Sawbones 343: Osteopathic Medicine

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Intro: (Clint McElroy): Sawbones is a show about medical history, and nothing the hosts say should be taken as medical advice or opinion. It's for fun. Can't you just have fun for an hour and not try to diagnose your mystery boil? We think you've earned it. Just sit back, relax and enjoy a moment of distraction from that weird growth. You're worth it.

[theme music plays]

Justin: Hello everybody, and welcome to Sawbones: a marital tour of misguided medicine. I'm your cohost, Justin McElroy.

Sydnee: And I'm Sydnee McElroy.

Justin: I don't know why I put the emphasis on "I'm". No one else is claiming to be Justin McElroy.

Sydnee: Yeah, I don't— nobody's fighting you for that position.

Justin: Except for CBC Canadian Justin McElroy.

Sydnee: But he's not claiming. He is.

Justin: Well, is he?

Sydnee: Yes.

Justin: I mean, he's Justin McElroy, but is he *Justin McElroy?* You know?

Sydnee: Mm, with that— I don't know if he would say it like that.

Justin: Probably not.

Sydnee: You know. That might just be you. Justin, I like on this show sometimes when I have the opportunity to dispel misinformation. I don't know if you've noticed that. [laughs]

Justin: Mm hmm.

Sydnee: Mm hmm.

Justin: You tend to take what some would describe as delight in it.

Sydnee: Recently in the news I have been very dismayed to see the way that some of my colleagues in the medical profession, specifically D.O.s, Doctors of Osteopathic Medicine, are being treated.

Justin: Um, I forgot for the intro for this episode, I wanted to be— I wanted to say, "Sydnee, are you ready to DO this episode?"

Sydnee: Oh. Like D.O. and… mm hmm. Is that really… that was— or did you just come up with that and then you wanted to try to—

Justin: I thought of it two days ago and I decided not to do it, and I don't know why— I think I have an extra organ in my body that makes me say the jokes I shouldn't.

Sydnee: [laughs] Well, you should have listened to Justin from two days ago.

Justin: Yeah.

Sydnee: Can we call him in here and do the show?

Justin: I don't know why I'm having a flare up of my—[laughs] my bad joke— my third kidney that makes me do bad jokes.

Sydnee: [laughs] So anyway, a lot of people have written in to ask about osteopathic medicine and osteopathic physicians. What is the difference? Is there a difference? What does it mean? You may have seen recent reports about this because the president's doctor, while he was admitted to the hospital, Dr. Conley I believe, is an osteopathic physician and there has been a lot of question as to not being able to fully decipher what the doctor was communicating, I think, to reporters during press conferences. He has been accused of kinda being cagey with some of his answers. And all that aside— I have nothing to say about any of that, I mean, frankly. I don't know this fellow. [laughs] I know nothing of his credentials, training, or communication ability.

Justin: Is he a fellow or is he an attending physician?

Sydnee: I was just calling him a fellow.

Justin: Oh.

Sydnee: Like, you know, fella. Feller.

Justin: Feller.

Sydnee: Feller.

Justin: You gotta say feller, it's less confusing.

Sydnee: [laughs] I don't know him personally and I'm not talking about him. But whatever, all that aside, the fact that he's an osteopathic physician should have nothing to do with your opinion of him. That is why I wanted to address this. Because a lot of people, I think, kind of looked into him, googled some stuff, got the wrong idea—

Justin: Got a hot take all in the chamber—

Sydnee: Yeah. Yeah, I mean, there were journalists, there were celebrities, there were a lot of just random people on social media who were insulting this person based on the fact that they are not an M.D. but a D.O. physician. And as we go through the history of osteopathic medicine and I seek to explain the difference and lack of difference in a lot of ways between the two, please keep in mind that the number one thing I want you to understand is there is nothing— there is really no fundamental difference in the care you are going to receive from an M.D. or a D.O. and there is no reason that you should be dissuaded from seeing a physician because they are a D.O.

They are wonderful, uh, I have reached out to some of my D.O. colleagues and some of our listeners that I wanna thank, Caitlin and Matthew and Jennifer and Audrey and Anita, for giving me some more information. Since, while I understand osteopathic medicine, I did not attend osteopathic school, and so they helped me get a little more insight into what the current thought is.

Justin: So, these people you talked to were attendings?

Sydnee: No. What are you—

Justin: That was another—

Sydnee: Ah ha, you're all over the place here.

Justin: Yeah.

Sydnee: I've actually spoken now with students, residents, fellows and attendings. How do you like that?

Justin: Wow, that is great, Sydnee.

Sydnee: Yeah. All levels of training.

Justin: All the different kinds of them.

Sydnee: As osteopathic physicians.

Justin: What about enthusiasts? What about amateur—[laughs]

Sydnee: Amateur D.O.s? No. I would not recommend an amateur doctor, whatever initials follow their name. [laughs] That's you included.

Justin: Well, agree to disagree.

