training seems redundant and a waste of a year just so that one can gain

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access into his chosen specialty sooner. However, I believe there are many points to be made about the value of an internship, and I am sad to see that it has virtually disappeared from the medical landscape.

The internship, particularly the rotating internship, provides new medical school graduates with the opportunity of having minimally supervised care of patients that is not reflected in their medical school training. This opportunity provides the time needed to gain both diagnostic and therapeutic skills, as well as exposure to disciplines that physicians entering specialty care may never encounter again.

As a subspecialist, I find nothing more frustrating than to have a patient referred to me by a well-intentioned primary care physician who has no concept of the disease processes with which I am dealing, nor the therapeutic modalities that are available. In such a scenario, patients may also be given misinformation or, worse, poor advice. Therefore, another valuable result of the internship is that it allows new medical school graduates with the opportunity of having minimally supervised care of patients that is not reflected in their medical school training.

The most important result of having completed the internship is that it gives the new graduate time to develop communication skills that may be used when interacting with patients, colleagues, and the community at large. As physicians gain time in practice, communication skills learned during their internship may help to prevent them from being engaged in a malpractice situation.

I agree with the premise of both gentlemen’s letters about this difficult question. In any case, I sincerely wish soon-to-be Dr Smith the greatest luck in his chosen profession.

Should DOs Be More Birdbrained?

To the Editor:

Hundreds of years ago, Lao Tzu encouraged followers to seek enlightenment by emulating nature. Two hundred years ago, Andrew Taylor Still, MD, DO, incorporated natural processes into a system of medical care that promotes the body’s ability to heal itself. Today, zoologists are studying birds to gain additional energy advantages and opportunities both would miss by operating alone. In healthcare delivery, results of studies show that the care outcomes of patients after myocardial infarction were better when both primary care physicians and subspecialists provided care than when either specialists or primary care physicians alone treated these patients.

Medical executives face management decisions akin to those faced by birds, for example, whether to continue operations in the current fashion, which are productive but possibly declining, or to change the method of operation or even to relocate. Corvids’ use of food sources—caching, advertising, collaborating, and even sharing scarce nourishment—is biologically unorthodox, providing a rich model for executives. After ravens discover abundant food, rather than returning to that source, they often continue searching farther away, resulting in greater risk but producing long-term sustainability. Another behavior related to management is that while navigating, corvids compensate for constantly changing reference standards as they go.

When medical executives cling to what they think is certain, they allow innovations to languish, they inhibit diffusion of major developments, and they fail to manage developing challenges to security (e.g., increasing burden of chronic illness, shrinking resources, expanding mission requirements, greater expectations from patients and stakeholders, increasing fragmentation of care).

Another avian behavior that has meaning for medical executives is the way in which corvids collaborate with unlikely partners (eg, wolves, dogs, humans) to gain additional energy advantages and opportunities both would miss by operating alone. In healthcare delivery, results of studies show that the care outcomes of patients after myocardial infarction were better when both primary care physicians and subspecialists provided care than when either specialists or primary care physicians alone treated these patients.

In an attempt to use available tools in more imaginative ways, it is helpful to observe ravens, which are the only members of the Passeriformes (perching birds) order that use their feet and beaks in novel ways: stacking crackers, locking feet and beaks with other ravens while in flight, and even carrying two oversized doughnuts at once. (This is achieved in two ways: (1) the bird hooks one doughnut around its beak and carries the other doughnut between the beak while in flight, or (2) the bird holds one doughnut horizontally between the beak while another doughnut sits vertically within the horizontal doughnut.) In addition, Pliny observed the phenomenon of ravens dropping stones into a container of water to raise the water level to within drinking reach. And, even more impressive is the fact that corvids conserve energy by shrinking and then growing their brain tissue according to need and season, thereby avoiding expensive maintenance of tissue that is not in use.

As medical executives face demands associated with the integration and maintenance of new digital systems which are too critical to be left solely to computer experts, they need to master information management as do the corvids: In one season a nuthatch caches between 22,000 and 33,000 seeds in more than 7500 places. To survive winter and spring, the
nuthatch must invoke mental maps enabling it to quickly recover these reserves.

Corvids even appear to communicate with humans. When an avid raven watcher in Maine called out to a raven flying overhead, “How’s it going?” the raven turned around, rolled, then resumed course. The raven repeated this when called at again. The observer commented, “I can’t prove the displays were for me. I understand the need for the scientific method, but there are times when nature speaks just once, and it is a loss not to listen.”

