

Thoughts on a white coat

To the Editor:

When I became a freshman in 1977 at the West Virginia School of Osteopathic Medicine, Edward A. Schaekel, DO, the family physician who taught medical terminology and physical diagnosis, took it upon himself to teach us about our white coats. Dr Schaekel, who was never seen without his white coat, introduced us to our white coats by telling us that we should wear them to class any time he lectured.

One very warm spring day, only the class brownnoser wore his white coat: the rest of us were comfortably dressed. When Dr Schaekel stepped in front of the class and saw that we had not worn our coats, he snapped. In his tirade, he declared that the white coat was a symbol of our profession and that it would one day bring us respect from our patients. It would bring us into a community leadership role. It was a symbol that our patients would learn to trust, and it would bring us privileges not afforded to other people.

Dr Schaekel concluded, "You will not know what I mean until someone in desperation grabs the sleeve of your white coat and crumples it in his or her hand. That person will tell you the innermost secrets of his or her heart and expect you to keep them in confidence. When that happens, remember this: don't jerk away. Stand there and listen." Dr Schaekel was so upset with us that when he finished these comments, he dismissed the class and marched out.

Two years later, I was a student on a rotation in Lancaster, Pennsylvania, with Harold Finkel, DO, an outstanding osteopathic pediatrician who has great insight into all aspects of medicine and teaching. I was with him the first time I saw a patient die. After we had done all we could to save the child's life, I walked in the room very sheepishly behind Dr Finkel so he could tell the family that their loved one was gone.

I watched as he spoke to the parents. As soon as he stepped to the bedside of the mother, she grabbed his sleeve. He never pulled away. It seemed like an eternity: he talked, she talked, her husband talked, and then she cried. After she stopped crying, she let go of Dr Finkel's sleeve.

When we left the room, Dr Finkel could tell I was upset. He said, "It's not always important what you do. It's important to be there for your patient. The way I see it, don't just do something. Stand there." I never forgot what Dr Finkel did and said that night.

It was another year before I had a white coat experience of my own. In May 1981, shortly before I graduated from medical school, I was treating a man in his 70s with congestive heart failure. We had treated him all week and had considered discharging him that particular day because he was doing so much better. Then it happened: the patient grabbed the sleeve of my white coat, and he started talking. He talked for 10 minutes before letting go of my sleeve. All I remember that he said was, "Son, respect your wife and your children; don't work your life away. That's the reason why I'm here today, dying alone." Minutes later, the patient died.

A dying man had given me 70 years of life experience, 70 years of life philosophy, 70 years of knowledge in 10 minutes. I should have written it all down, but of course, I did not. At 26 years of age, none of that meant anything.

Then came the end of medical school. As I entered my internship and residency, white coat experiences became too common. After too many problems, too late at night, one can become tired and cynical. However, about that time in my career, another side of my personality emerged—Sidney. Sidney was one of those wild and crazy guys, the kind of guy that could find humor in every situation. He always took it upon himself to make everyone laugh. Even during a code, Sidney would tell a joke—never

anything rude or out of place, but something to break the tension.

Sidney was often in trouble and needed to be corrected. I remember the last time Sidney was in trouble. After I received the chairman's tongue-lashing, and as I turned to walk out of the room, he stopped me and said, "Greg, I hope you never lose Sidney. Oftentimes, wearing a white coat takes it out of some of us." The white coat—the same white coat that Dr Schaekel had taught us was the symbol of the profession, would bring us respect, and would allow us privileges not given to other people—can weigh too much if not lightened by a sense of humor.

Twenty-three years have come and gone since those days. I have come full circle. I have learned that the white coat is a responsibility and a privilege that should be worn with pride and humility. The white coat contains many lessons: Don't jerk away. Don't just do something, stand there. Respect your family, don't work your life away. And don't let medicine snuff out the Sidney in you.

