47th annual Thomas L. Northup Lecture

Transitions: Our Own, Our Patients', Our Profession's

Doris B. Newman, DO, FAAO

ORIGINAL RESEARCH

Editor's note: Doris B. Newman, DO, FAAO, presented the AAO's 47th annual Thomas L. Northup Lecture on October 25, 2019, at the American Osteopathic Association's annual OMED conference in Baltimore. Thomas L. Northup, DO, for whom the lecture is named, was a founding member of the Academy of Applied Osteopathy, the forerunner of the modern American Academy of Osteopathy. The lecture has been edited for *The AAO Journal*. Dr. Newman's PowerPoint presentation is available at academyofosteopathy.org/OMED.

After serving on the faculties of the University of New England College of Osteopathic Medicine and the Nova Southeastern University Kiran C. Patel College of Osteopathic Medicine, Dr. Newman recently transitioned into private practice at the Osteopathic Medical Arts Center of South Florida (OMAC) in Wilton Manors, Florida, where she is delighted to be learning more about how to help patients find health.

Dr. Newman served as the AAO's 2015-16 president, and she also has served on the Board of Governors, Board of Trustees, and other committees.

The content of the lecture is from Dr. Newman's own musings and research and is not intended to be nor should be interpreted as representing any of the organizations for which she currently or historically held positions whether on boards, bureaus, or committees.

From the AAO's 47th annual Thomas L. Northup Lecture on October 25, 2019, at the American Osteopathic Association's annual OMED conference.

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Correspondence address:
Doris B. Newman, DO, FAAO
Osteopathic Medical Arts Center of South Florida
1201 NE 26th St Suite #109, Wilton Manors, FL 33305
(954) 381-7334
drnewman@omac.life

Introduction and Gratitude

As with all previous Northup lecturers, being chosen to deliver the Thomas L. Northup Lecture is a great honor for me, and I thank the Academy Board of Governors for this opportunity. Obviously, I never met Dr. Northup, so part of this honor is in gaining some insight and understanding of the man and his legacy. Like myself, and many other DOs, Dr. Northup did not have a direct path on his road to osteopathy. Dr. Northup spent his first 2 years of medical training in the early 1920s in an MD program at Syracuse Medical School. Facing some disillusionment about having no significant help for him and his family with the conventional medicine, he "packed up his family and moved to Kirksville, Missouri, to enroll in the osteopathic school."[1] Considered one of the founders of the American Academy of Osteopathy, ("The Academy"), Dr. Northup was concerned about graduates from the colleges of osteopathic medicine (COMs) lacking the "dedication to Osteopathic principles." In 1936, he organized a meeting during the American Osteopathic Association's convention, at which 66 DOs attended. Their mission? To "generate a petition for the development of a special section program at the AOA conventions to provide osteopathic structural diagnosis and manipulative therapy."[2] Ultimately, in 1938 the first organized meeting of the precursor to this Academy was formed and held their inaugural educational sessions. For his insight, dedication and forward thinking, I am indebted to Dr. Northup. We are all indebted to Dr. Northup.

Transition and Balance

Today I want to focus on 3 components of osteopathic medicine that might be considered the 3-legged stool upon which osteopathy balances every day. Without health in any one of these legs, the whole risks disease and will falter. These 3 areas are dynamic and ever evolving. Taking a thorough look at their present state of health is the only path to develop our differential diagnosis and from there, our plan of action. We must face the cold, hard reality of where we are, while at the same time looking forward to where we hope to be.

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AAO Mission and Vision

The Academy's mission for many years has been "to teach, advocate and research the science, art and philosophy of osteopathic medicine, emphasizing the integration of osteopathic principles and practice and manipulative treatment in patient care," and in 2015, the Academy's Board of Governors adopted a new vision statement, and as all good vision statements must, it is a bold vision: "All patients are aware of and have access to osteopathic medical care and osteopathic manipulative medicine for optimal health." It is with this vision in mind that today's topic was formulated.

Today's key message is:

- Like the ebbing and flowing of inherent motility, the state of the osteopathic profession is ever changing.
- Although uncertain, the future of osteopathy is most certainly in our hands.
- Today is the day and now is the time for you and me to recommit ourselves anew to the promise that is osteopathic medicine, with OMT as its fulcrum of motion, so that the Academy's vision can be realized.

