Letters

Has our profession become its own worst enemy?

To the Editor:

Having retired 1 year ago after more than 40 years of osteopathic family practice, I have had more time to observe osteopathic medicine from the outside and from a different geographic location. There have been many changes over the years, and these have become nearly exponential in the past 10 years. There have also been changes in the attitudes of osteopathic physicians toward their profession. The Campaign for Osteopathic Unity was developed to give the public an idea of what an osteopathic physician is and the beliefs that guide the practice. In school, we were trained in osteopathic manipulative treatment (OMT) and osteopathic principles, and while we know what makes osteopathic physicians different, patients knew only that OMT set us apart from allopathic physicians. When we attended conventions, it was a rule that a majority of the speakers had to be DOs, or at least refer to osteopathic principles.

I recently attended two state conventions. As a retiree, I was able to attend most of the lectures. Not one speaker mentioned osteopathic principles. At the end of a lecture on pneumonia by a noted MD pulmonologist, he asked the audience how many used OMT in their practice. Of 100 physicians, seven raised their hands. He then asked about lymphatic pump and rib-raising for treating patients with pneumonia, which he wanted to learn more about, but none of the osteopathic attendees could inform him about the practice.

I find it interesting to drive around my new location and note the large number of clinical groups made up of MDs, DOs, and chiropractors. The purpose of the chiropractor is to provide manipulative therapy when indicated. Before blaming our profession for this trend, consider that in many cases, insurance companies pay chiropractors for manipulative therapy but not osteopathic physicians (so I was told). Further, with the new time constraints placed on physicians by third-party payors, OMT is no longer cost-effective. In my practice, I found that conversing about health problems and family history while performing OMT was a good way to be time efficient and still obtain a history—even this is difficult when patients are allotted only 5 to 10 minutes. I notice that graduates come out of school well versed in osteopathic principles only to lose much of their enthusiasm after they plunge into the real world of today's medicine.

Perhaps the profession has become its own worst enemy. For more than 50 years, we have been trying to achieve parity with allopathic physicians. Having achieved that parity, the lines between osteopathic and allopathic approaches to medicine appear to have become blurred in the eyes of practitioners as well as the public.

I must applaud the work of the Campaign for Osteopathic Unity; however, I question its long-term success unless the profession is able to convince its own members that there is a difference and work with government and insurance agencies to obtain their cooperation.

Lyle L. Fettig, DO
Gilbert, Arizona

Respect the friendly adversary

To the Editor:

I would like to respond to the letter by Kevin C. Zorski, DO, and colleagues (*JAOA* 2001;101:329-330). Their letter is a threatening reprimand to James M. Norton, PhD, for challenging osteopathy in the cranial field (OCF).

Specifically, Professor Norton challenges the reliability of studies assessing patients' cranial rhythmic impulse, as published in physical journals. Professor Norton writes that "burden of proof of efficacy lies squarely with practitioners of OCF."

The friendly adversary is a common exercise used in all science disciplines. It allows any peer or peer group within the science communities the right to challenge any claims that arise in science, in this case medical science. The science of osteopathic medicine is a part of medical science and cannot be excused. Apparently Professor Norton's observations led him to conclude that if OCF is to survive within the medical sciences, it must answer this challenge.

The osteopathic physical therapy community has developed empirically and maintained its status on what A. T. Still, MD, DO, established when medical science was coming out of the Dark Ages. Medical science made tremendous advances during the 20th century, while the osteopathic medical science advances remained at a standstill.

The osteopathic medical community maintains its status quo by conducting itself as an unfriendly adversary; any challenge to the claims of osteopathic science is considered unfriendly. The osteopathic medical community has been successful in warding off friendly adversaries with grassroots, intraprofessional political intimidation, threats, withdrawal of friendship, and exclusion from positions of authority. This is defensive paranoia. A change in this academic environment is indicated—the friendly adversary system would be a marked improvement.

As an octogenarian, I recall a presentation and demonstration of cranial therapy by W. G. Sutherland, DO, during my years as a student at the Des Moines Still College of Osteopathy (1939–1942). We were given hands-on training in cranial physical therapy, which was accepted with much doubt. Most students believed that this manipulative treatment required more personal imagination than they could muster. Cranial

manipulative treatment was not added to the college's curriculum at that time.

The doubting students and faculty members did not challenge Dr Sutherland; our opinions were kept to ourselves as a courtesy. It is unfortunate that the friendly adversary environment was not acceptable at that time. If it had been, the benefits to be derived from this form of treatment would have been recognized and recommendations made, or the treatment would have been exposed as insufficient in its claims. While you may resent these impressions regarding Dr Sutherland's cranial manipulative treatment 60 years ago, I remind you that any peer or peer group of the sciences has the right to be a friendly adversary and to be received respectfully.

