Osteopathic medicine: A call for reform

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During the past 40 years, the osteopathic medical profession has undergone a transformation from "osteopathy" to "osteopathic medicine." The former was characterized by manipulative treatment; the latter, by full-service healthcare. During this transformation, the profession has won acceptance from the government, the military, and MDs. These changes in status have resulted in new problems for the profession because DO graduates are increasingly turning toward allopathic programs for residency training. Thus, osteopathic medicine's primary care orientation is being replaced by an emphasis on specialty training. The authors propose that osteopathic medicine return to its original mission of primary care, abandon or restrict specialty training to those who have completed primary care residencies, and rethink its separate-but-equal posture. They also propose that osteopathic medicine establish lines of communication with allopathic medicine, the American Medical Association, and the government to facilitate the development of a rational national policy for primary care that considers the potential osteopathic medicine has to offer in meeting the nation's primary care needs.

(Key words: Osteopathic medicine, primary care, graduate medical education)

I cannot help feeling rather inordinately proud of America for the gay and hearty way in which she takes hold of any new thing that comes along and gives it a first rate trial. I want osteopathy to prosper.—Mark Twain, 1893[1]

The osteopathic medical profession has undergone a remarkable change during the past 40 years. It has been transformed from "osteopathy"—characterized by manipulative treatment and family practice—to "osteopathic medicine"—characterized by full-service healthcare through a multispecialty orientation. Osteopathic medicine developed university linkages, broadened its financial base, increased faculty, upgraded its schools and curriculum, and improved graduate medical training. Additionally, osteopathic medicine has generally won acceptance from the government, the military, and MDs.[2,3] Full licensing of practitioners of osteopathic medicine and surgery in all 50 states, acceptance of its graduates into allopathic medical training programs, and the appointment of DOs to university faculty and government positions[4] demonstrate this acceptance.

On the one hand, Mark Twain's wish for *osteopathy* appears to have come true. On the other hand, one cannot help but to wonder if Twain were alive today if he wouldn't chuckle at the paradox now facing osteopathic medi-

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cine. Having gained unofficial recognition from allopathic medicine, the osteopathic medical profession now stands by in dismay as hundreds of its graduates abandon osteopathic graduate medical education (GME) programs in order to accept allopathic residencies, thereby threatening the structural integrity of the osteopathic medical profession.[5,6] Furthermore, during the past 20 years, the osteopathic medical profession lost whatever distinct image it had through *de*emphasis of manual medicine and the erosion of primary care as it rushed to achieve the status of a full-service healthcare profession with a multispecialty orientation, thereby evolving toward a mirror image of allopathic medicine. Although the crisis in osteopathic medicine is multifaceted, it is fueled by the profession's problems with respect to identity and GME.

This article analyzes the crisis and offers a plan to restore osteopathic medicine to its primary care orientation through reforms in osteopathic medical education and DO/MD relations.

Elements of the crisis

As osteopathic medicine marks its centennial anniversary, it is faced with a perplexing dilemma. Burdened by a tremendous lack of resources and battled all the way by allopathic medicine, osteopathic medicine has finally reached a point in its history where graduates of colleges of osteopathic medicine (COMs)are considered equivalent to those of allopathic medical schools; the DO degree is recognized in all 50 states; and practitioners of osteopathic medicine and surgery offer healthcare services to more than 25 million Americans, including 14% of Medicare and 25% of Medicaid patients.[7] From the perspective of public administration and education, this status represents a remarkable achievement that brings pride to all DOs.

Despite the foregoing accomplishments, a number of disturbing developments occurred during the past 10 years. Taken together, these developments must constitute a crisis for osteopathic medicine. How this crisis is resolved will largely determine the future role of osteopathic physicians in US healthcare.

Impact of the healthcare crisis

Unfortunately for DOs, the crisis in osteopathic medicine is unfolding amid the greater crisis impacting healthcare in general. That crisis is driven by the escalating costs of healthcare, reflected in an $800 billion budget, and led to the cost-containment movement, diagnostic related groups (DRGs), and health maintenance organizations (HMOs). As a result, hospital admissions fell, length of stay (LOS) decreased, services intensified, and bureaucratic red tape left physicians with less time.

Although the economic effect of these changes has been the most serious, medical education has also suffered. Because of the shortened LOSs, house staff officers have less time to spend with sicker patients. Thus, their ability to learn about their patients and from them is compromised. Same-day surgery and outpatient diagnostic testing limit the opportunities for house staff officers to learn about the natural history of disease and the techniques of proper diagnosis. The end result is that conducting ordinary GME programs has become more complex, time-consuming, and costly. The impact on osteopathic medical education training programs is even greater because traditionally these programs are smaller, less structured, and dependent on voluntary faculty.

Osteopathic hospital crisis

These changes in American healthcare have affected small community hospitals the most. As a result, the system of osteopathic teaching hospitals faces considerable jeopardy. At one time, osteopathic hospitals totaled 235. That number fell to 169 in 1992, with only 108 being teaching hospitals and only 13 having more than 300 beds.[8] Many of the remaining osteopathic hospitals face financial uncertainty, and many are engaged in affiliation negotiations with allopathic hospitals that will alter the nature of osteopathic medical institutions. The multiplicity of osteopathic residency programs dilutes scarce resources, and few hospitals have new resources for reforms in GME. As a result, the credibility of our system of hospital-based medical education is threatened.

