JAOA

HEALTHCARE POLICY

BARBARA ROSS-LEE, DO, SECTION EDITOR

Making sense of federal GME reforms: The need for secondary reforms

CHRISTOPHER T. MEYER, DO

Physician workforce issues in the healthcare reform debate have led to considerable agreement on the need to reform graduate medical education (GME) in order to control the cost, mix and supply of physician manpower. The osteopathic medical profession's infrastructure is ill-prepared to respond to many of the changes that policymakers are suggesting. In last month's issue, the author reviewed the Gephardt and Mitchell bills, which emerged during the last Congress, identified the reforms recommended for GME, and examined the elements of agreement between the bills. The position of osteopathic medicine vis-à-vis healthcare reform was explored and distinctions between the two bills were drawn. In this article, the author recommends comprehensive secondary reforms in the osteopathic medical profession's three institutions—its colleges, its hospitals, and its political organization, the American Osteopathic Association.

(Key words: Healthcare reform, physician workforce, generalists, primary care, Gephardt bill, Mitchell bill, graduate medical education)

In 1907, W.E.B. Du Bois, an icon of African-American civil rights, after failing to sustain the movement that would eventually evolve into the National Association for the Advancement of Colored People (NAACP), was led to remark that "the force of an idea is only as powerful as the politics supporting it."[1]

Correspondence to Christopher T. Meyer, DO, Associate Dean for Academic and Clinical Education, Ohio University College of Osteopathic Medicine, Grosvenor Hall, Athens, OH 45701-2979.

This remark exemplified the debate on healthcare reform throughout 1994. As the year began, reform was supported widely by various public interest groups, but the year ended with disappointments and lack of consensus. The politics supporting the idea were not strong enough to enact comprehensive healthcare reform legislation, and yet consensus over specific changes in the physician workforce and in graduate medical education (GME) surfaced as essential components of comprehensive healthcare reform.

Throughout 1994, in response to the acknowledged dearth of primary care physicians and the increasing ratio of specialist to generalists, the Clinton administration recommended that residency positions be allocated and funded through a centralized regulatory process sponsored by the federal government. Although this call for nationally coordinated planning of the physician workforce was an unprecedented step by a US president, it was not a new idea. The concept of managing the physician workforce mix has been advocated for decades by a few leading academicians,[2] has been recommended by several public and private organizations,[3-8] captured the attention of many healthcare reformers in 1994, and eventually was even endorsed by the medical education community.[9,10] The healthcare debate has evolved to a point where considerable agreement exists on recommended GME reforms, and this agreement was reflected in the two most widely accepted bills submitted during the last Congress—the Gephardt bill submitted in the House[11] and the Mitchell bill submitted in the Senate.[12] In light of the concordance between these two bills, incremental legislation affecting the physician workforce and GME may be achievable goals in the new Congress.

The purpose of this article is to recommend

proactive secondary reforms in the osteopathic medicine's three institutions—its colleges, its hospitals, and its political organization,the American Osteopathic Association (AOA)—to prepare for reforms in medical education at the national level.

Secondary reforms at the college level

At the college level, reforms should be considered in six general areas or functions that are likely to be affected by impending healthcare reform including:

- admissions;
- the structure of GME;
- curriculum;
- osteopathic principles and practices (OPP);
- opportunities for minority physicians; and
- geographic maldistribution.

Admissions policies

At a time when applications for medical school are skyrocketing, and the academic qualifications of candidates are increasing, osteopathic medicine must resist the temptation to chase after the grade point average (GPA) as the great equalizer. The osteopathic medical profession should continue to avoid summa cum laude science majors, and its admission policies should seek out students with backgrounds in the arts and humanities, older students, those with successful careers in other areas, and students from small towns and rural communities. Part of what makes osteopathic medicine different from allopathic medicine is that the osteopathic medical profession has been "fishing from a different recruitment stream" for decades, and in this time of reform it should strengthen and safeguard these recruitment and admissions policies.