Professor Norton is a friendly adversary and should be applauded for presenting the osteopathic medical community with his challenge. I hope the community will respond with more than intimidation and threats. I further hope that Professor Norton's challenge can be answered scientifically by practitioners of OCF. It is certainly the right time.

Roger B. Anderson, DO
Sun City West, Arizona

Change professional title for increased recognition of osteopathic physicians

To the Editor:

I am writing about an old issue that is new to me. I am an osteopathic physician who attended the University of Medicine and Dentistry of New Jersey–School of Osteopathic Medicine (UMDNJ-SOM). After finishing a family medicine residency in Long Beach, California, I worked in a primary care setting for 2 years in New Jersey. In July 2000, I started a geriatric fellowship at UMDNJ-SOM. As an attending physician before the fellowship, I became aware that many people did not know what a DO was. I was optimistic that once people learned what a DO was, they would recognize their qualifications as physicians, so I ordered the "What is a DO?" pamphlet and educated patients during visits. I learned just as my predecessors had that "it ain't easy!"

For some reason, this month has been most disappointing for the following reasons: (1) I attended the American Geriatric Society's (AGS) annual meeting in Chicago where I was updated by Ehab Tuppo, DO, on the new geriatric program that he and Mike Jeong, DO, are developing at the Western University of Health Sciences. An AGS employee told Dr Tuppo that the AGS was distributing the 2001 edition of *Geriatrics at Your Fingertips* to all medical schools. Dr Tuppo informed her that his school—an osteopathic medical school—did not receive any books, to which she responded that she had never heard of osteopathic medical schools. He has still not received the books for his students. Also while at the AGS, the woman who typed up the ID badges asked, "What is a DO?" (2) I was listening to a radio broadcast (New Life Live), and a psychologist asked a caller if she had consulted a medical doctor for her depression. The caller stated that she was seeing a counselor, and the psychologist responded, "I don't mean a counselor; I mean an MD. You need to see an MD." (3) A nurse called me and said, "The doctor's order states: 'If the blood sugar is over 300 mg/dL, call MD.' (4) I was reminded of a foreign medical graduate who has an "MD" degree. He has not yet passed his medical boards, but because people recognize his title as being a physician, he has worked at a busy medical practice for over 5 years. (5) I was recently told by a patient that she went to a DO a couple of years ago, but her friends only go to MDs because they do not consider a DO a physician. She also stated that many people believe that an MD is more qualified than a DO. (7) Finally, I learned today that osteopaths outside the United States receive the same "DO" degree from their foreign school but are nonphysicians.

As I thought about these events, it occurred to me that it is more than a lack of education that people still ask, "What is a DO?," that patients still consider MDs more qualified than DOs, and that patients want to be seen by an MD. Our country has poured massive funds into sex education programs, yet teens and adults still have multiple partners, do not use condoms, and sexually transmitted infections and unwanted pregnancies have increased. Educational programs on the dangers of tobacco have resulted in more teens smoking. Despite educational programs on obesity, exercise, and diet, 50% of our country's population is overweight, as well as an ever-increasing number of teenage girls who have type 2 diabetes mellitus. Educating patients about the potential dangers associated with nutritional supplements has not resulted in a decrease in the amount of money spent on these products. My point is this: the AOA's educational and advertisement campaigns may not work. When something is imbedded in the heart, mind, and culture, it is an almost subconscious response, especially in this postmodern era.

As an osteopathic physician, I believe we bring something extra to medicine. During our medical training, we receive extra training in the musculoskeletal system, including osteopathic manipulative treatment, and we practice a whole-person approach to medicine. Many of us chose to be osteopathic physicians for these reasons. However, I do not believe that spending thousands of dollars on educational materials trying to inform people about DOs will have the effect that we in the AOA intended, such as having DOs recognized as qualified physicians who bring something extra to medicine. When patients receive our care, they find out for themselves how qualified we are, and the quality of the osteopathic physician's patient care is the best advertisement available. It is not a matter of education; it is a subconscious or heart matter that rests on the recognition of two letters: *MD*. As we receive extra training above that of allopathic physicians, we should have an extra letter in our degree: *MDO*, medical doctor of osteopathy. The extra letter will clarify our additional training for patients. Another option is *OMD*, osteopathic medical doctor.

The AOA could redirect its finances from pamphlets and advertisement to other areas. Let us use the tools needed to get into the hearts and minds of patients. If it takes psychology, let's use it. Let us start this new millennium with new letters. Osteopathic medical doctors will then be recognized by patients in the United States, as well as internationally, as physicians who are equally qualified, if not more qualified than allopathic medical doctors.

Tara Reid, DO
Hillsborough, New Jersey

Response

To the Editor:

Thank you for your letter regarding public awareness of DOs and osteopathic medicine. You certainly present some valid arguments. The frustrations that you experienced have been experienced by not only myself, but by DOs throughout the country.

