As the premier scholarly publication of the osteopathic medical profession, JAOA—The Journal of the American Osteopathic Association encourages osteopathic physicians, faculty members and students at colleges of osteopathic medicine, and others within the healthcare 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 to the editor are considered for publication in the JAOA with the understanding that they have not been published elsewhere and that they are not simultaneously under consideration by any other publication.

All accepted letters to the editor are subject to editing and abridgement. Letter writers may be asked to provide JAOA staff with photocopies of referenced material so that the references themselves and statements cited may be verified.

Readers are encouraged to prepare letters electronically in Microsoft Word (.doc) or in plain (.txt) or rich text (.rtf) format. The JAOA prefers that readers e-mail letters to jaoa@osteopathic.org. Mailed letters should be addressed to Gilbert E. D’Alonzo, Jr, DO, Editor in Chief, American Osteopathic Association, 142 E Ontario St, Chicago, IL 60611-2864.

Letters to the editor must include their full professional titles and affiliations, complete preferred mailing address, day and evening telephone numbers, fax numbers, and e-mail address. In addition, writers are responsible for disclosing financial associations and other conflicts of interest.

Although the JAOA cannot acknowledge the receipt of letters, a JAOA staff member will notify writers whose letters have been accepted for publication. Mailed submissions and supporting materials will not be returned unless letter writers provide self-addressed, stamped envelopes with their submissions.

All osteopathic physicians who have letters published in the JAOA receive continuing medical education (CME) credit for their contributions. Writers of original letters receive 5 hours of AOA category 1-B CME credit. Authors of published articles who respond to letters about their research receive 3 hours of category 1-B CME credit for their responses.

Although the JAOA welcomes letters to the editor, readers should be aware that these contributions have a lower publication priority than other submissions. As a consequence, letters are published only when space allows.

Yes, Virginia, There Will Be Healthcare Reform

To the Editor:

More than 100 years ago, a young girl named Virginia O’Hanlon wrote a letter to Santa Claus.1 A newspaper reporter, impressed by the girl’s innocence, Editorialized this quest to believe in a fantasy representing good in the world by penning the famous line, “Yes, Virginia, there is a Santa Claus.”

This story came to mind a few weeks ago, when I was having breakfast with my daughter-in-law and she asked me what I thought about President Barack Obama’s proposed healthcare reform. Because I have been associated with the National Academies of Practice, a 10-profession interdisciplinary national health policy forum, for some years, I felt well positioned to answer her question.

I replied, “I do not believe that we will see universal healthcare in the United States in my lifetime.” I added, “I do not believe that the ‘public option’ [ie, government-run health insurance] included in some of the current proposals will be part of the legislation in its final form.”

I answered as I did because I believe that our capitalist society will resist the socialist nature of the public option. Indeed, this Robin Hood–like take-from-the-rich-to-give-to-the-poor approach has met a great deal of opposition. The public option flies in the face of former President Ronald Reagan’s “supply-side” economic approach—destroying financial incentives for the entrepreneurs and movers and shakers who drive our economy.

My daughter-in-law responded, “That’s because all you greedy doctors don’t want [healthcare reform with the public option] to pass.” I then felt that I had to explain some facts to her about the current financial pressures, including declining revenues and increasing costs, faced by us “greedy doctors.”

I informed her that in 1990 I received about $2000 per cataract surgery in Medicare reimbursement, but today I am reimbursed only about $500 for the same surgical procedure. Physician Medicare reimbursements have been steadily decreasing—at the same time that physician costs for basic practice operations and medical malpractice premiums have been increasing.3 I also told her that hospitals have agreed to forgo about $155 billion in reimbursement over the next several years.4 These reimbursement reductions come as the hospital I am associated with is losing about $1 million to $4 million a month.

I was quite surprised by my daughter-in-law’s focus on “greedy doctors,” because she has been exposed to the ups and downs of medicine in our family. My brother, two of my sons, and one of my other daughters-in-law are also osteopathic physicians. In addition, my wife is a master’s-prepared nurse, as is another of my daughters-in-law. I pointed out that although my physician sons do not have to pay off medical school tuition, they still have to pay off loans used for campus living expenses, and my physician daughter-in-law still owes $400,000 in loans. If they can live on little more than...
their resident salaries for 10 years, they can finally pay off these loans.