GME reforms

Colleges of osteopathic medicine (COMs) should consider and promote a more active role in GME, and osteopathic hospitals should consider encouraging greater college participation in their residencies. The future of osteopathic training programs lies in college sponsorship, joint accreditation, shared responsibility, geographic faculty, combined resources, and in formalized collaboration with allopathic medical institutions.

From an organizational and public policy perspective, it is not unreasonable to assume that hospitals conducting GME programs should have strong ties to medical schools. In allopathic medicine, which tends to set professional standards, this is the rule rather than the exception. In the past, osteopathic hospitals were content to conduct independent GME programs, and resisted college intrusions because of autonomy concerns. However, under the changes that will occur with GME reform, hospitals stand to gain by affiliating their GME programs with osteopathic or allopathic medical schools. College affiliations provide opportunities to improve academic quality through access to educational specialists, grantsmanship, and other in-kind services. Also, if colleges sponsored all hospital GME programs, their graduates would be eligible for college or university certificates of training, in addition to hospital credentials, which would increase the prestige associated with osteopathic GME. Finally, the American Association of Colleges of Osteopathic Medicine (AACOM) should work closely with the hospitals, specialty colleges, and the AOA to develop a new educational structure that more effectively manages osteopathic undergraduate and graduate medical education. The posture of the college should be one of collaboration, avoiding a take-over mentality that could threaten hospitals and delay much-needed progress.

Osteopathic hospitals should affiliate with one or more medical schools to cosponsor residency training programs. Those hospitals unable to negotiate college affiliations may not survive. The contractual arrangements that bind colleges and hospitals, however, must be more meaningful and substantive than they have been in the past. Colleges should provide regular nontenured faculty appointments for selected hospital clinicians, access to educational specialists, and joint sponsorship of academic and research activities. Additionally, colleges and hospitals should explore the development of regional consortia for osteopathic GME and training in order to better position themselves if government funding initiatives move in that direction.

Curriculum reforms

Many healthcare academicians argue that the country is producing the wrong types of physicians with the wrong types of skills. A recent survey shows that a majority of practicing physicians believe they were poorly trained in

the skills needed for managed care and health maintenance organizations (HMOs).[13]

Because the AACOM and its 16 colleges represent a small organization whose medical schools are largely dedicated to primary care, the osteopathic medical profession can speak as one and capitalize on the primary care initiative. Colleges of osteopathic medicine should consider enhancing instruction in:

- competence in managed care principles;
- a psychosocial orientation to health;
- training in health promotion and disease prevention;
- training in community and population health; and
- interdisciplinary training and practice.

Instruction in these areas will better prepare osteopathic physicians of the future to practice in managed care environments, and will help to solidify the profession's position on the leading edge of generalism.

The colleges, along with hospitals and specialty colleges, should also consider reforms in the structure for delivering the curriculum. To prepare primary care physicians for the 21st century, the curriculum should be seamless, and training should occur along a continuum from matriculation through residency completion and on into continuing medical education. Skills and education would be provided throughout this continuum, but the colleges and hospitals must share responsibility for developing effective programs.

Finally, the colleges and specialty colleges should continue to experiment with alternative curricula and accelerated primary care programs combining 3 years of medical school with 3 years of residency programs, as these types of initiatives will lead to educational innovations, reduce training time, and still result in exceptionally well-trained physicians. There is a consensus that the amount of medical information is too vast to master in a specified period of time. As a result, the designation of a 6-, 7-, or 8-year training requirement is somewhat arbitrary. Students today must be trained to be independent, life-long learners, which can be accomplished in 6 years as easily as 7, if the curriculum is effectively restructured to promote those goals.

