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.

Letter writers 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.

### Measuring Awareness, Interest, and Involvement in the Osteopathic Community Through Board Certification

**To the Editor:**

I read with great interest the June medical education article by Shannon C. Scott, DO; Elizabeth M. O’Connor, DO; and Robert A. Marlow, MD, reporting results of a survey of DO residents in Accreditation Council for Graduate Medical Education (ACGME)-accredited training programs (J Am Osteopath Assoc. 2009;109:302-311). I have been a diplomate of the American Board of Family Medicine since completing an ACGME-accredited family medicine residency program in 2003. I am also eligible for certification through the American Osteopathic Board of Family Physicians (AOBFP) until June 2010.

The survey respondents in the study by Dr Scott and colleagues did not include postresidency osteopathic physicians, such as myself, who trained in an ACGME-accredited program and now would like to reenter the osteopathic medical fold. I believe that a study of eligible postresidency osteopathic physicians would likely show similar barriers for attaining osteopathic certification as those reported by Scott et al, including lack of communication or understanding regarding eligibility criteria for American Osteopathic Association (AOA) board certification.

I agree with the findings of Scott et al that the multiple steps required to attain eligibility and AOA board certification are confusing. In addition, substantial time and financial sacrifices must be made by ACGME-trained osteopathic physicians who seek AOA board certification, including paying dual dues for multiple organizations, taking additional continuing medical education, preparing for tests, and traveling to testing sites. There is a paucity of available information regarding how to go through this process, and there is no source of information regarding the professional benefits of making the change to AOA board certification.

I have been less than encouraged in my quest for AOBFP board certification. Last year, I spoke over the telephone with an AOBFP representative who was unwilling to take the time to help me understand the certification requirements or process. In essence, I was told to send my pertinent records and an $800 check for the test to the AOBFP, and then I would be notified of eligibility. The only specific information that I received from that phone call was that I should consult the AOBFP Web site for answers to my questions. A letter that I sent to the AOA expressing my concerns regarding this interaction was dismissed with an admonishment that I just send the money and take the boards.

Because a larger membership base
may represent a greater voice for the osteopathic medical profession, I have several suggestions. Eligible ACCME-trained osteopathic physicians who are considering a change to AOA or dual board certification should be provided with transitional guidance. Such guidance should include information on the objective professional advantages for making this transition. The availability of certain provisions—such as financial relief, online testing, and eligibility extension—would make this transition more attractive. Strong consideration of these recommendations is essential for unifying the osteopathic medical profession.

Finally, I ask the AOA and associated specialty boards to promote further discussion and research about this important topic.

Mark L. Shatsky DO
Providence Medical Group, Lake Oswego, Oregon; Clinical Assistant Professor, Midwestern University/Chicago College of Osteopathic Medicine, Downers Grove, Illinois; Oregon Health & Science University, Portland

Response
My colleague, Mark L. Shatsky, DO, has made several points that highlight related findings in our study (J Am Osteopath Assoc. 2009;109:302-311). He describes from personal experience his frustrations with the American Osteopathic Association (AOA) board certification process, noting multiple barriers in the process, including communication problems. He also argues that these barriers, some of which were described at length in our article, continue to be encountered by osteopathic physicians several years after completing their Accreditation Council for Graduate Medical Education (ACGME)-accredited residency programs. Dr Shatsky represents a certain population of DOs who were trained in ACGME-accredited residency programs but who remain interested in also obtaining AOA board certification—or even in changing their board certification from the ACGME to the AOA.

Our study did not survey post-residency DOs who were trained in ACGME-accredited programs. However—as implied by Dr Shatsky—there is no reason to expect an improvement in experience with, or opinion of, the AOA board certification process among DOs who are out of residency compared with those who are still in residency. In fact, these postresidency ACGME-trained DOs may feel even more separated from the osteopathic medical community, leaving them frustrated at the multiple barriers to access the return pathway for AOA board certification. Obtaining AOA board certification may be more important for practicing DOs than for DOs newly out of postgraduate training, because this certification may be practicing DOs’ only link to ongoing competency assessment and important developments in osteopathic medicine. Our study supports Dr Shatsky’s call for leaders of the osteopathic medical profession to recruit, communicate with, and conduct research on DOs both during and after their ACGME-accredited training.

