JAOA LETTERS

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 osteopathic medical colleges, 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 copyediting. 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 letters be e-mailed to jaoa@osteopathic.org. Mailed letters should also be sent electronically, in one of the aforementioned electronic formats on an IBM-compatible compact disk or a 3 1/2-inch diskette, and 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 addresses, day and evening telephone numbers, fax numbers, and preferred e-mail addresses. Authors 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 authors 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.

Still's Concept of Connective Tissue: Lost in "Translation"?

To the Editor:

I read the May 2005 special focus issue of THE JOURNAL with great interest. I thank the editors of *JAOA—The Journal of the American Osteopathic Association* for their insight and initiative in the creation of this publication.

I have a small dispute with a central assumption present in the special communication article by Felix J. Rogers, DO, however ("Advancing a traditional view of osteopathic medicine through clinical practice." 2005;105: 255–259).

As William Garner Sutherland, DO,[1] once said, "we might readily observe the 'little things' as 'big things' to be seen in the science of osteopathy."

Although Dr Rogers' piece is very meaningful—it is an article that I learned from and harmonize with—I dispute his use of the word "musculoskeletal" as a defining element of osteopathic principles and practice when he reminds readers of the first of "two key features" of the 2002 Proposed Tenets of Osteopathic Medicine[2]: "an emphasis on the primary role of the musculoskeletal system in health and disease."

One of the conundrums that awaits osteopathic medicine's philosophers lies in the interpretation of the writings of our founder, Andrew Taylor Still, MD, DO. Still's work has often been interpreted to represent the "musculoskeletal system," though he himself did not use this term. An alternative interpretation of his work would lead us to the term "connective tissue." Depending on which interpretation any given philosopher of osteopathic medicine favors, there is a slight shift in perspective that may contain profound implications for the way he or she conceives of the practice of osteopathic medicine.

Dr Still not only reset his patient's hips, he also successfully treated goiters and acute appendicitis using manual techniques. Assuredly, he worked with muscles, bones, and joints, but, beyond that, he worked with the fascia, which he described as the dwelling place of the soul.[3]

From a fascial perspective, muscles, bones, and joints are all included within the connective tissue.

The extracellular matrix, the microscopic aspect of connective tissue, is inherently a gel. It is only because of the movement of calcium ions (ie, calcium waves) that nutrients and waste products flow to and from the cells. Calcium ions depolymerize and make watery this otherwise unyielding gel.

Similarly, when osteopathic manipulative treatment is used to treat

patients with somatic dysfunction, it decongests the connective tissues to restore their acidic, gel-like character to a healthy, fluid quality. Then blood, lymph, and nerve function can operate efficiently.

Without the chemical details, Dr Still knew that congestion is antithetical to life when he said, to paraphrase, that the fascia, "the framework of life," is where we live and die.[3] According to Still,[3] because "anyone can find disease," the goal of osteopathic medicine is to "find health" in the tissues.

This goal means that practitioners of osteopathic medicine must look for ways to support the healthy metabolic activity of the connective tissues in which cells reside. If a muscle, bone, or joint dysfunction is present, we can be sure that an underlying metabolic disturbance is also present.

Emphasizing the primary role of the connective tissue (rather than the musculoskeletal system) in health and disease recognizes the importance of the whole body down to the cellular level. When approaching the practice of osteopathic medicine with a concept of the primacy of connective tissue "in hand," the physician acknowledges and supports the osteopathic principle of the interrelationship between structure and function.

For example, the extracellular matrix and the cytoskeleton operate as an unified electromechanical and chemomechanical system to turn cell functions on and off. All the necessary elements for the health and maintenance of the organism exist in, and pass through, the extracellular matrix. Thus, we can say that the connective tissues are holistic, demonstrating a structure-function interrelationship and containing all the necessary resources for self-healing.

Connective tissue is osteopathic tissue. This is where the focus of osteopathic manipulative treatment resides—not just in the musculoskeletal system of muscles, bones, and joints.

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Whole Person Medicine: A Definition Articulated Osteopathically

To the Editor:

I enjoyed reading the May 2005 special focus issue of *JAOA—The Journal of the American Osteopathic Association*, "The Paradox of Osteopathy: Views on Thought and Traditions in the Discipline." However, I do not find the ideas described in this issue of THE JOURNAL to be true to the practice of osteopathic medicine.

It is quite simple: osteopathic medicine is not limited to the musculoskeletal system. While the musculoskeletal system may be used to access total body physiology, the musculoskeletal system is a means, not the end. Andrew Taylor Still, MD, DO, stated quite clearly that osteopathic medicine is about all of anatomy and its function.

Examples of "whole body" osteopathy are abundantly represented throughout Dr Still's writings. For example, in *Philosophy of Osteopathy*,[1] Still writes, "The Osteopath seeks first physiological perfection of form, by normally adjusting the osseous frame work, so that all arteries may deliver blood to nourish and construct all parts." In this same work, Still[1] elaborates further on the role of the osteopathic practitioner:

> Your duty as a master mechanic is to know that the engine is kept in so perfect a condition that there will be no functional disturbance to any nerve vein or artery that supplies and governs the skin, the fascia, the muscle, the blood or any fluid that should freely circulate to sustain life and renovate the system from deposits that would cause what we call disease.

Osteopathic medicine is about health. It is about understanding the nature of physiologic function with our hands and minds—and the use of the physician's hands and mind to restore normal physiology in our patients.

While it is certainly important to consider the whole person in medical care, this is not the sole jurisdiction of osteopathic medicine. The "whole person" should be the consideration of any good physician.

Without our hands, and without depth of application, osteopathic medicine is greatly diminished. In our quest for progress, the osteopathic medical profession must not forget the profundity of its origins.

