The Anachronistic Fight for Osteopathic Distinctiveness

To the Editor:
With all due respect to our “colleagues,” such as Dr Shore (2010;110[5]:299-300), who seem to be determined to change our DO degree for all manner of reasons—none of which have any serious rationale behind them—I would offer the following two thoughts: (1) federal funding of medical schools in the future will have nothing to do with degrees, but rather with perceived need and available funds, and (2) while you are on a crusade to “accelerate the process of professional unification” by changing a degree that most of its recipients seem to be happy with, you might also want to focus on other medical doctors who practice in the United States while holding degrees with diverse designations, such as the BM, BM BCh, BMBS, MB BCh, MBBS, and MB ChB, that all represent bachelor of medicine and/or surgery degrees earned in various countries.

Discussions centering on degrees that most people have earned, are pleased with, and have achieved professional success with waste valuable energy that both DOs and MDs in the United States should be directing toward more pressing issues. Among these issues are such questions as “how do we plan to stay in business after the reimbursement streams dry up and inflation deflates the value of fiat federal currency?” and “why can’t I fulfill my Category 1-A continuing medical education requirements in the osteopathic medical community by taking courses taught by the American College of Emergency Physicians if I want to retain American Osteopathic Association board certification?”

Why is it that the dental profession can exist with both DDS (doctor of dental surgery) and DMD (doctor of dental medicine) degrees without suffering an identity crisis—yet debate over DO identity continues? I practice with physician assistants whom many patients tend to call “doctor.” When patients do that, I do not regard my professional self-worth or identity as being challenged in any way because, quite frankly, when I am practicing, I save lives and change lives for the better, and my patients know this. The doctor of osteopathy degree is mine. I am a DO… period. I know what I am, I am proficient at my craft, and my patients call me “doctor.” So what is there to be upset about?

If you do not want to be a DO, then please go to any number of other US or foreign medical schools and get the degree that makes you happy—or the one that you think patients will “respect” more.

I urge JAOA—The Journal of the American Osteopathic Association to please bury this discussion and instead focus on the essential problems facing our national healthcare system. To do otherwise is to simply entertain “noise.”

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To the Editor:
I read with interest the letter by Eric I. Shore, DO, in the May issue titled “The Anachronistic Fight for Osteopathic Dis-
tinctiveness.” Although Dr Shore presents cogent and insightful arguments—many of which I agree with—there are two issues in which he appears to oversimplify, thereby nullifying his suggestion to assimilate the osteopathic medical profession with the allopathic medical profession. One issue is his American-skewed view of the global osteopathic profession. The other issue concerns the value of a distinctively osteopathic approach to patient management, including—but not limited to—the use of osteopathic manipulative treatment.

Healthcare systems and their regulation are the purview of each sovereign nation. Surely such systems need to be grounded in science, as well as in the social structure, of each country. Since the founding of the Kirksville College of Osteopathic Medicine in 1892, the thoughts of Andrew Taylor Still, MD, DO, have impacted healthcare systems in Europe and elsewhere, resulting in varied expressions of Dr Still’s vision. Amid this diversity, there remain many common features—most notably the emphasis on the musculoskeletal system and the means of restoring its integrity.

Osteopathic medicine/osteopathy, in its expression with or without the medical degree, has received official recognition in many countries and by the World Health Organization. It is also supported by the Osteopathic International Alliance, which, in turn, is supported by the American Osteopathic Association. The medicalized osteopathic physician model we have chosen in the United States has many strengths. However, this model is not seen as the optimal expression of osteopathic concepts in the contexts of all countries. This difference admittedly presents a problem for us in that our US DO degree is not viewed everywhere as being equivalent to, or as socially acceptable as, an MD degree. But such attitudes are to be expected in our diverse global culture, are they not?

The US expression of osteopathic medicine, as Dr Shore recognizes, is indeed floundering for its identity, mainly because of the split in strategies regarding how to achieve parity in privileges and public recognition with MDs. In one sense, this fight is won. We have achieved success in surviving the criticisms of the 1960s through 1980s, the collapse of the osteopathic hospital system during the economic consolidations of the 1990s, and the resultant emergence of dual-staff institutions. Yet, a more subtle loss of distinctive self-image has emerged as successive classes of osteopathic medical school graduates confront the ambiguity over the identity of our profession and as many of these graduates are trained in allopathic residency programs, in which mentoring of distinctive osteopathic behavior is extremely limited or nonexistent.