Dr Shatsky has made some compelling recommendations regarding areas of focus for future research. We agree that there may be financial disincentives for osteopathic physicians to take both the AOA and ACGME boards. For any DO considering taking one or both boards, these financial disincentives include the need to take time off from work, to pay for and travel to two examination locations, and to meet the continuing medical education (CME) requirements for both organizations. We further agree that DOs in ACGME-accredited residency programs and postresidency ACGME-trained DOs experience communication barriers within the AOA.

We would like to thank Dr Shatsky for highlighting the problems that postresidency ACGME-trained DOs are experiencing in the AOA board certification process, in CME, and in involvement with the osteopathic medical community. We look forward to the efforts of leaders of our profession to foster improved communication regarding these issues.

Shannon C. Scott, DO
Clinical Assistant Professor, Midwestern University/Arizona College of Osteopathic Medicine, Glendale

Response
The American Osteopathic Association (AOA) Department of Education appreciates the opportunity to offer remarks with regard to Dr Shatsky’s experience and concerns about the AOA board certification process.

The AOA has recognized some of the challenges that osteopathic physicians trained in Accreditation Council for Graduate Medical Education (ACGME) programs have experienced in achieving AOA board certification. In July 2008, the AOA Board of Trustees (BOT) established the Market Share Policy Council (MSPC) to analyze these challenges. After reviewing the ACGME training certification process, the MSPC presented final recommendations to the AOA BOT and House of Delegates Annual Business Meeting in July 2009.

Based on the MSPC’s recommendations, several changes in the board certification process have been approved by the AOA BOT and put into effect. These changes, which will assist ACGME-trained osteopathic physicians in obtaining AOA board certification, include the following:

- American Board of Medical Specialties–board certified DOs no longer must have completed residency training at least 5 years prior to becoming eligible for the AOA board certification process under Resolution 56 (A/2004).
- Verification of ACGME training for AOA board eligibility has been streamlined by eliminating a step in the training approval process. Resolution 56

(continued on page 45)
applications and materials will no longer be forwarded to specialty colleges and affiliates, which will not need to review and approve ACGME training. If a DO has successfully completed an ACGME program and the AOA has verified the completion status, the DO will immediately receive approval of his or her training.

The Bureau of Osteopathic Specialists (BOS) oversees the board certification work of the 18 specialty certifying boards of the AOA. The certification process is not meant to be an onerous task for candidates, but it is designed to protect the public by ensuring that the credentialing process for osteopathic physicians is reliable and defensible. It is crucial that the standards and guidelines for certification be followed consistently for all candidates and diplomates.

At its meeting in October 2009, the Standards Review Committee of the BOS performed a review of candidate requirements for each of the boards, focusing on improving the clarity of information provided to the public. In concert with representative specialty certifying boards, the BOS established a task force to review the certification process and identify opportunities to improve efficiency. This task force held its first meeting in early December 2009, and we anticipate that a number of improvements will be presented to the BOS at its meeting in April 2010.

In addition, the AOA BOT has launched the Educational Policy and Procedures Review Committee III, chaired by trustee Robert S. Juhasz, DO. This committee has been charged with reengineering the continuum of educational systems and processes to improve the efficiency of all AOA education procedures and processes. The committee will begin its work in January 2010.

We sincerely appreciate comments about the certification process, such as those made by Dr Shatsky. Only through input from the candidates and others affected by the certification process can necessary changes be made.