Transitions: Our Profession

The first leg of the osteopathic stool is our profession. All things in life are cyclical. Our inherent motility, our diaphragmatic respirations, heartbeat and vascular systems and hormonal fluctuations are all cyclical. The same is true for our profession.

In August 2018, Justin Kaplan, a journalist, wrote an article for 90.9 WBUR titled, "Doctors Without MDs: What Makes Osteopathic Medicine Different?"[3] What is this "difference"? We are told that many DOs do not practice osteopathic manipulative treatment (OMT), the most obvious and tangible difference. If DOs no longer incorporate OMT into patient care, then what is the difference?

In her 2014 Northup lecture, Judith O'Connell, DO, FAAO, stated that osteopathic medicine "is the fastest growing health care profession in America."[4] Let's begin by looking at who and where the US osteopathic profession is and some of the work being done to move the needle towards the realization of the Academy's vision.

Colleges and Schools of Osteopathic Medicine Update

According to the AOA's 2018 Report on the Osteopathic Medical Profession (OMP) and detailed in the article by Mr. Kaplan, there were 35 colleges and schools of osteopathic medicine with campuses in 53 locations.[3,5] But a recent review of the AOA's website revealed that in 1 year that number has grown to 38 COMs on 59 campuses[6] with no end in sight. With nearly 31,000 osteopathic students, this portion of our profession has seen a 34% increase in the number of COM enrollees in just 5 years.[6]

COM Locations and Actively Practicing DOs By State for 2018

The states with the highest number of actively practicing DOs—including California, Texas, Florida, Michigan, Ohio, New York and Pennsylvania—have all had a COM for nearly 40 years. The Philadelphia College of Osteopathic Medicine has been going for 121 years. These 6 states represent a full 50% of all actively practicing DOs. Encouragingly, research tells us that nearly 80% of resident graduates tend to stay and work in the state where they attended medical school and residency. Therefore, the states with COMs, branches, or additional campus locations opened within the last 5 years and having fewer than 1,000 practicing DOs—including Idaho, Utah, Arkansas, and Alabama—will likely realize a surge of actively practicing DOs in their states over time.[7]

MD vs DO Matriculants, 2006-2019

According to the American Academy of Medical Colleges' (AAMC) website, the rate of MD matriculants rose 30% (to 21,622) since 2006 while the DO matriculants rose at a rate of 164% (to 8,124) over that same period.[8] By the time these matriculants graduate, DOs could comprise as much as 37% of all medical school graduates. So, this all looks wonderful. We need more physicians. We are building more DO and MD schools and we have the qualified applicants willing to take on the burden of time and money to become physicians, so our student pipeline seems solid.

Actively Practicing DOs

The AOA tells us that in 2018, including osteopathic students, there were 145,343 actively practicing or training DOs in the US.

Of those more than 145,000 actively practicing or training DOs, 65% are under the age of 45, 74% of women are under the age of 45, 60% of men are under the age of 45, and 15% are near retirement at ages 55-64 years. The AAMC tells us that within the next decade, nearly 2 in 5 currently active physicians will be over age 65.[9]

The percentage of women in the field of osteopathic medicine has grown exponentially as well. Andrew Taylor Still, MD, DO, the founder of osteopathic medicine, was supportive of women studying osteopathy from the very beginning, and the first class at the American School of Osteopathy (ASO) enrolled 5 women in a class of 21 students. Except for some decreased enrollment numbers of women in the 1950s and '60s, female DO students have continued to make gains such that, at present, 41% of all practicing DOs are women.[5]

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Many COM graduates still enter the primary care fields, and at present some 56.5% of actively practicing DOs are in the top 3 primary care fields of family medicine, internal medicine and pediatrics. Family medicine continues to be the predominant field. But of those family medicine DO graduates, how many intend to incorporate osteopathic manipulative medicine (OMM) into their practices?

How Many DOs Are Using OMT?

One study published in *The Journal of the American Osteopathic Association* in 2017 found no significant difference by sexes in the number of graduates entering family medicine residencies versus other specialties; however, they did find a statistical significance in graduating female DOs who indicated they believed the use of OMT would enhance their practice over their male counterparts (P=.005).[10]

When 3,000 randomly selected osteopathic physicians were surveyed in 1998, over 50% of the 33.2% who responded reported using OMT on fewer than 5% of their patients.[11] Statistics such as these are worrisome and put our profession at risk of losing our most tangible and obvious distinction compared to allopathic physicians.