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Credit Where Credit's Due: Forebears of the Osteopathic Research Center

To the Editor:

I read with great interest the May special focus issue of *JAOA—The Journal of the American Osteopathic Association*. I must, however, take exception with a comment made by Felix J. Rogers, DO, in his article, "Advancing a traditional view of osteopathic medicine through clinical practice" (2005;105:255–259). Dr Rogers wrote, "'advocates for the advancement and acceleration of research in osteopathic medicine must note that the [Osteopathic Research Center at the University of North Texas Health Science Center at Fort Worth—Texas College of Osteopathic

Medicine] is the *first* osteopathic research site of its kind and is attached to but one of the profession's 20 colleges (on 22 campuses) of osteopathic medicine [emphasis mine]."

I do not know what Dr Rogers means by "of its kind," but while I was an osteopathic medical student at the Kirksville College of Osteopathic Medicine (KCOM) in Missouri in the 1950s, John Stedman Denslow, DO, as well as Irvin M. Korr, PhD, were both doing research in osteopathic medicine. I know for a fact that this research had been going on for quite some time before my attendance at KCOM.

Thank you for editing a great issue, for taking note of the above facts, and for advising Dr Rogers about this important work at KCOM.

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Continuity of Thought and Tradition in the Discipline Supported by Ongoing AOA Efforts

To the Editor:

I would like to compliment the timeliness of the May 2005 special focus issue of *JAOA—The Journal of the American Osteopathic Association*, titled "The Paradox of Osteopathy: Views on Thought and Tradition in the Discipline," particularly as it serves to highlight the "Pride in the Profession" theme of Philip L. Shettle, DO, the 2005–2006 president of the American Osteopathic Association (AOA).

The editorial by Gerald G. Osborn, DO, MPhil ("Taking osteopathic distinctiveness seriously: historical and philosophical perspectives." 2005;105: 241–244), is likewise apt. In his editorial, Dr Osborn comments on the issue's three main articles by Leonard H. Calabrese, DO,[1] Robert Orenstein, DO,[2] and Felix J. Rogers, DO.[3] However, I would like to note that the AOA is already working on most, if not all, of the issues raised by Dr Osborn.

For example, Dr Osborn mentions the vision shared by A.T. Still, William James Mayo, and Charles Horace Mayo of a "'patient-centered' model of medical care." During his 2004–2005 AOA presidency, George Thomas, DO, promoted that same vision with his "Year of the Patient–Patient-Centered Quality Care." This vision of measuring and improving the quality of care given by osteopathic physicians has become a reality with the growth of the AOA's Clinical Assessment Program (CAP) in residency programs (see http://cap.aoa-net.org/) and the movement of CAP into osteopathic physicians' offices.

Dr Osborn also notes how Dr Still and the Mayo brothers agreed that the medical establishment should focus on the patient instead of diseases. The AOA has long recognized this need, reaffirming its commitment by formally adopting the tag line "DOs: Physicians Treating People, Not Just Symptoms" in 1999 as part of the Unity I campaign.

In regard to research, the AOA supports efforts to increase research within the osteopathic medical profession. As Dr Rogers[3] noted in his article, the AOA was one of the founding organizations of the Osteopathic Research Center (ORC) in Fort Worth, Tex (see http://www.unthsc.edu/orc/about/). Since providing initial funding to the ORC in 2001, the AOA[4] has continued to support the Center. Most recently, at its annual meeting in July 2005, the Board of Trustees approved a second grant to the ORC amounting to $250,000 over the next 4 years.[5]

Although I am pleased to see that Dr Rogers supports the ORC, his implication that the ORC is tied to only one of the 23 osteopathic medical school campuses is troubling. While the ORC may be located at the University of North Texas Health Science Center at Fort Worth—Texas College of Osteopathic Medicine (TCOM), its reach spans to all of our colleges of osteopathic medicine and other research sites across the nation through multicenter national clinical trials.

For example, the ORC is monitoring the Multi-Center Osteopathic Pneumonia Study in the Elderly, fostering collaboration among the following groups[6]:

- Doctors Hospital–Ohio Health Inc (Columbus, Ohio);
- Kennedy Memorial Hospitals/University Medical Center, Stratford Division (NJ);
- Kirksville College of Osteopathic Medicine of A.T. Still University of Health Sciences (Mo);
- Mount Clemens General Hospital (Mich);
- Northeast Regional Medical Center (Kirksville, Mo); and
- TCOM.

In addition, in its June 2005 Annual Report, as presented to the Board of Trustees, the ORC released a nationwide call for collaborative research partners for the Developmental Center for Research in Osteopathic Manipulative Medicine.

I agree with Dr Osborn and all three authors that more research will help establish the osteopathic medical profession's distinctiveness. However, the AOA's ongoing research initiatives should not have been ignored in that analysis. The structure and function of both basic and clinical research efforts within the AOA are now in proper alignment, thanks to the reorganization the AOA Board adopted 3 years ago for its Bureau of Osteopathic Clinical Education and Research and its Council of Research.

At the end of his editorial, Dr Osborn poses the question, "To what extent is the distinctive osteopathic identity alive, well, and clinically demonstrable?" I cannot say to what extent because I believe the state of the profession is constantly changing and growing. But I can definitely say that, through the work of the AOA's members and its many volunteer leaders, the distinctive identity of osteopathic medicine is indeed *alive*, as shown by our ever-increasing research efforts; *well*, as shown by the growth in the number and class sizes of colleges of osteopathic

medicine[7,8] and by the AOA's commitment to ensuring that such growth is responsible[9]; and *clinically demonstrable*, as shown by the success of CAP,[10] which has been well-received by health insurance executives and federal health officials alike during collaborative meetings with the AOA.