Diane N. Burkhart, PhD
Director, Department of Education

Cheryl Gross, MA, CAE
Director, Division of Education

Thomas Duffy, MPH
Manager, Trainee Services, American Osteopathic Association, Chicago, Illinois

The DO Difference: An Analysis of Causal Relationships Affecting the Degree-Change Debate

To the Editor:
The July medical education article by Benjamin R. Bates, PhD, and colleagues titled "The DO Difference: An Analysis of Causal Relationships Affecting the Degree-Change Debate" (J Am Osteopath Assoc. 2009;109:359-369) was well written but also misleading.

The true/false items used in this survey-based study of osteopathic medical students to measure students’ "knowledge of OPP [osteopathic principles and practice]" do not measure OPP knowledge. Rather, these items, which did not appear in the study, measure knowledge of certain facts about the osteopathic medical profession.

After reading the article, I contacted the authors, who provided me with a copy of the true/false questions that were used to assess osteopathic medical students’ knowledge of OPP, as follows:

1. Both DOs and MDs complete four years of basic medical education.
2. After medical school, both DOs and MDs obtain graduate medical education through internships and residencies.
3. Graduate medical education prepares DOs and MDs to practice a specialty.
4. Both DOs and MDs can choose to practice in any specialty area of medicine, such as pediatrics, family practice, psychiatry, surgery, or obstetrics.
5. MD students are required to take the USMLE [United States Medical Licensing Examination] exam, while DO students are required to take the COMLEX [Comprehensive Osteopathic Medical Licensing Examination-USA] exam.
6. Both MDs and DOs must pass the same state licensing examination to practice medicine.
7. Both MDs and DOs are trained to conduct surgery.
8. Both MDs and DOs can receive osteopathic manipulative training during graduate medical education.
9. DOs receive more training in the musculoskeletal system than MDs.
10. DOs practice a "whole person" approach to medicine. Instead of just treating specific symptoms or illnesses, they regard your body as an integrated whole.
11. There has been recent discussion among osteopathic medical students, osteopathic physicians, the AOA [American Osteopathic Association], AACOM [American Association of Colleges of Osteopathic Medicine], and other interested parties about the possibility of changing the designation of the DO degree by adding the letter "M" to represent "Medicine."

These items were verified by JAOA editorial staff.

Had Bates and colleagues used these survey items to evaluate osteopathic medical students’ knowledge of certain facts about the DO profession instead of students’ OPP knowledge, the authors’ article would have some scientific validity. However, based on these survey items, how can the authors make the conclusion that the students’ opinions regarding changes in the DO degree name and formal designation are related to their knowledge of OPP?

Moreover, even if the tools used by Bates et al to measure students’ OPP knowledge were validated, the conclusions drawn from the survey cannot be generalized to the wider osteopathic
medical student population because of the small sample size (N=214) and the sample population’s composition (ie, limited to a single osteopathic medical school).

Given the importance of improving the public’s perception of, and research quality in, osteopathic medicine, I would like to urge caution and skepticism on the part of both investigators and editors when publishing studies in our most important periodical—JAOA—The Journal of the American Osteopathic Association.

Marlow B. Hernandez, OMS III
Nova Southeastern University College of Osteopathic Medicine, Fort Lauderdale, Florida

Response
Student Doctor Hernandez expresses concerns primarily about two topics in our medical education article. The first concern is related to our measures of knowledge of osteopathic principles and practice (OPP) among osteopathic medical students. The second concern is related to the generalizability of our study’s findings. We appreciate this opportunity to respond to these concerns.

In reference to Mr Hernandez’s first concern, he claims that our article is “misleading” because our survey items “do not measure OPP knowledge” but instead “measure knowledge of certain facts about the osteopathic medical profession.” This claim appears to rely on a universally accepted definition of OPP, but such a definition is not articulated. Moreover, the differences between OPP and “certain facts about the osteopathic medical profession” are not made clear. As such, readers are asked to judge our article negatively, but they are not provided with substantial grounds on which to make that judgment.

