

Increased awareness of osteopathic medicine is essential to the profession's survival

To the Editor:

Norman Gevitz, PhD, has spoken and written about what he terms the "osteopathic invisibility syndrome."¹ The class of 2001 at Touro University College of Osteopathic Medicine, San Francisco (TUCOM-SF) watched a videotape of Dr Gevitz's speech given at the March 1998 American Academy of Osteopathy Convocation. They then wrote papers sharing their ideas of what the osteopathic medical profession should do to ensure its future as the top healthcare profession.

Many agreed that making the public aware of the profession is essential. Some advocated using the media. Others thought that the real reward would come from educating the future members of the profession; that is, letting premedical students and advisees know about the profession and what an osteopathic physician can do for patients using osteopathic principles and manipulation (in addition to medicine and surgery) to enhance patient function and health. This "outreach" program should also extend to high school career days. The TUCOM students' reasoning was consistent among the class: The future visibility of the profession starts with being visible as an option for those entering the healthcare field.

Some students thought that the profession had lost its pride in being distinctive. They believe that our differences are what made us successful, but as Dr Gevitz said, we as a profession have become complacent in our success. The students were of the opinion that the profession should unite for growth and public recognition.

They think that an internal campaign to reestablish professional pride and zeal is

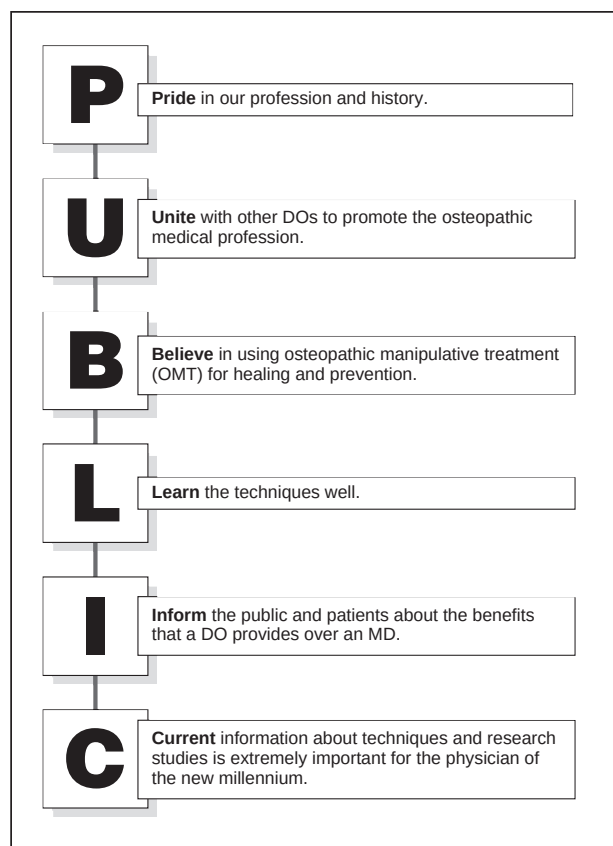


Figure 1. Acronym suggested by Paul Wang, OMS III, TUCOM-SF.

essential to our future. After all is said and done, if we are not proud of ourselves and who we are, how can we expect anyone to accept us? Two students even created "sound bite" buzzword acronyms. The first is "PUBLIC" (Figure 1). The second is "PRIDE" (Figure 2).

Several students, including a former marketing executive, advise that the osteopathic medical profession should make itself be the standard-setting or accrediting body for any medically supervised or administered manipulation program in the United States. Essentially, if any physician, MD or DO, touches a patient to perform a manipulative treatment, then it should be under the auspices of the American Osteopathic Association (AOA). As the marketing executive noted, "Intel Inside" is

a standard of quality in the computer industry, but Intel does not make computers—just the critical components. He thought that "Osteopathy Inside" could be the healthcare equivalent (Johannes Neuen-dorf, OMS III, TUCOM-SF). Osteopathic medicine would be the standard of healthcare for the United States—or perhaps the world.

