Voices from the Floor

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The Attending - Shaping the Osteopathic Physicians of Tomorrow - Pat Lannutti, DO

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Written by Justin Guthier, OMS-III

The perception of humanism in medicine is changing dramatically. Traditionally, when physicians enter a room, they should sit down when talking to their patient. They should display small gestures like touching the shoulder or the arm and always turn around, to face the patient when leaving the room. My generation of physicians was taught to do this. Despite the lack of blockbuster antibiotics and medications, patients appreciated the thoughtfulness of their physician. Contrast that with what a patient said to me yesterday, "I am disappointed you are converting to computers. When my wife goes to her physician, they are all about the computers. They turn their back as they are talking to type on their computer." The generation today is the 'text not talk' generation. It is time to get back to humanism and I am glad to see an effort is being put forth.

I graduated from PCOM in 1971 and graduated from my residency in Internal Medicine in 1975. In 1967, PCOM had a dress code, and there were 100 students in a class. There were few women and few minority students. The professors ruled and taught by fear and intimidation. Students would get random and difficult pop quizzes so they would constantly be in fear of testing. To pass, it was necessary to read constantly. I remember one pop quiz in particular. John Simelaro, DO and I were classmates and were studying together the night of Dr. Martin Luther King's assassination. I wanted to watch TV to be up on the day's events, but John insisted that we read. Sure enough, the professor gave a pop quiz the next day in Anatomy. It was unrelenting. Anatomy is quite different today- we had anatomy all year long. There was no SPOM course – it was anatomy and you had to remember it all. Testing was done through blue books – I am not sure if today's students remember blue books, but they were little blue composition books with your name on them. Your grades were kept inside, so when you got them back you were always reminded of your past performance. The students were not permitted into the hospital before the third year, and if they were caught, they would be punished. The constant fear of examinations and intimidation of students lended itself to a terroristic approach to teaching medicine – much different from the environment surrounding today's students.

Although PCOM today is a larger institution, it is more family-oriented and supportive of its students. We have a vast array of basic science professors, but the biggest difference between PCOM today and the PCOM of my time is the immeasurable opportunities our students have for future career choices as compared to students during my time. Today, a PCOM graduate can attain an allopathic neurosurgery residency at a South Carolina university, take the neurosurgery boards and get the highest grade in the country. Our advancements in the osteopathic profession are comparable to traveling from Earth to Pandora in 'Avatar' – it is just a whole other world. Although we were confined to the osteopathic hospitals, the students in my class carved out fellowships in Pulmonary, GI, Nephrology and Cardiology. Dr. Kanoff, one of our current professors did everything in a little enclave and created a lot of opportunities for students today in Neurosurgery; now he has his residents all over the place. Pennsylvania and other hospitals have opened up – there is just more of the 'O' word for our students.

Older physicians will recall the old City Line Hospital. There was a hospital associated with the medical school at one time. I was speaking with a group of students and the topic of the old City Line Hospital came up and one student asked in all sincerity, "What hospital? – I did not know we ever had a hospital there." Students today cannot relate to the experiences I had at PCOM years ago. Is it better that we have all these hospitals that students have access to and not have the home base? I am not sure – I am of a bifurcated mind as to whether I want PCOM to have its own hospital or that it is better that we have to be so good as to make students want to come to our programs.

Currently, I am the GME director at Roxborough. Dr Venditto is the Internal-Medicine Director – I am the Vice Chair of Medicine. I have always enjoyed ed-

ucation. My job at Roxborough leaves me feeling fulfilled. The best part is dealing with the interns. Over my career, I have always sought students who are early in their education. If I taught high school I would teach the freshmen. It is fun to be around medical students in their freshman and sophomore years. You get into their minds and you can begin to mold them. The students in turn are unadulterated – they ask questions and have an enthusiasm that has been left behind by some upper year residents. Interns make a dramatic transition over the course of one year. Up until mid year, the interns can be molded. Mid year is when they begin to ossify. Then, they become residents and you cannot talk to them anymore. The most fun is helping make sure their education is one of quality and substance and that their lectures are stimulating and of high quality. As the overall supervisor, teaching keeps my mind fresh. My master role model is Dr. Saul Jeck, DO, Professor and Chair of OB/GYN here at PCOM. Although he is no spring chicken, he still maintains a heavy schedule; he is inspirational-this man has a fascinating mind.

I face new problems everyday and I enjoy the challenge of solving them. I subscribe deeply to the following quote from Louis Pasteur, "Chance favors the Prepared Mind". If you are not prepared for the opportunities when they present themselves, you will not be as successful as you could be. The part of me who is young likes the challenges, the other part of me likes things to stay calm; there is no way to get bored in this job.

I believe it is important to teach new physicians how to multitask during their residency training. There is a big problem with the hours mandated by the government. I learned to work tired – you all will learn to work tired. Philosophically, I have a problem with the federally limited work week for residency training. A physician trains for a profession, not a job where you clock in and out – it is the patient who determines our working hours. Fulfilling our responsibilities to our patients should determine the time we need to spend at the hospital. New physicians need to learn to 'pick it up' not quit at the quitting hour. The other obvious tenet I wish to instill in my residents is excellence – pushing the envelope. I must reinforce this idea – medical education is not training for a job where you can clock in and clock out; I hear the terms 'precall', 'postcall', 'pre-precall' and 'post-postcall'. I rarely hear the word 'patient' even though it is the patient that should be the focus of everything! One of our present residents, Ben Saks has taken this tenet to heart. He is completely focused on the patient, giving more than a little extra, a wonderful role model. We all need to strive for excellence in performance, variety in development, while not forgetting the human being at the other end of the stethoscope.

