Letters

Forecast for osteopathic medical education programs in the for-profit hospital environs

To the Editor:

As the healthcare system in the United States continues to change, more hospitals are merging into for-profit hospital systems. This trend is continuing despite recent federal investigation into some for-profit systems for questionable billing practices, among other concerns. With the impending entry of the first for-profit hospital system into the state of Michigan, questions arise concerning the status of osteopathic primary care education programs for interns and residents in the for-profit hospital environment.

In searching the literature, I found no articles on this topic. Therefore, I embarked on personal discussions with directors of medical education, residents, hospital chief executive officers, and other hospital personnel to see how they're faring. I found primarily positive comments. Although some persons were unhappy about some of the corporate decisions, overall, most persons I spoke with expressed overwhelming approval.

Only one transaction in which a for-profit system bought a college osteopathic hospital elicited repeatedly negative remarks. Yet, as I gathered more information about this particular transaction, I've come to think that this negativity is really based on a series of misinterpretations, operational slip ups, and the failure to share complete information with all faculty and students. In this instance, things were done that caused confusion, but I do not think this is the usual scenario. In most outright purchases or even partnerships, personnel in the hospitals and colleges, as well as the physicians and residents, were pleased with the new arrangement; they viewed it as having a positive effect.

If anything, I get the feeling that for-profit hospital systems look favorably on osteopathic primary care medical education and its graduates, as they see us as good primary care providers. Primary care providers are, after all, a very important part of for-profit and not-for-profit hospitals.

Not specific to osteopathic medical education is the issue of cost efficiency with accountability, along with the ability to document good educational standards and outcomes. Accountability ranks important in for-profit hospital systems. Healthcare personnel must be ready to defend their budgets and programs. The days of small programs with one or two residents are probably over as are poor—or mediocre—internships and residencies.

Osteopathic medical training programs must be prepared to be judged against a national standard, including being able to compete with those Accreditation Council for Graduate Medical Education (ACGME)-approved programs that train osteopathic physicians. Establishing medical programs as bench marks, as well as setting standards for the quality of patient care and cost efficiency, is in progress.

The bottom line plays an essential part in almost all for-profit hospitals. Nonetheless, for-profit hospital systems support primary care programs. Specialty training programs are supported—if they can be adequately defended, are seen as needed in the hospital system, and are of high educational quality.

Osteopathic medical education should *not* be afraid of for-profit hospital systems. Like allopathic programs, osteopathic medical education programs will survive if they are quality programs that can justify their existence and show that they benefit the hospital system in ways that go beyond the bottom line and encompass the total operations of the system.

For-profit hospitals are a threat to the status quo. I do not fear them, however; rather, I see them as a breath of fresh air in a system set in its ways that fears *real* competition. Although a hospital's first priority is providing good patient care, the hospital is a business and should be run as such. Medical education is a part of that business and should be run as such. Likewise, universities and colleges of osteopathic medicine are businesses and should be run accordingly. Being accountable and able to justify a program's existence are reasonable expectations and are ones that we should be ready to meet.

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Examining quality improvement vs cost containment

To the Editor:

I was very interested in the article "Evaluation of a critical pathway for stroke" (*JAOA* 1997;97:269-272,275-276) by Gary Ross, DO, and colleagues. The authors reported their experience in creating a multidisciplinary task force to develop, implement, and monitor a critical pathway for the management of stroke patients admitted to the hospital. Because this hospital length of stay for this diagnosis was longer than that reported in the literature, stroke became a principal target for development of the critical pathway quality improvement project. After implementation of the pathway, a reduction occurred in the length of stay, and improvement was noted on a variety of performance measures.

I have no doubt that the reduction in variation achieved by implementing the critical pathway improved institutional efficiency and had potential to improve quality and patient outcomes. However, I question the original intent of this endeavor after reading the article. Was the team created to improve real or perceived problems with quality of care, or was the primary goal to reduce the length of stay? With the exception of length of stay, no other measures of patient outcome were reported. As Chassin[1] points out, "Much

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