US-Trained DOs' International Practice Rights

Where are DOs on the international stage? Internationally, US-trained DOs are making strides and breaking ground. Only last year, a United Nations' agency, the International Labor Organization, issued a letter affirming that US-trained osteopathic physicians are fully licensed physicians who prescribe medication and perform surgery, a recognition that should make it easier for US-trained DOs to gain practice rights internationally.[12]

Osteopathic International Alliance (OIA) data in 2013 estimated that at that time there were 87,850 osteopathic physicians worldwide with the vast majority in the US (82,500), but it might surprise some to know that even then, there were thousands of osteopathic physicians practicing in countries throughout the world with France, Germany and Russia having the most (1,600; 2,300 and 1,300, respectively).[13]

Progress in Osteopathic Research

In the 2011 Northup Lecture, Brian F. Degenhardt, DO, adeptly outlined the progress over the decades that the scientific community has accomplished in osteopathic research. He reminded us that more and more DOs are also PhDs and that when we cooperate with other health professionals, such as some MDs, chiropractors, physical therapists and others, our knowledge of the effects of manual medicine is enriched and broadened.[14]

But still, as an osteopathic physician, I often hear osteopathic physicians, residents, and students say, "OMT has no research to back it up." My retort is usually, "Have you looked?" One of the biggest barriers to searching for research concerning OMT and its application to disease states was the lack of osteopathic nomenclature being included in SNOMED, the Systematized Nomenclature of Medicine, a "systematic, computer-processable collection of medical terms." This lack of osteopathic terminology in SNOMED made researching topics in OMT difficult, if not impossible.

With the advent of electronic health records and through the diligent work of many osteopathic leaders, including the Academy's current president, Kendi L. Hensel, DO, PhD, FAAO, SNOMED now includes in its collection osteopathic medical terminology. Further, the Academy, initially focused primarily on the education of OMT skills and theory, is now deeply involved in scholarly endeavors. The *OsteoBlast*, highlighting manipulation research from several sectors, enters members' email inboxes on a weekly basis. Coupled with quarterly publication of *The AAO Journal*, the Louisa Burns Osteopathic Research Committee's (LBORC) extensive work, a robust poster competition, and the A. Hollis Wolf student case presentation competition every year at Convocation, the Academy and its volunteer physician researchers are doing their part in researching what we do. Today, you only need look for quality research on manipulative topics to find them.

In 2016, the AOA updated their "Guidelines for OMT for Patients with Low Back Pain." The new guidelines are based upon a systematic review by Franke et al, which reviewed 37 studies (16 excluded and 31 evaluated) on the topic of OMT for nonspecific low back pain.[15]

The updated guidelines report that OMT significantly reduces pain and improves functional status in patients, including pregnant and postpartum women, with nonspecific acute and chronic low back pain.[15]

It is studies such as this that led the Florida Legislature this year to include OMT as one modality that statutorily must be disclosed to patients as an alternative to schedule II drugs prior to prescribing.[16]

The Biggest Transition of the Osteopathic Profession in Our Lifetimes

The biggest transition of our profession and in our lifetimes will take place next year as our profession will see the end of AOA-accredited residency programs in favor of the single accreditation system from the Accreditation Council for Graduate Medical Education (ACGME). Gone are the days of the DO graduate almost

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always having a traditional rotating internship or AOA residency program available if their chosen specialty or their ACGME plans do not work out. Our graduates have enjoyed an almost protected status for these many years since neither MDs nor international medical graduates (IMGs) qualified for the AOA residencies.

ACGME data from 2019 reveals there are 11,621 accredited GME programs with 139,753 residents. All of this within 150(+) specialties and subspecialties.[17] Fewer than 2% (200, or 1.7%) of these ACGME programs currently have Osteopathic Recognition (OR). Disturbingly, the much lauded first program to obtain osteopathic recognition chose last year to forgo the designation, citing lack of interest from the faculty and residents. Conversely, some residency programs that were never credentialed under the AOA have sought and received ACGME osteopathic recognition.

History is being made. For the first time since its founding, the ACGME approved the osteopathic neuromusculoskeletal medicine (ONMM) residency standards, opening the door for DOs specializing in OMT to complete an ACGME residency and perhaps more significantly, for MDs to complete a program that focuses on incorporating OMT into medical care.