Many of us continue to view Dr Still’s teachings beyond how those teachings have been accommodated to the model of medicine-by-algorithm based on laboratory and imaging diagnostic tests and pharmaceutical and surgical treatments. Yes, medical science has progressed wondrously since Dr Still’s time. But what do we say to a patient who presents to a DO with back pain after undergoing serial laminectomies when that patient notes, “You are the first physician who touched me?”

Regardless of results shown by magnetic resonance imaging, the fact that the patient has a body that can be examined and cared for with osteopathic manipulative treatment is still worth factoring into management decisions.

Returning to the issue of osteopathic medicine in the context of the American experience, DOs in the United States are in an uncomfortable marriage. Some of us, like Dr Shore, are more than satisfied to assume our privileged place alongside our MD counterparts and to use this status as the basis of our identity. However, others of us prefer to teach and practice in ways that attempt to blend the principles and motivations of Dr Still with the findings of modern medicine to make medicine “something more.” In this regard, we are joined by both physician and nonphysician DOs worldwide in efforts to establish a higher standard that integrates traditional osteopathic principles into progressive bioc- science and healthcare delivery.

As stated by Norman Gevitz, PhD, osteopathic medicine is a type of reform, and reform is ongoing. Today, there is an ongoing global effort to blend the strengths of the various models of osteopathic medicine/osteopathy to form a stronger profession with a consensus of proficiency standards.

The debate about the identity of the osteopathic medical profession long predates the issues raised by Dr Shore in his letter. In fact, such debates formed the basis of the schism that developed between Dr Still and John Martin Littlejohn, who introduced osteopathy into the United Kingdom in the early 1900s. Such disagreements are inherent in any movement based on “philosophy.” Debate and tension within our profession will undoubtedly continue—though there is merit in maintaining a unified profession during this dialectic, rather than creating two separate minority factions. The latter option has been tried, and it does not seem to be wise.

Much more could be said, especially about the dynamics of international osteopathic practice and its continual evolution. However, I will close by simply noting that I am excited for the future of our profession.

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Response

I’d like to thank JAOA—The Journal of the American Osteopathic Association for the opportunity to respond to the comments by Drs Fredricks and Comeaux. Although I clearly do not agree with some of what they write, their concerns certainly need to be addressed.

In his letter, Dr Fredricks, who is obviously a staunch advocate of the “separate-but-equal” doctrine for osteopathic and allopathic medicine, makes several assumptions for which he provides no foundation. First, he asserts that “federal funding of medical schools in the future will have nothing to do with degrees”—yet he provides no insight as to how he arrived at this opinion. Federal dollars are at a premium and will be more so as a result of the Patient Protection and Affordable Care Act, signed by President Barack Obama in March 2010. Moreover, among the provisions of the act is the formation of a panel to apply the principles of both evidence-based medicine and “value-based” medicine to determine which procedures will be reimbursed. Certainly, we can expect the same principles to be applied to medical education.

In addition, Dr Fredricks’ own arguments regarding reimbursement and continuing medical education (CME) lend credence to my call for unification of the osteopathic and allopathic medical professions. He bemoans being mandated to attend 20 hours of American Osteopathic Association (AOA)-approved Category 1-A CME instead of any Category 1 CME. However, he neglects the obvious—that without such a requirement, most of these mandated, solely AOA-approved programs would fail to fill available positions. Thus, as a result of our professional separation, these programs would not be economically viable.

Dr Fredricks also makes much of the fact that multiple medical degrees are issued by various countries. Many of these medical degrees—similar to the LLB degree that used to be awarded to graduates of law schools in the United States—are anachronistic. Even those remaining medical degrees with diverse designations uniformly symbolize the same type of training around the world—unlike the training of a DO, which is substantially different outside of the United States than within the United States.

