

Wasn't A.T. Still an MD, too?

To the Editor:

Twenty years ago, I was medical director of the outpatient pediatric clinic at the University of Oklahoma-Tulsa, having finished pediatric training at Baylor College of Medicine, become board-certified, and nominated for a teaching award. After my second son was born, I left that position to establish my own practice and be more in touch with patients. Ten years ago, I took my first Sutherland Cranial Teaching Foundation basic course in Osteopathic Manipulative Medicine (OMM). That experience gave the expression "being in touch" a whole new meaning.

Given what I now know about the typical progression of training in OMM, it seems a rather odd place to have started, but for me it was an excellent introduction. After another year, another basic course, and an American Academy of Osteopathy (AAO) convocation (that emphasized pediatrics), I was swept up by the profession. I began taking OMM courses, as well as all examinations, at Oklahoma State University-College of Medicine (OSU-COM) with first- and second-year students. The more I learned, the more I incorporated OMM into my practice. In 3 years, I passed the competency exam in cranial osteopathy and was asked to teach in the OMM lab at OSU-COM.

Five years after that first introduction, the osteopathic perspective had virtually taken over my established pediatric practice. There was no such thing as a "straight" medical problem. I was constantly looking for the structural correlate to help explain and treat an illness. My prescription writing and subspecialty referrals plummeted, and allopathic colleagues began to think I was "out there." Wanting to justify myself, as well as improve reimbursement for my

activities, I began doing research on otitis media, funded by the AAO's Samuel Robuck Fund. The American Osteopathic Association (AOA) later granted me significant monies to expand that research to a multicenter trial using several other sites across the country. In addition to maintaining my private practice, I hold a 1/3 faculty position for teaching and research at OSU-COM. I lecture and table train at SCTF and Cranial Academy courses. I even contribute examination questions for the Osteopathic National Boards (COMLEX-USA).

I am a born-again osteopath and am passionate about the discipline's possibilities. Here is a profession where elders are respected for their experience and frequently remain active in some fashion until death. How refreshing to go to national meetings where participants do not just sign in and go play golf, but stay for lectures and gather outside the hall to talk. I also respect the deep spiritual foundation of the profession, as I have always maintained that the therapeutic relationship should be approached with reverence. To have that manifest between my hands is a profound gift.

Approximately 2000 continuing medical education (CME) hours and 10,000 osteopathic manipulative treatments later, I now believe that to overlook the somatic dysfunction in patients is a disservice.

As welcomed as I am made to feel by my osteopathic colleagues, I have come to realize that there is a glass ceiling for MDs in this profession. I am barred from taking the certifying examination for Neuromusculoskeletal Medicine and Osteopathic Manipulative Medicine (formerly Special Proficiency in Osteopathic Manipulative Medicine) that would recognize my hard-earned proficiency. I am not alone. There is a growing number of allopathic physicians with substantial osteopathic training and experience who have dedicated their lives to the osteopathic profession. We

deserve to be recognized by some level of certification—even a variant of that conferred on osteopathic physicians—that will be recognized by third-party payers and other professionals. I am aware of the efforts of the AAO and the AOA to credential this group of professionals; however, this effort seems to have floundered. I am concerned that osteopathic physicians are on the verge of giving away their authority in this field by hesitating on the brink of leadership.

I joined the AOA to signify my solidarity with the profession, but the AOA does not even provide me the courtesy of tracking my CME hours, as it does for osteopathic physician members. CME-granting institutions do not recognize that I have an AOA membership number. The profession seems to trust me with its students and its research money but refuses to validate my osteopathic education in a way that would convey to the community-at-large that these activities have merit. DOs have the right to enter into MD residencies and can be certified by allopathic specialty colleges. However, the favor is not returned to those who have achieved standards that many osteopathic physicians do not maintain.

It would surely be possible to measure whether a physician choosing to learn and practice osteopathic medicine has grasped its essence. Certainly one does not grasp the essentials from a weekend course, but one does not work intimately in so many aspects of this profession for 10 years without getting them. I am not suggesting the AOA blur the distinction between osteopathic medicine and allopathic medicine. I fully appreciate the historical lessons from the California merger disaster. I simply do not see why the profession refuses to set specific expectations for allopathic physicians wishing to be accredited to practice osteopathic medicine as a subspecialty. These credentials need only apply to OMM, as other specialties are provided by allopathic boards.