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Response

It is with pleasure that I respond to the letter to the editor by John B. Crosby, JD, regarding my editorial in the May 2005 special focus issue of this JOURNAL(*J Am Osteopath Assoc*. 2005;105:241–244). As the executive director of the American Osteopathic Association (AOA), it is appropriate and consistent with Mr. Crosby's position to call readers' attention to the profession's recent responses to the topics addressed in that issue of *JAOA*. The initiatives, themes, and examples Mr Crosby cites are all valid and accurate.

The AOA's role in the founding and ongoing support of the Osteopathic Research Center (ORC), located on the campus of the University of North Texas Health Science Center at Fort Worth—Texas College of Osteopathic Medicine, is indeed an important step toward developing a culture of research within the osteopathic medical profession.[1–3] The promotion of the Clinical Assessment Program (CAP) is, likewise, a major step in promoting structured documentation of the distinctive dimensions of osteopathic patient-centered care.[4,5] Similarly, just we applauded the vision of George Thomas, DO,[6] during his 2004–2005 term as AOA president in his campaign for "Patient-Centered Quality Care," we join current AOA President Phillip L. Shettle, DO,[7] in taking "Pride in the Profession." All of these measures are very positive, should receive the ongoing support of the entire profession—and should have been included in my editorial.

Mr Crosby's letter, however, confirms and reinforces the main points of the editorial and the articles by Leonard H. Calabrese, DO,[8] Robert Orenstein, DO,[9] and Felix J. Rogers, DO.[2] All the initiatives and efforts Mr Crosby notes are recent.

On its Web site, the ORC describes itself as "a relatively new organization, founded in 2001."[10] Although CAP was piloted in 1999, Dr Thomas' vision,[6] which expanded the applications of the program from osteopathic medical residency programs only[4,11] to private clinics,[5,6] date from his 2004–2005 presidency.

Within the historical context of a profession that is over 110 years old, the examples cited by Mr Crosby are, indeed, quite recent. The fact remains that the profession has yet to develop a culture of scholarly endeavor that will help to more closely align reality with rhetoric.

The intent of my May 2005 editorial, consistent with its title, "Taking osteopathic distinctiveness seriously: historical and philosophical perspectives," was to emphasize this broader context and encourage thoughtful reflection. The intent of the entire issue was to stimulate wider discussion. I am pleased that, from this perspective, we appear to have succeeded.

Since the issue's publication, I have had numerous interesting conversations with fellow osteopathic physicians on the topics addressed in that issue of the *JAOA*. I have also been engaged in one particular, ongoing conversation with a medical historian at Pennsylvania State University (University Park). However, these many discussions most frequently turn to the comparison made by Dr Orenstein[9] of Kirksville, Mo, with Rochester, Minn.

Many have speculated what the town of Kirksville might look like today if the leadership of Kirksville College of Osteopathic Medicine had developed a tradition consistent with the "Mayo model." Many of these conversations have been characterized by bewilderment as to why a "parallel and distinctive"[12] culture of research and inquiry did not develop expeditiously during the rapid expansion of the colleges of osteopathic medicine after 1969.

It is always interesting and vitally important to reflect on the lessons of history in a critical and unflinching manner. It is even more important to use these lessons to inform the present and actively shape the future. Mr Crosby's thoughtful and well-crafted letter reflects the importance of recent efforts by the AOA in shaping the future of the osteopathic medical profession. With the support of us all, that future will look even brighter.

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(continued on page 213)

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Response

I thank all four letter writers for their provocative comments.

The tenets and principles of osteopathic medicine can be advanced through research, scholarly publications, education programs, and clinical practice. To that list, John B. Crosby, JD, executive director of the American Osteopathic Association (AOA), adds advocacy by the presidents of the AOA and public relations/marketing.

R. Paul Lee, DO, makes a plea for "connective tissue," as opposed to the musculoskeletal system, to be a defining element of osteopathic medicine. This suggestion from Dr Lee highlights a challenge we faced as an ad hoc committee charged with updating the tenets and principles of osteopathic medicine in 2002.[1] Although we were tempted to make a statement of personal preference, our obligation was to present the dominant expression in philosophy and in clinical practice. The most prominent interpreter of osteopathic medicine in the 20th century was Irvin M. Korr, PhD, a member of our ad hoc group. Dr Korr often referred to the central role of the musculoskeletal system.[2,3] Dr Lee reminds us of our founder's description of the fascia as the dwelling place of the soul. That description has a certain charm. It calls to mind the colorful language Andrew Taylor Still often used as well as the many "supremes" that he cited, which include the artery, nerves, the lymphatics, the diaphragm, and cerebrospinal fluid.[4]

Mark E. Rosen, DO, addresses an issue that is often a challenge for those who try to define the distinctiveness of osteopathic medicine. If one is restricted to those areas where osteopathic medicine is unique, the "definition" becomes a short statement and misses the comprehensive scope of our profession. Likewise, an emphasis on attributes of osteopathic medicine that may be shared with other healthcare providers (eg, a "whole person" approach, the patient as the focus for healthcare) risks the interpretation that an osteopathic physician is just another "good physician." Our group tried to capture the distinctive and comprehensive nature of osteopathic medicine with the proposed tenets and principles of osteopathic medicine,[1] which updated the previous statement from 1953[5] and expanded it to define principles for patient care. Our work in 2002[1] represented the foundation for my May 2005 special communication.[6]

Douglas M. Goldsmith, DO, and Mr Crosby both mention the Osteopathic Research Center (ORC) based on the campus of the University of North Texas Health Science Center at Fort Worth—Texas College of Osteopathic Medicine. I did not want to emphasize the topic of research in my article[6] because the focus of my piece was the advancement of the tenets and principles of osteopathic medicine through clinical practice, which I feel is a practical goal.