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References

DO Notes Difference Between Residency Programs

To the Editor:
I would like to comment on the letter by Adam B. Smith, MSIV, evaluating the rationale of the osteopathic internship and the response by Michael I. Opipari, DO (J Am Osteopath Assoc. 2004;104:230, 231, respectively). My first thought was that neither author is aware of what he does not know.

As a fourth-year osteopathic medical student, I completed rotations in allopathic residency programs affiliated with my school. I followed that with rotations in osteopathic residency programs affiliated with osteopathic medical schools. I can say, without reservation, that a significant difference exists. The allopathic rotations’ morning report and grand rounds were always taught by an attending, whereas osteopathic rotations were taught by interns, second- or third-year residents, or, occasionally, an attending.

By the time I decided I wanted to do an allopathic residency in internal medicine, it was too late to apply for the match. Therefore, I ended up completing a rotating internship in an osteopathic medical institution. When I applied to the allopathic residency program the following year, I inquired as to whether my first year in an osteopathic medical institution would count toward the residency. As I was told that it would not, I had to decide whether to complete an intern medicine residency program at an osteopathic medical institution or repeat my first year in an allopathic residency program. I did the latter.

It is my experience that there is a marked difference between postgraduate education in an osteopathic residency program and an allopathic residency program. Having been on both sides of the fence, I feel qualified to know the difference.

If there is a question among osteopathic physicians as to how well the profession is doing, one need only look at the number of residents opting for an allopathic residency. When osteopathic medical students ask me what they should do about their training, I tell them to decide which is the best training possible by evaluating both programs wherever they are going, doing both rotations at the chosen hospital, and choosing their direction based on the quality of the training received. Every one of my students has taken my advice; most of them opted for allopathic residencies. This is the same advice I would offer Adam Smith.

My response to Dr Opipari is that osteopathic medical students truly know their roots but must decide where they will obtain the best training. Although it is impressive that a system of osteopathic residency programs has been in place for more than 70 years, one cannot assume there is no need for improvement.

Kevin L. Hornbeck, RPH, DO
Vandalia, Ohio

Response
Apparently, Dr Hornbeck did not read my response carefully. He attempts to make a strong case for Accreditation Council for Graduate Medical Education (ACGME)—accredited (allopathic) postdoctoral training programs versus American Osteopathic Association (AOA)—approved (osteopathic) programs. My response to the letter by Adam B. Smith, MSIV, was intended to justify the osteopathic internship as a training requirement, not to compare AOA-approved versus ACGME-accredited programs.

Dr Hornbeck asserts that “neither author is aware of what he does not know.” His knowledge seems to be based solely on his experience in clerkship rotations, an internship in an osteopathic medical institution, and an allopathic residency. I have had significant experience as well in both the osteopathic and the allopathic medical systems with 2 years of allopathic fellowship training and sev-
eral years in both teaching systems. Therefore, I know of which I speak.

I advise Dr Hornbeck to refrain from judging all osteopathic medical programs based on his limited experience. That his student clerkship rotations were below his level of expectation does not indicate that all AOA-approved programs are the same. Having reviewed AOA-approved programs for some time and having served or chaired the AOA Council on Postdoctoral Training for more than 17 years, I have seen both outstanding training and weak programs. I have observed ACGME-accreditation review meetings and discussed the process with ACGME members and leaders. Believe me, they have as many weak programs of concern as do we. Further, it takes their process considerably longer to terminate those weak programs than does our process. The truth of the matter is that both the AOA and the ACGME attempt to create the highest quality programs possible to ultimately benefit the health of the people our trainees will treat.

One cannot determine that we have a problem judging solely by the number of students selecting allopathic residencies. Students often have a perception of quality that is not always based on appropriate criteria of quality, but rather, on name visibility, size, geography, etc. It is bothersome that perception, rather than reality, is often the driving force in selection.

I wholeheartedly agree with Dr Hornbeck that students should select the best available training as I did; however, I believe the best training can be found in an AOA-approved program as well. I would therefore advise students to find a different AOA-approved program if the one they have chosen is not a good fit.

I am pleased that Dr Hornbeck believes osteopathic medical students “know their roots.” The osteopathic medical profession, which provided their education, can only survive if its students preserve and uphold the tenets of osteopathic medicine. I also agree that there is room for improvement; however, I remind Dr Hornbeck that this applies to both educational systems.

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

Erratum
In the August issue of the JAOA in the article “Tobacco Dependence Curricula in Undergraduate Osteopathic Medical Education,” by Norman J. Montalto, DO, Linda H. Ferry, MD, MPH, and Tiffany Stanhiser, BS, the e-mail address is incomplete. The correct e-mail address is nmontalto@hsc.wvu.edu.