I vacillate between being philosophical and frustrated over my situation. Perhaps my predicament is a microcosm of the identity issues many osteopathic physicians feel in trying to practice osteopathy in the medical environment today. I am reminded, however, that in his day, Andrew Taylor Still did not “fling the banner of osteopathy” for it to be hidden as a skeleton in the closet or to be a jealously guarded secret. He did it to reform and revolutionize modern medicine. We (yes, I include myself) still have the opportunity to take the lead and make this change. I can not fully join you in this endeavor unless I am recognized as a proper representative of this profession.

Embracing converts can only strengthen the profession and complete the mission of its founder. Allopathic physicians who practice osteopathic medicine are not a threat to the profession. Allopathic institutions do not and can not train and credential for osteopathic competency in the way that osteopathic institutions can. They lack long-established teaching programs and adequately trained faculty. The AOA must take this opportunity to make room for and give an identity to qualified MDs. Early osteopathy was full of MDs who switched camps with encouragement from Andrew Taylor Still, who was himself an MD.

I accept the tremendous challenge that is before me. I realize that it is more difficult to get board certification in OMM than any other specialty—osteopathic or allopathic. Moreover, it takes dedication, education, service, research, and years of hard work to become a Fellow in the American Academy of Osteopathy (FAAO). MDs and DOs of other specialties become fellows of their boards simply by paying their dues and putting in their time after examination. Being an FAAO is an enormous honor that is underappreciated by most MDs. Not this one. I implore you to remove the glass ceiling, end this reverse discrimination, and allow me to join you in carrying the banner of osteopathy.

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Article fails to recognize unequal partners equal odd coupling

To the Editor:

I am writing regarding the article, “Osteopathic medicine and managed care: A match made in heaven,” in *Managed Care Practice*.¹ You have got to be joking!

I refer you to a recent article in *American Medical News*² in which an internist was terminated by one of his health plans because of a higher-than-acceptable utilization of specialists. One must ask to whom this was unacceptable. His patients? No, his insurance company!

I was terminated by a health maintenance organization (HMO) and lost over 500 patients, as well as nearly losing many dollars per year in capitation payments. I was further humiliated by being in the awkward position of having to explain to those 500 patients that I was not terminated for being an incompetent physician.

The manner in which physicians are ousted from HMOs follows a pattern. The first step is a presentation of data dissemination to show you that other physicians, according to the HMO, conduct practices that are more cost-effective than yours. The second step is “friendly persuasion.” (Read: You are in imminent danger of being deselected.) The third and final step is deselection, which you are not allowed to challenge, only appeal. This process is a joke and much like the show trials of the Nazi regime.

Until physicians are allowed to negotiate the terms of managed care contracts to their satisfaction and until managed care companies are liable for litigation, I will continue to believe that osteopathic medicine and managed care is a match made in hell.

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References

1. McClellan C. Osteopathic medicine and managed care: A match made in heaven. *Managed Care Practice* 2000;7:1,5.
2. Page L. Physician fights plan's use of profiles. *American Medical News* 2000 Dec 18;cover, 1, 4.

On becoming a doctor

To the Editor:

When the old doctor approached the patient, extended his hand warmly, and said, “Hello, I’m Dr. S,” he seemed so comfortable with the title of “doctor.”

This scenario was in stark contrast to my experiences as a new resident. Although my patients referred to me as “doctor,” I felt somewhat awkward with the title. I began to ponder the question: When does one actually become a doctor? Did it occur at graduation from medical school or on completion of a residency program? Could it be related to a medical license or board certification? Although my mind raced with these thoughts, I knew that becoming a doctor involved something much less tangible. What was it that made Dr. S seem so comfortable with the title of doctor? The question lurked as I concentrated on surviving internship. I had no idea I would soon discover the answer to my enigma.

When I first met Mr. W, I looked at him with a filtered view. He was just another patient with multiple medical problems. I examined Mr. W every morning, and each time he would ask, “Doctor, how am I doing?” I always responded with indifference.

Over the next couple weeks, Mr. W began to deteriorate. His was a difficult case to manage because he had severe congestive heart failure with concomitant renal failure. We were constantly juggling his medications. He had severe dyspnea, which caused him to spend all day slumped over a railing, gasping for air. In spite of his obvious discomfort, I remained detached to avoid clouding my medical judgement with emotions.