On the other hand, establishing a research center is a daunting proposition. Centers of excellence in research typically call for start-up costs of between $10 million and $40 million—or more. Furthermore, such centers need to develop in the context of a major institution-wide program of research that is much larger in scope. The ORC was established with seed money ($1.1 million over 4 years) from the AOA, the American Osteopathic Foundation, and the American Association of Colleges of Osteopathic Medicine. This seed grant allowed the ORC to take the first step to apply for additional funding so that it may become a center of excellence.

As a member of the external advisory committee to the ORC, I know they have made remarkable progress in a short period, conducting multiple clinical trials and winning a U19 grant from the National Institutes of Health (NIH). Since my last visit to the ORC in April 2005, they have secured a grant from the Osteopathic Heritage Foundation that will allow them to conduct a national search for a research chair to head the basic science program. The next step for the ORC is to obtain funding for an NIH program project grant ($5 million to $10 million). At that point, the ORC will have a center of excellence in osteopathic manipulative medicine, the only such center in the country.

Like Dr Goldsmith, I was a medical student at the Kirksville College of Osteopathic Medicine in Missouri and had the opportunity to work with John

Stedman Denslow, DO, and Irvin M. Korr, PhD. That research program was unparalleled at the time and served in many ways as a model for the current ORC.

It is important to dispel the unfortunate impression that the ORC now meets the research needs of our profession, as might be inferred from Mr Crosby's comments. Osteopathic medicine is a complete school of practice. It is far too large for any one research center to establish a program to test our tenets and principles, much less to define our future growth and development.

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Let the Beauty of the Marketplace Benefit Healthcare

To the Editor:

I was interested to read the article on concierge care in the November 2005 issue of *JAOA—The Journal of the American Osteopathic Association* (Linz AJ, Haas PF, Fallon LF Jr, Metz RJ. "Impact of concierge care on healthcare and clinical practice." 2005;105:515–520). The authors provided a balanced presentation of the usual points brought up about this subject in the press and in other published journal articles since the 1990s. However, there are important additional points that are rarely made and that I think warrant mention.

First, monthly fee practices and similar financial arrangements between physicians and patients (which all may be considered types of "concierge care") represent the first serious effort in the past 25 years to create a genuine marketplace for medicine (ie, a place where physicians and patients mutually control the price, availability, and quality of care). Control of pricing has been gradually eroded by increasingly restrictive health insurance contracting practices. The "hold harmless" clauses in health insurance contracts were originally designed to protect patients against the insolvency of insurance carriers.[1] However, with the advent of preferred provider organizations (PPOs) in the 1980s, this contract language changed to give the insurer the additional right to determine the price of medical services and to constrain physicians from billing patients for the difference between the physician's charge and the insurer's maximal allowance (except for copays and deductibles, which are also determined by the insurer).

It originally appeared as if the regulators and insurers agreed that PPOs would be a good way to reduce the ongoing inflation in healthcare costs. In reality, however, insurers can make more money if the price of healthcare is higher, because a substantial portion of their income derives from investing the temporarily pooled money they have collected for reimbursing healthcare costs.

Despite the enhanced "hold harmless" clauses, which have become standard fare in health insurance contracts in the United States (certainly in all PPO and health maintenance organization contracts), the price of US healthcare has skyrocketed, particularly since the inception of the Medicare program in the 1960s.[2] Inflation in healthcare services has outstripped the rate of growth of the consumer price index by a whopping 50% since 1965 and by 70% since 1980.[2] When physicians cannot control their own prices, how can patients—who used to carefully monitor healthcare costs in the days prior to widespread health insurance—exert any influence on costs? Insured patients have had little incentive to demand lower prices, so they have rarely done so. However, if patients have little control over the cost of healthcare, they also have little control over the quality of care and services provided to them.

Physicians have not actually worked for their patients for at least the past 30 years, since health insurance became common. Instead, physicians today work primarily for their employers, insurers, or the government—and the quality of care reflects this fact.

Physicians spend inordinate amounts of time and money trying to satisfy the requirements of insurance companies. The cost of billing in many medical offices may exceed 25% of receipts, if one includes the costs of dedicated computer billing systems, excessive physician time spent on documentation, additional employees, delayed reimbursement, and complex electronic communications equipment to allow direct billing of insurers. Physicians are forced to study the fine points of billing codes in lieu of the fine points of medicine. Those physicians who spend extra time with patients and do the hard work of preventive medicine are paid the same as those who herd patients through the office like cattle.

As Linz and his colleagues appropriately point out in their article, patient satisfaction rates of less than 50% are a verifiable feature of the current system. Thus, the advent of a marketplace in which patients can purchase healthcare directly from physicians should be greeted with celebration from the medical community, government officials, and the public. The beauty of the mar-

ketplace is well known and time tested. The predictable evolution in market systems is toward increased consumer and vendor satisfaction, lower prices, greater availability, higher efficiency, improved services, and constant innovation. The current, traditional system of healthcare, by contrast, provides all the wrong incentives, and its outcome is also predictable: ridiculously high inflation, physician and patient dissatisfaction, glacially slow rates of adopting new technology, and constant roadblocks to innovation and improvement.

A second important point that should be made about concierge care is that monthly fee practices need not be available *only* for the rich. I have seen subscription rates for such practices in Seattle as low as $35 per month, for plans that provide patients with extra access to services and greater availability of physicians. When Mitchell Karton, MD, and I opened our retainer practice in 1997, we charged $65 per month for inclusive internal medical services, with no additional charges to patient or insurer for other in-house medical care or laboratory services.

