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Osteopathic graduate medical education programs *must* be maintained

To the Editor:

In his letter, Ronald Kienitz, DO, (*JAOA* 1995;95:155) advises that the American Osteopathic Association (AOA) should "phase out the training and certification of specialists." On behalf of its membership, the American College of Osteopathic Internists (ACOI) Board of Directors considers his comments to be ill-advised and unrealistic. Osteopathic internists are distinctive from their allopathic counterparts, both in the osteopathic medical training programs and clinical practice. Much needed studies are under way to identify and quantify these differences.

Without osteopathic medical specialty training programs, we think that our profession will cease to have a separate identity and would lose the basis for our heritage. The osteopathic distinctiveness is essential for the continued existence of osteopathic hospitals and colleges. Rather than relegate the contribution of the osteopathic medical profession solely to the American Academy of Osteopathy, the ACOI believes that this contribution must be integrated into every specialty's philosophy and practice. This goal can only by accomplished by developing first-rate training programs with a distinctive osteopathic medical emphasis, as well as maintaining existing osteopathic medical specialty training programs. The draft proposal outlining the osteopathic postdoctoral training institutions (OPTI) is designed to provide such guidelines. The OPTI proposal was approved at the Board of Trustees meeting in July in Chicago.

At a time when medical economics and viability is being determined by managed care programs with an increased emphasis on the role of the primary care physician, the ACOI believes that the osteopathic model of primary and specialty care may be more marketable and competitive than its allopathic counterparts *if* our distinctiveness can be identified, quantitated, and perpetuated. Within our generation, we have seen the development of excessive numbers of specialists and generalists. Meanwhile, the demand for physicians has declined as the use of more cost-effective paramedic personnel becomes more common. In such a medical-political future, the only way the osteopathic medical profession can continue to exist is to maintain our distinctive and needed contributions. Rather than discontinue osteopathic specialty training and certification programs, we must strengthen and support them.

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To the Editor:

With true concern, I read the letter by Ronald Kienitz, DO, "Time to abolish most osteopathic graduate medical education programs" (*JAOA* 1995;95:155). I wonder whether Dr Kienitz is cognizant that the DO degree he holds and the privilege of practicing medicine that it conveys exist only because of the distinctiveness of the philosophy and principles and practice of osteopathic medicine.

After earning the near-universal respect of patients, the military, federal and state governments, and third-party payers, why would the osteopathic medical profession give up the very educational programs, board-certification system, and distinctive approach to healthcare delivery that brought it that respect? The osteopathic medical education system gave us our degree, not the allopathic medical education system, or the Accreditation Council on Graduate Medical Education (ACGME), which Dr Kienitz thinks should now set the standard for DO training programs. Perhaps, Dr Kienitz should familiarize himself with the ACGME requirements for all specialties before suggesting that osteopathic residency programs should seek ACGME accreditation. Actually, most osteopathic residency programs would *not* be eligible for such accreditation. For the most part, osteopathic medical residency program directors are not eligible to be included under ACGME criteria. Most of the osteopathic medical institutions could not meet the ACGME training requirements for programs, faculty, and minimum training class size. More importantly, however, why should the osteopathic medical profession cast aside a system that has resulted in quality programs that successfully meet the needs of today's trainees?

Osteopathic specialty colleges monitor closely their training programs, often upgrading the curriculum standards. Programs accredited by the American Osteopathic Association (AOA) are under close scrutiny by outside accrediting agencies and are meeting these agencies' standards. Osteopathic specialty board-certification programs, such as those of the American Osteopathic Board of Internal Medicine, compare equally with allopathic specialty boards in their standards as well as the number of physicians who pass the board-certification examinations.

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Osteopathic graduate medical education programs and the specialty boards that confer board-certification status represent the heart, soul, and future of the practice of osteopathic medicine. We DOs who are proud of our heritage and degree will continue to teach the distinctive benefits of osteopathic medicine to students, interns, and residents, and to encourage them to seek osteopathic board-certification status. Fortunately, some 3200 interns and residents in AOA-approved programs felt the same way last year, too.

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Correct treatment for accidental epinephrine auto-injector–induced digital ischemia

To the Editor:

The article "Accidental epinephrine auto-injector–induced digital ischemia reversed by phentolamine digital block" (*JAOA* 1995;95:377-378), by Drs Hardy and Agostini makes several references to epinephrine and levaterenol as α-adrenergic blocking agents, a description that properly refers to α-adrenergic receptor antagonists, such as phentolamine. The article also incorrectly implies that reports of the use of levarterenol to treat accidental injection of epinephrine began to appear in 1989. In fact, the reports refer to the use of phentolamine for reversal of epinephrine-induced ischemia. The authors correctly identify and describe the use of phentolamine at other points in the article, but students may be confused by these inaccuracies. The case reported in their article provides a useful illustration of the digital block technique for phentolamine administration, although a discussion of the subject by Hinterberger and Kintzi (*Arch Fam Med* 1994;3:193-195) suggest that local infiltration of phentolamine at the site of the epinephrine injection may be the most prudent route of administration in that it allows phentolamine direct access to the affected alpha-receptors, whereas the digital block technique may allow phentolamine to diffuse proximal to the affected region. Moreover, the inclusion of lidocaine as used by Drs Hardy and Agostini may interfere with the clinical assessment of sensation once blood flow has returned, according to Hinterberger and Kintzi. ♦

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