

'Parallel and distinctive': The philosophic pathway for reform in osteopathic medical education

NORMAN GEVITZ, PhD

I have been a relatively close observer of the osteopathic medical profession for almost 20 years. In my doctoral dissertation at the University of Chicago, my subsequent book, and other writings,¹⁻⁹ I have looked at the many struggles and challenges that the profession has had to face over the course of its entire history. These struggles have included defining the scope of osteopathic medicine; that is, what diagnostic and therapeutic tools DOs should include in their armamentarium, the length and breadth of the curriculum, and upgrading the quality of its undergraduate educational program through higher preprofessional requirements, full-time instructors, and better facilities and equipment. I have also documented how the profession was able to secure equal licensure privileges, and achieve greater status in the basic science and allopathic medical communities. It is quite a story, and I hope I have done justice to a profession which, despite numerous disadvantages and roadblocks, has overcome so much to achieve its present standing and relative success.

However, the profession is currently facing significant problems. In my book,¹ published 12 years ago, I noted that osteopathic medicine had before it a number of basic issues that had gone unresolved and that how they would be addressed would be critical to the future of the profession. Two of these

concerns were the role of palpatory diagnosis and manipulative treatment in osteopathic teaching and practice, and the ramifications of asymmetric professional growth. I want to focus here on these two problems as they relate to the challenging ideas recently put forward by Christopher T. Meyer, DO (in collaboration with Albert Price, PhD) which have received wide attention before both osteopathic and allopathic medical audiences.^{10,11}

Examining a proposed change to the profession

Drs Meyer and Price, in their articles, note that the profession is without a clear idea of where it should be going. What they recommend is that osteopathic medicine "return to its original mission of primary care." To accomplish this, they propose that the profession "abandon or restrict specialty training to those who have completed primary care residencies." They also want the profession to "rethink its separate but equal posture."

With respect to the "original mission of primary care," I would point out that the fact that most DOs over the past three quarters of a century have been in general or family practice¹ and later, more inclusively, in primary care—has been of inestimable value to the political fortunes of this profession. As MDs increasingly shied away from the general practice of medicine and established their specialty and subspecialty practices in urban areas, DOs were able to fill these abandoned positions, winning the support of local communities and legislators which, in turn, led to improved practice acts, more legal privileges and, eventually, in some cases, state-supported osteopathic medical schools. Certainly, we as a society are now com-

This paper, in revised form, was originally presented at the fall meeting of the American Osteopathic Directors of Medical Education, September 9, 1993.

Dr Gevitz is associate professor of the history of medicine, College of Medicine, University of Illinois at Chicago.

Correspondence to Norman Gevitz, PhD, Department of Medical Education (M/C 591) College of Medicine, University of Illinois at Chicago, 808 S Wood St, Rm 986, Chicago, IL 60612-7309.

ing to grips with the problems of medical care costs becoming too great and many individuals—some 37 million of us—being uninsured or underinsured. Public policy is going in the direction of encouraging the greater production of primary care physicians to both lessen costs and extend basic services to more people. That the position of the osteopathic medical profession could strengthen as a result of this trend is undeniable, and I agree with Drs Meyer and Price that it would unquestionably be in your interest to “ride this wave” as long as it lasts. On the other hand, I believe the profession would be making a grave mistake if it came to the conclusion that “primary care” per se can become the most important point of differentiation between DOs and the MDs.

Is emphasizing primary care the answer?

First of all, allopathic medical schools are increasingly moving in the direction of producing more primary care physicians. Take the case of the school that employs me—the University of Illinois College of Medicine. This is a state school that, in terms of graduates, is the largest medical school in the country. Since the time of Flexner, this school has produced mostly specialists and subspecialists. It has a strong tradition in basic science and clinical research. A high proportion of its graduates located in major urban areas. However, as the result of demands of state legislators, who, after all, control the purse strings, the U of I has undergone significant changes in recent years. To produce more physicians in other parts of the state, three regional campuses were created which emphasized the production of primary care physicians and, more recently, the central campus in Chicago established a Department of Family Practice that is gaining in presence and power. In the past few years, the college has established a longitudinal primary care program in which our students spend 2 months in a clinician's office as part of their training. I realize that this is little time compared with that in osteopathic medical undergraduate programs; nevertheless, more of our students are now selecting family practice and other primary care practice specialties.