Many critics and pundits have chosen to ignore such lower-priced models of concierge care, most likely because these models do not fit well with their arguments that monthly fee practices foster inequality in the provision of healthcare.[3] However, what sane American would object to physicians providing same-day care, longer visits, understandable fee structures, and greater attention to preventive care?

Some critics object that the services provided in monthly fee practices are not universally available for free. Unfortunately, nothing worthwhile is free. If these services are not provided within a market-based environment, they will become increasingly expensive, awkwardly administered, rarely updated, and ultimately rationed as the cost of the system spirals out of control.

A third major point regarding concierge care is that people in the United States have labored for 50 years under the delusion that health insurance *is* healthcare. But it is not. Health insurance is simply a promise to pay for some portion of the cost of care. Insurance as a management vehicle for care is severely flawed. Insurers have not—and cannot—measure the quality of the services they are buying with any accuracy. As a result, there is little incentive to improve the quality of those services.

For better or for worse, the only people who have an informed opinion about the quality of healthcare are the doctor and the patient. Neither is consulted by the health insurance industry in any meaningful way. This is not to say that insurance doesn't have a place in healthcare. Obviously, health insurance is an invaluable aid in preventing financial devastation for the seriously ill. It is time, however, to acknowledge that insurers cannot reproduce the laudable aspects of a well-tuned marketplace.

Concierge care (or whatever name one chooses to call it) represents the first step in enrolling physicians and patients in a marketplace that will benefit them both. This movement has overcome significant resistance from insurers, the press, and the government, both at the state and federal levels.[4–7] The success to date of more than 250 physicians in monthly fee services (a conservative estimate based on membership in the Society for Innovative Medical Practice Design and MDVIP Inc, the leading franchiser of concierge care) has proved that patients are attracted to this type of healthcare model. In November 2005, MDVIP, of Boca Raton, Fla, was recognized as one of the fastest growing companies in the United States, with a sales growth rate over the previous 3 years of 1814%.[8]

In light of such successes, even the detractors of monthly fee practices should be compelled to admit that something that satisfies the needs of both patients and physicians may not be all bad.

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Response

To the Editor:

We appreciate the letter and comments by Garrison Bliss, MD, regarding our special communication article that appeared in the November 2005 issue of *JAOA—The Journal of the American Osteopathic Association* (Linz AJ, Haas PF, Fallon LF Jr, Metz RJ. "Impact of concierge care on healthcare and clinical practice." 2005;105:515–520). As president of the Society for Innovative Medical Practice Design, Dr Bliss expresses some concerns that we feel are worthy of additional dialogue. In our article, we attempted to remain objective and nonjudgmental in our review of the merits, as well as the shortcomings, to healthcare and medical practice of concierge-/boutique-/retainer-type medical practices. Our article's authors included an osteopathic physician from traditional healthcare (A.J.L.), an allopathic physician from concierge-style medicine (R.J.M.), a professor of public

health (L.F.F.), and an economist (P.F.H.). We expected that this mix would help provide an unprejudiced and balanced perspective on this emerging nontraditional practice model.

In the present response to the letter of Dr Bliss, we would like to further examine the issues of equity, costs, marketplace forces, physician and patient satisfaction, and insurance as they relate to concierge care and other monthly fee practices representing comparable financial arrangements.

Dr Bliss describes concierge-style practices as an innovative concept in creating a genuine marketplace for healthcare. We do not argue that concierge care is an alternative method to address the financial issues that exist between healthcare providers and patients. However, access to such care is limited to those having financial means. This type of care is not a marketplace that is accessible to all Americans. Although it is laudable, as Dr Bliss points out, that some physicians practicing concierge care set a range of fees to permit lower-income patients to gain access, marketplace incentives suggest that such a practice is not typical. Markets work on the principle of profit maximization. To the extent that higher-income families will gain more access to concierge care, concerns about equity in healthcare will remain.

Dr Bliss discounts the availability of concierge care for only the rich by citing his personal observations of lower-priced models of concierge care that provide patients with extra access to services and greater availability of physicians—models that, according to his letter, "[m]any critics and pundits have chosen to ignore." We feel that these models are certainly worthy of note. Yet, it must also be acknowledged that some researchers[1] have concluded that both concierge and nonconcierge care provide many of the same kinds of services.

For example, Alexander et al[1] found that, despite notable differences between concierge-style (retainer) care and nonconcierge (nonretainer) care, there was considerable overlap in the types of services provided. In a nationwide mail survey of retainer physicians (N=144, 58% response rate) and nonretainer physicians (N=463, 50% response rate), the researchers noted that a considerable proportion of nonretainer physicians reported providing 24-hour access (40% vs 91% for retainer physicians), same-day appointments (83% vs 96% for retainer physicians), and coordinated hospital care (59% vs 86% for retainer physicians).[1] Alexander et al[1] also found evidence that many patients discontinued their association with physicians after the physicians converted to concierge/retainer practices.