College reforms in the approach to osteopathic principles and practice

Osteopathic GME programs are not viewed by their students as providing any type of distinctive training. Because Accreditation Council for Graduate Medical Education (ACGME)–approved GME programs are viewed as more prestigious and perhaps credible, osteopathic medical students are leaving the profession in increasing numbers. As Gevitz[14] points out, in order to remain a parallel profession, osteopathic medicine must demonstrate a distinct philosophy underlying its existence which is expressed in actual differences in diagnosis and treatment of patients. Without these philosophic underpinnings and practice differences, there is no convincing reason that there should remain two sets of schools, two sets of boards, two sets of standards, and two types of degrees.[14]

Colleges of osteopathic medicine should consider reforms aimed at establishing their leadership in OPP and in producing appropriate numbers of specialists for the hospitals, which can then assist with the integration of OPP into training programs. Cooperation between colleges and hospitals will be essential, but reforms should target the following goals:

- expanding the number of OPP fellowships;
- strengthening the credibility of OPP fellowships (by extending the duration of training, or by combining Generalist/OPP programs);
- increasing OPP faculty and manpower;
- providing leadership for hospital training;
- integrating OPP into GME programs; and
- promoting distinctiveness.

Reforms addressing minority underrepresentation

The COMs should aggressively pursue the development of programs to increase the profession's numbers of underrepresented minorities. A few COMs have developed successful minority recruitment programs, and these strategies can be shared and emulated among the COMs. Each college should require strategic plans that include high school targets, post-baccalaureate programs, and strategies to recruit minority faculty members. Millions of federal dollars will be earmarked for these priorities, and the COMs cannot afford to pass up these substantial opportunities.

Reforms addressing geographic maldistribution

Healthcare reform legislation proposes the regulatory stick, but also employs the carrot, or

incentive, and nowhere is this more evident than in legislation being advocated to increase rural representation in medical schools. Both the Senate and House bills essentially equate the rural applicant with the status of underrepresented minority applicants, and create programs to identify, recruit, and train rural Americans. This represents another area in which millions of federal dollars will be invested, and it also happens to be an area in which osteopathic medicine has a particular strength, because as many as 20% of our physicians reside in rural areas, and several COMs are located in rural, underserved regions.

Colleges of osteopathic medicine, particularly those located in rural areas, should tailor reforms in admissions, curriculum, and resource allocation to capitalize on these opportunities.

Secondary reforms at the hospital level

Osteopathic hospitals have traditionally controlled the profession's GME programs, but state or federal GME reforms are likely to reduce the autonomy of hospitals, and precipitate the need for closer college affiliations. Both bills indicate that the criteria used for the allocation of funds to support GME should be based on three major principles:

- the quality of educational programs;
- minority representation; and
- geographic distribution.

While quality issues are difficult to get a handle on, the Physician Payment Review Commission (PPRC)[15] recommends that allocations to individual programs be based primarily on educational quality, after rejecting other approaches as either indiscriminate or administratively burdensome. Dimensions of educational quality that potentially could be measured as part of GME reform include physical characteristics such as facilities and faculty supervision; the adequacy of ambulatory training clinics; the content and character of clinical experiences available to residents; the competency of graduates; and other program outcomes, such as whether graduates pursue primary care practice or locate in medically underserved areas.

The existing educational structure in most osteopathic hospitals is not likely to conform with changes in GME structure induced by reform. Osteopathic hospitals should consider secondary reforms to promote the development of residencies that will be competitive with ACGME programs, and that will withstand the scrutiny of a national policy-setting board.

These reforms should include:

- dedicated faculty time;
- paid program directors and supervisors;
- access to educational specialists;
- faculty development programs;
- hospital-operated ambulatory training clinics;
- elimination of the 5-year model (general practice) in favor of a requirement for residency training; and
- reforms targeting the OPP and distinctiveness issues.

The quality difference that exists between osteopathic and allopathic GME programs is the better structure and function that results from part-time teaching faculty, educational specialists, and appropriate ambulatory facilities used in allopathic GME programs.