Gregory Wallace, DO

Associate professor of pediatrics
West Virginia School of Osteopathic Medicine
Lewisburg, West Virginia
Director of medical education
Greenbrier Medical Center
Fairlea, West Virginia

Fair hearing/peer review: truth or oxymoron?

To the Editor:

In 1986, the federal government enacted a law establishing the Joint Commission on Accreditation of Hospitals, whose stated goal was to simplify hospital staffing by allowing physicians to police themselves. The Commission was established to assist hospitals in issuing guidelines around which

departments and committees would form to strengthen a hospital's ability to govern itself and to give physicians a chance to work together to establish good quality healthcare. In theory, the plan of establishing specific committees (for example, quality assurance) to oversee physicians and work with those outside the norm to improve quality of patient care is a good idea. Committees would be composed of physicians and peers in the same specialty and, as such, would be qualified to generate an opinion regarding the practice of a specific specialty.

Many hospitals do practice this way; however, I have found that quality assurance (QA) in many hospitals in Dallas-Fort Worth is set up to reprimand physicians and use committee minutes against physicians during recredentialing. In fact, many committee members have served for years and, as a result, have gained political power that makes it easy for members to move things along when ousting a physician—particularly if the physician in question is perceived as competition.

The following describes the fair hearing process, peer review, and the proctoring requirements that some hospitals have incorporated into their bylaws.

The fair hearing process, a pseudo trial, is offered to physicians who have received an unfavorable recommendation by the Medical Executive Committee, which is typically made up of the chiefs of departments who vote. The committee chairman from the affected department initiates the recommendation, while remaining panel members, having no true understanding of that particular specialty, side with that chairperson. The physician in question may then initiate the fair hearing with a panel made up of specialists who are colleagues and not peers, creating an impossible situation—impossible because peers, who are frequently competitors, may initiate the unfavorable recommendation.

When one attempts to attain staff privileges, there is a 1- to 2-year waiting period during which one becomes temporary, then provisional, and, finally, active. During this period, proctoring is done by one's direct competitor, who has a financial interest in the outcome. All the proctor has to do during this period is state his or her bias and the proctored physician will not be given hospital privileges. In essence, committee physi-

cians (competitors) have the ability to destroy a new physician applying for privileges because the new physician is now marked by that hospital, the National Data Bank, the respective state board of medical examiners, and by local hospitals. There is too much at risk for the applying physician, especially if he or she is a surgeon. Where is the physician supposed to work after receiving an adverse recommendation?

It is time to objectively evaluate QA as envisioned by the Joint Commission and the manner in which the Medical Executive Committee functions. Many things have changed between 1986 and 2000. There is increased competition for decreased reimbursement, resulting in a need for an economic focus in one's medical practice. With younger physicians being critiqued more exhaustively than the "good old boys," what can be done to create equity at the hospital level?

We must make hospitals and their committees accountable for their actions. Hospital bylaws clearly indicate that the burden of proof of competency is placed on the physician who has requested privileges there. The standard is that one is guilty until able to prove innocence. Only in America can a professional who holds degrees and licenses have fewer rights than any criminal on the street. This is a tragic and difficult way to maintain cohesiveness within a hospital staff. An alternate way of creating accountability would be to require changes in bylaws whereby burden of proof becomes the responsibility of the Medical Executive Committee preceding their issuance of an adverse recommendation about a physician. (Obviously, this should exclude situations that involve alcohol and illicit drug use.) Another way to prevent abuse of power would be to require that the Medical Executive Committee allow independent reviews of a physician who has received an adverse recommendation. A final suggestion for maintaining fairness in the hearing process is to establish annual committee appointments so that no one has a chance of abusing these positions and forming networks based on the buddy system.

It is unfair that one's competitors are given the power to decide whether one receives an adverse recommendation. At issue here is one's right to practice, particularly with regard to surgeons whose practices are based on the ability to perform

surgeries in a hospital. Members of the Medical Executive Committee need to enlist the professional opinions of independent experts as to whether a physician is practicing within the scope of medical guidelines. Committees should not assume that proctors have no outside interest in what is decided.