One afternoon, I walked past Mr. W’s room and noticed he was extremely short of breath. He was slumped over the serving tray, his chin almost touching his chest. His breathing was shallow and rapid. The back of his neck glistened with sweat as he strained to breathe. As I looked at Mr. W, I could not help but feel sorry for him. His distress seemed to unlock my emotions from the isolated cage of clinical medicine.

I wanted to help him desperately, and

my mind raced for an answer. His pulse oxgenation was 98%, so there was no indication for intubation. His lungs were wet with bilateral rales, so my first thought was to give him a diuretic, but the combination of hypotension and renal failure made diuresis contraindicated. I was at the limit of my medical training.

In my search for an answer, I reached around to his back and noticed that his paraspinal muscles at the T1 through T5 levels were in spasm and that his rib cage was barely moving. At this point, compassion forced me to react. I placed the bed at a 45° angle because the patient could not tolerate lying flat. I then began to use paraspinal inhibition and, to my surprise, the patient started to breathe slower and deeper. A few minutes later, I switched to a modified rib-raising technique. By the time I had treated both sides at the T1 through T5 levels, the patient was breathing comfortably and was no longer in respiratory distress. He then reached up, touched my face, and said, “You are a good boy.” That was the first time he did not call me doctor, and ironically, it was the first time I felt like one.

As I walked down the hall, I finally understood what it was that made Dr. S so comfortable with the title of “doctor.” He had earned it through numerous experiences with patients. Becoming a doctor has nothing to do with a medical degree, board certification, or a medical license. It happens when our patient interactions become rooted in compassion and humanity. This is something that comes from within, and each medical school graduate must find his or her own path. I feel fortunate that my path involved osteopathic medicine, for it not only enabled me to help my patient—it allowed my to realize the moment I had become a doctor.

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Books

I have Harrison's on my sofa
Robbins on the floor
Stedman's on the table
With many many more.

I'm covered up in textbooks
From my toes up to my head
I have to shove them all aside
Just to get into my bed.

Then I close my eyes to sleep
I toss and turn all night
With dreams of Johnson's Physiology
And Immunology by Stites.

I was getting a little worried
Because you know these books aren't
really real
Till I found they're helping me
Perfect my palpatory skill.

You see, I reached into my bag one day
My listening hand was quiet
And scanned the spines of several books:
Moore's, Wheaters, Gartner and Hiatt.

I introduced some gentle motion
And found the one I sought
In the silky slippery spine
Of good ol' Lippincott.

So now I palpate all my books
I can percuss them just as well
I don't think I will auscultate
But only time will tell.

Bones and Blood and Guts

Bones and blood and guts inside
Brains and hearts and livers hide
Beneath our genteel frames
Underneath we're all the same.

Construction worker to beauty queen
Medical student to college dean
And everybody in between
Underneath we're all the same.

All pleasantries aside
By mortal pieces we are tied
The very things we need to hide
And hiding them seems such a shame
For underneath we're all the same.

The Nontraditional Student

She stands transfixed
And stares out at a sea of faces
And they all stare back
Sucking in her words
She is terrified
She draws in a breath
And it comes thundering out
Shuddering
The urge to run is strong
She longs for the anonymity of the
pine trees
And the geese and the dogs
And the people who love her
And don't care what she knows
And yet, she wonders at the
physiology
Of that indrawn breath
But even that is a fleeting thought
Because all her thoughts are fleeting
these days
There are too many of them crammed
inside her head
So that they push and shove each
other
Trying to be heard
The floor of the medical school
comes up
And wraps itself around her legs
And twines down her arms
And droops over her fingertips
Claiming her
You belong to us
You are where you need to be
So, she closes her eyes
And when she opens them again
She is one hundred twenty pounds
Blonde hair streaming down her
shoulders
A fearless nerd-child who knows
everything
And the sea of faces are
Round cheeked, downy haired,
diaper clad
Sucking their thumbs and raising
their arms
Wanting to be held
It was a brief illusion
But it helped

Neurology

Neurology's a bummer
It's making me uptight
I'm feeling dumb and dumber
Just can't get those quizzes right.

Dopamine schmopamine
GABA DABA DOO
So serotonin's 5HT?
I don't have a clue.

White matter, gray matter
Yeah, we have a brain
But all these little details
Are driving me insane.

I know we need to know it
I think it's up there in my head
Lost in neurofibrillary tangles
And in neurons that are dead.

—**Rita Roberts, MSII**

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