Sydnee: [laughs]

Justin: I'm still looking for a college to gimme that honorary doctorate by the way. If anybody can do that for me, let me know. I'll do anything at this point.

Sydnee: Not anything.

Justin: [whispers] Anything. Whatever nasty thesis you need from me.

Sydnee: If you listen to this show regularly, you know that medicine wasn't always…

Justin: [laughs] Good.

Sydnee: Competent.

Justin: There we go.

Sydnee: Um, we went through a lot of phases in medical history where we would just try things, and if it worked we would keep doing it and if it didn't work we might keep doing it anyway. But the idea that we've always had it figured out, I think you know is flawed. It's taken us a long time and there's still things we're figuring out.

Justin: Sure.

Sydnee: That's just the nature of knowledge, human knowledge, and scientific inquiry. Back when Dr. Andrew Still, who we're going to talk a lot about, the father of osteopathic medicine, back when he became a physician, he was originally an M.D. during the American Civil War, there was a lot to be desired. And that was Dr Still's main problem with medicine at the time. Is there were a lot of things that he was learning, his father was actually a physician, he studied and apprenticed under him, he worked as a hospital steward and then would— the way that that would go is you would, like, start out giving out medications and things and then eventually you would be caring for the sick and then eventually you would be doing surgery. [laughs] So, just—

Justin: Yeah. An accelerated track we have here. [laughs]

Sydnee: Exactly. And so, as he went through these different levels of responsibility and areas of medicine, he slowly was becoming more and more kind of disenchanted with the state of medical knowledge at the time.

Justin: Okay.

Sydnee: There were a lot of treatments that were just as likely to harm people as they were to help people and he kinda, he felt like— he started to get the inkling that there has to be a better way.

Justin: There has to be a better way.

Sydnee: There has to be a better way. And what really motivated him to start finding that, in his mind, better way, was after the war he very tragically lost his wife and children to meningitis.

Justin: Ugh.

Sydnee: It was terrible. And after that, he really decided, "You know what? There's a lot we haven't figured out," which is true, "and a lot of the treatments that we're using are really dangerous. And we need to kinda go back to basics and see are we going at this the wrong way? When we start bleeding people or giving them mercury or arsenic," or whatever was fashionable at the moment, "what are we doing?" You know. "Have we really gone down the wrong road?"

Justin: Okay.

Sydnee: And so, Dr Still went back and after a lot of thought and kind of contemplation based on his own knowledge as a physician, he came up with this concept that most disease gets back to— sort of like mechanics.

Justin: Okay.

Sydnee: It's a problem of bones and muscles.

Justin: Okay.

Sydnee: At the end of the day. And I think that the fact that he also understood a lot about, like, machines kind of makes all this— as I'm trying to envision him as a person and how his mind worked— he once patented a butter churn, so….

Justin: Nice.

Sydnee: [laughs] That's the way was his brain worked, and so mechanics as a way of understanding the human body kind of made sense to him.

Justin: Which is accurate. It's just what scale, right?

Sydnee: Right. Well, I mean, I think there is a— there are certain things you can apply this to for sure, and you'll see that this persists in osteopathic medicine. But when it comes to other physiological processes, this probably doesn't pan out.

Justin: Yeah. Not the most helpful metaphor.

Sydnee: But he decided that he was going to kind of restructure medicine with this new theory that he called Osteopathy. "Osteo" is a reference to—

Justin: Bones.

Sydnee: Bones. Hey! You got that.

Justin: "Path" is like roads or different ways you can go, so these are different ways your bones can go.

Sydnee: N- no. It's a reference to suffering. Like pathology.

Justin: Mm. Bone suffering.

Sydnee: Path— bone suffering. Suffering of the bones. [laughs]

Justin: Got it.

Sydnee: But it wasn't just about, like, the bones are the problem. It was more about the idea that the way that we could fix things, the way that we could treat disease is really through hands-on manipulation of the bones, the muscles, the tissues, to treat underlying disease processes.

Justin: Okay.

Sydnee: And he founded the first school of osteopathy based on this idea and it was called The American School of Osteopathy. It is now A. T. Still University, in Missouri. And this was back in 1892 when this all started. And, you know, if you look into, like, this period in history— and we've talked about this a lot on the program, there were a lot of other medical schools of thought popping up here and there. So, this idea was not odd.

Justin: The thought that you'd come up with a new kind of medicine to do was not that wild back then.

Sydnee: Right.

Justin: In this period we see a lot of people— I think we start to have, like, a groundwork without necessarily the best applications for all of it, and you start to see people like, "Well, we can all agree basically this is the way things are going in there, so maybe this is the way that we address it."

Sydnee: Yeah. And I think that some of this, obviously, distrust in the medical system that existed, like "I feel like I went to the doctor and I ended up worse than before," which sometimes was unfortunately true.

Justin: Fair, yeah.

Sydnee: We didn't know everything. Well, we don't know everything now. But we didn't know as much yet. But some of it gave rise to things that we know didn't work. Like homeopathy.

