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Part I. "To the person who does not know where he wants to go there is no favorable wind" …. Seneca

Vision is defined by what we want to achieve. It is about how we will be recognized. What will be the "niche" of the osteopathic physician in the future as we either maintain or re-establish distinctive osteopathic care?

My vision of the osteopathic physician of the future is herein based upon a review of our osteopathic history, and a perspective of what the future healthcare demands will be in the future. I will also outline what I believe it "should not be" and identify mechanisms by which it can be achieved. The visioning process is a method that recognizes where a group is now, and where it can be in the future. It is a seminal part of the strategic planning and implementation process.

Strategic planning provides a roadmap for direction, clarity, and focus. The primary purpose of the strategic plan is to connect an organization's mission and vision by addressing three questions:

What is our purpose? (Mission)

What do we want to achieve? (Vision)

How are we going to get there? (Plan)1

The mission of osteopathic medicine has long and valuable roots in the medical history of the United States. The hallmark of Osteopathic healthcare is the focus on health and wellness as opposed to the conventional disease-based approach. It utilizes a holistic approach based upon four fundamental principles:

The body is a unit, and the person represents a combination of body, mind and spirit.

The body is capable of self-regulation, self-healing and health maintenance.

Structure and function are reciprocally interrelated.

Rational treatment is based on an understanding of these principles: body unity, self-regulation, and the interrelationship of structure and function.

A.T. Still, M.D., D.O., founder of Osteopathy, said "the object of the physician is to find health, anyone can find disease." 2 This mission to promote health and combat disease has served osteopathic medicine well during the rapid growth of modern American medicine during the concluding part of the 19th and throughout the 20th

[1] https://www.achieveit.com/resources/blog/3-reasons-corporate-strategic-planning-important

[2] "The DO by AOA staff, Osteopathic Medicine: 125 years of history, Nov 15, 2017

century. As this is written there are currently "37 accredited colleges of osteopathic medicine educating nearly 31,000 future physicians, 25 percent of all U.S. medical students" demonstrating the historic growth of osteopathic medical colleges.3 This is easily demonstrative of the acceptance of osteopathic medical training and the healthcare it has historically offered.

As part of its historic growth and acceptance, osteopathic medicine promulgated itself in the arena of "Primary Care." This was not necessarily by choice. During the 20th century period of acceptance and expansion, limited post-doctoral training opportunities existed. Based upon limited training slots during the phase of growth "the majority of osteopathic physicians were funneled into careers in primary care medicine since they had few options to choose other medical specialties."4

Forces within the early 21st century have changed all that! As student class size increased, the profession saw a migration of recent graduates toward allopathic residency training, especially in the non-primary care fields. Contributing factors include, but are not limited to:

- The increased amount of student debt incurred by future physicians.
- Higher reimbursement for specialty care compared to primary care
- The continued evolution of managed care in healthcare delivery
- Changing attitudes in workforce among the current generation of medical students
- Marginalized geographic opportunities for practice growth
- The closure or absorption of osteopathic community-based hospitals by large healthcare enterprises
- The AOA-ACGME merger in post-graduate residency training.

This is just to name a few.

Based upon medical student migration to allopathic post-graduate training and the advancement of mid-level practitioners into the primary care fields, it is the position of this author that the Primary Care field is no longer the major domain of the osteopathic physician. Note: entering the primary care residency programs of general internal medicine and pediatrics does not denote an end career of primary care. These are merely steppingstones. Estimates are that as many as 80% of these residents make application for specialty training.

