More suggested changes to osteopathic medical curriculum

To the Editor:
Dr Papa's article, "Part 2: Readdressing the function and structure of colleges of osteopathic medicine" (*JAOA* 1993;93:701-704, 707-708), presents some intriguing reform proposals. I agree with several, but not all, of his suggestions.

Although excellent, the suggestion of incorporating intensive clinical topics early in the curriculum has a flaw. The focus here is disease-oriented. This focus may serve as a practical expedient, but our founder, Andrew Taylor Still, admonished us, "Seek health. Anyone can find disease."

The article seems to emphasize the cognitive aspects of learning. Where are the behavioral and psychomotor skills in early osteopathic medical training? Obviously, osteopathic manipulation skills must be a part of any new curriculum as must diagnostic skills. I suggest that some observation of experienced clinicians be included as part of the early clinical incentives. In this way, students are given a "reality check" on the cognitive knowledge garnered in the classroom. Such observation would reinforce the students' learning.

Academic deans or medical school administrators should be trained and experienced *medical educators*, just as the medical faculty should be as suggested by Dr Papa in his article. The academic deans should be the educational leaders—and educators. In my days as an osteopathic medical educator and faculty member, I knew many researchers who never became educators and many educators who never became researchers. The wisest reform capitalizes on the talents and diversity of unique individuals to achieve a common, esteemed goal.

Finally, on a philosophic note, research is good, but we DOs need to recover the belief in osteopathic medicine that our predecessors had. It was during that time when our fastest growth as a profession occurred. If we need more research to convince ourselves of the value of our profession, then we will have trouble convincing those persons outside of the profession of our value. During our first century, the osteopathic medical profession has done much research. We should never stop our research. However, we must ask ourselves, "How much proof is it going to take to convince those persons who have chosen *not* to believe in osteopathic medicine to believe?"

We need more stimulation for self-study such as that provided by Dr Papa's article. We must also remember that no one person has the complete answer.

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Response

To the Editor:
Dr Clark is correct when he writes that I emphasize diseases and their treatments in my proposed *problem-oriented, multidiscipline-developed learning segment (POMDLS)* approach to medical instruction. However, I must remind him that the focus of all presentations lies on "problems" (chest pains and dyspnea, for example) and not "diseases." As I note in my article, this shift from focusing exclusive attention on diseases to addressing problems makes it possible to devote time within each POMDLS for disease prevention and health promotion concepts. Thus, this switch will provide a more appropriate and coherent (problem-oriented) context in which students can learn. It would also provide a more supportive environment for fostering the health promotion/disease prevention concepts to which the osteopathic medical profession aspires.

Furthermore, I do support the notion that students be given early and frequent exposure to patients, as suggested on page 703 in my article, "At appropriate times during these segments, the clinical faculty would provide real or simulated patient presentations for problem-solving sessions." This statement is not meant to exclude time spent in the actual clinical environment.

In fact, a POMDLS curriculum approach would enhance the institution's ability to allow first- and second-year students to have blocks of time devoted to clinical situations. For example, first-year students could, in their first 2 months, experience POMDLSs dealing with hypertension, diarrhea, pediatric fever, and the like, and then spend

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2 weeks in an outpatient clinic actually treating patients with these same common primary care problems.

The students would then return to the classroom for another 4 to 8 weeks of POMDLS. During this time, the students would study other health problems in the classroom and return to the clinic environment to put the theoretical concepts into actual practice. Thus, the curriculum would be designed to encompass blocks of POMDLS and clinics from the beginning of the first year through graduation.

Such an approach to medical instruction makes it possible for students to actually experience a curriculum that makes learning immediately relevant and integrated. At the same time, it would quickly reinforce the students' classroom knowledge with actual situations wherein they could practice not only as diagnosticians but also as disease preventers and health promoters from the very beginning of their medical education. Isn't this what medical education is supposed to be about—*enjoying learning* by having an actual impact on patients' health?

I agree with Dr Clark that academic deans should have formal training in higher education as a prerequisite for holding that position. Furthermore, anyone aspiring to an administrative position, such as chairperson, should have experience in grant writing as well as a body of published academic research.

As to the issue of how much research should be devoted to osteopathic medicine, I personally remain an active supporter of A.T. Still's beliefs. However, much remains to be understood and explored in the area of osteopathic medical research. Dr Still did not lay out all the secrets of the somatic/visceral interaction. I believe that he simply opened our minds to understanding the nature of this relationship. Much more laboratory and clinical research needs to be done in this area if the profession is to actualize its fullest potential.

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Healthcare policy reform comes under fire

To the Editor:
Barbara Ross-Lee, DO, and Michael A. Weiser, BFA, have surely embraced the Clinton health reform propaganda, based on their article, "Healthcare regulation: Past, present, and future" (*JAOA* 1994;94:74-78, 82-84). Curiously, the authors provide three cases of government intrusion that have resulted in higher costs, more bureaucracy, and the creation of barriers between patients and physicians: Diagnosis-related groups (DRGs), utilization review forms, and the Clinical Laboratory Improvement Amendment of 1988 (CLIA).

In particular, CLIA demon-

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