Furthermore, Alexander et al[1] noted the tendency of retainer physicians to have a different mix of patient cases than their nonretainer counterparts, with smaller proportions of patients with diabetes mellitus (and perhaps other chronic diseases) being seen in retainer practices. Physicians in retainer practices also cared for fewer African-American and Hispanic patients than did physicians in nonretainer practices.[1] The authors proposed that part of this dissimilarity in patient populations may be the consequence of most retainer practices emerging in high-income locations.[1]

The American College of Physicians has expressed its concerns about equity in concierge care in an official position paper.[2] The paper submits the opinion that physicians who participate in concierge-type practices should be aware that, by limiting their patient populations, they "risk compromising their professional obligation to care for the poor and the credibility of medicine's commitment to serving all classes of patients who are in need of medical care."[2]

We agree with Dr Bliss that the costs for healthcare services have increased. However, we do not attribute all the blame for this to the lack of market forces in the healthcare industry. Some of the cost increases are the result of other factors, including innovations in technology. Unlike nonmedical industries in the marketplace, the healthcare industry has had rising costs of technology that have not been accompanied by decreased profit margins in products, services, and insurance.[3] Advances in technology, including methods for earlier detection of illnesses and better treatment of patients, have improved life expectancy and mortality rates in the United States at soaring expense. Yet, attempts to reduce cost factors in other areas have not been achieved.

In focusing on Dr Bliss's main argument, describing the effectiveness of market forces in providing healthcare, we wish to urge caution. As we stated in our article, "Often, the availability of [market forces] provides an incentive for increased or improved output by producers. Similarly, concierge care should remain a viable option for consumers as long as it does not drain resources devoted to the mainstream healthcare system." Dr Bliss is correct in stating, "Unfortunately, nothing worthwhile is free." But it should also be noted that, given limited resources, increased amounts of care will result only if there is increased efficiency, a greater number of providers, or a reduction in healthcare access for some patients. Dr Bliss apparently expects that improved efficiency and the entry of new caregivers will solve problems related to access to care. However, we are not so certain.

Dr Bliss writes, "The beauty of the marketplace is well known and time tested. The predictable evolution in market systems is toward increased consumer and vendor satisfaction, lower prices, greater availability, higher efficiency, improved services, and constant innovation." We agree that such results can be predicted in a system that has all the characteristics of a competitive marketplace—that is, many buyers and sellers, easy entry and exit of sellers, and adequate knowledge on the part of all participants in the marketplace.

Unfortunately, two of these three characteristics are not readily found in healthcare: entry into the marketplace is not easy, and an asymmetry of information exists between a physician and patient. When an individual purchases a car, there are many available sources in which a consumer can obtain useful and reliable information. Similar sources of information about healthcare providers are not usually available. Thus, the pressures to achieve competitive results are altered so that the market's "predictable evolution" cited by Dr Bliss is not inevitable.

Henderson[4] explains that markets and pricing serve as the most efficient ways to allocate or ration scarce resources. He describes the concept of healthcare rationing as affecting how dollars existing in short supply (rather than technologies or services) are distributed. Although competition exists in the healthcare industry, it is dramatically altered by societal interventions. Patients cannot rely on the usual competitive market forces and conventional economic models to achieve desirable outcomes in healthcare.

There are many aspects of healthcare that reach beyond the marketplace to have great importance in the public sector. Certainly, each individual should benefit from the care that he or she receives. But society as a whole also stands to benefit from a good healthcare system. The healthier the society, the more productive and resourceful it will be. In addition, to the extent that certain health problems are transmissible, appropriate healthcare is a public good that requires government intervention.

Thus, we have a dilemma. It is true that market forces tend to make markets more efficient, but these forces do not necessarily make healthcare more effective. As stated by economist Uwe E. Reinhardt,[5] "a cost-minimizing (efficient) policy that succeeds in immunizing only, say, 80% of a target population is not necessarily superior to a more wasteful (inefficient) policy that succeeds in immunizing the entire population."

Several related models of innovative practice appear to be evolving in the healthcare marketplace. We speculate that this may be, to a certain extent, one reason that the American Society for Concierge Physicians changed its name to the Society for Innovative Medical Practice Design.[6] The former name suggests ultraluxurious services for the wealthy, whereas the newer name suggests many different practice designs or models that the marketplace may find easier to accept. Although lower-fee monthly payment plans as described by Dr Bliss may be available, these are just one type of concierge model. Other plans purportedly charge much higher annual fees.[7] Many of the higher-cost plans accept a small percentage of patients who are unable to afford the retainer fee.[1] In this way, the physicians in these plans may contribute to the community. Still, it is also true that many patients who cannot afford retainer fees are forced to find other physicians to care for them.[1]

Whatever the healthcare model used, more time and focus on the needs of each patient would likely promote better care. Eventually, healthcare market forces may determine which practice designs become more successful, provided that intrusions from government and the insurance industry do not cause serious restrictions. We agree with Dr Bliss that the most important relationship in any healthcare system should be between the patient and physician. We also agree that market justice and the availability of more than one type of healthcare model would support the ability of patients to maintain the right to choose their own physicians and the types of practice they believe will give them the best value for their needs.

Dr Bliss notes that concierge care has the potential to address concerns about physician dissatisfaction with various aspects of traditional healthcare models, such as insufficient time spent with patients. Surveys support the idea that healthcare models that allow physicians to better manage their time will improve physician satisfaction. Landon et al[8] studied career satisfaction among primary care and specialist physicians who spent at least 20 hours per week administering direct patient care. In a series of three nationally representative telephone surveys conducted between 1996 and 2001 (>12,000 respondents in each survey), physician satisfaction varied greatly among geographic sites. The surveys found that the highest satisfaction levels were mostly associated with physicians' ability to manage their time, provide high-quality care to patients, and preserve their autonomy.[8]

Murray et al[9] examined physician satisfaction involving various delivery system settings in Massachusetts. The researchers concluded that physician dissatisfaction was most closely related to limited amounts of time they had to spend with individual patients, as well as to limited amounts of leisure time and few incentives for delivering high-quality services.[9] Such findings suggest that physician satisfaction could be enhanced by a healthcare delivery system similar to concierge care.