Justin: Mm hmm. Well, the jury's out, but go on.

Sydnee: [laughs] You get, like, groups like we've talked about, like the eclectics and the Thomsonians, who bordered on some things and then there were a lot of other things that didn't work. So, you get this kind of time period where a lot of different— medicine's going a lot of different directions as a reaction to, uh, I don't— and probably, like, based on the previous Heroic Era of medicine when if it, you know, "If you're going to die anyway we may as well do… whatever."

Justin: "A bunch of weird stuff."

Sydnee: Yeah. So, anyway. His initial plan as to teach people everything he knew in three months. That was the medical school.

Justin: Nice.

Sydnee: You can learn this in three months. Anybody can learn it, and it takes three months. He eventually realized that you probably need a little more time.

Justin: Four months.

Sydnee: [laughs]

Justin: Final offer.

Sydnee: He also, I think it is worth noting, he taught both men and women. Pretty revolutionary at the time.

Justin: Yeah.

Sydnee: Like, from the beginning, that was fine. And this main difference, I think, when we talk about, like, in a current climate, what is the difference between a D.O. and an M.D. in terms of their training, this was sort of codified in the beginning. Still taught, Dr. Still taught something called Osteopathic Manipulative Medicine, OMM, or Osteopathic Manipulative Treatment, some people— OMT. But the idea is that this is a way of treating disease by manipulating and moving the body around. It is a hands-on, um, "Lay down on this table, I'm gonna touch you and move you and make things better." Right?

Justin: Right.

Sydnee: And it's based on an understanding of anatomy. It includes movement of the bones, the muscles, the tendons, the fascia, which is a layer of tissue, a thin, strong layer of tissue that overlies the muscles. You have to work with tension in all those areas and dysfunction in those areas to manipulate them to take you back to health. Wellness.

Justin: Now, that sounds, if you're listening to this as sort of a layman, that might start to sound kinda like massage therapy?

Sydnee: There's— when you— if you've ever… well, I have had OMT performed. If you haven't, I will tell you that for someone that has not been trained in it, it would remind you of somewhere between, like, massage therapy and— I have never been to a chiropractor but I know there are some similarities between just some pieces. They are not the same thing, by any stretch, but some pieces. And even a little bit of physical therapy. Like, it's somewhere in the middle there. I found it—

Justin: Can you give me an example of, like, one manipulation, just so people with have an idea of what we're talking about?

Sydnee: Oh, well honey I wasn't trained in it—

Justin: I know, but like, neither were the laymen, but you had it done to you, right?

Sydnee: Yes. When I had it done, a lot of what I— I was pregnant with our first child and I was having a great deal of pelvic pain, especially in the front part of my pelvis, the pubic symphysis. And it was very tender and sore. And so, one of my colleagues who is trained in osteopathic medicine would, um, a lot of it had to with just like— I was laying down and she would— I don't know what these, I know there are probably D.O.s listening going, "I know what maneuver that is," and she would like, flex my leg up and over to the side and provide, like, tension against the way that— you know? I mean, it was a lot of just like…

Justin: So, stuff like, maybe, if you need a reference point, something like you'd see in physical therapy also.

Sydnee: Yes.

Justin: Sort of like that, sort of like that idea. That's the kind of thing we're talking about.

Sydnee: It doesn't— when you're seeing it, a lot of the time it looks a lot like, just stretching or massage. It looks like that from the layperson's view on the outside.

Justin: The reason I'm drilling down on it is it sounds— if you don't know what we're talking about, it can sound— it sounds made up.

Sydnee: No.

Justin: If you don't know that, like, what we're sort of say— "Well, how would that have anything to do—" I mean these are serious, like, you're doing something, right?

Sydnee: Well, and when I talk about energy and tension, I am not talking about, um, a philosophical concept.

Justin: Chi. Right.

Sydnee: I am talking about, like, physics. Like, you are finding points where there are contracted muscles and there are actually inflamed, tense parts of tissue, and working against the, like, counter-energy of that. Like, I'm talking physics here.

Justin: Okay.

Sydnee: Not, um, this is not conceptual. Does that make sense?

Justin: Yeah, absolutely.

Sydnee: Okay. And like I said, the initial idea was that anything could be treated this way. Like, anything.

Justin: So that's kind of where maybe the problem…

Sydnee: Right, right. And again, I wanna get into, like, how this has evolved. But before we, kind of as you have already alluded to, before you start thinking, like, "Well, this doesn't sound real," it's important to remember a few things.

Dr. Still was against a lot of pharmaceuticals, for the most part. He thought that we were probably evolving in a direction with medicine where the vast majority of illness, disease, could be treated by OMM. Some people will need surgery. And there will be maybe a handful of

pharmaceutical therapeutics that could be helpful in the future. He did not feel like those necessarily existed in his time. And when people were being given, like, opium and arsenic that's not a wild thought. To say, like, "I don't think these things are really helpful." I think that there were probably some who would argue, "Well, yeah, but we're moving in the direction and medicine will play a big part," and he thought that actual like, drugs would play a much smaller role in the future of medicine.