It was surprising that very few students suggested that we should emulate the allopathic medical profession even more. One example given was that we should have higher academic standards for admission. This suggestion is ironic because such standards would likely have disqualified those who made the suggestion. Conversely, one student thought that admission criteria needed to be changed from high grades

and MCATS to high character and ethical standards (Dan Collip, OMS III, TUCOM-SF). The colleges should seek truly caring individuals. Take a moment and read some of A.T. Still's comments about what should be required of a prospective DO student. He spoke not of grades, but high moral fiber, good character, nondrinking people who wanted to learn what he had to teach. This last point was emphasized by several students. Those who are not enthusiastic supporters of osteopathic principles when they apply to colleges of osteopathic medicine should not be accepted. If a profession chooses "nonbelievers" or "nonsupporters," it commits suicide.

An outstanding observation was made by one student and echoed by others. It is the osteopathic medical profession's success that has been part of its failing. The colleges of osteopathic medicine have phenomenal success in producing practicing clinicians. But what does the profession do to produce the physician-researcher, physician-administrator, or the physician-teacher? The few DOs who have dual qualifications did it on their own. The profession has not helped it happen. This group of students wrote that the profession should immediately start DO-MBA, DO-MSEd, DO-MS, or DO-PhD programs to attract the people necessary to do what must be done for the future health of the profession. More than half of the class thought that more research is essential to show the value of osteopathic principles. Yet, there are few DO researchers. The students thought that these dual-degree DO-MS or DO-PhD graduates would enter career paths oriented to research from the time they started osteopathic medical school and that the profession would benefit from their combined skills to do clinical and osteopathically oriented research.

Students thought that public education should be multifaceted. It should start with becoming proud to be DOs. One suggestion was that the AOA should create a magazine for patients of DOs (Inna Yaskin, OMS III, TUCOM-SF). It would have a mix of articles, including information about osteopathic history, osteopathic philosophy, osteopathic treatment of disease and injury, preventive medicine, and the accomplishments of the profession and its members.

This magazine could be given or sold to

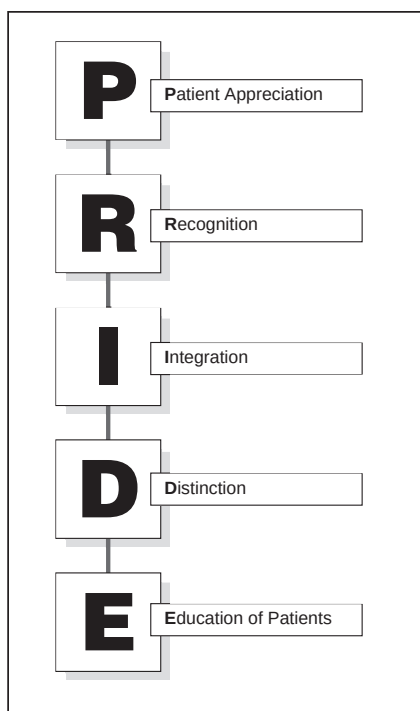


Figure 2. *Acronym suggested by Joseph Nguyen, OMS III, TUCOM-SF.*

any other person wanting to have it. Financing these efforts will take commitment from the profession and its leadership. Few students thought that additional fees should be levied on DOs; all who addressed the issue were of the opinion that the AOA was not using resources well and that making the public aware of the osteopathic medical profession was one of the major reasons for the AOA to exist. But some viewed the proposed increase in fees paid as a means to achieve greater patient flow or better payment (or both). In the end, they viewed the extra fees as investments in their futures.

The student consensus is that the osteopathic medical profession has the most to offer patients, but has been both a success and failure at the same time. We give the best care, have the most caring physicians, and yet few know we are here. We must heal ourselves from within by restoring our professional pride and self-identity. We must prepare the people for our future—teachers, administrators, researchers—and, in the words of one insightful student (Lee Janet Hyun Bong, OMS III, TUCOM-SF), we must find and support our missionaries who will help to inform the public.

