The Future of Osteopathic Medicine in the United States:

A Unique Opportunity to Embrace Public Health in Medical Education and Care

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The future of osteopathic medicine in the United States looks bright. This is especially true when you look at the growing numbers of osteopathic physicians and osteopathic medical colleges and branch campuses, and the increasing numbers of men and women of diverse backgrounds interested in entering the profession. With Single GME Accreditation (SGA) successfully falling into place this year, the profession now faces a metaphorical fork in the road. Which direction it takes will have implications for the identity of the profession for years to come.

As many within the profession know well, the vast majority of osteopathic physicians today do not utilize osteopathic manipulative medicine (OMM) in their practice, even if they make an earnest effort to embody osteopathic principles of holistic care in their professional work. As more osteopathic physicians enter residency and fellowship programs that have not had a track record of attracting large numbers of graduates of osteopathic medical colleges, and as providers and patients become more comfortable with telemedicine and telehealth (which, by definition, does not deliver hands-on care), even fewer osteopathic physicians are likely to utilize OMM in their training or practice. There will always be a place and need for OMM, one may safely assume given its enduring value, but osteopathic physicians trained in Neuromusculoskeletal Medicine (NMM) will likely be the masters and vanguards of those skills. Given the wider opportunities they now have to enter medical and surgical specialties (and subspecialties) of every imaginable type, osteopathic medical students may be less likely over time – as is already the case with their allopathic counterparts – to pursue training in primary care specialties (e.g., Internal Medicine, Family Medicine) in overwhelming numbers as their predecessors once did. The osteopathic profession likewise will be unable to describe itself as exclusively focused on "holistic care," as that term has also been embraced, for all the right reasons, by more MD-granting medical schools and allopathic physicians of every specialty. These trends are worsening an identity crisis that the osteopathic profession has long been experiencing.

Growth in the Number of MDs and DOs

The osteopathic profession has seen incredible growth over the last four decades. From 1980 to 2000, when many health care workforce researchers feared there would be too many physicians by the turn of the century – the term "physician glut" was often heard on medical school campuses and in hospital wards – DO-granting medical schools continued to grow by number and class size. Much of that growth was facilitated by the profession's undergraduate medical regulator, the Commission on Osteopathic College Accreditation, itself accredited by the U.S. Department of Education. The growth was in many respects opportunistic, in terms of which cities and states sponsored, supported and allowed new colleges and campuses to develop. Increases in class size at existing or additional campuses, meanwhile,

were enthusiastically supported by university leaders long reliant on osteopathic medical college tuition to cover their operational expenses and drive institutional improvements and expansion. That many of the new osteopathic medical colleges and branch campuses supported the health care needs of communities and nearby catchment areas was an added benefit, to be sure, though not always the principal motivator for the expansion or site selection of the campuses in the first place. MD-granting medical schools, by comparison, preferred to keep their numbers and class sizes small, in part because most of their revenue came from the millions of dollars of federal research grant monies they received and from the revenue they derived from operations of the ever-expanding university hospitals and health systems they usually owned. Between 1980 and 2005, in fact, the number of allopathic medical schools and the number of medical students did not increase.1 Libertarians have long argued, meanwhile, that the number of medical schools and students have been kept small intentionally, to limit competition and maximize revenue for those already in practice.2

The 1997 Balanced Budget Act under President Clinton put enduring limits ("caps") on the unfettered growth in numbers of MD and DO graduate medical education (GME) training positions (across all specialties) that many teaching hospitals had increasingly relied upon for remuneration and growth. Incremental increases in GME positions nonetheless occurred (especially in the osteopathic profession) because of a loophole in the law that permitted new residency programs to develop in those hospitals that had never had them before. As the year 2000 arrived, a surplus of health care providers did not materialize as predicted and workforce researchers instead began forecasting a worsening shortage of physicians (particularly in primary care but also in specialties such as geriatrics). The AAMC called upon leaders of MD-granting medical schools to increase the number of medical schools and class sizes, in a dramatic call to action that was ultimately heeded successfully. Predictions of a physician shortage have persisted, however. Zhang and colleagues currently predict a shortage of 139,160 physicians by 2030, with the Western part of the United States forecast to have the greatest physician shortage and the Northeast expected to have a surplus.3 A countervailing opinion holds that we may already have an adequate supply of physicians in place and should instead rely upon nurse practitioners and non-clinician providers to help close any health care access gaps.