Justin: Thought they would or thought they should?

Sydnee: Should, if things evolved the way he felt they should.

Justin: Okay.

Sydnee: [laughs] Would if things evolved the way he felt they should. And in addition to this, he was the first physician who pushed really strongly on the idea of preventative medicine. That really comes— Dr Still really focused on the idea that, like, we're so interested in treating pathology, but why aren't we putting this much energy into keeping people well? So that we don't have to treat the— since we're really bad at treating pathology, [laughs] why don't we try to prevent that from getting there? Which was, you know, is an incredibly important idea in medicine, and Dr. Still was one of the, you know, forerunners of this idea.

I want to talk about how if that is the origin of osteopathic medicine, which, I would say at the time was alternative medicine, certainly, back then, to what was considered the mainstream, allopathic medicine, how did that evolve into what I am arguing now is indistinguishable?

Justin: … I don't… I don't know.

Sydnee: I'm gonna tell you.

Justin: Oh, good.

Sydnee: But first I wanna take you to the billing department.

Justin: Aw! That one, actually, you got me on that one. That one you got me. Let's go.

Sydnee: Good.

[ad break]

Justin: Alright Syd, or should I say Tricky Syd, because you tricked me.

Sydnee: Oh, I like that.

Justin: Tricked me into commercialism.

Sydnee: Okay.

Justin: Not me. I'm not— if it were up to me, folks, no room for capitalism on this show. It's all about serving people.

Sydnee: Hey, oh, don't even. I long for a day where we have to rename the billing department because it no longer makes sense.

Justin: Oh yeah, we'd have to name it like… waiting six hours for a death panel, right?

Sydnee: Oh my gosh, no.

Justin: High five. High fi— whoa, you're high fiving me so hard, Sydnee!

Sydnee: [laughs] No. How about time to pay your taxes which are totally reasonable because you don't have to pay healthcare premiums or deductibles anymore?

Justin: I liked mine. I thought mine was a little catchier. [laughs] Neither of them are great.

Sydnee: Anyway. No, we'll workshop that.

Justin: We're gonna workshop—

[Siri: Interesting question.]

Justin: We— thank you, Siri. We probably have plenty of time to figure something out. [laughs]

Sydnee: Unfortunately. So, as I was saying, things definitely were going to evolve, because the pharmaceutical industry, the way that we make drugs, study drugs, prove if drugs work or not, you know, because for— in the beginning, like, that wasn't really necessary, right?

Justin: Yeah.

Sydnee: Eventually, we said, "You know what? We should regulate this stuff so that you're not— so that snake oil is not the default".

Justin: Yeah.

Sydnee: And so, the pharmaceutical industry started to grow, the FDA was created, we started to come up with our idea of standard ways of proving if a medicine works, right?

Justin: Right.

Sydnee: You know, placebo-controlled, randomized control trials, double-blind studies, all that stuff became sort of the way that you know if something works. Well, what got harder to study in that model are things like Osteopathic Manipulative Medicine. It doesn't fit as well into this method of studying as a drug does, right? It's a lot easier to control like, well you give them a sugar pill and you give them the medicine and then that's it, right?

Justin: Right.

Sydnee: That's a lot harder when you're talking about this type of treatment. To come up with what we call a sham treatment, meaning it looks and feels like I might be doing OMT on you but I'm not really, to see— that's really hard to do, right?

Justin: Right.

Sydnee: And so, it was hard to prove that any of these treatments worked in the same way.

Justin: You also have people doing it slightly differently, because you're introducing another human being into the— you know, it's not like you're giving them 20ccs of rubbing. [laughs]

Sydnee: Yes. [laughs] It was a lot harder to prove that it worked and it was definitely operator-dependent. The more you did it, the more practiced you were in it, probably the better effects you were going to have. And you know, also a lot of studies were being done on students. Like, we'll practice on the D.O. students who might necessarily not have any problem, and so, how much better did it make you if you weren't having any issues to begin with?

So, it was really hard to have it, like, kind of codified into out treatment protocols the same way that drugs are a lot easier to do. And this also, as we evolved, this also went into like, how things get paid for. You know.

Justin: Yeah.

Sydnee: Insurance companies like to pay for things that are standard, like, standards of practice and it's harder to put these things into standards of practice when they're not being studied the same way.

Anyway, all of this moved, like, it put pressure on osteopathic schools to move closer to M.D. schools in sort of their training. And this is what happened. A lot of the D.O. schools started to move in that direction, doing things like adding pharmacology to their curriculum, you know, which is kind of against what Dr. Still initially, you know, thought medicine would be like. And the schools started to evolve and say, "Well, but we have to change with the times and medicines work now." [laughs] "We have good ones."