Osteopathic medical college problems

Of the 15 COMs in existence, only six are state supported. The remaining nine are private and dependent on tuition dollars. Various rumors—each alleging financial instability—have circulated about different colleges. Amazingly, other rumors have circulated about the establishment of new colleges whose students would further burden the already struggling osteopathic teaching hospitals. Furthermore, COMs, with a few exceptions, always focused on the undergraduate curriculum, and most have not provided teaching hospitals with the leadership needed in GME programs. Finally, the COMs graduated more students in the 1970s than the profession could train in the 1980s. This situation increased the flight of graduates to allopathic medicine.

Revolution in GME

During the past two decades, a revolution occurred in GME characterized by a dramatic swing toward subspecialization, and a shift in emphasis from hospital-based to outpatient ambulatory care training.[9] Osteopathic physicians embraced the trend toward subspecialization, but they were not prepared for the shift in training to the outpatient sector. Thus, pervasive deficiencies exist in osteopathic ambulatory care facilities and in numbers of qualified supervisors. Those remaining graduates interested in primary care are drawn toward allopathic medical programs showcasing continuity clinics, ambulatory care curricula, paid supervisors, better salaries, and greater prestige.

Perception of educational inferiority

Several surveys[10,11] have indicated that DO graduates believe osteopathic residency programs face a credibility problem, and are perceived as being inferior in quality to allopathic GME programs. Furthermore, these graduates attribute the quality problem to a lack of structure and organization, reliance on service instead of academics, volunteer faculty, and inferior salaries that characterized traditional osteopathic GME programs.[5,10] Whether the faculty of osteopathic GME programs agree with this perception is irrelevant; students are voting with their feet by choosing allopathic residency programs.

Resource deficit

These problems are difficult to address because osteopathic medicine always had a resource deficit and will continue to have one. The profession includes 7% of the nation's physicians, 10.7% of its medical schools, and only 0.27% of its hospitals.[8] Clearly, the majority of societal fiscal resources available for healthcare and medical education are allocated to the allopathic medical profession. A human resource problem also exists: Whereas the American Osteopathic Association, representing the profession, has approximately 90 employees, the American Medical Association (AMA) employs several thousand workers.[12]

Furthermore, because the osteopathic medical profession relied so heavily on voluntary support for its institutions, it never developed a cohort of professional leaders to consistently guide its effort. A small profession with fixed limited resources will frequently develop problems with quality if it strives to compete with a much larger profession with much greater resources offering the same product. Given these conditions, it is imperative that osteopathic medicine be guided by a mission it can realistically accomplish—and one that uses its limited resources most efficiently.

Pull of DOs toward allopathic training programs

In retrospect, the 1969 decision by the Accreditation Council for Graduate Medical Education (ACGME) to accept DOs into allopathic residency programs was the spark that ignited all of the foregoing problems into a crisis.[13] With the gate now open, problems with desertion smoldered in the 1970s and burst into flames in the 1980s as increasing numbers of COM graduates left for the allopathic medical profession, seeking greater prestige and better salaries. The *Figure* demonstrates that the number of DOs in allopathic GME programs has increased steadily. In fact, since 1985, more DOs have trained each year in ACGME-accredited programs than in AOA-approved programs.[14] Indeed, only 35% of all DO residents

are currently training in the osteopathic medical profession.[15]

The impact of these changes probably will not be fully appreciated for another decade, but they raise a number of disturbing questions for the profession. Foremost is the continued existence of or a need for osteopathic medicine in our society. Why should the United States support parallel medical systems on the assumption that osteopathic medicine is different when, after graduation, most DOs choose to train in the allopathic medical profession, thereby obscuring whatever difference exists? This question points to the overarching problem in the crisis facing osteopathic medicine: its 100-year search for an identity that makes it comfortable!

Loss of identity and mission

The leadership of the osteopathic medical profession has identified the elements of the crisis facing it. However, despite numerous conferences and task forces, it has so far failed to develop a plan to deal with the crisis. The reason for that failure is directly related to the identity issue, and is reflected in Peter Drucker's *Management—Tasks, Responsibilities, Practices,* "If you don't know where you are going, any plan will do."[16] That's osteopathic medicine's problem: It doesn't know where it's going, so any plan—or no plan—will do just fine. The profession doesn't know where it's going because it has lost its mission, its vision, and thus its identity.

John Bryson, a developer of the institutional mission concept, relates, "Without a sense of purpose we are quite literally lost. Mission clarifies an organization's purpose, or why it should be doing what it does; vision clarifies what it should look like, and how it should behave as it fulfills its mission."[17] Here, Bryson is saying that identity is derived from mission and vision. *Mission* tells a profession what it should be doing; *vision* tells it what it should look like. Together, they give a profession *identity*. With these changes in mind, we can review the evolutionary changes that have occurred in osteopathic medicine (*Table 1*).