What makes a good resident? It is not a question with an obvious answer. Is it one who passes the board? Or is it one who can deal with a multiplicity of problems? Residents who are comfortable within themselves, who have confidence in their abilities, who do not feel the need to fire off huge differentials – these are qualities that make an exceptional physician. The boards are a concern to residents, and to many program directors – a hurdle. As long as there is a passing score, you will have a future. Some of our best residents do not have board scores in the 99th percentile. They are great doctors because of the personal qualities that drove them to careers in medicine. Those who keep the patient foremost will always be successful. We like to turn out general internists. The government's objective is to do this as well. We are encouraged when our residents wish to practice in areas that are underserved in the US. It says to me that our residents are 'people' people and I wish this for all our graduates. Our graduates can connect with their patients and create that humanistic relationship.

One of my favorite historical characters is General Eisenhower. He was not like General Patton- soldiers were scared to death of Patton. Eisenhower on the day before D-Day, walked among the troops. He said "You're from NY, I've been there – You're from New Jersey – never been there". He could command respect but still fraternize. I know I have been successful in my residents' education, when they can command the respect of their patients, their colleagues and their students, but still act in a humanistic way.

Medical students on rotation in comparison can find themselves particularly vulnerable; they do not know everyone, and everyone seems to know more than they do. When a medical student is asked a question they are only expected to know the basics-but they still need to have a thick skin as there are some who expect that you know even less than that. Internal medicine is a good rotation to have early in your training. I do not expect you to be able to do much at the beginning of the month, but at the end, you will be able to write a note, give a good differential diagnosis,

not obsess over an exam and be able to present a case. I cherish students who come to me and say, "I have no experience in Internal Medicine", and ask me to hammer away at them and make them the best junior they can be. I have had people come up to me at alumni dinners, and thank me for teaching them how to write their first note. You could describe me as tough but fair. I always ask a student if they do not know something, "For $40,000.00 why would you not want to look up that answer?" I will always say at the beginning of the rotation that no question is meant to embarrass. If they know your limitations, then a good attending will expand that student's fund of knowledge. One of the things I like to write in letters of recommendation for students is – "strives to expand knowledge" – this shows a residency director that you are striving to be your best.

Osteopathic GME continues to evolve into the future. It is ironic – students today strive to enter allopathic programs. Yet, the smartest thing those allopathic hospitals ever did was to let us in, because we can add another dimension to patient care. We need to decide what our relevance is as osteopathic physicians. When we have a woman with headaches up on the floor we should ask, " Did anyone do OMM on her?" We need to decide amongst the professionals in our osteopathic community, "What does it mean to be an osteopathic cardiologist? What does is mean to be an osteopathic nephrologist?" Only then will we be able to begin separating ourselves from our allopathic counterparts. The osteopathic profession needs charismatic spokespeople who can hold up themselves to the general medical community and promote our interests and advance the interests of all physicians. The government posts the Top 40 lobbyists in Congress every year. Professional baseball and the AMA are always on there. But where is osteopathy? I cannot emphasize enough our need for good representation nationally and locally in the medical community.

The osteopathic profession needs better PR. One kid made a video of himself walking around Rittenhouse Square and asking passersby what is PCOM? One bystander replied, "Is that a radio station?" Another asked, "Is that where you do not want to hurt animals?" When a prospective student comes for an interview, we ask them what does being an osteopathic physician mean to you. Of course the majority of applicants say that DO's have that human touch. And I will agree with that statement in its simplicity – we as osteopaths at PCOM have principles in our education that are different from Jefferson, Drexel or Penn. Our students definitely have more non-traditional applicants within the first year class. I think we turn out broader minded, more thoughtful people in terms of interpersonal relationships.

To all the students reading this publication, it helps if you know early what kind of practice you want to have - that way you can start planning for it. Students get worked up when you ask them what they want to be. It is not absolutely essential that you know on day one, but as time progresses, you can begin to choreograph your moves and make a name for yourself at your programs of interest. I had one student who came to me and said 'I cannot stand class'. He said he wanted to "get out of class and follow me around and be in the hospital". I was worried that I ruined his life. But let me tell you – he choreographed his moves, did his electives, aced his boards, got great letters and got into his program of choice at Dartmouth and was asked to stay. The best advice I can give students is to make up your mind within your comfort zone as early as possible and choreograph your moves. Talk to the residents in the program that interests you and let people know you are interested. People who know what they want can begin to get their life together earlier than their counterparts, simple as that. At some point you have to make a decision. Is it wrong to make a student think he or she has all the time in the world? Our catalogue makes you think everyone gets in somewhere and they do. But the catalogue cannot describe the maneuvering and all the hard work that went into that person getting into that hospital. So students – hammer away, stay late, be persistent and know what you want to do.