And so, students were trained in that, their curriculum was expanded from three to four years eventually, which is the same as M.D. school. And you get to a point as you move through, like, the 1900s up to the 60s and 70s where D.O. school is becoming pretty much M.D. school, with the addition of this Osteopathic Manipulative Medicine, that is still being taught, but all the other stuff M.D.s are learning, D.O.s are also learning. And so, along with that, the D.O.s had to start lobbying to be recognized as physicians. Because initially, they weren't called Doctors of Osteopathic Medicine.

Justin: What were they?

Sydnee: Osteopaths. It was removed from the concept of doctor.

Justin: That sounds like you have a psychic connection to bones. Like, you can talk to them.

Sydnee: [laughs]

Justin: Sounds like a Jennifer Love Hewitt series.

Sydnee: Well, I had to learn this, because it's weird, I initially— I have used those terms, like, interchangeably. Like, "Well, they're an osteopath," meaning they're a D.O., meaning they're a Doctor of

Osteopathic Medicine. But apparently, there was a time period where that's all. It was, like, intentional.

Justin: So you're diminishing them with that kind of language, Sydnee.

Sydnee: Well I didn't know. I didn't mean to. I didn't know that.

Justin: Oh, just cause you didn't mean to...

Sydnee: [laughs] Now I think they are all used the same way, because they're doctors. We know this.

Justin: Do you have anything in allopathic medicine, in your allopathic training, that you would equate these maneuvers to? Stuff that like, people don't really do that much but it is part of your training just for like, tradition or, um, some people still have faith in it? Is there anything, like, similar to that?

Sydnee: I wouldn't say there is, like, a body of knowledge that's similar to that. But there are definitely pieces of medicine scattered throughout, and my D.O. colleagues learn this stuff too, so they would probably agree with all this, there are things we do in various medical disciplines for treatment that have been done, like, back when we first thought that they would work and that since then evidence has not really borne them out to be incredibly effective, but we maybe don't have anything else and maybe we think it might work occasionally and it's not harmful, and so it continues to be done.

And as you're learning these things, sometimes your professor will mention that, or the person, your preceptor will mention that, but then tell you to do it anyway. You know— okay, here's something similar. The way that we prescribe steroids for various disorders has changed dramatically since I have been in practice, and that's because a lot of what we were first trained to do when I became a resident was just like, "We don't really know how long to give people steroids or how much to give them for different things, so we just sort of do this." Now, evidence has evolved and we have better ideas now, but when I first entered training, like, how long do you put somebody on steroids for a COPD exacerbation, it depended on which doctor you were working with. I mean, it really did. And everybody kinda knew that.

So, definitely. I mean, medicine's always evolving and changing and there are things that you continue to be taught because it's the best we know

right now. But we expect that we'll know better, different, more in the future. That's just the nature of science.

Anyway, so as D.O.s started to lobby to be recognized as physicians— one area, they wanted to be able to serve in the military as physicians, they were pushing very hard for that. A lot of what was happening against this were the AMA was fighting back. The American Medical Association was fighting to not allow D.O.s to kind of become doctors, join the ranks of M.D.s. And there was even, for a while the AMA said that it is considered unethical for an M.D. to associate with a D.O. That's how strong this divide was.

Justin: Wow.

Sydnee: But the D.O.s proved through, you know, turning out good physicians who knew what they were doing, that by the 60s that they are doctors and they are worthy of that title. And there even— there was a series of legal battles in California throughout like the 60s and 70s that finally had to put an end to it. Were like, they were making all D.O.s also go get M.D. licenses, which basically was sort of a racket. It was just money. You have to go pay to get one.

And anyway, after all of this legal stuff, after that time period, the two were seen as both pathways to becoming a physician. Equal, but slightly different in a little bit of that one aspect of the training. It's interesting too, because when you talk about, like, the philosophical underpinnings of the two, because that's the other thing.

So, what is the difference in the training? A D.O. will learn OMM, I will not as an M.D. There is this focus on preventive medicine that came from D.O.s, I would say that in M.D. school that has become part of our training as well, and so while that was a difference, it's probably not so much a difference now, and then the other thing that is often cited is this sort of holistic viewpoint. That D.O.s were trained to look at people as, like, a whole human. A mind, body, spirit connection that has to be treated. You can't just, you know, do a surgery or give a pill and make a person well.

Justin: You might say, you treat the illness, you win, you lose…

Sydnee: [laughs]

Justin: Treat the patient, you win every time.

Sydnee: It's funny, because that concept, and also, like, the idea that you cannot extricate the human that you're treating from their sort of social situation, like they exist within a context and you have to consider all of those things when you take care of a person—

Justin: Like on House. Like, maybe they had mold growing in their bathroom, so you had to consider that.

Sydnee: [laughs] Well, okay, yes that, but also things like do they have a home? Do they have money to pay for things? What kind of foods do they have access to? What kind of social connections do they have? All these different things. Which it's interesting, because as a family doctor, all of this stuff feels like, "Well yeah." I mean that's like, of course that was part of my training. Of course that's part of what I think about as a physician.