In 1999, when the American Osteopathic Association (AOA) conducted a survey of American households, we found that 89% of consumers could not describe the qualifications and functions of a DO. The leadership of the AOA understands that this is a large number of consumers to educate regarding DOs as fully licensed physicians who can prescribe medication and perform surgery, especially as a percentage of this population may have preconceived notions. Others in this group have never heard of DOs and do not realize that there are two types of fully licensed physicians in the United States. It is this population of people that we plan to educate about osteopathic medicine so that they will recognize the DO designation following a physician's name and choose that DO as their care provider. This group will, in turn, educate friends and family about the osteopathic manipulative treatment that DOs provide for low back pain, asthma, carpal tunnel syndrome, and other injuries or illnesses. As you say, the care that DOs provide for their patients is the best advertisement for the profession.

Although many of us are tired and frustrated because of the discrimination we encounter and from having to explain what a DO is once again, this is the time when we must fight even harder so that our voice is heard and our distinctiveness is noted. We must rise up and celebrate the fact that osteopathic physicians have a different philosophy of care and that osteopathic manipulative treatment is a cost-effective and viable treatment option that has few untoward side effects for our patients. It is time for DOs to be proud of the DO designation after their name, rather than hiding behind *Dr* or trying to change the designation.

Three years ago, leaders of the osteopathic profession chose to accentuate our distinctiveness instead of letting the profession simply fold into an allopathic-like medical system. This is how the AOA's Campaign for Osteopathic Unity began, with its goal of promoting the profession to the public. However, it has been only 2 years since the campaign started, and the public education ads only began running in national magazines last October. It will take time to educate the public about DOs and osteopathic medicine and even more time to change the minds of those who have preconceived notions about osteopathic medicine.

We need every DO—from small towns to big cities—to work together to educate their local media, friends, and families about DOs and osteopathic medicine. We need DOs like Dr Reid, who cares enough about the profession to write a letter to the AOA to express frustrations and offer recommendations as to how we can improve the plight of osteopathic physicians. We need all DOs to continue to reach out at the grassroots level to once again answer "What is a DO?," or express displeasure with a television newscast not properly identifying a DO. If the entire osteopathic profession is not committed to helping educate the public about DOs, then our journey to understanding will certainly be a longer one.

Donald J. Krpan, DO
Past President
American Osteopathic Association

Marketing lessons and retaining the traditional osteopathic internship

To the Editor:

In 1985, the Coca-Cola Corporation announced its decision to change the formula of their signature soft drink after 99 years of essentially the same taste. Four million dollars worth of market evaluation indicated that people preferred the taste of New Coke to the original; people wanted a sweeter cola. Coca-Cola was concerned about competition from Pepsi in the cola war. Coke's market share had been shrinking for decades, from 60% after World War II to less than 24% in 1983. Coke was, however, still the market leader, beating Pepsi by almost 5%.[1]

For several years, the American Osteopathic Association (AOA) has questioned the need for the traditional internship and has proposed exceptions and waivers. Since 1936, the AOA has approved traditional osteopathic rotating internships, which have successfully prepared osteopathic physicians for practice or additional training. Recent surveys by the AOA, however, indicate that many osteopathic medical students do not plan to participate in an osteopathic internship. Reasons cited include perceived quality problems, geographic location, and inconvenience.[2] An increasing number of graduating DOs now choose to directly enter allopathic training. The osteopathic internship is, however, still taken by most of DOs prior to additional training.[3]

Marketing studies demonstrated that consumers preferred the taste of New Coke to the original formula by 55% to 45%. Why then was Coca-Cola's announcement of the formula change met with such public outcry? What Coca-Cola apparently neglected to take into account was the fact that those among the 45% who preferred old Coke did so passionately.[4]

A study done by St. Vincent's Hospital of Toledo, Ohio, cited many osteopathic medical residents as believing that the osteopathic internship placed them at a disadvantage and that the internship should be structured more like an American Accreditation Council for Graduate Medical Education transition year.[2] Our allopathic colleagues did away with the internship for many specialties years ago. Why then has talk about eliminating the internship met with resistance from our profession? What experts overlook is the conviction among many osteopathic physicians that our rotating internship has intrinsic value and has provided them with the broad clinical foundation necessary to becoming a competent osteopathic physician.

In less than 3 months after New Coke's release, Roberto Goizueta, Chairman of Coca-Cola declared, "We have heard you," and the original formula was reintroduced as Classic Coke. New Coke had been such a marketing blunder that Pepsi was outselling New Coke and Classic Coke combined. Classic Coke regained its popularity, again becoming the number one soft drink in 1986. New Coke, the favorite in premarketing surveys, began to fade from the marketplace and was renamed Coke II in 1990.[2]

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