The price to osteopathic medical institutions for closing the GME gap between the two professions will be the cost of acquiring the infrastructure, sufficient faculty, and monetary resources to develop competitive programs. Allopathic institutions regard these costs as the direct and necessary consequences of training residents.

Finally, osteopathic hospitals should coordinate their efforts with COMs to develop hospital-based training programs that are viewed as distinctive by osteopathic medical students, and which will give them a reason for staying within the profession. The AOA should require that hospitals conducting osteopathic GME have departments of osteopathic services to support those programs. These departments should be operated jointly by colleges and hospitals and should be responsible for promoting distinctiveness in training, for integrating OPP into all training programs, and for protecting the integrity of osteopathic medicine and its educational programs. Together the hospitals and colleges should consider reforms that will promote interest in OPP, improve the credibility of OPP training programs, and produce faculty members to serve in hospital-based departments.

Opponents will argue that such reforms will create a specialty of OPP and will release rank-and-file osteopathic physicians from caring about or practicing it. Nonetheless, every

hospital training program requires leadership and, as a result of these reforms, OPP would be more visible to patients and accrediting agencies. This approach, supported by a defined curriculum, clinical workshops, and academic lectures, would bestow on OPP the same type of credibility that is enjoyed by other hospital teaching services. Finally, a requirement for departments of osteopathic services in teaching hospitals would address the merger menace and serve to protect the integrity of osteopathic medical educational systems. When two hospitals merge, there is a negotiating imperative to accommodate the clinical departments of each institution.

Because osteopathic/allopathic hospital mergers are increasing, the osteopathic medical profession would be better positioned to protect its educational integrity if a requirement for departments of osteopathic services existed. This approach makes it more likely that the interests of osteopathic medicine will be sustained when an osteopathic hospital merges with an allopathic hospital.

Secondary reforms in the AOA political structure

Political reforms that support education (undergraduate and graduate) are needed in the political structure of the osteopathic medical profession, but they cannot be accomplished in isolation of the existing organizational structure. In recent years, several papers have been published about reforms that are needed in either the hospital leg or the college leg, and a good deal of discussion and movement toward reform in these areas has been achieved. Less discussion, however, has been directed at reforms that might be needed in the political leg of what AOA Past President Edward A. Loniewski, DO, referred to in his campaign slogan as the three-legged stool of osteopathic medicine. Consensus is building that the problems facing the profession are so complex as to require a comprehensive, or holistic, approach.

The reluctance to discuss AOA political reform can be attributed to the small size of the osteopathic medical profession, which makes it hard to tackle political issues without getting personal. If the profession wants to address political reform, it must depersonalize the debate. DOs must forget that they all have friends serving as board members and decide whether the board and the presidency are structured appropriately to meet the challenges facing osteopathic medicine and osteopathic medical education. For most of the osteopathic medical profession's history, an informal but powerful network dominated by a few individuals has served it well. Battling for political existence, those individuals could make command decisions and implement them swiftly with little interference from other decision-making bodies in the osteopathic medical profession. But times have changed, the war for parity has been won, and new battles of a different nature face osteopathic medicine and osteopathic medical education. Now, DOs must decide if the existing political structure is appropriate for the challenges of a reformed healthcare system.

Individual members might argue that their interests would be better served by a reformed political and organizational structure designed to provide greater diversity, broader representation, more effective leadership, excellence in the AOA workforce, and educational standards that will be competitive in a reformed healthcare system.

The standards of care in this nation's communities now require residency training, and those DOs who lack this instruction will increasingly face administrative difficulties and professional isolation. The AOA must consider educational reforms that call for the elimination of 5-year training models for general practice. At the same time, the AOA must find ways to safeguard and maintain the ratio of generalists to specialists at approximately 55:45. In order to respond to the need for educational reform, the AOA would do well to consider secondary political reforms.