So, I really don't think all of these ideas are that different from where medicine evolved naturally for a lot of us. I mean, maybe not everybody thinks of all these things, but I don't think these differences are as stark as maybe they were in the origins of this back in the late 1800s, right? The misunderstandings, I think, come from a couple areas. One, I think the initials M.D. have just somehow become a shorthand for, like, doctor. They're an M.D. And so not everybody is as familiar with D.O. I just think that there's a familiarity. It's like, get the name out there and people will recognize it more readily.

Justin: Right.

Sydnee: It's just recognition. So, I think that's just part of it, is like, "Well I don't know what D.O. means." Well, here's what it means. They're a doctor. It's fine. [laughs] Everything's fine. I think the other misunderstandings come from things like, uh, [sighs] Dr. Still did not specifically focus on cranial osteopathy, which is like osteopathic manipulation of the cranium, of the skull, the bones of the skull, but Dr. William Sutherland, who was a physician who kinda followed in his footsteps, he did.

And his theory on this is that if you look at the places where the bones of the skull connect, the sutures we call them, they look, I mean, they look that way. They look like sutures. They look— he thought they looked like gills. And he thought that it indicated that there might be some slight movement there.

Justin: Okay.

Sydnee: Like, breathing almost. Respirations there.

Justin: Alright…

Sydnee: And so, he felt like you could fix—

Justin: Getting a little weird, but I'm trying to hang in there.

Sydnee: [laughs] He felt like you could fix problems through very gentle, subtle manipulations of the bones of the skull and that you could fix, like, the underlying cerebrospinal fluid and the membranes underneath and, like, a lot of things could be treated by manipulations of the skull.

Justin: Does it work?

Sydnee: Now, as I've alluded to, if it's hard to come up with the same kind of, like, exact 100% proof positive evidence for OMT in general, it's even harder, I would say, to prove that this works in our general scientific sense. And so, cause he would feel these, like, rhythmic movements, like feel the skull and that you could feel this rhythm. And I've talked to some of the D.O.s that I've reached out to and they say it's kinda like… it's one of those things where, like, you learn it and then it is not necessarily a large part of their training in school. It was not returned to a lot. And there are certainly people who go on and do specialized extra training in this specifically.

Justin: [doubtfully] Is it real?

Sydnee: [sighs] Here is what I think. There are D.O.s who are trained in this who have done specialized training in this who have spent many, many hours learning these techniques who have seen improvement in patients. One thing that some of the D.O.s I talked to mentioned specifically was for headaches, who can do some of these manipulations and help with headaches. What I have seen through reading about it that has arisen from this is that there are, there's cranio-sacral therapy, which is kind of building… it's like the extension of cranial osteopathy. And cranio-sacral therapy is practiced by a lot of people who are not D.O.s. Who did not go through all of this rigorous medical training, who did not go to medical school.

Justin: They're just squeezing your head. You can just do that.

Sydnee: Yeah. And I would— here is what I would say. Do not go to those people. If someone is not a licensed D.O. I would not let them do Osteopathic Manipulative— you know, Treatment on me, and I wouldn't let them do any sort of cranial therapy on me. I didn't find evidence that it's dangerous per se, because it seems a lot of, like, very gentle manipulations that would be so subtle you wouldn't even know necessarily what was happening if you were watching. And again, I have talked to D.O.s who say that this does work, in the proper hands, this is helpful for some of those conditions. Um… but if it's just, like… Larry in a strip mall who does like cranio-sacral therapy and also has a variety of tinctures that he's made on his own that he will sell you and, um, I don't know. [laughs] Has a degree in something totally other, I would not let him touch your head. Is that fair?

Justin: That's fair. I got it, I got it. If it says D.O. at the end, DO go to them.

Sydnee: Yes. Yes. And again, a lot of the— that's the other thing about OMM that's really interesting. So, not all D.O.s practice it. Many don't. Many go on to practice medicine the same as an M.D. because even though they learned this stuff in medical school, it did not become part of their practice. And it also has to do with what residency you attend. If you attend a residency where you're not working with other D.O.s, you won't continue to practice these techniques and so they'll probably fall by the wayside. And you might just not use them anymore. And that is true for many osteopathic physicians is they just don't continue to do OMM.

The ones who do really seek out additional training and do the hours to make sure that, like I said, it's operator dependent that you actually receive benefit from what they're doing. So, a D.O. who does this on a regular basis can do this effectively. Just some guy who read a book about it, or girl, [laughs] probably can't. Can't, Let's not put a probably there. Can't do it. The principles, like I said, the principles today of osteopathic medicine are laid out, basically, I would say— they actually did a survey of M.D.s from medical schools and said, "Do you agree with these concepts? The body is a unit— the person is a unit of body mind and spirit." Yes.

Justin: Okay.

Sydnee: "The body is capable of self-regulation, self-healing and health maintenance."

Justin: Fair.