Mission and identity should be reflected in an organization's members. If that is the case, then from 1892 to approximately 1950, osteopathy was dominated by manual medicine. Manual medicine was osteopathy's mission, and it was endorsed by most DOs of the day.

By the 1950s, however, DOs were growing uncomfortable with manual medicine as a mission because of the comparison to chiropractic and because, after World War II, DOs increasingly offered patients other primary care services. So, between 1950 and 1970, the osteopathic medical profession's mission became general practice with an interest in manual medicine. By 1978, 85% of all DOs were engaged in primary care, and the profession's mission was again endorsed by most DOs of the day.[18]

In 1970, the osteopathic medical profession began what may be its final evolutionary stage in regard to mission and identity. This new generation of DOs wanted nothing to do with "cracking backs" or taking care of common problems like colds or the flu. Furthermore, these DOs would do whatever necessary to erase any remaining doubts the public might have regarding DO inferiority. As a result, this new generation of DOs sought out allopathic residency training, became specialists and subspecialists, and proudly claimed they could do anything MDs could.

They returned to the osteopathic medical profession, established specialty and subspecialty residency programs, and became the role models for today's students. Osteopathic hospitals and colleges rushed to support them by acquiring the technology they might need to compete with allopathic medicine and, if that meant subspecialty surgical suites, endoscopy laboratories, catheterization laboratories, and magnetic resonance imaging, then so be it. Through three decades, the profession blinked its eyes, and its mission changed from manual medicine to family practice, and finally to full-service healthcare through multispecialty orientation. As a result of these changes, osteopathic medicine is now left with a number of disturbing demographics:

- 58% of DOs are engaged in primary care.[19]
- 60% of students say they will be subspecialists.[17]
- 40% of osteopathic residency positions are allocated to primary care.[14]

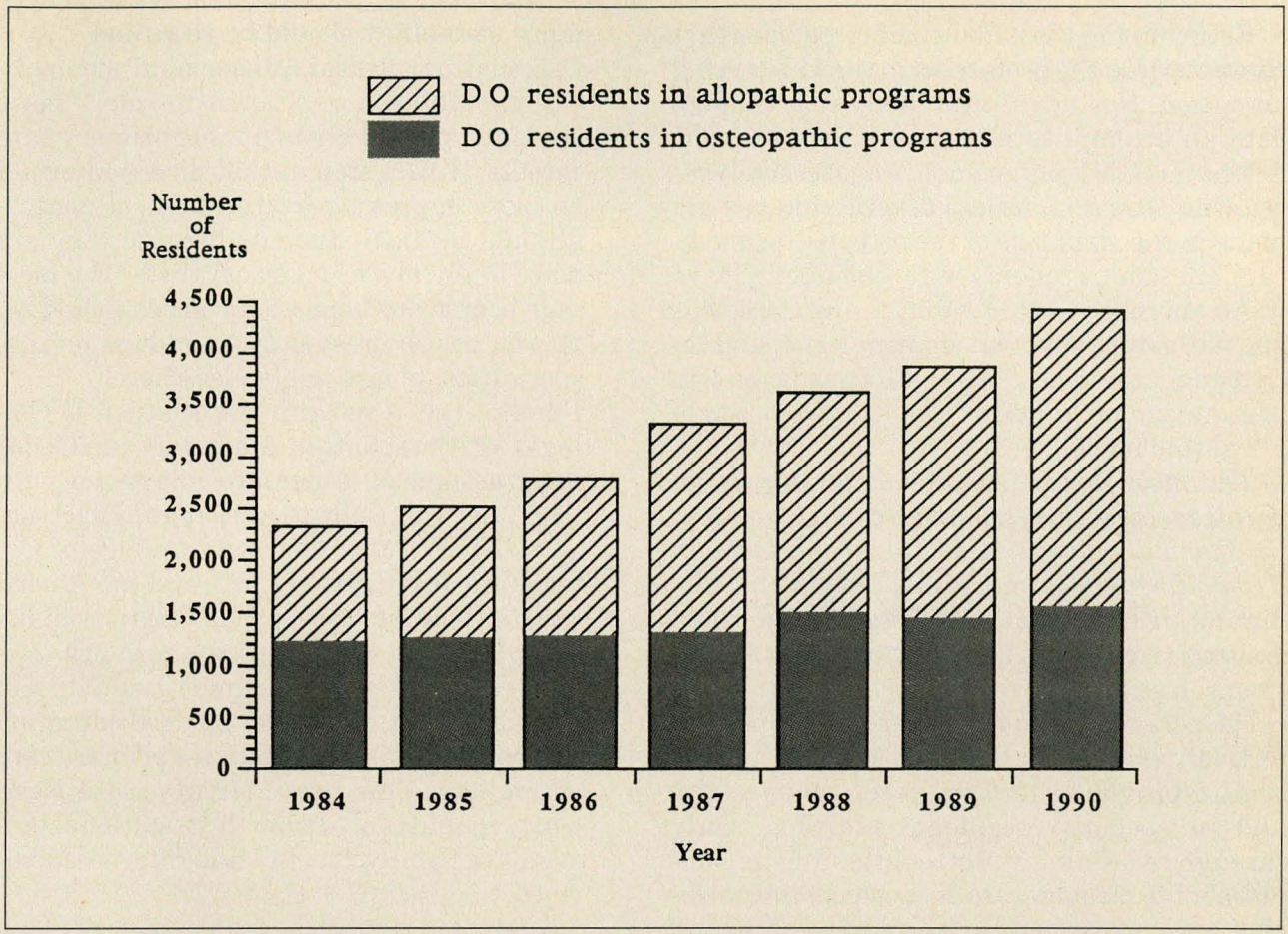

Figure. *Number of DOs in allopathic versus osteopathic residency programs.*

- 33% of osteopathic primary care residency positions are filled.[15]