ACGME's ONMM—not to be confused with neuromuscular medicine, or NM—programs total 27 in number, 0.23% of all ACGME residencies, and this year the ONMM Review Committee (RC) approved 3 different entry points into an ONMM program. Specifically designated as ONMM-1, -2, and -3, allowing applicants to choose to:

- complete a full 3 years in ONMM by entering in the first year of a 3-year program,
- complete 2 years in ONMM following an internship, or
- complete 1 year in the ONMM-3 entry point following successful completion of another ACGME residency program (previously labelled NMM+1).

So, the opportunities for growth and expansion in the ONMM residencies, although not well known, are available to DO, MD, and IMG applicants with individual qualifications and basic OMM training being the purview of the individual residency program director.

But how are DO graduates faring in the ACGME match? American Association of Colleges of Osteopathic Medicine (AACOM) reports regarding students matching into residency revealed that in 2016, the first year after the beginning of AOA's exit from residency credentialing, 99.61% of DO students matched. At that time, the majority of DOs were still matching into AOA-accredited programs.[18]

By 2019, the numbers remained promising, but they have declined over the ensuing 3 years to 99.34% in 2017, 98.14% in 2018 and this year, 2019, 98.46%.[18]

Osteopathic physicians are infiltrating and infecting the ACGME with osteopathy and can now be found at all levels of leadership and committee work. As a membership organization, one of the first changes the ACGME made in preparation for the single accreditation system was to change their bylaws, thereby paving the way to increase their membership from 5 to 7 and to include the AOA and AACOM as members on their board.[19] In October 2019, ACGME announced that AAO member and AOA past president Karen Nichols, DO, was elected to serve as chair-elect of the board.[20]

DOs dominate the review committees for Osteopathic Recognition and ONMM, as we would expect. And incidentally, at the ONMM RC meetings, there are always 2 OMM tables, and yes, treatment happens. DOs can be found on 86% of the 28 ACGME review committees including the primary care and specialty disciplines and in the case of family medicine, emergency medicine, transitional year, obstetrics, and ONMM, DOs hold either the chair or vice chair positions.[21] As the most significant change in the osteopathic profession takes place, DOs are showing up, doing the work, and bringing osteopathy to the ACGME.

Recap

So, let's recap so far. Osteopathic medicine has had incredible growth in the number of COMs and number of students that are matriculating and graduating. DOs continue to enter the primary care fields, led by family medicine. Women have been in the field from the beginning and their numbers continue to climb. DOs are younger, and there are some gender differences in the perception of DO graduates who believe they will use OMT in their practices. Although many people perceive research supporting the use of OMT to be nonexistent, there is mounting evidence supporting the use of OMT, and the osteopathic literature is more accessible than ever and is being utilized to create state laws.

Why so much focus on the ACGME in a talk about the present and future state of osteopathic medicine and this Academy? Because, as of next year, our future is inextricably linked to our ability to train residents within the ACGME system. If we fail to increase osteopathically recognized residency training, if we fail to increase ONMM residencies, the vast majority of DOs will cease

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to learn the value and skill of OMT after the second year in osteopathic medical school.

Transitions: Ourselves

What are some of the transitions osteopathic physicians, themselves, are facing today?

I, myself, became a statistic in 2017 when I suffered what appears to be a case of physician burnout. Why do I say appears? Because, like many physicians, I did not seek formal medical treatment. I self-diagnosed and ultimately quit my job in order to reorganize my life around health rather than stress and disease.

3 Cardinal Signs of Burnout

Burnout is very difficult to diagnose and research for several reasons, including the "variability in prevalence estimates of burnout … and marked variation in burnout definitions, assessment methods and study quality." [22] As suggested in a large systematic review and published in *JAMA* in September 2018, we must first determine how to define burnout.[22] The Maslach Burnout Index (MBI) is the "most widely used and validated survey tool" which identifies three cardinal signs of burnout:[22]

- emotional exhaustion
- depersonalization
- reduced personal accomplishment or experience of ineffectiveness.