Public education via advertising, patient-

oriented publications including a magazine, and most especially letting the future generations of doctors who are in high schools and colleges today know the "holy grail" of healthcare has been here officially since 1892 and it is the Doctor of Osteopathy. A three-word sentence by one student (Stephanie Casalman, OMS III, TUCOM-SF) sums up Dr Gevitz's and the whole class's view of what the profession should do:

ACT, NOT REACT

Robert C. Clark, DO, MS

Chairperson
Department of Osteopathic Manipulative
Medicine
Touro University College of Osteopathic
Medicine
Vallejo, Calif

Reference

1. Gevitz N. Parallel and distinctive: Perspective from three years later. Presented at American Academy of Osteopathy Convocation. March 1998.

Response

To the Editor:

I would first like to commend the TUCOM Class of 2001 for their thought-provoking piece. At my July 1999 inaugural address at the House of Delegates, I proclaimed my presidential year as *The Year of the Student*. I firmly believe that our osteopathic medical students, and their desire to implement the osteopathic principles and practices, are vital to the long-term survival of this profession. Our mutual goal must be to ensure that osteopathic medicine remains a valuable, important, and necessary part of American healthcare.

There are several interesting points made in the article on which I would like to comment. First, there is no question that we must do a more effective job of informing the public about osteopathic medicine. Osteopathic medicine has been referred to as "the best-kept secret in medicine." At the time Dr Gevitz delivered the speech on which the letter is based, the leaders of the osteopathic medical profession were meeting to form the tenets of what would eventually become the Campaign for Osteopathic Unity. The campaign was created to combat osteopathic medicine's greatest

weakness—its lack of public visibility. Through the Unity Campaign, we have targeted the media in an unprecedented manner, educating them about the profession and its role as a resource for health and medical information. We have sat across the table from major print and television editors and writers to tell them about the DO philosophy. It is through consistent media coverage that we will be able to reach the public, including those interested in a career in medicine.

Another important goal of the campaign was to create a spirit of unity and cohesiveness among osteopathic medical organizations. When we began work on the campaign in January 1999, it became quite evident that we would not move forward successfully without the support of every osteopathic organization. Seven months later, at the July 1999 House of Delegates meeting, we were very proud to report that the Unity Campaign had received support from 100% of our affiliate organizations. It would have seemed almost inconceivable a few short years ago that we would have brought together all 90 or so organizations to begin speaking with one powerful voice. But now, with the support of every osteopathic organization, we stand together, working to ensure the future of this profession.

Another point brought up is that of accreditation. The AOA, through its Healthcare Facilities Accreditation Program (HFAP), is very proud of its status as a nationally recognized accrediting body. For the past 50 years, HFAP has been the pre-eminent group to set standards and track compliance for osteopathic hospitals and affiliated healthcare facilities. And it is expanding its standards to cover facilities such as laboratories and ambulatory healthcare clinics, putting the program in a position to have a larger presence in a greater number of places where DOs practice.

It is interesting that one of the criteria listed for improvement was the academic requirement. I would like to point out that, according to statistics compiled by the American Association of Colleges of Osteopathic Medicine and the American Association of Medical Colleges, osteopathic medical colleges reject a larger percentage of applicants than allopathic medical colleges. For every student who successfully enters a college of osteopathic medicine,

four applicants are rejected, whereas for every student admitted to an allopathic medical college, two students are rejected. My main hope is that our medical schools continue to accept top students who understand and believe in the osteopathic philosophy. Those potential students who are committed to the osteopathic philosophy of treating people, not just symptoms, should continue to be actively sought and welcomed with open arms.

Osteopathic research is another vital component to the overall survival of this profession. Osteopathic medicine has spent more than 100 years producing physicians treating people, while not widely conducting research. The importance of research in validating the efficacy of osteopathic manipulative treatment (OMT) with the media and our critics has never been more evident than with the recent flurry of coverage surrounding the low back pain study and accompanying editorial published in the *New England Journal of Medicine*.^{1,2} These findings should encourage every practicing physician and current student to take a closer look at this wonderful, hands-on method of healing. To most of the public, OMT is what makes us unique among healthcare providers. We can look forward to several more studies to come that will test the osteopathic philosophy and OMT, and how they affect patient outcomes.

Public education is the next phase of the Unity Campaign. The most credible way to shape public opinion is through the news media. Therefore, once we finished conducting consumer and physician research, our strategy was to target influential media outlets. The result is that we have been able to reach many more people than ever before. *Wellness Watch*, a bi-monthly newsletter, disseminates the latest osteopathic-oriented health and medical information to more than 1000 media outlets.