Such points, however, are irrelevant because had Dr Fredricks read my original letter carefully, he would have noted that I actually advocate the awarding of both MD and DO degrees at graduation. Such a combination of degrees would provide both the recognition and acceptance of an MD degree, along with the ability to maintain osteopathic professional distinctiveness where it exists. Moreover, with an MD, DO degree combination, the display of a particular professional designation would be an individual’s choice. Dr Fredricks would not have to display his MD if he chose not to, and if most graduates of osteopathic medical schools are happy with their DO degrees, they too could choose not to display their MDs. If that is the case, so be it.

Dr Comeaux makes some valid points in his letter. I agree with him that every nation has a right to extract from Dr Still’s teachings whatever it desires and to apply those teachings as it wishes. However, we live in the United States, where nearly a century was spent fighting for full licensure for DOs in every state and at the federal level. I differ with Dr Comeaux in regard to his feeling that the fight has been won in any but a strictly legal sense. His own definitions of the “criticisms of the 1960s through the 1980s” and the “collapse of the osteopathic hospital system” are symptoms of a fight that is already lost both internally and externally.

What Dr Comeaux views as a “medicine-by-algorithm” approach is what most medical authorities today call evidence-based medicine. Surely, Dr Comeaux is not advocating a system in which patients are exposed to medical procedures based on anecdotal reports rather than peer-reviewed studies.

Few of us doubt that osteopathic manipulative treatment (OMT) has a place in managing musculoskeletal disease. Perhaps the problem with the patient that Dr Comeaux describes as having back pain is that the patient should not have had those serial laminectomies in the first place. However, to base an entire profession on a single therapeutic modality, such as OMT, defies logic. Instead, let’s help physicians who do not use OMT see the value of incorporating this manipulative therapy into patient care when and where appropriate, thereby adopting it throughout the wider medical profession. Imagine how many more patients would benefit from that approach.

Regarding Dr Comeaux’s emphasis on philosophy and reform, I’d like to point out that if reform is our goal, then bringing the benefits of OMT into the mainstream of medicine should be our method. Only then will larger numbers of patients in the United States and around the world gain access to, and benefits from, this valuable treatment modality. Surely this would be the goal of Dr Still if he were alive today.

I have heard “osteopathic philosophy” described in many ways by many people throughout the years. Even in
the July issue of the JAOA, Felix J. Rogers, DO,† alludes to the fact that the distinctiveness of osteopathic medicine is difficult to define. Mostly, descriptions of osteopathic philosophy seem to involve a holistic approach to patient care. I’m sure that Dr Comeaux has not failed to note the increasingly holistic approach being taught in most medical schools, at least in the United States. The failure of physicians to use a hands-on approach is usually the result of instruction in this approach becoming buried by other clinical teachings during the postdoctoral training years. We can best effect positive change in this matter by increasing the roles of osteopathic physicians as teachers in hospitals throughout the country.

Finally, I find it ironic that the individual who taught me the most about patient-centric medical care and a hands-on approach was not a DO. I spent some time studying cardiology with William Likoff, MD, during my early training. Dr Likoff was a world-renowned cardiologist, yet I never recall him entering patients’ rooms without fluffing their pillows, holding their hands, sitting and talking with them, and carefully examining them. In fact, on rounds, Dr Likoff rarely allowed us to see patients’ test results until we had given patients this kind of attention and arrived at our own conclusions by analyzing their medical histories and physical examination results. Neither did Dr Likoff allow us to consider only the cardiovascular system in our diagnoses and treatment. Rather, he insisted that we treat patients as people, not as organ systems, with the same degree of humanity as he did.

I wish that all physicians—no matter the types of degrees they have—were as dedicated, knowledgeable, and holistic as Dr Likoff. I urge those of us who practice a patient-centric, hands-on approach to medicine—regardless of our specialties—to use the greater acceptance and recognition of the proposed MD, DO, designation to spread that approach and philosophy throughout the medical profession.

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References

Proposed LOCAM-LT Mnemonic for Mastering Examination of Mental Status and Cognitive Function

To the Editor:
Changes in mental status are a major reason for neurologic consultation and hospital admission. Despite the frequent need for mental status assessment, the evaluation is often abbreviated, with important aspects omitted. Such inadequate examinations cause physicians to miss crucial information that could speed the accurate diagnosis of mental status change needed for proper management. For example, a patient inappropriately evaluated for altered mental status might have an overlooked aphasia localized to the dominant temporal lobe as a result of ischemic stroke. Speedy diagnosis of such aphasia is necessary to provide proper thrombolytic treatment to the patient within the therapeutic time window.