Sydnee: "Structure and function are reciprocal—reciprocally—" [laughs] "Reciprocally…"

Justin: Recipricol— wow.

Sydnee: It's a hard word to say!

Justin: Recipricurly… oh my gosh.

Sydnee: "Interrelated."

Justin: Interrelated, let's skip to that. They should have put that a different way.

Sydnee: "Rational treatment is based upon an understanding of the basic principles of body unity, self-regulation and the inter-relationship of structure and function." These are all— I mean, like, yes. None of these things are untrue, like, an M.D. would agree with all these things.

It is, I think it is the natural extension of practicing medicine in the real world is you would have some people, especially— that's the other thing about osteopathic physicians. The original mission was really primary care. The original goal was to create a lot of primary care physicians. The thought was as a primary care physician you really need to understand your patient as a whole. You're going to spend time with them their whole life, maybe, and you need to know not just, like, what is wrong with a piece of their body, but their whole situation to help them feel better, get to wellness, and stay there. Like, that's not—that's not a wild idea. That's a good idea.

That patient-centered idea is really the way that all medicine has moved, so in some ways Dr Still was kind of ahead of his time saying that. Because that is the way that— I mean, in M.D. school, that's the same— those same principles are taught. I would say that they are very much focused in primary care and I am probably biased to say that I learned a lot of that because I went to a family medicine residency and we talked about this stuff constantly. I mean, these ideas were very much ingrained in my training that you have to see a person as a whole to take care of them. You can't just take care of their wrist or whatever.

Justin: You're saying sort of—

Sydnee: Oh no. Again?

Justin: [laughs] I'm sorry. Stop misquoting Patch Adams and I won't have to give you the correct Patch Adams quote. This is a very Patch show today.

Sydnee: But like M.D. school, even though I went into primary care, which is— and especially family medicine, I think we have this reputation as being a little, like, you know, touchy-feely, [laughs] yes that is who I am, I would say. I will own that. There are D.O.s who go into every medical specialty just like M.D.s. So, there are D.O.s who go into the not-so touchy-feely medical specialties of, you know, radiology or pathology or anesthesiology, or whatever subspecialties of subspecialties you can think of. You will find D.O.s all of them.

They are completely qualified to do all of those things just the same as an M.D. Whatever helps you make a decision as to, like, who should be your doctor— I mean, cause you know, it is important to think about what matters to you and, like, a good fit. I've said that many times on the show, you gotta find somebody that's a good fit for you, whether they are an M.D. or a D.O. should not have anything to do with your decision, unless you really want OMT, in which case you should go to the D.O. because I don't know how to do it.

I did say I have had it done on me. I did find it— this is anecdotal, though, I'm just— I did find it helpful. I won't say that all of my pain vanished, but it did make the pelvic pain I was having a lot more bearable. I have seen it work, I refer patients to D.O. colleagues to do OMT for, like, chronic pain issues and things like that. I have seen it work for those issues. I have had patients need less medication because they're having that done. Similar to, you know, patients who go to physical therapy or massage therapy or some other form of hands-on manipulative therapy that helps them move their body in ways and, you know, manipulate their tissue in ways where they have less pain. Which is a good thing.

Justin: I need— I wanna speak frankly for a moment, if I may. Because I can tell that you are— if I was a listener, I feel like I would be sort of a little bit confused at this point. And let's talk about the central issue with doing this episode, the thing that has been challenging to you. Is that a lot of the arguments you could make against OMM are arguments that we have made against therapies that are fake. Right?

Sydnee: Yes.

Justin: Fair. And it becomes hard— like, Sydnee has just provided anecdotal evidence for this, right? Which is something that we have cautioned against on this program innumerable amounts of times. But what you're up against with this is one, like you said, hard to do a study and have a sham treatment. Also, not as much— I mean, there's not the, like, pharmaceutical levels of money in proving the efficacy, right?

Sydnee: Right.

Justin: Now flip, flip that around, that is also the same argument that's made about, you know, fill in the blank. CBD or whatever. But— and there's not, like, a so this is the explanation of it, this is just in talking to you about it, this has been sort of the back and forth struggle of if you feel like I'm, um, you know, saying it correctly.

Sydnee: No, I do—

Justin: I don't want people to think that we were making an exception for, you know, the scientific method of proving treatment is effective, you know, except in this one regard. This isn't that situation.

Sydnee: No, and I think what I have seen through reading osteopathic journals and talking with osteopathic physicians is that this conversation is happening within that community. Like, D.O.s are talking about this. I read articles from osteopathic physicians arguing that cranial osteopathy should not be taught anymore because it does not have a solid evidence base. I read arguments from other physicians saying, "Well, but we can't study it in the same way and I have spent many, many hours devoted to learning it appropriately and I can do it appropriately and I have seen it work and I have evidence that it works, cause, you know these studies are ongoing," and whatnot.

And so, like, I think it is still an area that is being studied and understood and you will find people who are D.O.s on both sides of that. So, it's not without critical thinking. It's not—

Justin: And I think that's the difference, right?