In January 2015, Minnesota began issuing a separate license for advanced practice nurse Practitioners (APRN) and became one of 12 states in the U.S. to allow NPs to practice and prescribe independently. In December 2016, the Department of Veterans Affairs (VA) gave full practice rights to advance nurse practitioners who work for the VA. "The NPs were granted permission to practice independently without an overseeing physician and the decision overrode any state restrictions on NPs practicing independently, aside from a few exceptions, such as prescribing controlled substances."5

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[3] https://www.aacom.org/colleges-of-osteopathic-medicine-v1?utm_expid=.4kO8UdGkRmaH5YUpdBkoWA.1&utm_referrer=https%3A%2F%2Fwww.google.com%2F

[4] The Irony of Osteopathic Medicine and Primary Care Cummings, Mark PhD; Dobbs, Kathleen J. PA-C, Academic Medicine: July 2005 - Volume 80 - Issue 7 - p 702-705

[5] https://nurse.org/articles/doctor-vs-np-va-grants-full-practice-authority/

Increasingly, patients are seeing mid-level practitioners with great satisfaction and at a cheaper cost to the institutions that employ them.6 One study demonstrated that "In an ambulatory care situation in which patients were randomly assigned to either nurse practitioners or physicians, and where nurse practitioners had the same authority, responsibilities, productivity and administrative requirements, and patient population as primary care physicians, patients' outcomes were comparable."7

It is the opinion of this author, based upon the shift in numbers of osteopathic trainees actually entering primary care combined with the increased utilization of mid-level providers, that the osteopathic profession will NOT meet the demands of primary care medicine, and a new vision and direction is necessary for osteopathic medicine to find a new "niche" in the healthcare delivery paradigm. I say this despite predictions of physician shortage "of between 54,100 and 139,000 physicians, including shortfalls in both primary and specialty care, by 2033."8 The cost, length of time, and specialty choice of students involved in osteopathic physician education cannot possibly meet this demand, and it will continue to be absorbed by less-costly providers in the arena of primary care. It is time for a new vision and paradigm shift.

Part II. Healthcare Demands of Osteopathic Medicine in 2020 and beyond: "The only constant in life is change" ...Heraclitus

Evolving 21st century healthcare economics and medical practice combined with the current pandemic of 2020 have accelerated change in healthcare delivery. There are new paradigms for infrastructure, geographic distribution of providers, and care settings. These will affect the osteopathic practitioner in the future:

A few examples:

1. Virtual Care: With the arrival of COVID 19 and stay-at-home orders instituted across the country, physicians turned to telemedicine as a way to remain engaged with their patients.9 Recently, "through the collaboration with 98point6, Sam's Club members can purchase a quarterly subscription. The subscription includes visits for just $1, with unlimited use, and access to U.S. board-certified doctors 24 hours a day and seven days a week."10

2. Delivery of elective care in dedicated facilities: COVID 19 closed much of the elective care delivery in large portions of the United States. Patients were blocked from necessary elective procedures and laboratory / radiology studies at institutions now consumed with care dlivery for COVID 19 patients. New healthcare delivery models are evolving to minimalize this problem in the future, and further shift elective and laboratory

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[6] https://www.healthcarevaluehub.org/advocate-resources/publications/provider-scope-practice-expanding-non-physician-providers-responsibilities-can-benefit-consumers

[7] JAMA. 2000 Jan 5;283(1):59-68.doi: 10.1001/jama.283.1.59.

[8] https://www.aamc.org/system/files/2020-07/aamc-2020-workforce-projections-15-year-outlook-key-findings-f2.pdf

[9] https://www.ama-assn.org/practice-management/digital/5-huge-ways-pandemic-has-changed-telemedicine?gclid=EAIaIQobChMIo4jJvfOJ7AIVB77ACh2MOQUnEAAYAyAAEgJAvPD_BwE

[10] https://corporate.samsclub.com/newsroom/2020/09/22/sams-club-teams-up-with-98point6-to-offer-exclusive-subscription-plan-options-with-the-98point6-mobile-app

procedures from hospitals. This will reduce valuable sources of revenue for hospital corporations and reduce physician employment in key areas. We have seen substantial decreases in physician salaries in 2020 and this is expected to continue through 2021. With the large cost of medical education debt, this will be unsustainable if prolonged.