During the summer months, we worked hard to build relationships with editors and reporters, and we are finally seeing the results. Just look at the successful coverage we have received from the *New England Journal of Medicine* piece. From the wire services, to the *New York Times*, *Washington Post*, and *Chicago Tribune*, to Web sites like *CNN.com*, *ABCNews.com*, *WashingtonPost.com*, and *DrKoop.com*, we are able to better educate the media

about the DO Difference. And by consistently appearing in the mainstream media, we will reach a much larger and wider audience than if we would try to print and distribute a magazine. And quite frankly, it will be much less expensive.

Finally, there is the issue of money. I agree with you that money contributed to the Campaign for Osteopathic Unity is an investment in the profession's future. There are many organizations that recently have levied mandatory dues from \$40 to \$400 per year to help fund national public relations and advertising efforts, which are incredibly expensive. The AOA has never been able to amass the kind of money necessary to launch a large national public awareness campaign while performing all its other member service functions. With the mandatory assessment and large contributions from individuals and osteopathic organizations, we raised more than \$1 million to support the first year's activities. We were able to conduct surveys, focus groups, National Unity Day, video news releases, desk-side trips to New York, the *Wellness Watch* newsletter, national media and message training, and the AOA Ambassador Network. And we were able to obtain 100% support from our osteopathic organizations.

We have made great strides in the past 12 months of this campaign, but unless we continue to receive support, and funding through the now-voluntary contribution, the ground we gained in 1999 will be lost again by 2001. I urge all members of the osteopathic medical profession to wholeheartedly support the Campaign for Osteopathic Unity. Without you, the Unity Campaign will fade into oblivion. And in time, without a commitment to public education and preservation of the teachings and practices of osteopathic medicine, we risk witnessing the end of our great profession.

Eugene A. Oliveri, DO, FACOI
AOA President

References

1. Andersson GBJ, Lucente T, Davis AM, Kappler KE, Lipton JA, Lourgans S. A comparison of osteopathic spinal manipulation with standard care for patients with low back pain. *N Engl J Med* 1999;341:1426-1432.
2. Howell JD. The paradox of osteopathy [editorial]. *N Engl J Med* 1999;341:1465-1468.

'Unity' benefits extend beyond AOA public relations programs

To the Editor:

In response to the editorial, "Osteopathic unity must continue," (JAOA 1999;99:510) by Kenneth E. Ross, DO, I extend kudos to Dr Ross and his colleagues at the Missouri (the "Show Me" state) Association of Osteopathic Physicians and Surgeons. They should be recognized for showing all of us that the benefits of professional unity extend far beyond public relation programs of the American Osteopathic Association (AOA).

Just like osteopathic distinctiveness, osteopathic unity comes in many forms. For Missouri, this includes scholarship, convention funding, and loan programs to support its students. For others, unity activities might include community outreach initiatives such as career days or health screenings. And while at the national level we will continue working with BSMG Marketing Firm on our public relations objectives, we will also be working with all affiliates and DOs on our shared goal of increased public awareness.

As we proceed with year 2 of the Campaign for Osteopathic Unity, we will also be examining opportunities to build unity in the clinical setting. It is our hope that increased use of osteopathic manipulative treatment in patient treatment and diagnosis will bring physicians, hospitals, and directors of medical education closer together.

John B. Crosby, JD
Executive Director
American Osteopathic Association

In defense of Dr Kevorkian

To the Editor:

I, too, read with interest the editorial by Frederick J. Goldstein, PhD, on physician-assisted suicide.¹ Dr Hartman's rebuttal to this rather one-sided view on end-of-life issues² was both eloquent and representative of the views of both myself and many of my colleagues.

With all due respect to my former pharmacology professor, Dr Goldstein's reply to Dr Hartman was equally as one sided.