In addition, many allopathic medical schools created in the 1970s, as well as other state-supported allopathic medical schools, are moving to encourage their students toward primary care, and federal and state governments undoubtedly will be providing more incentives to support this

trend. Although I have no doubt that a greater percentage of DOs than MDs will be in primary care in the year 2000, the gap is likely to narrow. But even if it does not, the fact is that both DOs and MDs will be occupying the same “occupational space.” How is primary care as a field going to differentiate DOs from MDs? It will not. That a larger percentage of DOs than MDs are in primary care in no way ideologically justifies the existence of two distinct professions doing the same thing.

Osteopathic philosophy should distinguish professions

The most powerful ideologic argument as to why there should be a “parallel profession” of medicine is based on the presumption that the smaller profession has a distinct philosophy underlying its existence which is expressed in actual differences in diagnosis and treatment of patients. Without that belief and practice differences, there is no convincing reason that there should be two sets of schools, two sets of boards, two sets of standards, and two types of degrees. The only way I see this profession justifying its existence is on the basis that the osteopathic medical profession believes that the musculoskeletal system plays a greater role with respect to health and disease than is conventionally recognized, and that palpatory diagnosis of the spine and manipulative treatment are important aids to overall patient evaluation and management. If you do not start with this central premise as the basis for the maintenance of your undergraduate and graduate educational programs, anything that you decide to do with respect to “fixing the system,” such as adopting the praiseworthy and innovative 6-year primary care continuity curriculum, will be beside the point.

Drs Meyer and Price^{10,11} argue that the trend toward more DO specialists in non-primary care areas has been bad for the profession. On a theoretic level, however, I would argue that whether a DO becomes a family care practitioner or a cardiologist is not as important to the continuation and success of the profession as whether this physician believes in and practices a distinctive osteopathic approach to medicine. Where I agree with Drs Meyer and Price is that the distinctive osteopathic approach to healthcare has, for a number of reasons, been weakened over the years. Thus, the more training one receives that does not include osteopathic principles, the less likely one is to practice distinctively from allopathic medi-

cine. Indeed, the practical consequence of this trend is for graduates to more closely identify with allopathic medical practices and institutions.

Why then are so many young DOs opting for allopathic residency programs? Drs Meyer and Price¹⁰ note one study that surveys these DOs¹² and the principal reason that they give as to why they chose allopathic over osteopathic residency programs is their belief that the former are superior qualitatively. How do they define superiority? This may be on the basis of prestige of the institution, the organization of the program, the faculty associated with it, the number and variety of the type of conditions seen. Nowhere, it seems, does "philosophy" enter into the equation. In other words, these DOs believe that there is nothing so distinctive about osteopathic postdoctoral programs that would be lost by choosing an allopathic residency. This is the fundamental ideological problem that I see today with osteopathic postdoctoral education. If there is nothing "distinctive" in terms of the content of osteopathic postdoctoral education, then it is not only natural but it should be expected that given desirable educational opportunities outside the profession, many DOs will follow the path toward what they believe are the most beneficial programs to becoming the best physician they can be. On this basis, one can see Drs Meyer and Price's point, that head to head—given the small number, average size, patient mix, and part-time faculty participation—many osteopathic institutions would have a hard time competing for osteopathic interns and residents. Add to this the lower salary offered postgraduates by osteopathic hospitals and it is not hard to see the problem.

If, on the other hand, the undergraduate osteopathic medical education experience imbues students with the belief—throughout the 4-year curriculum—that there is something distinctive and important about osteopathic medicine and, if the postdoctoral education experience promises to extend and reinforce that belief, then you would be adding something very significant to students' decision-making. But that is not what I see today at osteopathic medical schools, at least to a desirable degree.

Therefore, problems on the postdoctorate level should not and cannot be seen as independent from what is going on at the predoctoral level. And frankly, in my opinion, arguing the virtues of an exclusively primary care mission versus a broad-scope osteopathic mission is frankly miss-

ing the central philosophic problem in osteopathic medical education today. All of you in the profession have to decide what does it mean to be an osteopathic physician.