When these trends are complete, osteopathic medicine will no longer be a primary care profession. It abandoned that mission in favor of a multispecialty orientation just as it deemphasized its commitment to manual medicine. Having lost its primary care base, the osteopathic medical profession will eventually lose market share in healthcare. Unlike the previous evolutionary changes, this one was not endorsed by the entire osteopathic medical profession; it just "sort of happened." As a result, Bryson would say that osteopathic medicine lost sight of its mission, it is no longer certain about what it should be doing, and it lost sight of its vision; it no longer knows what it should look like. It is time for the profession to decide if this final evolutionary change has served it well and if DOs want to continue in this direction.

Options for the osteopathic medical profession

As it maneuvers to resolve its crisis in GME and establish a new role in American healthcare, the osteopathic medical profession has limited options. The growth that characterized the profession in the 1970s is not likely to resume. During that time, the number of COMs increased from 9 to 15; and the number of graduates more than tripled to 1,689 in 1989.[14] But the United States needs no additional medical schools, and most communities already have too many hospital beds. Also, continued growth could further jeopardize the structural integrity of osteopathic medicine because the increase in the number of graduates already exceeds the number of residency positions available in the profession by 1,885.[20] Further growth will lead to a greater exodus of postdoctoral trainees to allopathic residency/specialty programs.

Returning to the expansionary policies that characterized the profession in the 1970s is *not* an option. Nor are events likely to accommodate an attempt to maintain the status quo. Allopathic GME programs are aggressively recruiting DOs and, unless drastic changes are made in the structure of the osteopathic medical profession, students will continue to leave it. An approach toward maintaining the status quo will not resolve the identity issue, and increasingly the role of osteopathic medicine will become one of "copying" the achievements of allopathic medicine.

The most logical solution is for the osteopathic medical profession to establish an identity that will reform its GME programs through a commitment to primary care. Osteopathic manipulative treatment (OMT) will be of limited assistance here; it is becoming a lost art within the profession. Nor can the osteopathic medical profession, given its resources, compete effectively with the allopathic medical profession in providing tertiary care and specialty and subspecialty residency training. Only through redefining and strengthening its commitment to primary care does osteopathic medicine have a reasonable chance of establishing a separate identity and resolving its GME problems.

Osteopathic medicine should return to its historical mission of providing primary care. It may not be too late to reverse the profession's trend toward specialty and subspecialty care. Osteopathic medicine's 15 colleges with their tradition of primary care and its system of community-based teaching hospitals could serve as a core for the nation's commitment to primary care. This should be the profession's mission; this should be its identity! Osteopathic medicine should restructure, reorganize, and retrench for primary care. Consistent with this mission, the osteopathic medical profession should consider the following reforms.

Medical school reforms

- Osteopathic medical schools should become academic centers of excellence in primary care. College faculty should be predominantly primary care specialists, and only those specialties necessary to support the primary care effort should be recruited.
- Osteopathic medical college admission policies should be restructured to select those students most likely to pursue primary care careers. A first step in that direction would be more aggressive recruitment of nontraditional medical students because they are more likely to become generalists. The message behind our admission policies should be, "If you are interested in specialties or subspecialties, please apply elsewhere!"
- Finally, the American Association of Colleges of Osteopathic Medicine (AACOM) must assume a leadership role along with the American College of General Practitioners (ACGP), the American College of Osteopathic Internists (ACOI), and the American College of Osteopathic Pediatricians (ACOP) in developing a new primary care residency that spans the undergraduate and graduate years, recognizes medical education as a continuum, and graduates primary care specialists. This new Primary Care Residency should evolve from the traditional programs in Family Practice and Internal Medicine.

Graduate medical education reforms

- Osteopathic GME should be reformed to reflect the profession's mission and identity, which should be primary care. *Only those subspecialties deemed crucial for the support of primary care programs should be accredited. All weak or nonessential residency programs should be eliminated.*

Table 2 compares osteopathic and allopathic specialty and subspecialty training. The numbers of DO residents engaged in these programs clearly demonstrate that osteopathic medicine does not have a significant impact on physician specialty training in the United States. Furthermore, *Table 2* demonstrates that the credibility issue is valid. Substantial differences in quality exist between allopathic and osteopathic medical specialty training. For the MD residents, the subspecialty effort is supported by a university structure, ample financial resources, full-time faculty, and defined curriculum. For the DO residents, the effort is supported