In May of this year, *The DO* reported the costs of physician burnout to be as high as $4.6 billion annually.[20] They quoted Edward Ellison, MD, executive medical director of the Southern California Permanente Medical Group as saying, "Physicians find practicing medicine harder than ever because it *is* harder than ever. … Nearly everything a physician does in 2019 is monitored, rated, assessed, and reported. The electronic health record has many benefits, but it can also be a burden, adding substantially to the time physicians spend in front of a computer screen while robbing them of what brings them joy: spending time with their patients."[23]

When Does Burnout Begin?

The path to burnout begins as early as medical school and probably pre-medical school. No fewer than one-third of all medical students report symptoms of burnout. Burnout most certainly follows us into residency, into fellowship, and into our osteopathic careers. The risk factors are the definition of medical training:

- Heavy workload and long hours
- Isolation
- Putting others' needs before our own

And they are compounded by:

- Lack of family and spousal support
- Poor leadership within the organizations that employ physicians
- Lack of outside hobbies and interests
- Poor nutrition, like pizza
- Missing out on family events
- Lack of time for self-care such as exercise, meditation, etc.

When your "energy account" is empty, you are at risk of burnout.[24]

Alarming Statistics

At this moment in our history, physicians are suffering symptoms of burnout at alarming rates. In 2019, the *Mayo Clinic Proceedings* published a study that surveyed more than 5,000 physicians over 8 years in which 54% of doctors reported they were burned out, 88% were moderately depressed, and 59% would *not* recommend a career in medicine.[25]

The ones who-suffer the most may well be our students. They enter this profession somewhat idealistically, but when confronted with these statistics, they become confused and concerned about their choice. I recall a dismayed third-year student who desperately wanted to become an obstetrician. She interviewed every OB that she could find to ask about their careers, and of the 5 physicians she spoke with, none of them recommended OB to her. She was very disillusioned and confused. My recommendation to her was to follow her dream but to do so with her eyes open. I told her that to avoid the same fate, she must put her own health at the top of her to-do list.

A report from the Massachusetts Medical Society (MMS) in partnership with the Massachusetts Health and Hospital Association, the Harvard T.H. Chan School of Public Health, and the Harvard Global Health Initiative states that physician burnout is a "public health crisis that urgently demands action."[23] This workgroup provides a bit of historical perspective on how we got here. Physicians, medical students, and residents who show signs of fatigue fear being seen as weak or not fit for the job. But this report tells us, "It is not that physicians are inadequately 'tough enough' to undertake their work, but that the demands of their work too often diverge from and indeed contradict their mission to provide high-quality care."[26]

Some scholars point to the Affordable Care Act (ACA) of 2010 as "the most significant single change in the landscape of American

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health care" that led to these disturbing statistics today.[26] However, the researchers of this "Call to Action" point to events preceding the ACA, including the 2009 American Reinvestment and Recovery Act which mandated the use of electronic health records (EHRs). This mandate was a response by lawmakers to the prevalence of medical errors. Coupled with a rise in the digital age, EHR data "brought new attention to quality improvement and the value of physician reporting and accountability."[26] The conflict leading to burnout came in this "new era" as medicine moved from the "historical investment in physician professional autonomy" to the current era of "measurement and accountability targeting quality, errors, inequities, and soaring costs."[26]

The most recent Medscape National Physician Burnout, Depression and Suicide Report shows us that "bureaucratic tasks" far outweigh all other contributing factors of burnout today.[27]

Urologists, neurologists, and physiatrists seem to be most affected in this latest Medscape report. Emergency medicine, family medicine and internal medicine specialists round out the top 6 with over 50% of physicians in these specialties reporting burnout.[27] Statistics were not available for NMM specialists. Most often, our specialty is not in any of the dropdown boxes for anything. I hope to see this change over time.

High Costs and Consequences

The consequences not only affect physicians but also our trainees, and they heavily impact our patients and the public at large. The MMS' call to action warns that "if we do not immediately take effective steps to reduce burnout, not only will physicians' work experience continue to worsen, but also the negative consequences for health care provision across the board will be severe."[26] That severity will be seen in the loss of physician workforce contributing to the predicted shortage of up to 90,000 physicians by 2025, according to the US Department of Health and Human Services (HHS), contributing to the soaring costs of the US healthcare delivery with the cost of replacing 1 physician reaching as high as $2 million (including lost revenue and recruiting costs).[26]