Improvements in patient satisfaction in concierge care, compared with traditional healthcare models, are also suggested by Dr Bliss. We agree that concierge care models that ensure continuity of care with a consistent provider are likely to be particularly beneficial to patients. Nutting et al[10] found that continuity of physician care was valued by patients, especially those who were most vulnerable (eg, those who were elderly or less educated, those who relied on Medicare or Medicaid insurance, those who had several chronic conditions and used many medications, and those who visited physicians frequently).

Gross et al[11] found that patient satisfaction increased when office visits were longer than 15 minutes. Dr Bliss argues that increased length of

office visits is a likely added amenity of concierge care. Nevertheless, opponents of concierge care counter that such "luxuries" in primary care may promote services that are inappropriate and contribute to healthcare overuse.[12]

In regard to medical insurance, we concur with Dr Bliss that health insurance and healthcare are not synonymous. Health insurance, a method to reduce the out-of-pocket expenses of healthcare, initially began as a way of providing protection against catastrophic expenses. In an era of relatively low costs for healthcare, it evolved into a process for reimbursing essentially all medical expenses. Today, the higher costs of healthcare are increasingly shared by patients and providers of insurance. Although Dr Bliss acknowledges that the concierge care movement has experienced some success in overcoming resistance from insurers, as well as from the press and government, we remain unconvinced that concierge care has proven itself to be equally beneficial to both physician and patient.

Dr Bliss concludes his letter by stating, "In light of such successes, even the detractors of monthly fee practices should be compelled to admit that something that satisfies the needs of both patients and physicians may not be all bad." Although we agree in part with this assessment, we must counter his argument by reiterating that—because of issues involving equity, access, and cost—concierge care is not available to all persons.

We would like to conclude by proposing that concierge care is not a universal solution for meeting the healthcare needs of society. However, we concede that this type of practice model satisfies many desirable requests of a very small and select niche of privileged or franchised patients and physician providers.

The evolution of concierge care and similar innovative styles of medical practice remains uncertain as physicians, patients, insurers, purchasers, healthcare organizations, and government agencies attempt to cope with a healthcare environment characterized by increasing regulation and demand, limited resources, mounting costs, expensive technology, decreasing professional autonomy, and asymmetry of information. Scott[13] has suggested that if an alternative model of healthcare similar to concierge care becomes much more prevalent, it is likely to cause increasing inequity between our society's haves and have-nots, further intensifying what many view as a three-tiered healthcare system consisting of one tier for the rich, one for the middle class, and one for the poor.

As controversy continues between proponents and critics of concierge-style care, an ultimate verdict on this healthcare model will await further study. The jury remains out.

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Residents' Wisdom Regarding Narcotics

To the Editor:

I read with interest the letter by Dr Todd Fredricks in the November 2005 issue of *JAOA—The Journal of the American Osteopathic Association* ("Doctors' dilemma: prescription pain medications." 2005;105:493–495). I agree that there are many patients who are being prescribed narcotics for relatively minor medical concerns and that it is relatively easy for these patients to find physicians who will fill prescriptions for controlled substances. The improper prescribing of pain medications can cause a number of problems for physicians and patients.[1–3]

One dilemma commonly confronted by faculty members in residency training programs is how to advise residents to treat a patient who has a history of escalating narcotic usage with no definite or objective physical findings. During the Difficult Case Discussion, a resident case conference held in Portland, Ore, in November 2005, I, as a faculty member, presented the case of a patient of mine who had been using narcotics (acetaminophen/hydrocodone [Vicodin]; acetaminophen/

oxycodone [Percocet]; methadone [Methadose/Dolophine]; oxycodone [OxyContin]) for a sustained period. I then asked the residents to "guide" me through a strategy of treating this patient.

At the beginning of the conference, I asked the residents to carefully consider my patient's medical history, the results of his physical examination, and the symptoms he described at each of his encounters with me. I also let the residents know that I was in a bit of a quandary as to how to proceed with my care for this patient.

The patient was a 50-year-old man who had symptoms of neck, shoulder, and back pain for an unknown duration. He told me that the pain began after a series of automobile accidents. His first visit with me came after he had "helped a friend move a refrigerator." This activity prompted a trip to the emergency department in which he was treated for a flare-up of his neck pain. The narcotic and muscle relaxant prescribed by the emergency department physician was not providing enough relief, however. He said that he came to see me because he wanted something a little stronger.

The patient told me that he had recently been discharged from another physician's care for repeatedly missing or being late for his appointments. He said he had also been discharged from a pain specialist's care after testing positive for cannabinoids in his urine. Since being discharged, he had been obtaining his pain medication by ordering it from certain Web sites. During this first visit with me, he requested a small increase in his pain medication, asking if he could have a prescription for two Vicodin pills every 4 hours (compared with his existing prescription of one pill every 4 hours).

At our next meeting, which came alarmingly just 10 days after our first encounter, the patient told me that he was about to run out of his Vicodin. He pointed out that he was taking his pain medication exactly as I had prescribed—one to two pills every 4 hours. However, he added, he was taking a total of 12 pills per day because, "I never sleep more than 4 hours at a time." In fact, he told me with a straight face that he probably could make due with a prescription for 320 Vicodin per month or a change in his prescribed medication from Vicodin to Percocet or OxyContin.

A brief trial of OxyContin, which is a longer-acting opioid than Vicodin, failed to result in decreased usage of Vicodin by the patient. He returned to see me, reporting that he had again been in automobile accident and was in worse pain than before. He also told me that he had not called the police or emergency services (911) despite suffering a 10-minute loss of consciousness. During this third visit, we again discussed options for nonnarcotic pain relief (eg, anti-inflammatory medication, osteopathic manipulative treatment, physical therapy, psychological counseling, neurosurgery). I could not understand why this patient with a history of chronic pain was moving a refrigerator. Nor could I understand why he did not call 911 after his stated loss of consciousness.

