Time to take bolder initiative with regard to public accountability

To the Editor:

It's time our profession took a bolder initiative with regard to public accountability. Whenever an organization, research firm, government agency, or other publishes data indicting physicians for their role in medical errors, poor outcomes, failure to police fellow practitioners, or issues relevant to quality of care and patient safety, our collective response has been twofold: provide all the "moss-covered" arguments about why certain information already available is not reliable and valid and therefore cannot possibly be of value to challenge the question at hand, and offer a "potential" solution designed, "over time," to respond to the public's growing anxiety. A most recent reference is to the Institute of Medicine's reports on deaths due to treatment errors and the notion to make public the National Practitioner Data Bank information.

I sincerely respect those who advocate proper study design to address specific quality issues; absolute perfection before performance information is released; perfection regarding data reliability and validity; and perfection in how data are adjusted to account for patient risk factors. I also respect those who demand that all information be accompanied by comprehensive data interpretation caveats. I adhere to all of this.

But there is clear evidence that valid and reliable data are already available (albeit, not perfect) and that these data accompanied by proper interpretation caveats are useful in partially satisfying public accountability and meeting consumer demands, accelerating the rate of continuous quality improvement and improving patient outcomes, and thwarting consumer attitudes inherent in the "Avis syndrome" associated with our profession. Is it true that we are a nation that is "data rich" and "information poor"? Or is it simply a matter of the data's not being perfect?

The very practice of medicine is imperfect. That is why what we do as physicians is called "practice"—we expect to improve with practice—and referred to as a "work-in-progress." Physicians—allopathic and osteopathic—never allowed imperfections in medical technology to thwart treatment of our patients. Otherwise, our treatment of patients would be limited to whole-leaf digitalis and thyroid abstract, the only medicinals available a century ago. Today, most of us strive to apply evidence-based practice standards to the care of our patients. We should not allow the imperfections of measuring and comparing quality and safety to interfere with the use of and advancement of the art and science of measuring and comparing the quality of healthcare we provide individually or collectively.

Perhaps in the opinion of some, I am not qualified to make this assessment or render my opinion. Nonetheless, please allow me to present my qualifications. I have been an osteopathic physician since 1963, a practicing pediatrician from 1969 to 1981, and a health system chief medical officer from 1981 to 1992. My introduction to the frustrations of purchasers and consumers with regard to information about quality began in 1989, when I became directly involved with the Cleveland Health Quality Choice Program. This 10-year experience placed me at the very interface of provider-purchaser interaction regarding the access, cost, and quality of healthcare in Cleveland. Employers and consumers want and need valid and reliable information that will help them make more informed purchasing decisions.

If we truly believe, as osteopathic physicians, that we offer "value-added" services to patients, then we should be in the forefront (as a profession) of developing and advocating the use of present-day information to assist consumers to make more informed healthcare choices. Most important, we should be in the forefront of pursuing and advocating advanced and innovative methodologies to meet purchaser consumers' needs for usable information.

Our efforts should not be solely directed to constructively criticize and "debunk" available data sources and portended uses of available information. We must also and bilaterally advance new, innovative ideas that will meet the needs expressed by those who must choose, purchase, and pay for the care we render. I urge as a profession that we seek a careful balance between our adversarial position regarding the use of available data and assume an advocate role proffering viable solutions to the expressed need. It is important to listen to the members' concerns, but also the concerns of our patients.

I am proud to serve as a consultant to the American Osteopathic Accreditation Program Task Force on Quality. At our most recent meeting in April, the Task Force was informed that it will be recommended to assume a larger role with regard to quality within the ranks of the AOA. In delineating a mission and charge for the group, I sincerely hope that this group will be invigorated and supported in its efforts by the consensus support of the AOA trustees and membership and directed to take an innovative lead in quality.

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(continued)

Another great article on osteopathic manipulative treatment

To the Editor:

I continue to enjoy reading articles on the use of osteopathic manipulative treatment, and the recent case study of refractory torticollis (*JAOA* 2000;100:148) was no exception.

