1-1996

Marketing Key to Increased Women Applicants to COMs

Stephen M. Payson

Response

To the Editor:

Dr Bratzler is obviously well-versed in the area of medical quality, and he clearly understands the intent behind the Cooperative Cardiovascular Project (CCP). As he indicates, the initial pilot project for the CCP started in 1992. The indicators were changed somewhat and updated in 1995, with the deletion of the performance of stress testing and the administration of heparin sodium, as Dr Bratzler notes.

It is the unfortunate nature of review articles, however, that by the time of publication, some of the information may not be 100% accurate. Such is the case with the CCP data. Some of the information has been modified since the results from the four-state pilot project were published in May 1995. Nonetheless, some of the outcomes data on heparin and stress testing as supplied in our supplement article may be useful to readers.

We want to thank Dr Bratzler for his comments concerning the Health Care Financing Administration (HCFA). Clearly, the timely use of thrombolytics, aspirin, and beta-blockers is of national priority and should be reviewed carefully. We think our article supplied outcomes data and studies to support the importance of this effort.

Dr Bratzler indicates that the information collected in the CCP is being used by peer review organizations in working with hospitals to improve the care of patients with acute myocardial infarction. He emphasizes that physicians will not be cited for inappropriate or missing documentation. The reason for this is that the number of cases being reviewed is too small to generate accurate statistics.

We certainly agree with Dr Bratzler that it is *not* the intention of the US Government to "cite" physicians for inappropriate or missing documentation; however, *many hospital* quality assurance committees are examining the adherence to these guidelines and indeed, are asking physicians to justify their treatment plans when they do not comply with the CCP guidelines for treatment of patients with acute myocardial infarction. At the vast majority of hospitals, this is, indeed, and "educational" effort. Unfortunately, when such an effort occurs, many physicians do resent it and do feel "cited."

Robert J. Stomel, DO
Chief of Cardiology

Raymond A. Wood, DO
Cardiac Fellow
Botsford General Hospital
Farmingham Hills, Mich

Marketing key to increased women applicants to COMs

To the Editor:

I read with great interest the article, "Female enrollment in colleges of osteopathic medicine: Five years and five percentage points behind," by Helen H. Baker, PhD (*JAOA* 1995;95:604-606). I found the article to have merit and to be correct in its factual presentation. It is well known that in both the osteopathic and allopathic medical professions, women's representation and advancement have been troubling.

However, I think that by omitting some pertinent facts, the article presents an unfair picture of the admissions policy at the colleges of osteopathic medicine (COMs). Dr Baker states that women have accounted for 42.2% of the first-year allopathic medical school students in the academic year 1993–1994. During that same period, women accounted for 35.7% of first-year osteopathic medical school enrollment. These statements are true.

Yet, one must look a little further to see the reasons for this discrepancy. The applicant pool for the allopathic medical schools for the class that began in 1993–1994 was 41.95% women. During that same period, 36.7% of the applicants to the COMs were female. I do not think that one would find a significant difference between the ratio of women who applied to either profession and the number who matriculated.

This parity would indicate that the COMs, as well as the allopathic medical schools, are gender neutral in their selection of students. Those who apply are taken on the basis of their credentials and potential to practice medicine without regard to their gender.

The question becomes, then, Why do fewer women apply to COMs than to their allopathic counterparts? Having been involved in admissions for a number of years, I can only report what minority students tell me about their choice of a medical school. Students report to me on a fairly regular basis that if they were born a minority, they would rather not join a minority profession. The problem therefore lies not in the admissions policy or the selection process of the COMs, but in the marketing of the osteopathic medical profession to these minority candidates. It is the job of the osteopathic medical profession to explain, whenever possible, that osteopathic medicine might be a minority profession, but it offers something more, something unique, and something truly superior in healthcare. Only when osteopathic medicine is understood by the general public will the number of applications of minority students—including women—reach the same as that of the allopathic medical schools.♦

Stephen M. Payson, MS
Associate for Student Affairs/Registrar
The University of Health Sciences College of Osteopathic Medicine
Kansas City, Mo