The Board of Trustees has exercised relatively absolute authority over all affairs of the osteopathic medical profession. It has been reluctant to share its powers, and it has remained insular, comprising exclusively osteopathic physicians. The board should add voting positions for a student representative, and for a representative from the American Association of Osteopathic Postgraduate Physicians (AAOPP) in order to provide those constituencies with appropriate input. After all, in essence, the osteopathic medical profession exists for students and residents, and yet they have never been represented at this important forum. The AOA might consider reforms to promote diversity in the Board of Directors. The benefits resulting from board members who might be execu-

tives at General Motors, the United Auto Workers, Blue Cross, John Hancock, or Columbia University seem too great for the osteopathic medical profession to pass up. The AOA should also consider reforms to promote broader physician participation in the AOA Board, and develop programs that promote pathways to leadership that are less political and based more on substantive merit. One strategy might be to seek out DOs with demonstrated expertise in business, law, or public administration. Another strategy might be to recruit an outstanding DO to serve as a full-time executive vice president for a term of 5 to 7 years, similar to the American Medical Association structure. Such a step might promote greater continuity in leadership, support the roles of the president and executive director, and provide the profession with a highly visible physician spokesperson.

Finally, the role of Executive Director needs to be less subject to the political influence of the Board. The Board should confine its attention to determining broad policy issues while leaving the Executive Director sufficient latitude to implement policy and manage the organization.

In the words of W.E.B. Du Bois, "The force of an idea is only as powerful as the politics supporting it."[1] The political leg of the osteopathic medical profession is vitally important to the future of osteopathic medicine. DOs should not shortchange themselves by believing that reform is necessary only in the other two legs of the stool; if the profession does that, it may find itself sitting on the floor.

References

1. Lewis DL: *W.E.B. Du Bois: Biography of a Race.* New York, NY, Henry Holt & Co, 1993, p 482.

2. Ginsberg E, Ostow M, Dutka AB: *The Economics of Medical Education.* Josiah Macy Jr Foundation, New York, NY, March 1993.

3. O'Neill EH: *Health Professions Education for the Future: Schools in Service to the Nation.* San Francisco, Calif, Pew Health Professions Commission, 1993.

4.*Report of the Josiah Macy, Jr. Foundation.* New York, NY, Josiah Macy Jr Foundation, 1993.

5. *The Robert Wood Johnson Foundation Annual Report 1990.* Princeton, NJ, The Robert Wood Johnson Foundation, 1990.

6. National Health Policy Forum: *Proposals to Reform the Physician Work Force: Tipping the Scale Toward Primary Care.* Washington, DC, George Washington University, June 21, 1993, No. 623.

7. Alliance for Health Reform: *Commanding Generalists.* Washington, DC, Alliance for Health Reform, July 1993.

8. Faulkner & Gray: *Primary Care and Health Reform: Reallocating Resources.* Washington, DC, Faulkner & Gray's Healthcare Information Center. 1994.

9. Council on Graduate Medical Education: *Fourth Report: Recommendations to Improve Access to Health Care Through Physician Workforce Reform.* Rockville, Md, US Department of Health and Human Services, January 1994.

10. Shea P: Schools build strategies to meet generalist challenge. *AAMC Reporter* September 1993;3(1):1-2.

11. US Congress: House. 1994. Guaranteed Health Insurance Act of 1994. 103rd Cong, 1st Sess, HR 3600. Congressional Record. Vol 139, No. 163. Daily ed (November 20, 1993), H10469.

12. US Congress: Senate. 1994. Health Security Act. 103rd Cong, 2nd Sess, S 2357. Congressional Record. Vol 148, No. 105. Daily ed (August 3, 1994), S10538.

13. Rivo ML: Internal medicine and the journey to medical generalism. *Ann Intern Med* 1993;119(2):146-152.

14. Gevitz N: 'Parallel and distinctive': The philosophic pathway for reform in osteopathic medical education. *JAOA* 1994;4:328-332.

15. Physician Payment Review Commission: *Annual Report to Congress, 1994. Graduate Medical Education Reform.* Washington, DC, 1994, pp 237-263.