To those familiar with using cranial osteopathic manipulation in their treatments, the case was neither surprising nor particularly unusual. It is common for pelvic lesions to contribute to or cause cranial and cervical lesions. The authors state, "while the actual mechanism by which the pelvis affected the cervical musculature is not known, [we] suggest several possible mechanisms, including increased dural tension...." This *is* the mechanism in this case. Falling forward with her left knee bent caused the patient's left posterior innominate, and the authors, to their credit, were able to correct that lesion. In most cases, this type of pelvic torsion reflects to the cranial base, and the result is a left temporal bone that is internally rotated and a compensatory right temporal bone that is externally rotated. This causes a disturbance to both occipitomastoid joints, with possible entrapment/irritation of the 11th cranial nerve.

The dura is connected firmly to the sacrum, and then its next "anchoring" is C_2, then on to the cranial base. It is common to have pelvic/sacral dysfunction in whiplash injuries, for example, and that is the same mechanism only in reverse. Osteopathic manipulative treatment of the cranium is particularly useful for infants with torticollis as the result of birth trauma.

I applaud Dr. Sandhouse and student physician Marc Kaprow for writing this article, and the *JAOA* for continuing to publish articles on osteopathic manipulative treatment. I also applaud all osteopathic physicians who continue to use their hands to diagnose and treat their patients.

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Name change diminishes osteopathic medicine's approach

To the Editor:

The board certification name change from "Special Proficiency in Osteopathic Manipulative Medicine" (SP-OMM) to "Neuromusculoskeletal Medicine and Osteopathic Manipulative Treatment" (NMS & OMT) greatly shortchanges all of us. The latter implies that we examine the neuromusculoskeletal body systems and treat them with OMT.

SP-OMM is more comprehensive and representative of what we actually do in practice: we treat not only the neuromusculoskeletal systems, but also all the patient's systems—nervous, musculoskeletal, circulatory, lymphatic, cardiac, gastrointestinal, EENT, endocrine, urinary, reproductive, mental/emotional, etc. We don't treat just symptoms; we treat the whole person. Osteopathic manipulative medicine is a method of evaluating, treating, and preventing structural and internal health problems of all kinds. The name change to NMS and OMT diminishes the entire osteopathic medical profession and must surely have our founder, A.T. Still, rolling in his grave.

One of our leaders told me three reasons he supported the name change: (1) the change would spur insurance companies to reimburse for electromyographs; (2) this outcome might end the divisive words and actions surrounding this issue; and (3) family physicians were having problems getting insurance companies to pay for OMT. As for the first point, I feel this is a hollow rationalization. Regarding the second, I believe it would be better to have all parties discuss and iron out their differences. Third, insurance claim forms do not ask if we are board-certified in OMM. Further, DOs with certificates of special proficiency in OMM (CSP-OMM) have the same trouble getting insurance reimbursement for OMT as family physicians and other DOs.

The leader added that he felt "justified to sacrifice the few" (DOs with CSP-OMM) to help the many (family physicians), by agreeing to the name change. It seems misguided to tack on OMT at the end of the American College of Osteopathic Family Physicians (ACOFP) board certification just to have OMT made visible in that board certification. What about every other osteopathic specialty board? Are they all supposed to put OMM or OMT at the end of their board certification titles? The point that's been missed is that all DOs can perform OMT and can use OMM in their practices rather than the limited group this name change implies. We must work together to educate insurance companies about OMT and the appropriateness of payment for OMM services regardless of osteopathic specialty.

Although the name has already been changed, it's not too late to reevaluate and correct this shortsighted error.

I believe it is better to take the high road together and protect and preserve the board certification wording of CSP-OMM. We must not tear it down with politics and rationalizations. We must work together so our osteopathic medical profession's light can truly shine, remembering that we are all one family of osteopathic medicine. We must support each other in our chosen specialty. When we build each other up, we build ourselves up.

We must overcome the limitations of politics. I would like to see all DOs and all osteopathic medical organizations support reinstating the previous board certification names for special proficiency in OMM and family physicians. We must remain true to our roots and to each other. To tear down one part of osteopathy weakens the whole of osteopathy. I want osteopathy to remain strong.

On a final note, I agree with Dr Frymann (*JAOA* 1999;99:557) when in her eloquent yet succinctly written article she states that the American Osteopathic Board of Special Proficiency in OMM (AOBSPOMM) should serve as the sole certifying board for those with special proficiency in OMM.

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