In summary, most physicians and other healthcare professionals are not getting rich in medicine these days.

I further pointed out that although the salary of the chief executive officer of a major health insurance company may be as high as $125 million, these funds—when prorated over the possibly 100 million uninsured or underinsured individuals in the United States—amount to only about $1.25 for each of these individuals. These figures indicate that a middleman is using up a great deal of valuable resources, which is a good reason to have a single-payer universal healthcare system only if you trust government’s traditional inefficiency to run it.

I next explained to my daughter-in-law that a pharmaceutical company may sell an eye ointment for more than $100 per bottle in the United States—when it may cost less than $10 to make—because of high research and development costs. However, the company may sell this product overseas at a 25% to 50% lower cost.

Finally, I informed my daughter-in-law about the projected physician shortage in the United States. Although many new osteopathic medical schools have recently been established to meet the expected demand for physicians, no consideration has been made for osteopathic graduate medical education to train these new physicians after graduation. This situation seems like a disaster waiting to happen—and it is occurring just as the millions of baby boomers are entering the chronic illness market.

There are rumblings in the healthcare reform debate of rationing healthcare—an issue of great importance for those aging baby boomers. Will we invoke the utilitarian perspective of what is good for most is good for all? In other words, will we say, “Well, grandma had a good life. Now it’s time for her to go take a pain pill and free up some health-care resources for younger people.”

I concluded my discussion with my daughter-in-law by noting that I did not see an easy fix for the complex problems involved in US healthcare, including inadequate physician reimbursement, growing physician financial pressures, high pharmaceutical costs, and the projected physician shortage. I do not think that things will change much in the US healthcare system, but who knows? I tend to feel that, like the young believer in Santa Claus, believers in healthcare reform may be in quest of a feel-good fantasy. So perhaps I should have answered my daughter-in-law by paraphrasing the newspaper reporter, “Yes, Virginia, there will be healthcare reform.”

Richard F. Multack, OD, DO, CS
Midwest Physicians Group, Olympia Fields, Illinois

References

Protecting Patients and Maintaining Professional Sovereignty in the Midst of Intrusive Government Change

To the Editor:

While reading the summer 2009 issue of California DO, I was confronted with an article written by Richard Pitts, DO, and originally published online in 2006, that posed the question, “Healthcare: What Should It Cost?” Indeed, in the midst of the battle being fought over “healthcare reform” in Washington, DC—a battle being waged around legislation created by a Congress made up of few physicians and more than 40% attorneys—I have yet to see anyone survey physicians and ask, “What should healthcare cost?”

Physicians wait every year to learn what the government will grant us in terms of Medicare and Medicaid reimbursements. We also have to negotiate with insurance companies over reimbursements. I know of no other profession that has as schizophrenic a method for reimbursements as does the medical profession. Certainly, the grocer is paid at time of service. The plumber gets paid or doesn’t come out to fix your toilet. Lawyers have hourly rates that they establish as they see fit. It is a mystery why, as one of the most highly educated groups of people in the United States, physicians seem to be so impotent at simply telling society, “This is the fee. Period.”

Physicians are seemingly the only professionals who are uncomfortable with the concept of cash flow, so we accept the system that we have. No sane businessman or businesswoman would ever take part in an enterprise in which routine reimbursements take months to receive and frequently involve multiple inquiries that demand proof of need.

We are now facing a massive intrusion by the federal government into our professional lives. Having practiced military medicine, which is a “single-
payer” system, I am quite certain that most civilian physicians lack the marsh-
all discipline to simply tell themselves—as is often said in the military—
“suck it up and deal with it” without experiencing intolerable frustration. Yet
that is exactly what we will be forced to do should we find ourselves solely dependent on the government for our livelihoods.