It is my fervent hope that organizations understand the times in which we now live and that what was appropriate and fair at one time needs to be reevaluated and focused to address current times. The US Constitution is based on checks and balances; the same should be expected of hospital bylaws that put one's practice, one's way of life, and one's future in others' hands.

Roland F. Chalifoux, Jr, DO
Neurosurgeon
Arlington, Texas

Time for Medicare reform is now

To the Editor:

The time is overdue for the Medicare program to move toward a model more congruent with its beneficiaries' needs. Osteopathic physicians, as primary care providers, must voice their concerns politically to ensure that Medicare coverage for their patients and future generations is assured by legislation.

Medicare must prepare for increasing numbers of elderly as baby boomers and disabled patients who require more expensive technology, services, and medications grow older.¹ Benefits paid by Medicare from 1990 to 1995 surged 73% (to \$113 billion), while funds financed through payroll taxes grew 40% (to \$96 billion).² The Congressional Budget Office estimates that Medicare expenditures will increase from \$176 billion in 1994 to \$286 billion in 2000.³

Although a government surplus is predicted for the next several years, progress toward Medicare reform remains dormant. President Clinton has proposed an expansion of those eligible for the current Medicare program to include unemployed workers aged 55 to 65 years for an estimated cost of \$4 per month, while early retirees

could purchase the program for \$3 per month. This may sound appealing to many, but adding 700,000 uninsured displaced workers to the Medicare rolls could crush the system.⁴

Inadequacies of benefits currently afforded to members must also be resolved. Needs not covered by Medicare insurance include routine checkups, eyeglasses, hearing aids, dental work, usual plastic surgery, and prescription drugs.⁵ Medicare also does not cover "government determined" services, which can be deemed "medically unnecessary" at any time, affecting the patients' personal finances and perhaps their physician's liability. Medicare patients are often forced to choose between buying costly prescriptions, paying rent, paying utility bills, and buying groceries.⁷

Although the current plan does approve certain coverage, it is fraught with costly deductibles and copayments.⁵ For example, Medicare regulates hospital inpatient day coverage under Part A with time limits. A beneficiary is responsible for a deductible payment of \$768 for the first 60 days of care, \$192 per day for days 61 through 90, \$384 per day for days 91 through 150, and all costs beyond 150 days. Part B services require the beneficiary to pay an annual \$100 deductible fee, a basic monthly premium, and 20% of Medicare-approved charges.

Kidney transplant patients are expected to pay for all necessary antirejection immunosuppressive drugs after 36 months following transplantation, though the transplant could easily fail as the result of organ rejection due to a patient's inability to pay for medications. Out-of-pocket costs can easily devastate a limited fixed income common to many elderly and disabled persons who are unable to work. The need for reform remains critical as thousands of elderly are faced with the crisis of being dropped by their Medicare HMOs and risk losing their prescription coverage. Consequently, many Medicare beneficiaries are forced to seek, when available, expensive supplemental insurance.⁶

Gail Wilensky, Chair, Medicare Advisory Committee, has stated that Congress is not under enough pressure "to make the difficult decision that a major change would take."⁷ It is now time to apply that pressure to develop a solution for the Medicare program. It is overdue and must be urgently

addressed by Congress. The solution must keep the costs of Medicare affordable for both the government and beneficiaries. The government surplus that is now available should be targeted to improving Medicare.

Osteopathic physicians have traditionally been patient advocates, and that support must now be heard in support of Medicare reform. Patients should be encouraged to support Medicare advocacy groups such as *The Century Foundation* and *Citizens for Better Medicare* to establish a united appeal. Congress and the president must not delay in enacting cost-effective, comprehensive change to address Medicare's inadequacies.