The mental status examination is an often daunting task for medical students, residents, and many practicing physicians because of the variety of methods used to conduct this test. The Folstein Mini-Mental Status Examination (MMSE) is probably the most routinely used screening method for assessing a patient’s mental status. However, many of the methods are complex and time-consuming, involving inherent difficulties in recalling sequential steps; some are overly simplified, missing important neurocognitive features; and others are designed with only a narrow focus on limited domains of cognitive function. As a result, the mental status of patients is often inconsistently and inappropriately evaluated. The optimal test would consist of easily remembered sequential steps, it would include a comprehensive screen of multiple domains of neurocognitive function, and it would be adaptable to focus on specific areas of cognitive testing as desired.

To reduce these complicating factors in performing a mental status examination and evaluating cognitive function, I would like to propose a new method, which I developed while serving a residency in neurology at the Cleveland Clinic in Ohio, as a way of teaching other residents and medical students. The technique provides an easy-to-remember and efficient, yet comprehensive, evaluation of a patient’s mental status and cognitive function, including the six crucial components of language testing that are important in screening for acute stroke. The proposed method can be easily used by all healthcare professionals in any stage of training to proficiently describe a patient’s mental status and cognitive examination. An additional benefit of the technique is that it includes all aspects of the Folstein MMSE, so the gathered information can be easily extrapolated to generate a standard MMSE score if desired.

Remembering a simple mnemonic—LOCAM-LT—is required to perform the technique. When each of these letters is thought through sequentially, all information needed to comprehensively evaluate and comment on the patient’s mental and cognitive status is obtained:

L: Level of Consciousness
Determine if the patient is hyperalert, alert, drowsy, obtunded, or comatose.

O: Orientation
Evaluate the patient’s orientation to

Let's Level Of Consciousness Determine If The Patient Is Hyperalert, Alert, Drowsy, Obtunded, Or Comatose.

O: Orientation Evaluate The Patient’S Orientation To
person (eg, self); place (eg, state, city, hospital, floor, room); and time (eg, year, month, date, day, time of day).

C: Concentration/Calculation
Ask the patient to spell WORLD backwards, or to subtract 7 from 100, and then 7 from that sum—continuing in that pattern for 5 total subtractions (ie, “serial 7s”).

A: Attention
Information on the patient’s level of attentiveness should be obtained by observation of whether the patient appears attentive or distracted during the preceding step. The patient can also be asked a question such as, “If the lion chased the bear and the bear killed the tiger, which one died?”

M: Memory
Various aspects of the patient’s memory should be evaluated. Immediate memory can be tested with 3-item recall or 7-digit recall. For example, ask the patient to repeat the following numbers in the given sequence: 1-9-7-6-4-2-9.

Working memory can be tested with mathematical manipulation of the 7-digit recall. For example, the patient can be asked to “add the first and last digit of the number sequence you just repeated.” Then, ask the patient to “multiply that number by 2” and “subtract that number by 7.”

Recent memory can be evaluated with a repeated recall of the same 3 items used in immediate memory testing. However, consider testing for recent memory after remote memory testing in order to obtain a longer time interval between the immediate and recent memory tests.

To evaluate remote memory, ask the patient for such personal information as date of birth, place of birth, and questions about family members or well-known historical events.

L: Language
This item is especially useful for localizing potential acute stroke. Comprehension of language can be tested with a 3-step complex command. For example, direct the patient to “hold up your right thumb, touch your left ear with it, and then stick out your tongue.” In addition, patients can be asked to demonstrate how they would perform certain purposeful movements, such as combing their hair and holding a nail while hitting it with a hammer. Difficulty with these movements could reveal signs of dementia (eg, apraxia).

Ask the patient to perform language repetition by repeating such phrases as “no ifs, ands, or buts” and “it’s a sunny day outside today.”

Evaluate naming ability by asking the patient to name common objects, such as a pen and a watch. You may also ask the patient to name as many “S” words as possible in 1 minute to screen for frontal subcortical dysfunc-

Fluency should be evaluated by listening for dysarthria when you interview the patient. Listen for abnormal vowel pronunciation by asking the patient to repeat, “Me-tho-dist, E-pis-co-pa-lian.”