Does anyone believe that prior authorizations for medications and other treatments will get better under a government-run, single-payer health-
care system? I am here to tell you that they only get worse. Under a govern-
ment-run system, the treating physician gets the formulary decided on by
a handful of lawyers, accountants, and nonpracticing physicians, and it is
almost uniformly based on costs rather than efficacy. Several years ago, Amer-
icans were discussing government waste in the form of hammers and toilet seats costing hundreds of dollars, and just a few years ago, Americans were
upset by the flawed federal and state response to Hurricane Katrina. Are we
now suddenly satisfied that those efforts were optimal and more efficient than
those of the American Red Cross? How quickly we forget.

Current comprehensive medical insurance plans emerged from relatively affordable, high-deductible plans that were designed to give the purchaser a fall-back option to deal with something catastrophic that might arise—similar to modern home insurance. No home-
owner would ever think to file a claim with his or her home insurance policy to
be reimbursed for costs of landscaping and painting. These are routine mainte-
nance issues that are rightfully expected to be the responsibility of the home-
owner. Yet, medical insurance has evolved to the point where many oth-
erwise intelligent people believe that they cannot access any care at all—not even routine checkups—if they pay out-of-pocket instead of by using insurance.
This way of thinking is a travesty for a “free” people.

As a profession, physicians should have had enough self-respect to

As a profession, physicians should have had enough self-respect to
demand that we be compensated for our time and expertise. Notice that I
did not say how much that compensation should be, because each practi-
tioner should have the right to determine what he or she is worth and charge accordingly.

As a former small business owner who operated a private medical con-
sultation service for 10 years, I was very much aware of how competition forced
my pricing to a “reasonable” level. When customers pay cash for a product, they pay attention to costs—allowing the business owner to know
directly what price is “fair.” It is interesting to note that you become very
aggressive with your own overhead when you understand what things cost.

The medical profession is long overdue for a correction regarding
insurance and compensation. I under-
stand that many physicians are con-
vinced that a nationalized healthcare insurance system will cure the ills with
which we all struggle. Sadly, this belief is utter foolishness. Under a govern-
ment-run, single-payer system, physi-
cians will be forced to accept whatever compensation we are given and to prac-
tice in whatever geographic location is
deemed to be in greatest need—just as
is done in the military. As I write this
letter, the state of California has its
employees on mandatory furlough. The
state workers had no choice in the
matter. The government came in and
simply told them that they would not be paid for the furloughed days and
that they had to take the days off. End
of story.

Do we really want to put ourselves in such a position? Currently, Medicare and Medicaid provide enough of a con-
trast for us to compare the effectiveness of fee-for-service and third-party cov-
erage against government-managed healthcare. This useful contrast would
vanish under a single-payer system.

I believe it is time for the medical profession to seriously consider a return
to a fee-for-service healthcare system. Physicians need to set rates—individu-
ally—and then inform the insurance companies and the state and federal gov-
ernments that we will no longer accept assignment for noncatastrophic services.
Of course, hospitalizations, surgeries, and other “big-ticket” items are another
story. These are the types of services that medical insurance was originally and
appropriately designed to cover.

A number of actions can be taken to help consumers pay for healthcare
within a new fee-for-service system, including establishing health savings accounts and requiring providers to list
menus of their prices for common pro-
cedures to allow consumers to “shop” accordingly. In addition, competitive restrictions, such as those on sales of
health insurance across state lines, should be eliminated—as should restric-
tive covenants and networks.

Returning to a fee-for-service system will be difficult. Physicians will
initially have to adjust their fees down-
ward and reduce their overhead costs through staff cuts. They might see a
reduction in patient volume as people “shop the market,” but this downturn will level out as physicians learn how to
respond to compete fairly with other
providers. Benefits gained from fee-for-
service would be simplicity of billing
and a clearer idea of cash flow over
time—reducing the need for the armies of
staffers who do nothing more than try to get payments for physicians.

Would a new fee-for-service system work? Surely. If more than
100,000 family physicians stop pro-
viding routine care for assignment, all
535 members of Congress, the 50 gov-
ernors, and countless state representa-
tives and insurance company execu-
tives will take notice and have no choice but to listen. Physicians simply need to speak with a unified voice, emphasizing
that our patients deserve the dignity of
care based on a relationship with their
physicians, and physicians deserve to be

(continued on page 651)
compensated on their own terms. This relationship has no room for third parties or bureaucrats who, as noncontributing middlemen, provide nothing more than headaches and vastly increased costs.