Drs Meyer and Price object to the term "separate but equal," and I agree with them. Instead of "separate but equal," I would strongly recommend the phrase "parallel and distinctive." It is up to you to decide what is so "osteopathic" about osteopathic medical education. If you do not have a distinctive philosophy of medicine providing the foundation for your existence, then you will go from fashion to fashion to continually justify yourselves. In the 1970s to mid 1980s, it was "holistic medicine." Now it is "primary care." These are transitory phenomena—important trends in their day, yes—but no one group has ever had or will have a lock on these belief systems or practices.

Drs Meyer and Price have called for a refocusing of osteopathic medical education. I agree, though my emphases are different from theirs. I would not, as they would, discourage those applicants to osteopathic medical schools who manifest a specialist or researcher orientation. I do not agree that the osteopathic medical profession needs to identify itself overwhelmingly with the practice of primary care. I do not necessarily agree with the premise that the profession must drastically limit the number of residencies it offers in non-primary care specialties. With respect to the existence of non-primary care residencies, I believe the most essential criterion is that these osteopathic postdoctoral programs offer their trainees a quality education experience.

As an interested "outsider" with no constituency to defend, what would I therefore recommend to you with respect to revitalizing the osteopathic postdoctoral system? In other words, what then do I believe is necessary for what I call a "parallel and distinctive" profession of medicine to thrive and prosper?

Recommendations

As I have said, I cannot divorce predoctoral from postdoctoral education; my suggestions have to do with the educational system as a whole. Some of what I recommend deals with "philosophic" issues; other points are concerned with more mundane, but equally important, "structural" elements.

■ With respect to matriculation, I believe that the test for admittance should be whether the applicant shows promise to become a highly qualified and distinctive osteopathic physician not

whether one wants to be a primary care practitioner. If the individual has the intellectual capacity and wants to practice good medicine in a different way, the eventual type of practice (whether generalist or specialist) makes little difference to this profession's future. Furthermore, potential applicants who have a research orientation and are interested in osteopathic principles and practices should be highly encouraged to apply, because it will be these individuals who are most likely to contribute to fundamental osteopathic basic science and clinical research, which needs to be expanded.

■ The total number of matriculants to osteopathic medical schools must be linked in a planned way with the total expected number of approved osteopathic internships and residencies. This is a structural change. The osteopathic medical education system since the 1970s has undergone a process of asymmetric expansion. In a little more than a decade, the number of schools jumped from 5 to 15, while the number of participating osteopathic hospitals in postdoctoral education programs declined. This decline has continued, yet we see existing schools increasing the size of their classes, one new school recently opening, and another proposed school in the works. At the postdoctoral level, this trend is like someone who wears a size 10 shoe trying to fit into a size 4. I think it is more important for the future of this profession to guarantee each student the opportunity to have a continuous osteopathic medical education through the postdoctoral years than it is to produce more DOs, many of whom will not have that opportunity, or who will come to think that because of the abundance of graduates the existing opportunities in osteopathic postdoctoral training programs have become less than satisfactory and will therefore shun them.

■ In the undergraduate years, Osteopathic Principles and Practice (OPP) must occupy a central and unifying role throughout the curriculum. The notion that OPP merely provides something "additional" to the osteopathic medical student's education is not sufficient, in my opinion, to justify a "parallel and distinctive" profession. It is not appropriate for OPP programs to be located in departments of family practice; rather, they should have their own organizational entity. Although it is expected that they should be composed of individuals who chiefly use palpatory diagnosis and manipulative medicine, it is vitally important that other generalists and specialists be directly affiliated with these programs to convey to students

the relative value of such principles and practices in a variety of medical disciplines. It is necessary that acquisition and use of OPP skills continue in the third and fourth years of training. It is each college's responsibility to ensure that clinical clerkships off campus incorporate these experiences. Finally, each school should have an ongoing basic science and clinical research program dealing with distinctive osteopathic methods with which students should be involved.

■ Osteopathic medical colleges must bear responsibility for the total number of osteopathic internships and residencies in their region. Each osteopathic medical school should be required to identify, help to create, and make possible, on a regional basis, the same number of osteopathic internships as the number of its expected graduates. Furthermore, a formula-generated number of available residencies based on the same principles should also be instituted. Given the desirability for DO graduates over non-United States-trained graduates at many allopathic medical institutions, it is incumbent on osteopathic medical colleges to arrange further, and perhaps new, types of consortia or free-standing arrangements for postdoctoral training of the students whom they admit to their schools.