Where are physicians going after they burn out? Historically, after retirement, physicians would reduce work hours and keep seeing patients. "In years past, physicians who 'retired' often worked part time or kept a small patient base. However, with high malpractice premiums, rules and regulations, and the stress and aggravation that physicians experience, they are often more likely to just want out," says Leslie Kane, senior director of Medscape Business of Medicine.[27]

Some Good News

According to the *Mayo Clinic Proceedings*, we may have seen the peak of physician burnout in 2014. Physicians reported less burnout in 2017 but more depression. The rate of physician burnout remained 40% higher than that of the general population, however.[25]

Prevention and Treatment

The first 3 months after leaving my position as assistant dean, I focused on 2 things: being present for my family and being actively present for my own health. I joined a meditation group and attended regularly, I did yoga daily, I found a healthier connection with my body, and I slept. Boy, did I sleep.

In fact, a 2012 article in *The International Journal of Psychiatry in Medicine* reveals mindfulness courses can decrease burnout and improve well-being with "limited success," but it puts the full burden of burnout back on the physician's shoulders without addressing the true cause of the problem.[28]

The MMS group recommends that to truly address the root problem, we must address the systematic and institutional issues that lead to a poor physician work experience. The group recommends 3 actions to "mitigate the prevalence of burnout"[26]:

- Support proactive mental health treatment and support for physicians experiencing burnout and related challenges.
- Improve EHR standards with strong focus on usability and open application programming interface which gives physicians the ability to open and close portions of the EHR and customize and streamline the use of the EHR.
- Appoint executive-level chief wellness officers (CWO) at every major health care organization.

The burden of this health care crisis and its resolution should be levied not on just physicians but on other stakeholders, including health plan insurers, the National Committee for Quality Assurance, state and federal agencies (those that certify the EHR systems), osteopathic and allopathic medical schools, residency programs and the ACGME, EHR vendors, hospitals, health systems and provider organizations, and boards of registration of medicine and osteopathic medicine.[26]

The Summit Medical Group is the largest independent multispecialty group in the US and has similar recommendations as the Harvard group including:[29]

- Improve communication.

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- Foster a sense of community.
- Bolster physician support services.
- Hire trained volunteer physicians who proactively reach out to their colleagues.
- Hire nurse practitioners and physician assistants to deal with vacationing physicians' EMR inboxes and prescription refills.
- Recommend to *really unplug* when on vacation.

How Are DOs Doing With Burnout?

The Journal of the American Osteopathic Association published a report in 2016 in which the authors surveyed 180 residents across 12 residency programs at Doctor's Hospital in Columbus, Ohio. The residents were asked 30 questions based on the Maslach Burnout Inventory. With a 72.8% response rate, researchers noted, "The majority of the osteopathic residents surveyed reported experiencing burnout."[30] Certainly, more data is needed, and data concerning ACGME residents in programs with OR and ONMM programs will be needed.

There is work to be done in order to move toward our own health and the health of our colleagues and future DOs. On the other side of the burnout syndrome myself, I can say, "Hang in there. Reach out to your loved ones or other support systems. Make a change. Prioritize your own health. We are up for this challenge."

Transitions: Our Patients

Finally, the third leg of our 3-legged stool must be our patients. "All patients are aware of and have access to osteopathic medical care and osteopathic manipulative medicine for optimal health" is a bold vision and one that drives the Academy leadership in their work.

Patients' Concerns

There are so many facets of the health care industry that are changing and affecting our patients. From artificial intelligence to precision medicine, consideration of universal health care and the vast amount of medical information at the patients' fingertips. This allows our patients to self-diagnose and self-treat long before they call their physician. One of my concerns in this digital age is how to get the "truth of osteopathy" to the masses. That concerns me, but what are the concerns to real patients? This detail is somewhat more difficult to unearth. Some questions I had on the topic were:

- Of the US population (approximately 327 million), how many people know what a DO is and understand the distinction?
- In a country with roughly 870,900 practicing MDs and 114,400 DOs (12% and rising), how do people "discover" osteopathy?
- Once a person knows about osteopathy and OMT, do they have access to and can they afford OMT?

These are some of the presumed barriers to realizing our vision, and unfortunately, answers to these questions are elusive. What I did find about patients' concerns was from Gallop polls.

