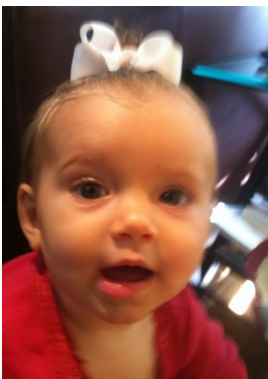


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## Dr. Dalton's Family



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## What is a D.O.?

I often hear patients say, "What is a D.O.? Is it different than a M.D.? Can you take care of me as my OB/GYN?" Hopefully this brief description will help to explain the nuanced differences, between D.O.s and M.D.s.

D.O. stands for Doctor of Osteopathy. In the U.S., there are 2 types of medical schools: Allopathic (M.D.) and Osteopathic (D.O.). In fact, you may have seen a physician in the past that was a D.O. and never noticed a distinction. When I was in college and looking for a D.O. to shadow, (application to an Osteopathic medical school requires that you shadow a D.O.), I was surprised to find that my pediatrician and my family practice doctor in Pontiac were D.O.s--I had just never noticed. Allopathic and Osteopathic medical schools have the same undergraduate requirements and require the same testing (MCAT) to get into. Both are 4 years and require the same se-

ries of medical board examinations. Osteopathic curriculum includes the same coursework that Allopathic curriculum does; however, Osteopathic schools have an underlying philosophy of "mind, body, and spirit," which essentially means that true healing requires addressing not just the bodily complaint. Also, Osteopathic students learn manipulation, which is similar to physical therapy or chiropractic manipulation. Chiropractic is actually an off-shoot of Osteopathic medicine. In the early 1900s, there were certain Osteopathic physicians that believed manipulation could cure all, so they started their own branch.

Personally, I chose an Osteopathic school, because I liked the "mind, body, spirit" philosophy, but also, because I thought that I was going to work overseas as a missionary. I wanted well-trained hands to diagnose and treat disease

in the absence of CT scans, stat labs, and state of the art facilities (which I thought I would encounter on the mission field). For OB/GYN residency, I went to an Allopathic residency, so I've not performed a lot of manipulation these last 4 years, but have utilized the small opportunities, in order to avoid losing my skills. The ability to diagnose with my hands is useful every day.

I am still happy to help address musculoskeletal complaints in the office, but my hope is to treat my patients' minds, bodies, and spirits, and that together we can find true healing.

*Dr. Dalton*

# The Initial Female Reproductive Health Visit

Dr. Rachel Dalton

## When should young women begin to see a gynecologist?

The American College of Obstetrics and Gynecology (ACOG) recommends an adolescent begin gynecologic care at age 13 to 15. This may seem young to many people, especially to parents, but the primary goal of an initial female reproductive visit is educational information and guidance. Not all pediatricians and family practice doctors feel comfortable discussing female reproduction with adolescents. Statistically, age 13-15 is an important time because 47% of adolescents age 15-19 are sexually active or have engaged in intercourse.

Education at an initial visit would be tailored to age and risk assessment. The age-appropriate discussion may include pubertal development, normal menses, timing of gynecologic visits, healthy eating habits, sexually transmitted infection, pregnancy prevention, gender identity, substance use/abuse, and rape prevention. Specifically, discussion of normal menses would entail average age at first cycle, appropriate flow, menstrual hygiene and duration/frequency of bleeding. Often, charts, models, and diagrams are helpful aids to discussion. The age range of 13 to 15 is a key time to discuss healthy eating habits and screen for disordered eating. Adolescence is the most common time for eating disorders of anorexia and bulimia to begin.

## What happens at a first gynecologic visit?

Ideally, a first visit would have specific time for the patient and parent together, the patient alone, the parent alone, and then the patient and parent back together.

A gynecologist can review medical history, family history, and immunization status with a patient and her parent. After the gynecologist explains the exam process, the adolescent patient can elect to have a parent present or not present for the exam. Establishing open lines of communication between patient, parent, and physician is typically best.

What most parents and adolescent patients want to know is, "Do I have to have a pap?" Thankfully (for all parties), the first gynecologic visit does not include a pap. In fact, ACOG does not recommend routine paps, until age 21. Unless there is a gynecologic problem, no internal pelvic exam is necessary. Mostly, a first exam includes a visual external examination for sexual development. A physical breast exam is an ACOG recommendation after age 18. If screening for sexually transmitted infections is appropriate (based on a patient's risk factors), chlamydia and gonorrhea can be screened non-invasively by urine sample.

## What about confidentiality of sensitive issues for adolescent young women?

Overall, discussion will remain confidential between an adolescent patient and her physician. However, if a patient discloses any evidence of risk or bodily harm to herself or others, confidentiality will be breached. The goal of an initial visit is to start a physician-patient relationship built on trust, counsel young women regarding healthy behaviors, and dispel myths/fears. Therefore, confidentiality with adolescent patients is just as important as with older patients.