Seize opportunity to foster osteopathic pride

To the Editor:
I find myself compelled to respond to recent articles written under the premise that osteopathic medical students are allopathic medical applicants who entered medical education through the “back door” by Shirley Johnson, PhD, MPH, MSW, and David Bordinat, MA, and the response by Mitchell Kasovac, DO. I write this letter from the perspective of a recent graduate.

First, the assertion that a growing portion of osteopathic medical students (up to 50%) are attaining their medical education through the back door phenomenon is misleading. Everyone knows that those who could not get into Harvard went to Yale, New York University, or Tufts, Stanford hopefuls went to University of California–San Francisco. In fact, the entire American educational system, unlike its European counterpart, is open ended. It has been designed this way to maximize opportunities for prospective students at any level of education, so as not to impede their progress because of failures at a young age. If we follow this line of thinking and examine Dr Johnson and Mr Bordinat’s assertions more closely, in fact, we realize the major flaw in the back door phenomenon. This so-called phenomenon assumes that it is easier to enter osteopathic medical schools than allopathic ones. A close look at the data published by the Association of American Medical Colleges reveals that the requirement in a major number of allopathic medical institutions are in fact very lax. For example, in 1990, the University of New Mexico School of Medicine interviewed 124 of 134 “in-state” applicants, and had a class grade point average (GPA) of 3.4, with an average Medical College Admission Test (MCAT) score at about 8. It is even easier to get into East Tennessee State University program where, in that same year, the class GPA was 3.23 and the average MCAT score was 7.2. These scores are in sharp contrast to my class’s average GPA of 3.7 and MCAT score of 9 in 1992.

The point is that it is far easier to get into most midwestern state-sponsored allopathic medical schools than into most osteopathic medical institutions. Yet, I do not hear the cry of outrage of these applicants who truly define the back door pathway.

Second, Dr Kasovac’s contention that the screening process of Western University of Health Sciences College of Osteopathic Medicine of the Pacific (Western U COMP) helps to ensure osteopathic medicine-oriented applicants also misses a more important point. Although it is important to give consideration to “osteopathic minded” applicants, it should not truly matter whether an applicant is “osteopathically oriented” or not. What really matters is how we foster osteopathic philosophy once they are in. A quick look at the Western U COMP’s statistics in this year’s review of osteopathic medical education in the November 1998 issue of JAOA reveals that 41% of its graduates do not even participate in the Osteopathic Match. This is a problem not particular to that school. To graduate osteopathically oriented physicians who participate in the osteopathic internship and maintain their AOA membership is a far more important endeavor than our concerns over the back door applicant. Instead, we are allowing our profession to erode from within by institutions that encourage their students to form “AMA” clubs. Remember, whether these applicants set out to be osteopathic physicians is irrelevant, because they have eventually chosen to become DOs, thus giving the profession the unique opportunity to foster osteopathic pride—an opportunity too often missed.

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References

Push OMT for healthcare

To the Editor:
Several editorials and letters to JAOA in the December 1998 issue address the distinctiveness of the osteopathic medical profession, that is, in terms of osteopathic manipulative care.

I am very happy that you addressed this topic in JAOA. I wish and hope that more and more DOs talk about osteopathic manipulative treatment (OMT) and practice it on more and more of their patients.

And, we should talk about OMT being effective for illnesses, not just musculoskeletal complaints.

Osteopathic manipulative treatment was started back in the 1880s by A. T. Still, MD, because in those days, there were very few medications that actually worked. When Still could not convince his MD colleagues to use OMT for illnesses, he started the first college of osteopathic medicine, the American School of Osteopathy, in Kirksville, Mo.

I was well aware of the osteopathic approach to all illnesses while in the early 1930s, when I was a preteen. Of course, if surgery was needed, it was done.

My father received his doctor of osteopathy (DO) degree in 1913. First, he had attended an allopathic medical college for 2 years. He then switched to the osteopathic medical school in Kirksville because there were so few medications that worked. He
met my mother-to-be there. He was helping
to teach anatomy and physiology while a
student and was switched to the Chicago
College of Osteopathy. My mother mar-
rried him and went to Chicago with him. She
was graduated in 1914.