First, I find it very difficult to believe that Dr Kevorkian would simply take people at their word and not perform at least a rudimentary inquiry to find if they have a terminal illness. If, in fact, this were the case, would not Dr Kevorkian have been charged and convicted of murder several years earlier? And, if "certain autopsy results" indicated no identifiable pathologic process, then what exactly were the circumstances behind their deaths? Dr Goldstein failed to elucidate these so-called "facts."

Second, Dr Goldstein seems to demonize Dr Kevorkian, charging "[he] kills patients in motel rooms....[he] has no interest in trying any form of treatment—other than termination of life." Perhaps so. But, does Dr Goldstein imply by this statement that physician-assisted suicide is okay as long as it is done at the patient's home and only after all other forms of palliation are exhausted? It seems that Dr Goldstein wants to paint a disparaging picture of humane physician-assisted suicide by using "Dr Death" as its sole example. Dr Kevorkian is evil. Dr Kevorkian practices physician-assisted suicide. Therefore, physician-assisted suicide is evil.

Finally, Dr Goldstein's clinical research undoubtedly should be applauded. Thank God for people like him who have such an active role in palliative care and end-of-life issues. But let us leave the ivory tower for a moment, and join me in the real world. Most patients do not have access to large research-oriented institutions. At best, their diagnoses are made by their family physicians, they are treated by specialists, and if those physicians are especially astute, their treatment will involve hospice well in advance of the disease process. The problem is that palliation and end-of-life issues are not simply a matter of titrating the right dose of opioids and selective serotonin-reuptake inhibitors—they are also spiritual, family guided, and extremely personal. I have often thought, would I want to go on living as long as my pain is under control, and I was receiving therapy for comorbid depression as a result of my illness? Well, that depends. I suppose if I were happy being bedridden...or ventilator dependent...or dependent on others for

round-the-clock care to do everything from feeding me to bathing me, then I would want to go on. But I cannot say that at this point. Should I have the choice? Absolutely. Physician-assisted suicide is absolutely in keeping with the osteopathic perspective. Like osteopathic manipulative treatment, it is another weapon, which if used rationally and in conjunction with patient and family education, hospice, and the research of people like Dr Goldstein, can help to eradicate pain and suffering. Is not that our job?

Society will ultimately decide if physician-assisted suicide has any place in our arsenal against pain and suffering. I honestly hope it decides for it. That way we can regulate it, control it, and use it only when appropriate. Gone will be the days of white coats skulking the corridors of hospitals at 3 o'clock in the morning "adjusting" morphine drips to respiratory rates of zero. And I'll say "Amen."

Michael E. Suls, DO
Corpus Christi, Texas

References

1. Goldstein FJ. Kevorkian kills patients along with the clinical research to help them. JAOA 1999; 99:77.
2. Hartman SE. Kevorkian plays important role in advancing physician-assisted suicide. JAOA 1999; 99:393.

Responses

To the Editor:

I appreciate having the opportunity to respond to Dr Suls.

■ **Terminal status of patients killed by Dr Kevorkian**—Of 39 patients whose lives were ended by Dr Kevorkian, 32 were *not* terminal. The majority of these cases were reviewed by Oakland Medical Examiner Ljubie J. Dragovic. Patients in whom there was no identifiable pathologic process include:

- ☐ a 58-year-old woman who complained of "severe pelvic pain," but physicians could not find a physical cause;
- ☐ a 39-year-old woman "treated" for multiple sclerosis, but again, no signs were found at autopsy;
- ☐ a 42-year-old woman with "chronic

fatigue syndrome” and some “muscle disorder” of unknown origin (this patient’s husband, who was present at the killing, had been previously arrested twice for assaulting his wife);

□ another patient in whom only Alzheimer’s disease had been diagnosed.

■ **Death site**—In my reply to Dr Hartman,¹ I identified the environment that Dr Kevorkian uses only to show that nothing he does is humane. For Dr Suls to extract this segment of mine and expand it as he did is inappropriate logic and misses my primary point.

■ **Clinical research**—Dr Suls fails to recognize the contributions to the practice of family medicine that are made not only by “large research-oriented institutions” but also by others such as the Philadelphia College of Osteopathic Medicine (PCOM), where research is very important but not a primary focus. We take our scientific mission seriously. We target clinical problems that are dilemmas for nonresearch-oriented physicians and develop studies to try to find solutions. When positive results are obtained—and lead to new approaches in treatment—researchers make their findings known at national meetings and in medical journals to reach as many health professionals as possible, including physicians in community medicine. Therefore, it is unfortunate that Dr Suls cannot make this connection.