To readers who doubt the potential for a return to a fee-for-service system, I would point out that until the World War II era, this system was standard for physicians and patients and it worked just fine. Why should we continue to be the only profession that lacks the inherent self-respect to work on a fee-for-service basis?

Some readers may find the ideas expressed in this letter to be radical. If so, that is a sad commentary on our current state of thought and discourse in the United States, as well as on our understanding of our own professional history. Our patients deserve our best advice. We simply cannot provide that advice if we are dependent on some third party for our livelihoods. We have an ethical obligation to give objective and clear recommendations to our patients. However, once we are forced into a highly controlled and centralized system, we will cease to be autonomous and we will often find ourselves powerless to positively affect the people who trust us with their lives.

The majority of us did not enter medicine to relinquish our duties to our patients. Thus, we must take a stand and make our position clear to those who would attempt to usurp our professional sovereignty.

Todd R. Fredricks, DO
Assistant Professor of Family Medicine,
Ohio University College of Osteopathic Medicine, Athens

References

Perception of Osteopathic Medicine Among Allopathic Physicians in the Deep Central Southern United States

To the Editor:

I read with much interest the June special communication article by Roy R. Reeves, DO, PhD, and Randy S. Burke, PhD. In their article, Drs Reeves and Burke analyzed survey results to reveal perceptions of osteopathic medicine among allopathic physicians in the deep central southern United States. The findings reported in the article should serve as a wake-up call to osteopathic physicians and osteopathic medical students across the country.

It was frightening to read the perceptions that some allopathic physicians hold of the osteopathic medical community. Drs Reeves and Burke reported that many allopathic physicians responding to their survey believed that osteopathic residency training is not equivalent to allopathic residency training; that research has not been conducted to gain understanding of the scientific basis of osteopathic medicine; and that osteopathic medicine is not as beneficial as traditional medicine for most medical problems.

Although the authors were careful to point out limitations in the applicability of their data, I believe that their findings can probably be broadly applied to any geographic region that is dominated by our allopathic colleagues. We cannot place all the blame for the misconceptions reported by Drs Reeves and Burke on personal biases and discriminations among allopathic physicians in the South. Because of the limited number of osteopathic medical schools compared with allopathic medical schools, the strong regional ties of osteopathic graduate medical education, and the choices of many new osteopathic physicians to undertake training in residency programs accredited by the Accreditation Council for Graduate Medical Education (ACGME), many DOs end up being an invisible force in US healthcare.

As an osteopathic medical student, I am encouraged by the fact that the American Osteopathic Association (AOA) has placed on the continuing development of high-quality graduate medical education in all specialties of osteopathic medicine. An example of this focus is the creation of new AOA-approved residencies in orthopedic surgery in both Michigan and Oregon.

In Oregon, the opening of a residency program in a surgical subspecialty, with associations to major teaching hospitals, in a region heavily dominated by allopathic physicians is an especially positive step by the AOA. Working to ensure exceptional residency training in a wide spectrum of osteopathic medical disciplines throughout the United States should help to attract the interests of the most motivated students and serve as a solid strategy for promoting loyalty to the osteopathic medical profession.

Unfortunately, based on my reading of professional literature and on my association with senior osteopathic medical students and practicing osteopathic physicians, it seems that the AOA has sometimes taken this loyalty for granted—or even rejected it. For example, previous letter writers in JAOA—The Journal of the American Osteopathic Association—have criticized the AOA for not having an adequate board-certification process and for not welcoming DOs who trained in ACGME-accredited programs. The AOA seems to assume that osteopathic medical students who enter into ACGME-accredited programs are doing so with the intent of leaving behind their osteopathic identity. However, current data
suggest that many DO residents in ACGME-accredited programs are unclear as to their place within the osteopathic medical community.7

This problematic issue can be avoided in two ways. First, the AOA should continue to add more high-quality AOA-approved residency programs in multiple specialties, thereby recognizing the desire of many osteopathic medical students to specialize. Second, the AOA should increase its efforts to reach out to DOs in ACGME-accredited residency programs with AOA-approved internships via Resolution 42 (A/2000, Approval of ACGME Training as an AOA-Approved Internship), ensuring that those DOs who wish to remain tied to their osteopathic medical heritage can do so.