3. Inpatient stays will likely remain undesirable by the non-COVID population. Patients may choose to avoid hospital stays whenever feasible, accelerating the transition to ambulatory care settings for increasingly complex care and procedures. Physicians will have to transition their practice knowledge and patterns to this new paradigm.

4. There is a need to review and share emerging science, best-practices and policy shifts that affect how communities, healthcare and public health systems, insurers and providers respond to and manage the COVID-19 pandemic.11 Osteopathic providers will require a broader base of knowledge and practice in the arena of public health and its role in healthcare policy and medical practice delivery.

5. In this 21st century paradigm, we live in a world of global travel. This has implications for the spread of global infectious disease as well as the contributions to global medicine and disaster response. Hurricanes, tornadoes, earthquakes, fires are all demanding increased response from the healthcare provider community.

In no way are these "demands" meant to be complete. They rather are exemplary of the rapidly changing environment of 21st century healthcare.

Part III. "Vision Statement of the Osteopathic Physician in the 21st Century and Beyond"

The 21st century osteopathic physician will be the most sought-after healthcare provider by patients and healthcare delivery systems. He / She will exhibit the highest exemplary skills in medical knowledge and clinical medical care for his/her patients and community. He / she will demonstrate compassionate and culturally competent care as a physician.

In strategic planning terminology, this vision would be known as a "BEHAG", a big, hairy, audacious, goal. This vision exemplifies a long-term goal that will encompass specific competencies demonstrated by practicing physicians. By its very nature, it incorporates the four osteopathic principles, the important philosophy of Dr. Still, and the utilization of manipulative medicine as part of the osteopathic physicians' armamentarium. The 21st century osteopathic physician will include all medical disciplines from primary care to sub-specialty medicine.

[11] https://www.phi.org/press/protecting-public-health-during-the-covid-19-pandemic-phi-response-resources/

Part IV. What competencies are necessary to achieve the osteopathic vision of the future: "If you want to be successful, don't seek success – seek competence, empowerment; do nothing short of the best that you can do"…Jaggi Vasudev

To achieve the vision outlined above, a strategic plan must be developed with tasks that will inculcate specific competencies among DO physicians. These competencies must include:

Demonstrable "top level" expertise in medical knowledge by all osteopathic practitioners.

Demonstrable "top level" expert clinical skills in physical diagnosis and medical treatment by all practitioners.

A broad working knowledge of public health with each DO achieving an MPH degree at some future date. Regardless of specialty practice.

Each DO will have demonstrable knowledge in Disaster Medicine, including the global spread of disease and community-based emergencies. They will have certification in basic and advanced disaster life support, regardless of specialty practice.

Each DO will have demonstrable competencies in community based cultural medicine, regardless of specialty practice.

Osteopathic physicians will exhibit a broad and demonstrable knowledge of healthcare delivery systems at the macro and micro level.

Osteopathic physicians will have demonstrable exemplary knowledge in telemedicine and the latest technologically advanced means of healthcare analysis and delivery. This will include computer-based methods of community-based analysis and artificial intelligence.

Within our medical arena, there are three possible arenas to develop pathways of achievement towards the 21st century osteopathic physician competencies. Please note: the osteopathic physician of the future is the sum total of osteopathic physicians in our community.

Pathway 1: A top down, trickle down approach by those DO's already in practice, who will adopt the new competencies necessary to achieve the 21st century vision and train to achieve them. Present day physicians do not have the time, money, or resources to make this happen at a global level. It will NOT happen via this pathway.

Pathway 2: Incorporation of the competencies as a requirement at the post-doctoral residency level. With the recent AOA / ACGME merger and the number of current and future DO's training in allopathic residency programs, this will NOT happen via this pathway.

Pathway 3: Incorporation of these demonstrable competencies at the osteopathic medical school level by COCA accreditation requirements and mandatory testing prior to graduation by the NBOME. Then continued education and testing as part of a lifelong learning process in osteopathic board certification and re-certification.