Table 1
Evolution of Osteopathic Medicine's Mission and Identity

Time span	Mission/identity
1892 to 1950	Manual medicine
1951 to 1970	Family practice/manual medicine
1971 to present	Full-service care/multispecialty orientation

Table 2
Number of DO Residents Versus Number of MD Residents in Specialty Training Programs—1991[4, 15]

Program	No. of DO residents	No. of MD residents
Allergy/Immunology	0	322
Cardiology	12	1,677
Dermatology	6	824
Diseases of the Chest	6	725
Endocrinology	1	295
Geriatrics	2	15
Gastroenterology	9	764
Hematology	0	405
Infectious Disease	3	460
Nephrology	1	417
Neurology	10	1,211
Nuclear Medicine	0	156
Oncology	0	534
Ophthalmology	36	1,446
Otorhinolaryngology	10	1,002
Anatomic Pathology	3	2,364
Pediatrics	7	6,115
Psychiatry	41	4,673
Radiology	47	3,775
Rheumatology	0	281
Surgery Subspecialties	42	1,774

by a community hospital structure, inadequate financial resources, voluntary faculty, and no defined curriculum—only scheduled rotations. College-sponsored residency programs are generally better organized, but are still small by conventional standards.

Despite the fact that the osteopathic medical profession's most prominent specialists will declare that osteopathic GME programs graduate specialists equivalent to the allopathic GME programs, osteopathic medicine still has no business training in these areas. The profession lacks sufficient resources, cannot compete with the allopathic medical profession, and does itself a discredit by trying.

Elimination of the osteopathic residency programs listed in *Table 2* would signal the maturation of osteopathic medical philosophy. And, it would demonstrate that the profession's leadership recognized that it evolved too rapidly and in directions never intended and thus the profession returned to its historical mission of primary care so DOs could be different from MDs.

- Those specialty residency programs deemed crucial for the support of primary care programs should be regionalized to COMs and hospitals recognized as centers of excellence. Hospital-sponsored residencies should have strong linkages to COMs for support. To-

gether, they should administer the remaining residency programs in Anesthesia, General Surgery, General Orthopedics, Obstetrics/Gynecology, and Emergency Medicine. *The total number of residency positions allocated to these specialty programs, however, should not exceed 25% of the total.*

- Finally, all candidates for these remaining osteopathic specialty residency programs should be required to complete the profession's primary care residency, which would begin in the final years of medical school before entering into specialty training. This requirement will have the effect of further discouraging subspecialty choices, and will also lead to a new type of specialist, one with a primary care background. If the osteopathic medical profession continues to dabble in its current array of specialty training, it will be difficult to reverse the negative trends impacting it in regard to primary care. This profession will have no more success in dealing with the issues of subspecialization than the MDs have had. Osteopathic medicine cannot occupy the primary care niche if as soon as its graduates reach the hospitals, they have a full menu of marginal specialty residencies from which to choose.

Restructuring OMT training

The osteopathic medical profession should rethink its methods for providing training in osteopathic manipulative treatment to students, interns, and residents. Students receive mixed messages in that OMT is emphasized as valuable and important at the college level, but it is either downplayed or ignored in the GME programs conducted by osteopathic hospitals. Despite this dichotomy, most practicing DOs acknowledge that OMT provides benefits to patients, particularly in primary care areas. Lack of emphasis on OMT in osteopathic postgraduate training programs is related not so much to skepticism about its value as it is to logistic problems occurring in the hospital that make OMT difficult to teach.

Unlike other clinical services in most teaching hospitals, no one is in charge of OMT and osteopathic principles and practices. Few osteopathic hospitals maintain a Department of Osteopathic Medicine to provide consultative services, inpatient treatment, and direction for the training programs. Family practitioners, the physicians most capable in OMT, are engaged in their outpatient offices and generally are not available to assist trainees during busy working hours. Rather than having unsupervised interns and residents administer OMT in the hospital, OMT is left "on the back shelf." Most DMEs are not qualified to lead the OMT effort and therefore discharge their responsibilities by scheduling occasional lectures or perhaps a workshop on OMT. The end result is that OMT has lost its role in osteopathic teaching hospitals, even though most agree that it is important and it is a way the profession can be different.

If osteopathic teaching hospitals are to be charged with the responsibility for making OMT a viable force in training programs, then they must allocate resources to accomplish the task and the methods for training should be restructured. Each teaching hospital should hire an OMT specialist to develop a Department of Osteopathic Medicine to provide inpatient consultative services and inpatient treatment and to supervise the training of interns and residents.

In many ways, psychiatry, another outpatient specialty, has faced problems similar to the OMT dilemma. To address this problem, "liaison psychiatry" programs have been developed that feature services tailored to the specific problems of inpatients hospitalized with emotionally traumatic, but nonpsychiatric, illnesses. Osteopathic teaching hospitals should copy this idea and develop liaison OMT services that tailor their approach to the specific needs of the hospitalized patients. Osteopathic manipulative treatment consults for these patients would be appropriate and billable, and would provide the nucleus for a hospital-based teaching program.