As medicine in the United States faces a crossroads, I hope that the AOA will remember that there are osteopathic medical students and osteopathic physicians—both new and highly experienced—who want to be driving forces in the growth and further recognition of the osteopathic medical profession.

**Response**

As director of the Department of Education at the American Osteopathic Association (AOA), I want to assure Student Doctor Brown and all AOA members that the current leaders in osteopathic medical education are committed to the development of high-quality AOA-approved residency programs in multiple specialties. In 2008, AOA President Carlo J. DiMarco, DO, focused his presidential theme on the development of osteopathic graduate medical education (OGME).

Medical Education Summits (MES) I and II, in 2006 and 2007, brought together leaders from the entire osteopathic medical profession, including student and resident representatives. The AOA and the American Association of Colleges of Osteopathic Medicine have been busy implementing and tracking progress on recommendations that were approved at these summits, with the intent of providing high-quality education and training. Many innovative changes that support the needs of our graduates and trainees have already been approved and implemented. After MES I and II, the AOA developed a number of initiatives to remove barriers and streamline the accreditation process for OGME. It took almost 2 years of planning to restructure the osteopathic internship so that graduates from colleges of osteopathic medicine had the option in most specialties to start residency training immediately after graduation (effective July 2008).

The AOA intends to be prepared for the physician workforce shortage predicted by about 2015,1,2 but we cannot achieve all the MES goals alone. The responsibility to create new training programs in competitive specialties and in desired geographical locations must be assumed by the entire osteopathic medical profession. The AOA is providing trend data to all stakeholders who have the opportunity to develop residency programs and training slots. For example, from 1998 to 2008, one popular surgical specialty demonstrated a 43% increase in number of AOA-approved residency positions. However, during the same period, the number of graduates from colleges of osteopathic medicine increased by 55%. Thus, this specialty should be reviewing its plans for growth in the future.

Osteopathic physicians have been widely accepted into primary care specialty programs accredited by the Accreditation Council for Graduate Medical Education (ACGME)—though these are not considered competitive specialties. With the expected growth in number of allopathic medical school graduates over the next 4 to 5 years, all ACGME-accredited residency positions are likely to become more competitive.3 Strategic planning by the osteopathic medical profession is further complicated by difficulties in finding a balance between providing the number of residency positions in desired specialties and locations and meeting public healthcare needs. Finding funding for these positions is equally challenging.

Leaders of the AOA agree that our profession must increase its efforts to reach out to osteopathic physicians in ACGME-accredited residency programs. As a result of Resolution 42 (A/2000, Approval of ACGME Training as an AOA-Approved Internship), ACGME-trained osteopathic physicians are no longer required to prove significant hardship due to unusual or exceptional circumstances. Core rotations in an AOA-approved OGME program during the first year of residency are still required, but the AOA allows the rotations to match either the internship or first-year rotations approved in the osteopathic specialty.

Very few applicants through Resolution 42 have been denied approval, and those applicants who were denied approval in previous years for not meeting the exceptional circumstances requirement have since been notified that they are now approved. In addition, the AOA Division of Trainee Services will work directly with ACGME.

References


Jonathon M. Brown, OMS II
Touro University Nevada College of Osteopathic Medicine, Henderson
training programs to approve the entire training program, and the division has also streamlined its operations, resulting in a quicker and less cumbersome process for applicants to complete.

Applications for approval of ACGME training via Resolution 42—along with directions for completing the application and contact information for assistance—can be accessed on the DO-Online Web site (http://www.do-online.org) by selecting the “For Residents” tab on the left side of the page, and then clicking on “AOA Approval of ACGME Training Applications.”

The AOA staff in the Department of Education is dedicated to assist you in all matters related to training. The AOA Division of Trainee Services can be contacted at (800) 621-1773, extension 8276.