Sydnee: And I think that's a huge difference.

Justin: Yeah, right.

Sydnee: Because in that way, it's the same as allopathic medicine. It's the same thing. We have many things that we are developing our ideas of. You're watching it in real time with COVID.

Justin: Yeah.

Sydnee: Right? With medications that we think work and then don't, or didn't think worked and then might. We're seeing that happen in real time right now, and that happens in allopathic medicine, so certainly it is still happening in osteopathic medicine as well.

Justin: It's sort of what we're talking about is the difference between— and I don't know if this is the exact right terms, but like, supportive versus alternative therapies, right?

Sydnee: Yes.

Justin: This started as an alternative therapy, which now is more of a supportive therapy in… uh, working in conjunction or in concert with allopathic medicine.

Sydnee: And it's hard, because I'm not— I mean, I think I've been clear— I'm not a pragmatist, I do not just feel like, "Well, if it works, then go for it." That's never been my line, and so me saying I felt like I received benefit from OMT, I do not believe is enough foundation for me to no holds barred recommend it to everybody all the time, right? I do not believe that. I believe in finding evidence for things. And I think that that— in this case, the evidence is just gonna be really hard to accumulate in the same way that we study pharmaceuticals. You're just not going to see it that way.

Justin: Yeah.

Sydnee: But when you have these therapies— and I mean, massage therapy's the same, and a lot of people receive a lot of benefit from massage therapy without a huge body of evidence that says, you know, it can definitely do these things. But if we're talking about, like, a whole person, risk versus benefit, all those other things that go into practicing medicine in the real world and not just in a lab, then these therapies can help some people. And I would always go to a D.O. who is practiced in them, I would never have somebody who wasn't a D.O. do these things to me. Or you. Please don't. But, you know, I think at the end of the day, the main thing I wanted to get across is there is no reason a D.O. can't

provide you all the services that an M.D. can. Um, my mentor in residency was, is a D.O. physician who is incredible, one of the best doctors I've ever worked with and is the model for the kind of doctor I wanted to be and I learned a ton from. So—

Justin: Him and Patch. You would say.

Sydnee: Her.

Justin: Her and Patch.

Sydnee: You just assumed it was a dude there, did ya?

Justin: I thought it was the guy you worked with at— I was just confused about who you were talking about.

Sydnee: [laughs]

Justin: [laughs] Sorry.

Sydnee: Nah, she was my chief. But anyway, the point is… my D.O. colleagues have gotten so much crap over this one doctor who took care of Trump, and it's not fair. They're great, there is no reason to ever consider a D.O. less competent than an M.D. They are wonderful and that ad for scrubs that Figs put out…

Justin: Sydnee, you are making a reference to something as though everybody knows what you are talking about when a very small subsection of humanity knows what you're talking about.

Sydnee: [laughs] Well then I won't talk about it, I guess.

Justin: No! You're going to give me a very quick summation of the issue. Because it highlights it.

Sydnee: There are these scrubs that you can get, that are called Figs, and um, I own some. I own some, they're a nice product. But they put out an ad, unfortunately, of a female physician dressed in their scrubs holding a book called Medical Terminology for Dummies upside-down wearing a nametag that said D.O.

Justin: Mm.

Sydnee: And… they have apologized since, but…. [sighs]

Justin: Hoo… should be careful. Don't be like those people.

Sydnee: Yeah. That was, I mean, it's just not, it's not fair. D.O.s are wonderful, caring, competent physicians and they have done nothing to deserve that, and please spread the word.

Justin: Yep.

Sydnee: D.O., M.D., that part does not matter. They are both completely capable of taking care of you.

Justin: Best way to spread the word, I think, just share quickly, this episode, get those clicks going.

Sydnee: [laughs]

Justin: As long as you're clicking stuff, I would like to humbly ask that if you enjoy video games you check out my video game program, The Besties. It's a Spotify original, you can only find it there, but you can get it for free on Spotify if you search for The Besties. It's me, my brother Griffin and our friends Chris and Russ, as we talk about a new videogame every week. It's fun, it's lighthearted, you'll hear about all the latest and greatest in home interactive entertainment. And it's called The Besties and it's on Spotify, so please go check that out if you would be so kind.

I also want to thank The Taxpayers for the use of their song "Medicines" as the intro and outro of our program. Hey, we got a new, delightful horseshoe crab shirt up at McElroyMerch.com. It's a lovely blue shirt that says, "Have you thanked a horseshoe crab today?" Of course, for their contribution to making sure vaccines are safe.

Sydnee: That's right. I love horseshoe crabs.

Justin: Thanks horseshoe crabs. Not a horseshoe. Not a crab. But this has been an episode of Sawbones. And that will do it for us for this week. So, until next time, my name is Justin McElroy.

Sydnee: I'm Sydnee McElroy.

Justin: And as always, don't drill a hole in your head.

[theme music plays]

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