■ Postdoctoral programs in osteopathic medicine must offer a distinctive education experience to their students. Though it is important to offer equivalent facilities and equipment, mix of patients, and quality mentoring, the environment must encourage the use of OPP, where appropriate, in overall patient evaluation and treatment. All osteopathic hospitals should have a section or clinical department of OPP, and all consortia institutions should have regularly scheduled workshops of, or clinical rounds in, OPP.

■ There should be no significant differences between the salaries of osteopathic interns and residents and those of their allopathic counterparts. Osteopathic medical students, on average, graduate with a greater amount of debt than MDs. They should not be expected to make an even greater financial sacrifice on the postdoctoral level. Certainly, either conforming to or changing federal guidelines with respect to greater hospital reimbursement for education programs is one answer, but the profession must also secure support from within. Just as undergraduate institutions have for many years benefitted from the Osteopathic Progress Fund, so too should there be a serious and organized national fund-raising effort to encourage members of the profession and

its 25 million patients to support quality osteopathic postgraduate training programs.

■ I think that implementation of these ideas would greatly reduce the number of osteopathic medical students now seeking postdoctoral training in nonfederal allopathic residency programs. On the other hand, DOs in nonfederal allopathic residency programs will not completely stop, nor should it stop. I view the availability of allopathic residencies, on a structural level, as a "safety-valve." There will always be osteopathic medical graduates who, for a variety of reasons, will want further training at allopathic medical centers. It is a mistake to stop them, or to put sanctions upon them. Young DO graduates must make their own education decisions, and should they want to "return home"—that is, to be active players in the osteopathic medical community—they should be encouraged and welcomed. Comparison and competition between programs (allopathic vs osteopathic) can also be invigorating and beneficial. The returning osteopathic physician who has trained in an allopathic medical institution brings with him or her a different approach or point of view—perhaps a challenging one—that should be heard and discussed.

Comment

Osteopathic medicine is a social movement as well as a profession. Because it occupies the same occupational space as another, older, and majority profession, it must say to the public, legislators, members of the other medical profession—

and most importantly—to its own members, that there is something distinctive and important about the training programs of osteopathic medicine that justifies and legitimizes the profession's independent existence. The better you can define what is distinctive about the profession and the more you actually practice distinctively, the greater the likelihood that you will continue to exist and to thrive.

References

1. Gevitz N: *The D.O.'s: Osteopathic Medicine in America*. Baltimore, Md, Johns Hopkins University Press, 1982.
2. Gevitz N: The challenge of osteopathic medicine. *The DO* September 1984;25:95-96.
3. Gevitz N: *Osteopathic Medicine in Chicago, 1900-1985. Proceedings of the Institute of Medicine of Chicago* 1985;38:152-160.
4. Gevitz N: Sectarian medicine. *JAMA* 1987;257:1636-1640.
5. Gevitz N: The osteopathic dilemma. *JAMA* 1987;258:44.
6. Gevitz N: Andrew Taylor Still and the social origins of osteopathy, in Cooter, R (ed): *Studies in the History of Alternative Medicine*. London, England, Macmillan, 1988, pp 155-170.
7. Gevitz N: Osteopathic medicine: From deviance to difference, in Gevitz N (ed): *Other Healers*. Baltimore, Md, Johns Hopkins University Press, 1988, pp 124-156.
8. Gevitz N: The reason to be. *The DO* September 1991;32:23-24.
9. Gevitz N: The fate of sectarian medical education, in Barzansky B, Gevitz N (eds): *Beyond Flexner: Medical Education in the Twentieth Century*. Westport, Conn, Greenwood Press, 1992, pp 83-98.
10. Meyer CT, Price A: The crisis in osteopathic medicine. *Acad Med* 1992;67:810-816.
11. Meyer CT, Price A: Osteopathic medicine: A call for reform. *JAOA* 1993;93:473-485.
12. Pecora A: Factors influencing osteopathic physicians' decisions to enroll in allopathic residency programs. *JAOA* 1990;90:527-536.