My parents were practicing in Chicago
during the flu epidemic of 1917 and 1918.
They and their DO colleagues lost very few
patients to the flu. They used OMT. Their
MD colleagues lost hundreds of patients
in Chicago because there was no effective
medical care for the flu.

My parents moved downstate in Illinois
and continued providing OMT for sick
patients. So, I grew up with that approach.
I know it works. Yes, surgery is necessary
at times. I became aware in the 1930s that
whenever my parents contacted the American
Osteopathic Association (AOA) for backup help with their OMT practices, the
AOA ignored them! The AOA was doing
everything it could to educate the public
that DOs were like MDs. The AOA did
not push OMT.

I was graduated from the Chicago Col-
lege of Osteopathy in 1948. The AOA did
push OMT at that time. I interned in Den-
ver, Colo, and then started my own gen-
eral practice in Aurora, Colo, in 1950. I did
medical, surgical, and osteopathic manip-
ulative care. During the 1950s and 1960s,
I became aware that my college and the
other colleges of osteopathic medicine (there
were only five then) were cutting down on
teaching the osteopathic principles for
healthcare.

Because there were so few of the Denver
DOs doing OMT, I cut out the medical
and hospital parts of my practice in 1979.
Since then, I have been doing only osteo-
pathic manipulative care for most medical
problems. I do advise my patients to con-
tact their family physician for the approp-
riate medical care, if necessary.

My Chicago College of Osteopathy
changed its name to Chicago College of
Osteopathic Medicine of Midwestern Uni-
versity a few years ago. The most recent
alumni newsletter that I received several
weeks ago had an article in it about “os-
teo-pathic manipulative medicine” (OMM).
It stated that the Department of Osteo-
pathic Manipulative Medicine was going to
seize “the opportunity to revitalize OMM”!
Of course, I had been aware for several
decades since graduation that the Chicago
College had quit pushing osteopathic
manipulative care, and so had the other
colleges of osteopathic medicine.

Because I have been associated with
OMT for all of my 70+ years and have
been a DO for more than 50 years, I am
well aware that my profession has failed
to push the manipulative approach to most
human health problems. I use it in my prac-
tice and I know it works. Of course, because
I used medicine and surgery during my first
27 years, I know they work now also. But
I am convinced OMT should be done at the
beginning of caring for most illnesses. It
should be continued if it works. And, it
does in 90% to 95% of the cases. Medical
care may be done, also.

I have written similar letters to the AOA,
Congress, and so forth in the past. The
only response I ever had was about 20
years ago from the then JAOA Editor
George W. Northup, DO. He agreed with
me.

I hope I can remain optimistic now hav-
ing seen the letters in the December 1998
issue of JAOA. Please keep pushing OMT
for healthcare.

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those of the editors, the American Osteopathic
Association, 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, Chica-
go, IL 6061 I. No unsigned letters will be con-
sidered for publication.

1. (d) Meckel’s diverticulum is of a con-
genital origin. It is also “true” in nature
and possesses all layers of the bowel wall.
2. (d) Jejunal diverticulosis can present
with nausea, left epigastric pain, intesti-
nal hypermotility, and distention/thickening
of the jejunal wall.
3. (c) The acute surgical abdomen is a
phrase, often used by surgeons, to describe
a constellation of symptoms. In the
strictest sense, it implies an acute patho-
logic event that requires surgical inter-
vention. It is often corroborated by peri-
toneal irritation, suggested by rebound
tenderness and tenderness to percussion.
Acute appendicitis is a typical pathologic
entity associated with the acute surgical
abdomen.
4. (a) The most common complications
detected at surgery are inflammation and
hemorrhage.
5. (a) Small bowel diverticulosis is usu-
ally asymptomatic.
6. (d) Signs and symptoms of jejunal diver-
ticulosis include diffuse abdominal pain,
postprandial bloating, and malabsorp-
tion.