

## What to tell patients who want ciprofloxacin

**L**ittle is new in the world of infectious disease and microbiology. Anthrax, smallpox, tularemia and plague have been around for centuries.

What is different now is that anthrax has become a public issue, even though only 22 cases have been confirmed as of Dec 12, 2001, in the United States, which has a population of more than 280 million.

Then what should physicians tell patients who are eager to get their hands on ciprofloxacin hydrochloride or who want to be vaccinated against smallpox?

The leaders of the Maryland Association of Osteopathic Physicians (MAOP) offer the following guidelines:

- If a patient has a fever and shortness of breath, think about "zebras" like colds or the flu, which are more likely culprits than anthrax. Unless additional symptoms appear, common illnesses are the most likely culprits.

- *Bacillus anthracis* is a lousy bacterium to use for bioterrorism. As a pathogen, it is hard to contract and not contagious person-to-person. *B anthracis* generates more fear than it does disease.

- Anthrax can be treated with antibiotics other than ciprofloxacin and doxycycline. Ofloxacin and levofloxacin are very effective too. Penicillin is also effective against many strains of *B anthracis*.

- Data reported in the *Israel Journal of Medical Sciences* and in *Harefuah* show that the majority of casualties caused by bioterrorism and chemical terrorism result from taking antidotes and suffering from stress-induced sudden cardiac death.

- DOs should calm patients' fears about terrorism. The number of people who



have contracted anthrax is small. The purpose of the terrorists seems to be to infect Americans with fear rather than with disease.

The MAOP would be happy to answer any questions you have about bioterrorism. You may reach the MAOP by telephoning (410) 664-0621, by sending e-mail to [maops@maops.com](mailto:maops@maops.com) or by writing to the Maryland Association of Osteopathic Physicians, 6103 Westcliff Drive, Baltimore, MD 21209-3535.

**Tyler Cymet, DO, and Col Ruth Robinson, DO, MC, USAF (Ret)**

*Dr Cymet is the MAOP's president, and Dr Robinson is the membership chairman.*

### Trying to help: Medical student reports

Sept 11, 2001, is a day that haunts everyone. The purpose of this letter is to share my experience as a medical student who was in New York City on that infamous day.

I was living in Bronx, NY, while rotating in the emergency department of a nearby hospital. I worked the late shift on

Monday, Sept 10, and returned home the next morning to sleep. On Tuesday, Sept 11, I awoke at 1 pm to several messages on my cell phone from concerned family members and friends, all telling me that the World Trade Center had been blown up.

I immediately turned on the news and heard that physicians and nurses were desperately needed to help near the disaster scene. Soon after, I rushed down my street to the emergency department to provide whatever help I could. Surprisingly, there weren't any patients there. I was told that the victims of the catastrophe were being sent to hospitals in Manhattan because all the subways and highways were closed. I felt frustrated because help was clearly needed and I was unable to provide any.

### A surreal ride

My gut feeling told me that I could find a way downtown, where I might be able to provide some assistance. I ran over to a police officer parked outside the emergency department, and he offered me and another eager student a ride to a local police precinct. When we arrived at the precinct, we jumped into a police van and received a high-speed escort, passing military roadblocks, driving down one-way streets and traveling along streets never before so desolate.

We were scared. The magnitude of

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If the letter is a word-processed document, please send a copy of the letter on diskette along with the typewritten draft. Word-processed documents can also be sent by e-mail to [TheDO@aoa-net.org](mailto:TheDO@aoa-net.org).

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the situation was so overwhelming that the ride was surreal.

During the ride, one officer told us that his father, who had been working on a construction site nearby, was missing. The officer desperately wrote down his telephone number for us, and we promised to call him with any information we might learn.

We were dropped off at an acute triage center at Chelsea Piers Recreation Center, which is just blocks from the World Trade Center. Because of the unprecedented attack and the ensuing chaos, the site was loosely organized. We entered a room set up like a MASH unit. It was filled with more than 70 beds, each with an assigned team and stocked with intravenous equipment, chest tubes, medications and other supplies. I had never before felt such unity among healthcare professionals, nor had I ever felt so needed as a medical student.

### Ready to help

I was assigned to a table with a breast cancer surgeon, an otolaryngologist, an anesthesiologist, a physical therapist, two nurses and two volunteering patients from St Vincent's Hospital and Medical Center in Manhattan. Our role was to stabilize patients and control bleeding before sending them to a nearby hospital.

We were told not to resuscitate anyone because of legal issues. If someone coded, we were to place him or her in a bag and move onto the next patient.

We didn't know what might come in from the outside, which was flooded with flashing lights and sirens from emergency vehicles returning from the World Trade Center.

Outside hundreds of volunteers were passing medical supplies and food in an assembly line, while others stood behind police barriers to encourage the volunteers. Meanwhile, we stood in gloves and gowns ready to help, but no patients ever arrived.

After eight hours of waiting, our hopes began to fade. Tragically, we had all of these healthcare professionals and



Osteopathic medical students and other volunteers travel to ground zero after terrorist attacks leveled the twin towers of the World Trade Center. (Photo by Paula K. Grimaldi, DO)

other resources ready to help, but so few victims survived. Yet we did treat a number of firefighters, emergency medical services personnel and police officers for asthma exacerbation and ocular pain.

By 11 pm, it became apparent that the triage center would be converted into a morgue.

### Into the war zone

While I was waiting for a ride home, an EMS worker approached me and asked whether I wanted to go to ground zero and help with rescue and recovery. I jumped into a van with two EMS workers, six firefighters and an army reservist. We drove through what looked like a war zone, passing street carts, traffic lights and cars coated with ash. Our view was often obscured by smoke, and the smell was unforgettable.