Anthony J. Linz, DO

Clinical Professor of Pulmonary and Internal Medicine
Ohio University College of Osteopathic Medicine
Firelands Community Hospital
Sandusky, Ohio

References

1. *Medicare: Past, Present, and Future*. Alpharetta, Ga: The Medical Management Institute; 1987.
2. Spears J, Clark K. Medicare's bad prognosis. *Fortune Magazine*; May 27, 1996. Available at <http://cgi.pathfinder.com/fortune/magazine/1996/960527/economy.html>
3. *Re-envisioning medicare: facts on medicare and congressional proposals to change it*. League of Women Voters; 1999. Available at <http://www.msnbc.com/news/215703.asp>
4. Gleckman H. Clinton's medicare plan: good politics, bad policy. *Business Week Online*. January 12, 1998. Available at <http://www.businessweek.com/bwdaily/dnflash/jan1998/nf80126.html>
5. *Medicare and You 2000*. Original Medicare Plan and Other Medicare Health Plan Choices. Health Care Financing Administration, US Department of Human Services; 2000:1-8,20-21.
6. Galewitz P. Medicare misery. *Associated Press*. August 31, 2000.
7. Lagando L. Choosing between drugs, necessities. *Wall Street Journal*. April 1999. Available at <http://www.msnbc.com/news/215703.asp>

Questioning of OCF should rouse osteopathic response

To the Editor:

Recently, while browsing electronically, I entered the term *craniosacral* in the search

engine for Current Contents (all editions), which turned up three articles¹⁻³ that should demand the attention of all those practicing osteopathy in the cranial field (OCF). These are rigorously designed studies generated by three independent groups and published in peer-reviewed journals that call into question the ability to palpate the primary respiratory mechanism (PRM). More important, statements appear in the abstracts of these articles (the portion most likely to be read by the casual browser) that question the very existence of the PRM. Examples follow: "The results did not support the theories that underlie craniosacral therapy..."¹; "Further studies are needed to verify whether craniosacral motion exists..."²; and "It is possible that the perception of craniosacral rhythm is illusory."³ Those authors' conclusions resemble those in a published summary of my own research,⁴ based on a "tissue pressure" or "interactive" model for the cranial rhythmic impulse originally published in this journal.⁵ My findings were presented as a challenge, to which I have received no response from the osteopathic community.

I strongly encourage those who use this form of manipulative treatment in their practices to design, conduct, and publish in peer-reviewed journals scientific studies, done with the same experimental rigor demonstrated in those cited above, and confirming the existence of the PRM, and clinical studies demonstrating the efficacy of OCF. Clearly, the burden of proof of efficacy lies squarely with practitioners of OCF. In addition, published evidence must be consistent, scientifically reasonable, objectively and rigorously evaluated, and replicable. These recent studies represent a challenge to which the osteopathic profession must speedily respond before scientifically unsubstantiated claims regarding OCF threaten acceptance of this modality and weaken the public image and scientific credibility of the osteopathic profession.

James M. Norton, PhD

Professor and Chair, Physiology and Pharmacology
University of New England College of Osteopathic Medicine
Biddeford, Maine

(continued)

References

1. Rogers JS, Witt PL, Gross MT, Hacke JD, Genova PA. Simultaneous palpation of the craniocervical junction at the head and feet: intrarater and interrater reliability and rate comparisons. *Phys Ther* 1998;78:1175-1185.
2. Wirth-Pattullo V, Hayes KW. Interrater reliability of craniocervical rate measurements and their relationships with subjects' and examiners' heart and respiratory rate measurements. *Phys Ther* 1994;74:908-920.
3. Hanten WP, Dawson DD, Iwata M, Seiden M, Whitten FG, Zink T. Craniocervical rhythm: reliability and relationships with cardiac and respiratory rates. *J Orthop Sports Phys Ther* 1998;27:213-218.
4. Norton J. A challenge to the concept of craniocervical interaction. *AAO Journal* 1996;6:15-21.
5. Norton JM. A tissue pressure model for palpatory perception of the cranial rhythmic impulse. *JAOA* 1991;91:975-984.