Diane N. Burkhart, PhD
Director, AOA Department of Education,
Chicago, Illinois; Secretary to the Task Force to
Study the Impact of Admitting MDs into OGME Programs

References

Keeping the Osteopathic Medical Profession Parallel and Distinctive

To the Editor:
The osteopathic and allopathic medical professions share more similarities than differences, with osteopathic medical students and osteopathic physicians often training and working alongside their allopathic colleagues and with both professions becoming increasingly evidence-based. Some DOs fear that the osteopathic medical profession may be losing its distinctiveness and may even eventually be called to merge with the allopathic medical profession. The best-known attempt to merge the two medical professions happened in 1962 in California, when the California Osteopathic Association and California Medical Association—believing there was no justification for the continued existence of osteopathic medicine—agreed to grant “academic” MD degrees to DOs who paid a $65 fee.

I would like to present three reasons that the osteopathic medical profession remain parallel to and distinctive from the allopathic medical profession.

The first reason is related to the growing public interest in complementary and alternative medicine (CAM). According to data reported in 2007 by the National Institutes of Health’s National Center for Complementary and Alternative Medicine (NCCAM), approximately 38% of adults in the United States used some form of CAM that year, compared with 36% in 2002. Approximately 12% of children used some form of CAM in 2007.

According to the National Center for Health Statistics’ 2007 National Health Interview Survey, Americans spent $33.9 billion out-of-pocket on CAM during the previous 12 months. The results of that study6 also showed that Americans in 2007 spent approximately $11.9 billion on an estimated 354.2 million visits to CAM practitioners (including, according to the study, acupuncturists, chiropractors, massage therapists, osteopathic physicians, and traditional healers).

Most allopathic medical schools in the United States have responded to this public interest by offering some forms of elective instructions in CAM.6,7 Also in response to the public interest in holistic and preventive healthcare approaches, the NCCAM awarded 15 grants to academic institutions for the development of integrative medicine centers and programs from 2000 to 2008.6 In 2003, the Steering Committee of the Consortium of Academic Health Centers for Integrative Medicine—consisting of 23 prestigious academic health centers—endorsed a proposal of adding core competencies in integrative medicine to the undergraduate medical curriculum.8 The proposal was advanced in hope of instilling graduating physicians with the values, knowledge, attitudes, and skills needed to improve physician-patient communication.8 Furthermore, both the efficacy and safety of CAM are likely to be enhanced if physicians become more versed in integrative and alternative medicine.

This trend in healthcare presents osteopathic physicians with a unique opportunity to be seen as leaders—thanks to the long tradition in osteopathic medicine of a holistic and preventive philosophy to patient care. This tradition has a firm foundation in osteopathic principles and practice and the following tenets of osteopathic medicine:

■ The body is a unit.
■ The body possesses self-regulatory mechanisms.
■ Structure and function are reciprocally interrelated.
■ Rational therapy is based on an understanding of body unity, self-regulatory mechanisms, and the interrelationship of structure and function.

The second reason that osteopathic medicine needs to remain parallel and distinctive is that musculoskeletal conditions and injuries are among the most common causes for visits to physicians in the United States. According to the National Center for Health Statistics,11 musculoskeletal conditions were the leading cause of activity limitation among adults aged 18 to 64 years in 2003 and 2004. Twenty-one percent of individuals aged 18 to 44 years, 59% of those aged 45 to 54 years, and 98% of those aged 55 to 64 years reported limitation of activity because of musculoskeletal conditions.11 According to a 1999 survey by the Steering Committee on Collaboration Among Physician Providers Involved in Musculoskeletal Care,12 the percentages...
of allopathic physicians who felt adequately prepared to physically assess problems of low back pain and foot pain were, respectively, 31% and 10%. By contrast, the percentages of osteopathic physicians who felt adequately prepared to physically assess low back pain and hand problems were, respectively, 84% and 41%. Thus, training in osteopathic medicine appears to position osteopathic physicians at the forefront of addressing major healthcare issues and fulfilling public demands for patient-focused care.

The third reason that osteopathic medicine needs to remain parallel and distinctive is that the existence of two distinct branches of medicine is politically beneficial—helping to counteract the aggressive legislative activities of other, allied health professions for prescription and surgical privileges. A number of nonphysician professions have upgraded their education and training and awarded themselves with the titles of “doctors.”