Reforms targeting OMT would also provide benefits in the ambulatory care setting, where it is most useful. Guided by what they learned from the hospital's Department of Osteopathic Medicine, residents would now be able to practice these reimbursable techniques in the ambulatory care setting. As a result of these re-

forms, osteopathic principles and practices would be more visible to patients and accrediting agencies. And, this type of approach supported by a defined curriculum, clinical workshops, and academic lectures would bestow on OMT the same type of credibility that is enjoyed by other hospital teaching services.

Why reform?

These reforms beg a question. Why should a profession that has struggled for 100 years to be recognized as full service now step back and redirect itself toward primary care? First, because osteopathic medicine did it! It did that! The osteopathic medical profession reached a point where its graduates were considered equal, and it provided specialty services of every type. It can be rightfully proud of that achievement. But the profession should recognize that such a mission is not consistent with the development of a distinct identity and reason for being, and it should return to its original mission of primary care.

Second, it was never intended that osteopathic medicine should be dominated by specialty medicine. It was clearly never Andrew Taylor Still's intention, nor was it the intention of DOs as recently as the 1950s and 1960s. The osteopathic subspecialty boom of the 1970s and 1980s wrested control of the profession. But now osteopathic medicine's mission must be returned to primary care.

Third, the profession should emphasize primary care because, barring a few exceptions, it does not have the resources to conduct specialty training that is equivalent to allopathic specialty training.

Finally, and most important, osteopathic medicine should eliminate and reduce specialty training programs because it is only through such institutional sacrifice that the profession will convince the government and allopathic medicine that it is serious about primary care. Why have they never listened before? Because osteopathic medicine said it was a primary care profession, but it kept turning out all of these specialists. Armed with a commitment to primary care, the leadership of the osteopathic medical profession should negotiate with the government and with the allopathic medical profession for its rightful role as providers of primary care in the United States.

Opponents of these reforms will say it is too risky for osteopathic medicine, and that it would mean the end of the profession. We disagree. Peril for osteopathic medicine lies in continuing its present course; it will end up a mirror image of allopathic medicine with no reason for being. Others will correctly point out that these reforms will discourage applicants who are interested in specialty training or who have not made up their mind, but those students entering COMs will be more dedicated to the establishment of the osteopathic medical profession as a leader in primary care.

Opponents will also claim that the profession will be unable to conduct primary care residency programs without the diversity offered by subspecialties. That is not true, though, because these reforms do not close the door on specialty training but instead create a series of turnstiles to direct flow toward primary care and to slow the movement toward subspecialties. Some will argue that these reforms will bankrupt the osteopathic hospital system because osteopathic primary care physicians will be forced to refer to allopathic medical specialists who will take their patients to allopathic hospitals. That situation could be prevented by creative negotiations and arrangements. Moreover, allopathic medical specialists already serve some osteopathic residency programs and, in the future, hospitals offering osteopathic residency training will frequently be mixed-staff institutions, sometimes conducting both osteopathic and allopathic residency programs.

The COMs will express concerns that given current trends toward specialization, limiting the pool of COM applicants to those interested in primary care will result in reduced admissions and tuition revenues, thereby threatening the COMs' survival. However, there is a consensus growing in the Clinton administration, the Congress, and the healthcare world that the problem of specialty maldistribution must be addressed through incentive programs to increase interest in primary care through debt-forgiveness program for students, im-

proved reimbursement for generalists, and by reductions in the number of specialty programs. The COMs should gamble that the trends away from primary care will be reversed, and they should position themselves to capitalize on these initiatives by dedicating their missions to primary care, acquiring faculty expertise in generalism, developing primary care residencies that incorporate the final years of medical school, and by negotiating with specialty colleges and hospitals to reduce the number of specialty programs in the profession.

Many will oppose the formation of a new Primary Care Residency to replace traditional programs in General Practice and Internal Medicine. Yet, there are good reasons to consider this innovation. With each passing decade, the two specialties draw closer together in regard to training and scope of practice. Nowadays, most DO graduates interested in general practice serve residencies and, since the ACGP extended its postdoctoral training to 3 years, it now takes the same time to prepare both types of specialists.

Curricular differences between the two specialties are disappearing: internists are incorporating medical gynecology, office orthopedics, behavioral sciences, and ambulatory care training into their programs, thus becoming more like general practitioners; general practitioners are deemphasizing obstetrics, increasing exposure to specialty rotations, and requiring intensive care unit/cardiac care unit (ICU/CCU) experiences. Thus, general practitioners are becoming more like internists. Increasingly, both general practitioners and internists are relinquishing hospital practices in favor of outpatient and ambulatory care settings. Combining the strongest features of both specialties into a new Primary Care Residency would not only be more efficient but it also would allow osteopathic medicine to capitalize on the name recognition and momentum attached to the primary care label and help to crystallize the profession's identity.

The major barriers facing consideration of a new Primary Care Residency are specialty college autonomy concerns. Opponents of a Primary Care Residency argue that it offers nothing new over current osteopathic residency models but, if successful, it would obviate the need for training programs sponsored by the ACGP and ACOI in General Practice and Internal Residency, respectively. The elimination issue is so divisive that we prefer to think of it in terms of evolution. A major tenet of higher education is that good training programs should continually evolve to meet the needs of a changing society. Osteopathic residency programs are no different, and there is a need for the profession to move toward a primary care model that is more appropriate for the 21st century. Furthermore, evolutionary changes in General Practice and Internal Medicine have resulted in enough similarities that perhaps it is time to consider combining the strengths of the two specialties.