The steps along this path require a journey that begins with college education and osteopathic medical school matriculation. Although many of our COM's have favored selection towards the primary care fields, the new

direction would favor meeting the seven competencies outlined above, without a necessary predilection towards primary care. Applicant preference would be given towards college applicants who have a predilection for community service, public health, and experience with underserved / underrepresented communities.

COM Curriculum Changes and Certification Changes:

The current COCA research requirement of osteopathic medical schools would be eliminated. This would allow a shift of funds and faculty resources directed towards clinical educational endeavors. It would also help keep COM tuition requirements at lower levels. Faculty models would not require key percentages of time in the research arena, so their efforts can be directed towards educational endeavors that enhance clinical practitioner competency, medical practitioner knowledge and public health education. COM's could continue along research lines if they so choose, but they still must meet the other requirements of the standards of osteopathic training.

A newly established requirement of an MPH degree must be established at all COM's. A public health degree will be a requirement for each DO graduate. Having an MPH degree will be an important step in establishing the advanced osteopathic professions niche. It is consistent with osteopathic philosophy and osteopathic principals. With MPH training, future DO's will understand current health and wellness trends and learn specific methods and best practices to affect positive change in health delivery and wellness in their community. Specialized public health training can occur in rural and underserved areas.

The primary goal of osteopathic colleges must be the clinical training of future expert physicians. This must consist of both bedside and telehealth practice competencies. An osteopathic physician requirement of "telehealth" should be established by the NBOME, with demonstrable competency in telehealth a requirement for all graduates as part of the level II NBOME exam. A certificate of telehealth competency would be issued to those tested in the program. Certainly, the two-year basic science curriculum / two-year clinical curriculum has worked in the past, but it is time for a change to meet increased practice demands. A shift would occur in the first two years of medical school training with increased emphasis on physical diagnosis and clinical therapeutics in the outpatient, inpatient, and auxiliary setting. Although the basic sciences would still be taught, emphasis would be based upon those topical areas that are most clinically relevant (anatomy, physiology, pharmacology, and pathology). Other areas can be studied at later adjunct times. The time for basic science allocation should be reduced to 16 months, with the remaining time devoted to the enhancement of clinical skills.

Enhanced training in clinical years III and IV must be developed using new medical simulation techniques incorporating standardized patients and high-fidelity computerized models. A clinical portfolio will be established by all colleges for each student. This portfolio will track and trend student competencies in performance of "entrustable professional activities." These portfolios will become the property of the student and the student will be able to pass these along to residency trainers and eventually to certification boards and credentialing committees.

Each COM would also be required to conduct educational programs in basic and advanced disaster life support. All students would require this certification as a graduation requirement. This will enhance the role of the osteopathic physician as a sought-after physician at the community and corporate enterprise level. Any new emerging disease (i.e. COVID 19 for example) is an airplane flight away from any location in the U.S. Community disasters occur on a regular and recurring basis. This tasks the physician community to become part of the

disaster response team. Advanced training in this multidiscipline approach will assist the community and advance osteopathic medicine as a community healthcare leading discipline.

Osteopathic specialty colleges will develop "Master - Level" competency designations through rigorous examination. All candidates must demonstrate clinical skills beyond those necessary for basic board certification. This Master – Level designation will serve as an exemplar of excellence to the public and serve as a goal for the osteopathic physician to continue his / her path towards clinical distinction in the practice of medicine.

Part IV. "A leader's role is to raise people's aspirations for what they can become and to release their energies so they will try to get there."-- David Gergen

One of the strengths of the osteopathic community is less bureaucracy combined with our ability to change rapidly. We are still a relatively small profession, with the capability to adapt and adopt quickly.

Our growth and acceptance have been largely due to our ability to train highly qualified physicians who meet the needs of our communities. We have performed admirably but we can become more than highly qualified. We can become the best at training the next generation of physicians in our Colleges of Osteopathic Medicine. Our graduates will meet the needs of our communities with the highest clinical skills. This can become our identity and "niche."