Hardship deferment saves residents' money

To the Editor:

About this time of year every year a new group of interns contemplates how to handle repayment or deferment of loans accumulated during 4 years of medical school. Many students borrow the full \$8500 subsidized Stafford and \$30,000 unsubsidized Stafford loan each year of school. That can lead to a debt at graduation of nearly \$180,000 including interest. Often, students are not aware that they may apply for deferment or forbearance for each individual loan and do not have to choose one option for all loans.

One way to minimize the growth of debt after graduation is to try to qualify for economic hardship deferment of the subsidized Stafford loans in lieu of a forbearance. What is the difference? The government pays interest when subsidized loans are in deferment status. Since the benefit only applies to subsidized loans, the unsubsidized loans could be placed in forbearance. However, it is simpler to put all loans in hardship deferment status. Splitting deferment and forbearance status among different loans will not preserve deferment time for the later loans. There are up to 36 months of economic hardship deferment status available per account regardless of the number of loans placed in that category at one time.

For most students in private medical schools, the subsidized portion of Stafford loans represents a small fraction of their debt, and using the deferment option saves significant interest accumulation. If residents wait until they are attending physicians, they may earn too much to qualify for hardship deferment. The time to apply is as soon as possible to ensure maximum benefit of 36 months of government-sponsored interest payments. There are strict guidelines as to whether one can qualify for hardship deferment, but because medical school is so expensive, more people can qualify. The two criteria follow:

- ☐ Loans in repayment have to exceed 20% of current annual gross income (AGI). Many loan-servicing organizations will accept 1 month of pay stubs as proof of AGI.
- ☐ AGI minus annual loan payments must not exceed \$24,750 in all states and DC except for Hawaii (\$28,446) and Alaska (\$30,932) for year 2000.

To estimate annual loan payments, take the current interest rate of the loans and find the corresponding factor given below. Multiply that factor by the loan balance to get the estimated monthly payment, then multiply by 12 to get an annual payment. Most Staffords are at 8.25% this year (.0122653); use the factors .0121328 and .0120011 for 8.0% and 7.75%, respectively.

For example, an intern finishes medical school and approaches repayment with a \$100,000 balance. His salary is \$35,000 per year, and the interest rate on his loans is 8.25%. He took out \$8500 per year in subsidized Staffords for a total subsidized portion of \$34,000. His estimated payments are $\$100,000 \times .0122653 = \1226.53 per month, or \$14,718 per year.

Check first criteria, AGI: 20% of \$35,000 = \$7,000, which is less than \$14,718.

Check second criteria: AGI—annual payment less than or equal to \$24,750 ($\$35,000 - \$14,718 = \$20,282$, which is less than \$24,750). Therefore, the intern can qualify.

How much will he save? For a balance of \$34,000 ($\8500×4 years) at the current interest rate of 8.25%, \$280 per month. That interest of \$840 per quarter would

also then be capitalized each quarter. At the current interest rate of 8.25%, and a subsidized Stafford balance of \$34,000, he can save \$9727 of interest if able to qualify for hardship deferment for the full 36 months. The savings are even greater if applied to future loan payments. The total savings over a 10-year repayment is \$14,317 in the above example. Without a hardship deferment, if repayment is ignored for just 4 years of residency at 8.25%, the balance will grow by 37%. Thus, for those who can qualify, a hardship deferment lessens the financial burden of today's medical education.

At 8.25%, the \$34,000 in hardship deferment will mandate approximately \$417 per month repayment for 10 years. If hardship deferment is used now, future payments could be reduced on a monthly basis through consolidation (more interest in the long term) if found to be too great a burden, but that is another issue altogether.

Andrew Weinberg, DO

Intern, Delaware County Memorial Hospital
Drexel Hill, Pennsylvania

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