Because pain is an inherently subjective experience (pain has been defined as "an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage"),[4] my patient's requests for narcotic pain relief presents a dilemma. It is complicated by the fact that he characterized his experience of pain as a cause for significant disability in his life. However, he refused every other therapeutic modality, including osteopathic manipulative treatment, that I suggested. So, I asked the residents at the conference, "How would you treat this patient?"

I was pleased to hear the following suggestions offered by the residents in response to my question:

- You are not obligated to prescribe this patient narcotics; you have enough doubt about his motives to refuse to supply him with these medications. Tell him that you are not going to provide him any more controlled substances until you can better understand his problems.
- Explain to the patient that pain is a physiologic response to injury that can be further intensified if he is depressed. Perhaps this patient could benefit from other forms of treatment (eg, antidepressants, psychotherapy), rather than narcotics.
- The patient should sign a narcotic contract in which he agrees to specific parameters for his behavior.

I discussed these suggestions with my patient at our next—and final—visit, and he responded by telling me that he saw no need to continue as my patient. He said that if I was not going to continue to prescribe him the pain medications that he was requesting, he would find someone else who would. While I don't typically relish losing a patient, I was somewhat relieved that he was quitting my practice based on refusing my offer to provide him alternative treatments for his pain. Hopefully, the next physician that he contacts will request to see his past medical records.

For physicians who find themselves with similar patient situations, I have a number of recommendations. The advice that the residents gave at the conference is well worth considering. Interactive discussions among healthcare providers can serve as an opportunity to use a "team approach" rather than an individual approach in determining patient care. In addition, it is important that physicians at all levels of experience be exposed to quandaries similar to this so that they don't become unwitting participants in drug seekers' efforts to obtain narcotics.

I thank Dr Fredericks and the *JAOA* for bringing this subject to light and allowing a dialogue to occur.

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Follow Precautions When Prescribing Opioids

To the Editor:

Important issues were raised in the letter by Dr Todd Fredricks in the November 2005 issue of *JAOA—The Journal of the American Osteopathic Association* ("Doctors' dilemma: prescription pain medications." 2005;105:493–495). The anecdotal experience described by Dr Fredricks concerning the abuse of opioids by patients with no medical need for these pain medications highlights the valid concerns of many physicians. To confront these concerns, I urge physicians to review the list, compiled by Cole,[1] of common practices that get physicians in trouble when prescribing opioids. These practices include the following.

- Failure to evaluate the patient, such as not obtaining a personal history or conducting a physical examination of the patient.
- Failure to make any diagnosis prior to starting treatment with a controlled substance.
- Failure to obtain outside medical records of the patient, to talk with practitioners who previously treated the patient, or to obtain any verification at all of the patient's condition.
- Failure to establish goals for treatment (eg, reduction in pain, improvement in function).
- Failure to suspect patient misbehavior or substance abuse (eg, no screening for addictive potential, no monitoring through treatment).
- Failure to document the diagnosis, treatment plan, and goals for treatment, as well as the patient's continuing need for medication and test results.
- Failure to understand what information drug testing can and cannot reveal about patients.
- Deviation from the physician-patient "contract" (eg, patient misbehavior is never addressed properly by the physician).
- Blind acceptance by the physician of everything said by the patient regarding his or her condition.

Being aware of these pitfalls and following simple precautions to steer clear of the dangers can help physicians avoid the unfortunate experiences that Dr Fredricks outlines in his letter, in which a patient went from physician to physician falsely claiming to have posttraumatic stress disorder so that he could obtain pain medication. Many practitioners have learned the hard way that strictly following such precautions is crucial for the protection of their patients—as well as for the protection of themselves.

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Calling All Osteopathic Physicians in New England!

To the Editor:

I was glad to read the letter by Charles Perakis, DO, in the November 2005 issue of *JAOA—The Journal of the American Osteopathic Association* ("Dynamic duo: Maine-Dartmouth Family Practice Residency Program and University of New England College of Osteopathic Medicine." 2005;105:495–496). Dr Perakis described the evolution of an osteopathic family practice residency program that is integrating well into an allopathic residency program in Maine, resulting in the development of many family physicians in rural areas. I would like to echo the plea of Dr Perakis for former osteopathic medical students and residents to assist in improving the overall education of osteopathic residents throughout New England, as well as in other parts of the United States.

I am the director of medical education at the New Hampshire–Dartmouth Family Practice Residency (NHDFPR) in Concord, NH. Our Accreditation Council for Graduate Medical Education-accredited residency program was launched in 1995. We have had an established American Osteopathic Association (AOA)-approved internship since 2002, and our application for an AOA-approved residency program has been submitted.

Since my tenure at the NHDFPR began in 2000, I have observed the high caliber of osteopathic medical students who have graduated from the Kirksville College of Osteopathic Medicine of A.T. Still University of Health Sciences in Mo; the New York College of Osteopathic Medicine of New York Institute of Technology in Old Westbury; the Philadelphia College of Osteopathic Medicine in Pa; and the University of New England College of Osteopathic Medicine in Biddeford, Me. The most exciting aspect of this experience has been watching the allopathic faculty and staff at Concord Hospital also recognize the high caliber of students and residents that the osteopathic medical schools are turning out.

I call out to New England osteopathic physicians interested in bolstering resident education—especially in the area of osteopathic manipulative medicine—to help contribute to the education of new osteopathic physicians. I appreciate and extend a

"thank you" to those who have already had a part in this endeavor. I would also like to thank Dr Perakis, who was one of my instructors at the University of New England College of Osteopathic Medicine in the 1992–1993 academic year.

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