We advocate the development of a pilot program for a Primary Care Residency sanctioned by the AOA, AACOM, ACGP, and ACOI so that graduates are guaranteed board eligibility in General Practice and Internal Medicine. The purposes of this pilot program would be to increase interest in primary care training, to increase the production of osteopathic primary care physicians, and to serve as a demonstration project to attract government interest and support. The philosophy underpinning the new program would be that the training of primary care physicians occurs on a continuum from medical school through residency, and thus the final 2 years of medical school would be integrated with 3 postgraduate years into a residency graduating primary care specialists. The curriculum would feature problem-oriented learning, early clinical exposure, primary care experiences, ambulatory care training, and improvements in structure and organization that accrue from college sponsorship.

On completion of this pilot program, outcomes analysis could be applied. Then, the profession could determine to abandon the pilot program, continue offering it as an alternative residency, or adopt it to replace programs in General Practice and Internal Medicine. If the last option were to be chosen, then the profession might consider adopting the pilot program on a national level; administering it through the AOA, AACOM, hospitals, and the

specialty college in Primary Care Medicine; and providing no opportunity for exit until a student had completed the seventh year. Thereafter, those DOs interested in specialties could pursue osteopathic or allopathic residencies; however, the profession's mission would be transformed into primary care.

The Michigan State University—College of Osteopathic Medicine is in the process of completing a primary care residency that is sufficiently different from current programs offered by the ACGP and ACOI that it should at least be reviewed and considered by the specialty colleges and AACOM as a model for the future.

Although these proposals face a political mine field, there is a growing consensus that osteopathic medicine should attempt to claim the primary care niche and, therefore, it should examine all models that might facilitate that goal. *For that reason, we encourage others to join us in calling on the AOA, AACOM, and specialty colleges to convene a task force to determine the feasibility of a primary care residency program.*

We recognize that our call for reform will gore many oxen; however, the failure of the profession to develop a plan for the problems facing it is the reality that drives us toward these proposals. If they are too onerous for most DOs, then perhaps, through a process of modification, a compromise plan can be reached that is more suitable for the profession. Better still, perhaps our arguments will catalyze others in the osteopathic profession to develop plans that will address the profession's needs in terms of the establishment of an identity and in reversing its losses in primary care.

If nothing else, though, we are convinced that the time for talking is quickly slipping away; soon the crisis facing the profession will demand bold action if osteopathic medicine is to survive. *For that reason, we encourage others to join us in calling on the AOA's president and its other leaders to convene a task force to make recommendations to the profession regarding reforms needed to improve the quality of osteopathic medical education and to return the profession to its primary care orientation.*

Reform of MD/DO relations

One issue bearing on the inadequacy of resources remains to be discussed. Even if osteopathic medicine were to make this institutional sacrifice for primary care and eliminate or reduce supspecialty residency programs, it could not occupy the primary care niche alone. The osteopathic medical profession's resources are too few. It would need the assistance of the government and allopathic medicine.

However, at the national level, there is a conspicuous lack of activity between MDs and DOs. Even though DOs and MDs today work closely together, no open, regular lines of communication exist between the AOA and the AMA, or between the American Association of Medical Colleges and AACOM, the respective representatives of both schools of medicine. No dialogue exists aimed at assisting DO graduates of allopathic residency programs with joint accreditation issues. There is no discussion between the two professions about how to best meet the healthcare needs of the United States. From a public policy point of view, MD/DO relations need to be reformed to reflect events occurring at local levels, to create appropriate lines of communication, and to facilitate the development of a rational national policy for primary care.

Securing AMA recognition

The AOA should secure official recognition from the AMA and allopathic medicine as an equivalent system whose physicians provide equivalent healthcare to the citizens of the United States. The AMA stopped short of this position in 1961, when it left to each state medical society the right to determine if it would recognize osteopathic medicine.[21] This issue has never been revisited, although "unofficial recognition" is suggested by the increasing number of DO graduates accepted for allopathic training and as allopathic program faculty.[4] The allopathic medical profession's recognition would resolve this discrepancy and bring its GME policies into line with an official national policy in regard to relations with DOs. Also, official AMA recognition would assist DOs in dealing with remaining problems of status inconsistency, heal old wounds that

have prevented the two professions from communicating effectively, and establish a catalyst for dialogue.

Rethinking of separate-but-equal position

The osteopathic medical profession should rethink its separate-but-equal position. It should remain a distinct profession with a distinct identity, but "separate but equal" may no longer be tenable or realistic. Reality is that DOs are being integrated into all levels of allopathic medicine, with absorption already under way. Reality is that:

- Osteopathic physicians are joining staffs of allopathic hospitals and vice versa;
- Osteopathic and allopathic hospitals are merging because of economic considerations;
- Osteopathic and allopathic medical schools are cooperating to jointly train students; and
- Osteopathic hospital administrators and COM presidents are negotiating with allopathic medical centers for residency training services.