Ophthalmologists are continually facing aggressive political actions from the optometric community, which is seeking to gain surgical privileges at state legislatures. Psychologists have obtained prescription privileges in Louisiana and New Mexico. Clinical pharmacists have obtained institutional prescription privileges, and nurse practitioners and physician assistants often act as primary care providers in so-called “retail clinics.”

In 2004, the American Association of Colleges of Nursing (AACN) endorsed the creation of a Doctor of Nursing Practice (DNP) degree by 2015. In the meantime—with the purpose of expanding the practice scope of nursing to that of independent primary care providers—the AACN is phasing out all masters programs for advanced nursing.

The parallel and distinctive existence of osteopathic medicine helps the medical profession as a whole to be identified as a profession requiring full, formal medical training as essential for the sake of patients’ health and safety. By comparison, the allied health professions seek to expand their scopes of practice through legislative processes or through revising their definitions of scopes of practice.

As medicine becomes increasingly evidence-based, it is important to keep in mind that the art and the philosophy of medical practice should not be discounted. By fullyembracing new advances in technology and medicine while retaining its distinctive holistic philosophy, osteopathic medicine can maintain its solid foundation in the healthcare delivery system. The growing public interest in self-care and CAM is conducive to osteopathic medicine playing a leading role in providing the healthcare that the public wants.

Tayson DeLengocky, DO
Specialist in vitreoretinal surgery, Peoria, Illinois

References
required to not only examine patients, but also to interpret electroencephalograms, electromyograms, and radiographs. I do not believe that the allopathic neurology board examinations typically require such interpretations. Thus, I believe that the lack of recognition of osteopathic board certification by the UCNS and AAN is both discriminatory and arrogant.

I work with many allopathic physicians, and we view each other as equals. I make diagnoses of neurologic conditions and treat patients just as well as my allopathic colleagues. I should not be discriminated against simply because I have a “DO” after my name instead of an “MD.”

The federal government, including the Department of Veterans Affairs and the US Armed Forces—as well as thousands of hospitals across the United States—recognize osteopathic board certifications. Why the UCNS and AAN do not is a mystery.

I have observed that the American Osteopathic Association (AOA) and the American College of Osteopathic Neurologists and Psychiatrists have tried throughout the years to get various organizations to accept AOA subspecialty certifications, and they have achieved a great deal of success. Unfortunately, there remains much more to do.

I encourage all osteopathic physicians—especially those who are neurologists—to write the UCNS and AAN to urge them to accept osteopathic neurology subspecialty certifications. If we stick together and fight, perhaps we can continue to move the osteopathic medical profession forward.

Carl Hoegerl, DO, MSc
Bloomsburg, Pennsylvania

Reject Influence of Pharmaceutical Industry

To the Editor:
In his editorial in the July issue,1 American Osteopathic Association (AOA) Editor in Chief Gilbert E. D’Alonzo, Jr, DO, announced that The DO would convert to a strictly online publication in October and that JAOA—The Journal of the American Osteopathic Association would reduce its print circulation while increasing its Web presence. According to Dr D’Alonzo,1 these moves will save the AOA more than $535,000 in the current fiscal year and nearly $870,000 in the next fiscal year.

I suggest that the osteopathic medical profession take advantage of this fiscal windfall by removing pharmaceutical industry advertisements from our journals. My reading of the AOA budget2 indicates that removing pharmaceutical industry advertisements from the JAOA and other AOA publications would cost the AOA about $254,000 annually in ad revenue. According to the KMR Group, “osteopathy” publications receive the lowest ad revenue of any medical “specialty,” amounting to less than 1% of the revenue received by such top journals as JAMA.3,4

A major reason that the AOA should reject pharmaceutical industry advertisements is that the JAOA provides continuing medical education (CME) to many osteopathic physicians. Last year, the American Medical Association’s Council on Ethical and Judicial Affairs recommended that medical institutions and journals not accept pharmaceutical industry funding to support CME.5 The pharmaceutical industry has corrupted many aspects of CME.5-8 For example, some physicians rely on industry ads in journals for their education about drugs, and then they improperly issue prescriptions for those drugs to their patients.7