■ **End-of-life procedures**—Dr Suls can narrow his written response to mesh with his views, but they do not—and never have—represented mine. As pointed out in my February 1999 editorial,² I directly observed and collaborated with staff members at Walter Reed Army Medical Center who provided emotional and spiritual support to terminally ill patients. Further, I have never advocated pharmacotherapy as the sole means of end-of-life treatment. However, it is this part of terminal care to which I can offer my scientific expertise.

My final comments are directed at two other statements made by Dr Suls. He says that “physician-assisted suicide is in keeping with the osteopathic perspective.” I have been on staff at PCOM for 7 years—and have served for 5 years as director of our second-year medical school course in oncologic sciences, in which we have several sessions on the dying patient—and I have never heard any of my osteopathic

physician colleagues make (or even acknowledge) such a statement. In addition, Dr Suls referred to “white coats” in hospitals who “at 3 o’clock in the morning ‘adjust’ morphine drips to respiratory rates of zero,” and my reply here is that any physician who knows of such an occurrence needs to report it because it is murder—as Jack Kevorkian can now attest from his jail cell.

Frederick J. Goldstein, PhD, FCP

Professor of Clinical Pharmacology
Philadelphia College of Osteopathic Medicine
Philadelphia, Pa

References

1. Goldstein FJ. Kevorkian plays important role in advancing physician-assisted suicide: Response. *JAOA* 1999;99:393.

2. Goldstein FJ. Kevorkian kills patients along with the clinical research to help them. *JAOA* 1999; 99:77.

Editor’s response

I have reviewed the letter that was sent to me by Michael E. Suls, DO, concerning the editorial by Frederick J. Goldstein, PhD, on physician-assisted suicide (*JAOA* 1999; 99:77).

I agree that end-of-life issues are not simplistic and require a great deal of skill when dealing with patients who are dying and their families who are going through this very difficult process. We as osteopathic physicians are obliged to care for the patient in a way in which we can minimize pain and suffering. I believe that our osteopathic oath, which we each took at the time of our graduation, states that we should do everything possible to treat the pain and suffering. However, I do not believe that it gives us the right to practice physician-assisted suicide. I firmly believe that this practice is not part of the osteopathic perspective.

I strongly believe that physician-assisted suicide is unnecessary and that terminally ill patients can be treated with palliative therapy and therapy to relieve pain and suffering.

The American Osteopathic Association stated the profession’s position in a 1997 resolution concerning physician-assisted suicide.¹ Physician-assisted suicide is wrong. Our oath states that it is our responsibility

to preserve the health and life of our patients and further, not to use deadly drugs, even though such use may be requested by the patient or the patient’s family.

Our profession has encouraged our schools to specifically address this issue in the course of study and to concentrate on pain management and palliative treatment of the terminally ill patient. The American Osteopathic Association (AOA) has encouraged our schools to focus specifically on the goals, objectives, and value of hospice care and intervention. Furthermore, continuing medical education programs are being encouraged by the AOA to present to physicians information and resources on supportive care which are valuable to our patients who are in the dying process.

Again, I want to make my position perfectly clear. Physician-assisted suicide is *not* in keeping with the osteopathic perspective. In fact, it is directly contrary to what we should be doing and what we promised to do, by our osteopathic oath, at the beginning of our career. I believe that Dr Suls’ opinion is emphatically wrong. ♦

Gilbert E. D’Alonzo, DO

Editor in Chief

Reference

1. American Osteopathic Association: 1999 *Yearbook and Directory of Osteopathic Physicians*; 615-616.

All opinions expressed in the JAOA are those of the authors and not necessarily those of the editors, the AOA, or the institution with which the authors are affiliated. Letters may be e-mailed to letters@aoa-net.org or they may be mailed to the Letters Editor, AOA, 142 E Ontario St, Chicago, IL 60611. No unsigned letters will be considered for publication.