The two professions should start working together to meet the nation's healthcare needs. Their cooperative effort might lead to solutions to the problems of shortages of primary care physicians, specialty maldistribution, and geographic maldistribution.

Establishment of official lines of communication

The osteopathic and allopathic medical professions should open regular official lines of communication that will allow for an ongoing dialogue on healthcare and residency training. Initially, such a dialogue might focus on "safe" issues like the accreditation issues facing our residents. Eventually, however, a dialogue between the AOA and AMA might include discussion of the potential the osteopathic medical profession has to offer in meeting the country's primary care needs. In the past, the osteopathic medical profession and its colleges were oriented toward family medicine and primary care. The trend toward specialization is newer and, perhaps, reversible. The consensus among DOs is that osteopathic medicine must establish its identity as providers of primary care services.

Establishing a linkage between the resources of COMs, community-based teaching hospitals, and the tradition of primary care with the allopathic medical profession to address national deficiencies is worth considering. Such a linkage is only feasible if both professions are willing to consider concessions and if the federal government is willing to continue allocating financial resources for primary care development. It may sound like heresy, but it is time for DOs to confront and negotiate absorption—the "A-word"—rather than ignoring the processes that are weakening the profession through loss of its graduates and its primary care orientation.

Comment

As the osteopathic medical profession ponders solutions for its crisis, it would do well to remember the words of Gevitz,[2] a keen observer of osteopathic medicine:

> Movements such as osteopathy, homeopathy, and eclecticism generally have a natural life cycle. They are conceived by a crisis in medical care; their youth is marked by a broadening of their ideas; and their decline occurs when whatever distinctive notions they have as to patient management are allowed to wither. At this point, no longer having a compelling reason for existence, they die.

A. T. Still and the generation of DOs following him established the osteopathic medical profession. The DOs of the 1930s, 1940s, and 1950s somehow sustained the osteopathic medical profession through a string of legal battles. The DOs of the 1960s, 1970s, and 1980s transformed "osteopathy," characterized by manipulative medicine and family practice, to "osteopathic medicine," characterized by full-service care and a multispecialty orientation.

To the present generation of DOs fall the most serious challenges. They must somehow guide the osteopathic medical profession safely into the 21st century by clarifying the profession's mission and reforming its medical education system in such a way as to provide the profession with a clear, distinct identity. If they fail, there will be no bicentennial! Osteopathic medicine will simply fade away in the years before that time.

References

1. Paine AB: *Mark Twain's Letters*. New York, NY, Harper and Brothers Publishers, 1923, p 690.

2. Gevitz N: *The D.O.'s: Osteopathic Medicine in America*. Baltimore, Md, Johns Hopkins University Press, 1982, p 123.

3. Shea J, Norcini J, Benson J Jr: Performance of U.S. osteopathic and Canadian medical school graduates on the American Board of Internal Medicine Certifying Examinations, 1984–1988. *Academic Medicine* 1990;65:523-526.

4. Rowley B, Baldwin D, McGuire M, et al: Graduate medical education in the United States. *JAMA* 1991;264:822-832.

5. Meyer CT: Crisis management for osteopathic graduate medical education. *Triad* 1990;1:25-31.

6. Cummings M: The pull toward the vacuum: Osteopathic medical education in the 1980s. *JAOA* 1990;90:353-362.

7. *American Osteopathic Association Comparative Data 1989*. Chicago, Ill, American Osteopathic Association, 1989.

8. American Osteopathic Association: *Yearbook and Directory of Osteopathic Physicians*. Chicago, Ill, American Osteopathic Association, 1991, p 515.

9. Colwill JM: Where have all the primary care applicants gone? *N Engl J Med* 1992;326:387-393.

10. Powell V: Academy Osteopathic Director's Medical Education (AODME) Intern Survey 1988, unpublished data.

11. Pecora A: Factors influencing osteopathic physician's decisions to enroll in allopathic residency programs. *JAOA* 1990;90:527-536.

12. American Osteopathic Association 1991, unpublished data.

13. Revision of 'Essentials of Approved Residencies' pertaining to osteopaths. *JAMA* 1969;208:1416-1417.

14. Baker HH, Wachtler J: Osteopathic postdoctoral education. *JAOA* 1990;90:1010-1019.

15. Baker HH, Wachtler J: Osteopathic graduate medical education. *JAOA* 1991;91:1128-1140.

16. Drucker P: *Management—Tasks, Responsibilities, Practices*. New York, NY, Harper & Row, 1973.

17. Bryson J: *Strategic Planning for Public and Non-Profit Organizations*. San Francisco, Calif, Jossey-Bass, 1988.

18. Zobell D: *Debts and Career Plans of Osteopathic Medical Students in 1989*. Rockville, Md, American Association of Colleges of Osteopathic Medicine, 1990.

19. Mullen FR: Community oriented primary care. Presented at American Osteopathic Association Graduate Medical Education Conference, 1992.

20. Wood D, Esdale R: Michigan State University—College of Osteopathic Medicine, data on residency deficiencies, 1989, unpublished data.

21. Osteopathy: Special report of the Judicial Council to the AMA House of Delegates. *JAMA* 1961;177:124-126.