A 2017 Gallop poll of 1,000 US adults reveals that the number 1 problem facing the people of our nation was poor government leadership.[31]

Health care concern was second on the list with 10% of respondents citing it as a top problem facing the nation.[31]

By 2019, a similar Gallup poll[32] broke down the most important problems facing the country into economic and non-economic. Again, poor government leadership topped people's concerns and was cited even more often, with 23% of respondents citing it as their number 1 concern. Health care fared worse and dropped to the fifth highest concern of respondents with only 5% of people placing health care as a "most important problem."

Looking specifically at concerns about health care, a 2019 Kaiser Family Foundation (KFF) survey[33] broke down components of health care topics that people thought the US Congress should prioritize. The top 3 areas identified as the "top priorities" are:

- Lowering prescription drug costs
- Maintaining the Affordable Care Act's pre-existing condition protections
- Lowering what people pay for health care[30]

Patients' Expectations

Once patients come to understand what OMT is and how it can benefit them and their families, is there any evidence of what expectations they have? There is a 2013 survey published in *BMC Complimentary and Alternative Medicine* that sought to figure out patients' expectations of private osteopathic care in the United Kingdom (UK). Researchers surveyed 1,649 individuals receiving OMT at a non-physician osteopath's office and asked about 51 aspects of expectations and if those expectations were met or not met.[34] I found the results fascinating and will change my own practice policies to reflect some of these patient expectations.

Those aspects of patient expectations that were met included listening, respect, information-giving, and improved quality of life and relief of symptoms. Fascinating to me that listening and respect topped the expectations of patients and that osteopaths in the UK are meeting those expectation. The top expectations that went

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unmet included not knowing there was a procedure for complaints, difficulty paying for OMT, and a perceived "lack of communication between the osteopath and their GP."[34]

Difficulty paying for the treatment was expected and is a concern for my patients as well, but I must say, I have been guilty of the other 2 unmet expectations and will strive to do better.

A similar survey of UK patients concerning their primary care visits focused on different topics like physician competence and fast access to care. The differences in patient expectations from the osteopath's office to the primary care physician's office is also fascinating.[35]

If the Academy is going to realize its vision, patients must be able to find a DO, have access to a DO that does OMT and be able to afford OMT. We must concern ourselves with tracking our patients to find out who did and who did not follow-up and why.

Gone are the days of "lost to follow-up, presumed cured."

How Do Patients Find An OMT Clinician?

In a review of my patients in the first few months of joining the Osteopathic Medical Arts Center (OMAC), I was interested in understanding how many of my patients were scheduled for a follow-up visit and if they were not scheduled, why not? My review went something like this:

- 36% were awaiting insurance approval and OMAC getting credentialled on their insurance.
- 27% had follow-ups on the books.
- 5% were concerned about the co-pay and $6,500 deductible.
- 9% lived too far and would come only as needed (Mexico and 2+ hours away).
- 4% were too ill or would call after vacation.

Our practice will not succeed if we have less than 30% of patients that need OMT scheduled for a follow-up. We have chosen to become credentialled on insurance and in the first year, it is a nightmare. But, if it works out, it will be a huge benefit to more patients.

Spreading the Truth of Osteopathy

How do you bring the truth of osteopathy to the world –TODAY?

For many of us, the answer must include social media, of course. Facebook, Instagram, LinkedIn, Tumblr, Pinterest, Reddit, Flickr, are a few of the avenues available today. I would invite you to use them cautiously and judiciously, but use them. You might need to ask a student for help.

I hear from patients regularly that "they found me on the internet and reviewed my profile and ratings" before coming to see me. That is a huge change in health care and will affect how the Academy's vision will be realized.

A review of how the first 100 patients found my office showed that health care referrals and word of mouth are still king. However, I continue to see 1 to 2 new patients per month that find me through the "Find a Physician" directories of the AAO and The Osteopathic Cranial Academy. The price of your membership is definitely worth 6 to 12 new patients per year.

Lastly, I encourage each of you to go on the internet and "claim" your profiles on vitals.com, healthgrades.com, Doximity, and others. Employ assistants to do this; it should only take a few days to do and will not only advertise your good work, but will educate everyone that sees your listing to understand a bit more about osteopathic medicine.

Again, I thank the Academy, Dr. Northup and most of all, you, for your attention and interest. We all must move the Academy's vision closer to reality as we navigate the transitions within our profession, our own lives and our patients' lives.

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