To put it simply, there is no “dictionary definition” of OPP. Even the American Association of Colleges of Osteopathic Medicine’s Glossary of Osteopathic Terminology explicitly conflates OPP with “osteopathic philosophy” rather than defining OPP.

Although we recognize value in emphasizing the human body as a dynamic unit having self-regulating and self-healing functions and structures that are reciprocally related and to which rational treatment can be applied, we also agree with the following claim from Gevitz:

“[T]here is nothing in any of the various iterations of osteopathic principles that would necessarily distinguish osteopathic from allopathic physicians in any fundamental sense.

Rather than focusing on conceptual issues of osteopathic medicine, Gevitz urges OPP faculty to focus on encouraging osteopathic medical students “to discover what works for themselves through direct participation in demonstrations and experiments” and to “experience these [distinctive osteopathic] methods [of diagnosis and treatment] for themselves.” We agree that emphasizing what members of the osteopathic medical profession do rather than what they philosophize is crucial to understanding the distinctiveness of the profession.

At this “operational” level of understanding, the definition of OPP knowledge used in our survey is clearly superior to an unarticulated set of assumptions about what constitutes knowledge of OPP—for the following three reasons:

First, as we indicated in the review of literature in our article, identifying constituents of OPP—as opposed to general medical practice—requires recognition that some osteopathic principles and practices are identical to allopathic and allopathic medicine though others are not. Thus, the best evaluation of students’ knowledge of OPP would be a measure that assesses knowledge of these similarities and differences. Indeed, many of the knowledge-assessing items used in our survey were drawn directly from this AOA pamphlet.

Even if a couple of the knowledge items in our survey were poor fits for knowledge assessment, our use of structural equation modeling (SEM) provided correction in this area. Compared with manifest variable statistical techniques (eg, least squares hierarchical regression), which allow for only piece-meal investigation of complex models, SEM offers two chief advantages: SEM permits the researcher to holistically assess overall global fit of an a priori specified model in a single procedure.
In addition—perhaps more pertinent to Mr Hernandez’s concern—SEM corrects for error variance, allowing for more accurate identification of parameters of interest.

In essence, SEM purifies manifest variables of error variance and generates truer tests of association between latent constructs of interest. By explicitly modeling measurement error, SEM can be used to derive unbiased estimates for the association between latent constructs. Thus, our data analytic technique removed much of the error that was associated with the knowledge construct.

In reference to Mr Hernandez’s second concern—that results of our study cannot be generalized because the sample size was too small and the participants came from only one osteopathic medical school—we find the claim about sample size to be incorrect. Each structural model analyzed in our study contained 104 degrees of freedom. For models of this size, 132 participants are necessary to have sufficient statistical power to determine a close model fit of .05 RMSEA (root mean square error of approximation). This RMSEA value is within the 90% confidence interval for all of our structural models. Therefore, our sample size of 214 individuals is more than sufficient for deriving valid parameter estimates.

In regard to our sample population being from a single osteopathic medical school, we agree with Mr Hernandez that this factor is a limitation. Indeed, we noted this limitation in our article. As nearly any statistics textbook explains, however, results from a sample population will generalize better to populations that are similar to the original sample than to populations that are not similar. If one compares the demographics of our study to the demographics of Teitelbaum’s 2005 cross-sectional study of a nationally representative population of 2345 fourth-year students at 19 colleges of osteopathic medicine across the United States, the populations of both of these studies are quite similar. As a result, we can most likely safely generalize the main findings from our sample of osteopathic medical students at one school to the larger population of osteopathic medical students in the United States.

We agree with Mr Hernandez that scientific studies should indeed measure what they purport to measure and that studies should make claims only as far as their data support those claims. We differ from Mr Hernandez in that we believe that we as study investigators—as well as our study’s peer reviewers and the editors of the JAOA—more than adequately met all obligations toward scientific validity and rational argumentation in the design and presentation of our article.

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References

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