At last we were dropped off just before the ruins of the once-mighty towers. I walked through streets deep in mud, ash and debris, wondering with each passing second what the next would bring and what I might see that would stay with me forever.

We still had hopes of helping someone out of the wreckage. Outfitted with a hard hat, a mask, my white coat and my

scrubs, I pressed on with the group.

First we went to a triage center set up at nearby One Liberty Plaza. But again we found no survivors, underscoring the loss of life that had just occurred. We stared, feeling overpowered and helpless, as rescue workers with bulldozers attempted to chip away at the fallen towers.

I heard stories all night from others who had lost colleagues. I sadly realized that there was nothing else for me to do that evening. Eventually I walked away from ground zero, constantly looking back and feeling guilty that I was leaving.

### Inescapably haunted

I returned to the Bronx at 4 am, where I watched the news and stared at my mask, hard hat and muddied shoes in disbelief.

On Wednesday, I called the police officer who helped me and learned that he had eventually found his father safe.

Living in New York City during the following days was like reliving the event. New York's EMS Worker of the Year, who had worked at my hospital, died in the collapse of the towers, leaving behind her 8-year-old child. Reminders were everywhere: streets lined with patriotic symbols and messages, newspaper stands

stuffed with disturbing images and subways crowded with candles and photographs of the missing.

The event was so immediate and so horrible that no escape was possible. When I got together with friends, we found ourselves unavoidably discussing the disaster and sharing our stories.

No matter where we were on Sept 11, we are all inescapably haunted by the events of that day. When I walked through the devastation that night, I felt so angry that people could have so much hatred that they could justify this mass destruction. However, New Yorkers' unrelenting will to help and persevere during this crisis also moved me. Witnessing Americans' demonstration of inner strength and compassion on Sept 11 reaffirms that our love and our conviction will prevail against terrorism.

#### Steven E. Sampson

*Sampson is a fourth-year student at the Chicago College of Osteopathic Medicine of Midwestern University in Downers Grove, Ill. He was serving an emergency medicine rotation at St. Barnabas Hospital in Bronx, NY, when the World Trade Center was attacked.*

#### Medical doctors first and foremost

I applaud the letter from osteopathic medical student Michael A. Shing in the October 2001 issue of *The DO*. Shing's opinions are controversial, but he is correct on many fronts.

We have spent far too much time defining the differences between DOs and MDs when we should be embracing the similarities. His suggestion that the degree *DO* should be changed to *MD* is excellent. After all, we are medical doctors first and foremost. It is our specialties, not our degrees, that distinguish us.

Perhaps, as Shing suggests, an osteopathic medical specialty track could be created for those MDs who wish to pursue this training.

One observation I would add has to do with continuing medical education for osteopathic physicians and the difference

between Category 1-A and Category 2-A credits. It is ludicrous that to obtain AOA Category 1-A credits, I have to attend conferences at which at least 50% of the speakers are DOs. Even if I go to a conference with nationally or internationally recognized speakers, I am eligible for only Category 2-A credits if most of these speakers are MDs—which is normally the case.

This should change, but I am sure it will not. Because the number of MD conferences far surpasses those sponsored by osteopathic medical organizations, if Category 1-A credits were awarded to DOs for attending MD conferences, DO conferences would be poorly attended.

Where I live, an allopathic medical school sponsors an outstanding five-day CME conference each year. Even though the content of this conference is superior to any DO program I have attended, I would receive only Category 2-A hours at the end of the five days. When I explain this to my MD colleagues, they find it difficult to believe.

I am earning my Category 1-A credits to remain an AOA member at the expense of missing out on some outstanding conferences. And more often than not, the osteopathic medical conferences I do attend are inferior to their allopathic counterparts.

My solution to this dilemma is to allow DOs to earn Category 1-A credits by attending allopathic conferences but to mandate that DOs obtain 10 to 15 credit hours in osteopathic principles and practice. This would allow DOs to refresh themselves with this aspect of their training while being able to earn Category 1-A credits at the more available and usually superior allopathic conferences.

No matter how much we attempt to distinguish ourselves from our MD colleagues, our allopathic friends will be the ones shaping public opinion and indeed the future of medicine nationally and internationally. Allopathic medicine receives more funding for research in evidence-based medicine, it has world-renowned training facilities, and it is much

more familiar to the public than osteopathic medicine will ever be.

As Shing so aptly writes, "By and large, osteopathic physicians are consumers of and not contributors to modern medicine." For this to change, we must stop alienating ourselves from the 90% to 95% of the members of the medical world who have *MD* at the end of their names.

#### Joseph E. Badolato, DO

*Dr Badolato practices family medicine in Vancouver, Wash.*

#### AOA replies to Dr Badolato

Joseph A. Badolato, DO, is only partially correct when he states that he must attend conferences at which at least 50% of the speakers are osteopathic physicians to obtain Category 1-A credit.

Osteopathic physicians may also obtain Category 1-A credit by attending and passing advanced life-support courses, as well as attending courses on bioterrorism. Those courses are taught mostly by non-osteopathic physicians (see the box on Page 15). Osteopathic physicians may also obtain Category 1-A credit by teaching at osteopathic medical colleges. In addition, Category 1-B credits can be obtained by being a preceptor for osteopathic medical students and by reading certain osteopathic medical publications.

In 2000, the AOA House of Delegates reiterated that osteopathic CME is different than allopathic CME. Osteopathic CME is required because there is a difference in the osteopathic medical approach despite the fact that many of the tools of the trade are the same.

Moreover, attendance at osteopathic CME courses has the added benefit of providing DO fellowship. Our allopathic colleagues have recognized for years the importance of the fellowship component to CME.

But let's put Dr Badolato's argument in a slightly different context. In essence, the AOA requires that 60 hours of each AOA member's 150-hour CME requirement be osteopathic CME. The