T: Thought Process
Abstraction in thought should be evaluated in patients. Ask for similarities and differences between various objects or settings—such as a tent vs a cabin or a river vs a lake. In addition, during your general conversation with the patient, listen for symptoms of psychosis, delusions, and tangential or pressured speech.

By remembering the sequence and components of the LOCAM-LT mnemonic, physicians will be able to simplify the seemingly complex and time-consuming, yet important, task of evaluating patients’ mental status and cognitive function. The sequence of steps in this method can be adjusted based on the particular clinical scenario, or the steps can be performed in the sequence described in the present letter for a comprehensive evaluation of neurocognitive function. Either way, the LOCAM-LT method allows for a complete assessment of a patient’s mental status and cognitive function.

It is important to note that the LOCAM-LT method should be accompanied by a thorough neurologic examination of the patient to avoid missing a potential neurologic emergency—such as acute stroke, which may reveal hemiplegia or other focal findings—and to provide further evidence for diagnosis. I believe that the easy-to-remember LOCAM-LT technique, together with a neurologic examination, can provide the physician with complete confidence that an accurate evaluation of a patient’s mental status and cognitive function is obtained.

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OMT Relieves Low Back Pain During Pregnancy

To the Editor:

Hoorah! While reading the December 2009 issue of the JAOA—The Journal of the American Osteopathic Association, I discovered in “The Somatic Connection” a discussion of an article on osteopathic manipulative treatment (OMT) and low back pain during pregnancy. Researchers at the University of North Texas Health Science Center—Texas College of Osteopathic Medicine in Fort Worth reported the results of the first randomized, placebo-controlled clinical trial of OMT for low back pain during uncomplicated pregnancy.

Evidence-based literature on the safety and efficacy of OMT for low back pain is necessary and laudable. As an old-time rural osteopathic general practitioner, I had many obstetric patients under my care. In the study, patients were treated from the 30th week at regular intervals until parturition. My patients were seen and treated with OMT at each visit, every 2 weeks, until week 36, then weekly until delivery.

Although the study did not use high-velocity, low-amplitude on patients, it was my main OMT technique—with other methods such as muscle energy and soft tissue when necessary. Also, our clinic charged a flat fee for prenatal care, postnatal care, and delivery, which enabled me to tell patients that if back ache or any problems arose between scheduled visits, they should come in immediately—not wait for the next visit. This understanding worked out well and enabled the patients and I to head off minor problems, whether musculoskeletal or physiologic, before they became major problems.

Of course, I was not doing research but rather giving care to the women who were carrying their precious burden of new life. During each visit I was able to take the time while administering OMT to become physically aware of changes, to answer questions, to allow me to make each woman aware of what to expect during labor and delivery, and to let her get to know and trust me.

It is only hearsay evidence, but all of these women appreciated the OMT. The primiparous patients really just thought that “this is the way it’s supposed to be” while the multiparas patients, especially those who had “normal” obstetric care elsewhere, always commented that it was “so nice to go the whole 9 months without a backache.”

When I taught Family Practice Obstetrics at the West Virginia School of Osteopathic Medicine, I started a “Lying in Facility” program at the school. We took carefully screened obstetric patients and, at delivery time, used some especially prepared rooms at the school (not the hospital) and with a closely supervised student assigned to each patient, conducted labor and delivery procedures right there. Each patient had received OMT throughout her pregnancy under supervision at each visit. My purpose for this program was to show our students that most pregnancies were “normal” and could and should be handled by a well-trained family physician. Not being one to write down numbers, I didn’t record these facts, but our mortality rate was zero and our maternal and fetal morbidity rate was close to that.

Osteopathic physicians must not forget postnatal care and the use of OMT. We must not forget that the woman’s pelvic structures are rearranged by the passage of a new 6-lb to 9-lb human being passed through over a period of hours. Structure needs to be normalized as function may return to normal.

Let us do more research studies to prove to the world that the “thing we do” is safe, efficacious, and should be a major part of “normal” obstetric care.

Paul G. Klem, DO
1Dr Klem died February 26, 2010.

References

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