The osteopathic medical profession should lead efforts in disengaging the pharmaceutical industry from providers of CME. After all, osteopathic medicine began in 1874 as a drug-free school of medicine. However, the influence of the pharmaceutical industry may encourage osteopathic physicians to practice a drug-intensive style of medicine.9,10 Rejecting this drug-based approach to medicine can bring osteopathic physicians and their patients back to the cost-effective osteopathic centerpiece of lifestyle modification—proper nutrition, exercise, and perhaps osteopathic manipulative treatment.11

John M. McPartland, DO
Assistant Clinical Professor, Department of Osteopathic Manipulative Medicine, Michigan State University College of Osteopathic Medicine, East Lansing

References

Cranial Palpation Pressures Used by Osteopathic Students

To the Editor:
Rafael Zegarra-Parodi, DO (England), and colleagues are right on the mark regarding their July response1 to the four letters2-5 criticizing their February original contribution,6 which reported measurements of the effects of standardized protocol training on palpation pressures used by osteopathy students in France.

For more than 20 years, I have been hearing from members of the osteo-
pathic medical profession that it is more important to feel then to measure. During this same time, however, the osteopathic medical profession has been “selling off” its osteopathic manipulative medicine (OMM) techniques to other professions through courses given to physical therapists and through training provided at The Upledger Institute in Palm Beach Gardens, Florida. Thus, although the critics of Zegarra-Parodi et al expressed concern about the use of manual techniques of osteopathic origin within nonosteopathic professions, it is time for the osteopathic medical profession to recognize that this “cat is already out of the bag.”

In their medical education article in the July issue, Benjamin R. Bates, PhD, and colleagues highlighted related aspects of the osteopathic medical profession’s difficulties. Reporting results of a survey of osteopathic medical students, they concluded that “[t]he improved student awareness of OPP [osteopathic principles and practice] is essential to maintaining the DO difference in clinical practice and with regard to the DO degree designation.”

One of the solutions to all of these problems is to finally push forth a new frontier of scientific research into the physiologic processes behind OMM. There are surely enough talented and brilliant individuals in the osteopathic medical profession to make this happen.

Controversy regarding the physiologic processes that occur in patients undergoing osteopathy in the cranial field has been ongoing for many years. However, even when scientific facts on this matter are presented, some members of the osteopathic medical profession tend to dismiss them. One principle example of this tendency concerns the sphenobasilar synchondrosis. Although scientists have known for many years that the sphenobasilar synchondrosis fuses by adulthood, some practitioners in the osteopathic medical profession continue to profess that there is flexion and extension at this fused juncture, as first taught by William Garner Sutherland, DO.

The idea seems to be, “we can feel it, therefore it is.”

Evidence-based research could investigate the physiologic nature of osteopathy in the cranial field and resolve the controversy once and for all. If the evidence clearly proves that a unique, reproducible craniosacral rhythm exists, such a finding would herald a golden age for osteopathic medicine. If in the end, however, the evidence shows that no unique, reproducible craniosacral rhythm exists, then a new direction for determining causes of observed clinical responses in osteopathy in the cranial field needs to be pursued.

There is certainly “something” that is occurring therapeutically in patients who are treated with our OMM techniques, and it is time to push forward and determine what it is. I congratulate Zegarra-Parodi et al. for their attempts at conducting such research in the realm of cranial manipulation. The last substantial research into the physiologic basis of OMM was conducted by Irvin M. Korr, PhD. We now have the technology to begin a new era in this type of research. Imagine if you could actually understand how Ford’s percussion vibrator technique works, or if it really is this technique that is causing observed responses in patients. The clinical possibilities resulting from such knowledge are endless.

Osteopathic manipulative medicine techniques have taken us as far as they can based on palpation alone, and it is now time to move forward with measurable evidence-based research. Who knows how far such research could take us?

Samuel E. Coor, DO
Private practice, Lacey, Washington; Clinical Instructor, University of Washington School of Medicine, Seattle

References