Today, there are 153 MD-granting medical schools and 37 DO-granting medical schools that offer instruction at 58 teaching locations. Roughly a quarter of the nation's medical schools are colleges of osteopathic medicine, and one in four medical students in the United States attends an osteopathic medical college. Osteopathic physicians make up 9.1% of all licensed physicians in the United States – 89,764 out of 985,026 – but those numbers and percentages will continue to bump upward as more individuals enroll in osteopathic medical colleges and then graduate, become licensed and enter the health care workforce.4 There are now 21,972 osteopathic physicians in ACGME-accredited residency and fellowship training programs in the United States, compared with 86,410 MD graduates of medical schools in the U.S. and Canada, and 32,234 international medical graduates.5

Moving Beyond the Numbers

Numbers alone will not be enough, however, for the osteopathic profession to survive and thrive as a unique and distinct means of promoting health and preventing and treating disease. What is necessary is for the profession's practitioners, medical educators and leaders to clarify for themselves, their patients, their colleagues, and society at large, where osteopathic medicine best fits into the health care

system the country will need in the future, especially after the pandemic subsides. Fifteen years ago, in a report commissioned by the AOA and AACOM, Teitelbaum described osteopathic medicine as a "living profession," meaning that "it (evolves) and (adapts) to changes in its environment.6 The description remains apt in 2020, perhaps even more so.

The success of Single GME Accreditation has already started to place varying degrees of pressure on other areas along the continuum of osteopathic medical education to align or consolidate, such as in undergraduate and continuing medical education accreditation, and in medical licensure assessment and specialty certification, as osteopathic medical students begin to wonder aloud (and on social media, a medium in which they are digital natives) why dual systems (and dual costs) remain in place when there is so much harmonization between the two schools of practice. Opponents of greater alignment may fear loss of control (and money) and wonder if too much consolidation will lead to dilution, and therefore dissolution, of what makes the osteopathic profession unique and distinct. Unless the profession rebrands itself, efforts to consolidate will persist.

Embracing Public Health

The largest gains in life expectancy in the United States have occurred during the twentieth century, in large part due to dramatic advances in public health, including the greater availability of potable water, better food and health inspections, vaccination against childhood diseases, improved waste management, motor vehicle safety through mandatory seat belts and automotive speed limits, and rules requiring safer workplaces.7 Each of these significant changes came about as a result of the policies and practices championed by public health professionals. While there are 63 schools of public health in the United States, there are not enough physicians with public health degrees or backgrounds to meet the needs of our growing nation.

As Murphy and Pollack-Porter recently articulated related to federal legislation, "It is time for a second public health revolution—one that prioritizes human health, well-being, and equity. The confluence of "a global pandemic, economic collapse, and structural racism laid bare," they write, "has finally brought our fundamentally unfair societal structure to light." With health inequities pervasive and evidenced by worsening disparities in life expectancy that are closely tied to where one is born and raised, now is also an opportunity for the osteopathic profession to lead the effort to incorporate the principles and practices of public health within its lecture halls and in the community.

With so much changing in health care due to COVID-19, and much that remains unpredictable, the osteopathic medical profession needs to consider making public health part and parcel of the DNA of every future osteopathic physician. Whether this is accomplished through the establishment of joint DO-MPH degrees for every osteopathic medical student at every campus, or by adding required courses8 and practical work in public health is up to osteopathic medical educators and leaders to ultimately decide.

The current pandemic has disrupted the daily lives of Americans in ways not seen since the 1918 influenza pandemic, write Rasmussen and Jamieson, but one can imagine future emergencies (e.g., a bioterrorist attack or radiation emergency) in which even more rapid and drastic decisions may need to be made.9 The osteopathic profession needs to begin preparing now to put in place changes in its

approach to undergraduate and graduate medical education to better serve the public health needs of the nation, just as its physicians helped make a palpable difference (literally) during the Great Influenza Pandemic of 1918.10 In the final analysis, leaders in osteopathic medicine will need to ask themselves if they should continue to allow events and trends to dictate their reactions, or if they should plan a long-term strategy and lead the profession to a better future, one that resonates with the nation's short-term and long-term needs and makes a difference in the lives of all patients.

References

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[2] While the Flexner report of 1910 is usually celebrated for improving the quality of undergraduate medical education throughout North America because it led to the closure of scores of proprietary and under-resourced medical schools, those schools included a handful of osteopathic medical colleges and several allopathic medical schools that uniquely catered to women or African American students.

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