Taking Osteopathic Distinctiveness Seriously: Historical and Philosophical Perspectives

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The current issue of JAOA—Journal of The American Osteopathic Association includes three interesting and thought-provoking articles—by Leonard H. Calabrese, DO; Robert Orenstein, DO; and Felix J. Rogers, DO—that focus on the history and philosophy of osteopathic medicine. Although each article presents differing dimensions of the profession, all three pieces (1) discuss what makes osteopathic medicine distinct from allopathic practice, (2) identify common themes, and (3) suggest solutions.

The history and philosophy of osteopathic medicine can be summarized as a noble social reform movement that is more than a century old. This movement, however, despite remarkable successes, is now struggling mightily to find a cohesive and distinct voice within the healthcare community—a voice that is clear and prominent when addressing the public it serves and compelling and influential within the scientific community.


The article by Dr Rogers (“Advancing a Traditional View of Osteopathic Medicine Through Clinical Practice.” 2005;105:255–259), however, is a critical analysis of the three main ways the profession has regarded itself, sought to foster change and development, and made sense of its own history.

All three articles propose a way to achieve osteopathic medicine’s “distinctiveness.” All three authors conclude that the profession’s ability to establish its distinctiveness is dependent on the ability of its members to develop a culture of research and scholarly endeavor.

Orenstein’s Mayos

Dr Orenstein discusses the similarities in how Andrew Taylor Still and William James Mayo and Charles Horace Mayo envisioned the future of medical care and the considerably divergent paths they followed in developing their respective institutions. The vision they shared, however, is clearly a “patient-centered” model of medical care.

Still and the Mayo brothers recognized independently—though, remarkably, less than 300 miles apart and both in isolated, rural communities—that for the medical treatments of their time to improve patient care, physicians needed to recommit to the Hippocratic ideal of focusing on the patient with the disease instead of the disease itself.

In outlining the respective strategies these men used to develop models of patient-centered care, Orenstein notes the impact of the different forms of medical training received by Still and the Mayo brothers. The Mayos, informed by their training as surgeons, adopted an integrated, team-oriented approach to patient care. They continuously added the expanding expertise of other developing specialties while always viewing the patient as the central focus of care; leading to the Mayo Clinic’s longstanding reputation for being “patient friendly.” Still, however, was trained as a generalist and strongly resisted the trend toward medical specialization in both training and practice.

At this early stage, one of the greatest differences between the approaches of the Mayo brothers and Still was to be found in the attitudes and practices at each formal institution with regard to research. From the outset, the Mayo brothers embraced systematic clinical investigation as a method to improve patient care. The Mayo brothers funded early research at their institution by investing a considerable amount of their practice earnings in the endeavor.
A similar dedication to research and commitment in the form of real dollars was neither an established policy nor part of the ethos of the early American School of Osteopathy (ASO).

Early osteopathic physicians typically followed a tradition of preliminary classroom and anatomically oriented education, preceptor-based clinical instruction, solo or small group general practice, and a sanguine acceptance of the wide anecdotal evidence for the efficacy of their unique approach to patient care.3

A brief visit to the two communities and institutions that have gained wide renown through the influence of these men—Rochester, Minn, and Kirksville, Mo—demonstrates the staggering difference in the outcomes of the different paths the Mayos and Still followed.

Orenstein concludes with affirmative suggestions about the lessons the osteopathic profession might take from the Mayo Model of Care, particularly in the realm of pursuing research opportunities.

Calabrese’s Osler
Dr Calabrese takes a similar approach to that of Orenstein, noting interesting historic parallels and differences between Still and Sir William Osler, who remains one of the most highly recognized names in the history of modern medicine. Calabrese effectively chronicles the esteem in which Osler, as a physician, is held—partially based on his socioeconomic background, early education, entry into medical school, expansive European training, and subsequent distinguished career.

Calabrese goes one step further, however, describing the personal qualities and characteristics of Osler, making Osler’s lifelong passionate concern for the combination of academic rigor and medical humanism even more understandable.

Osler was indeed a man of extraordinary intellect and curiosity combined with a powerfully driven work ethic that he was able to maintain throughout his professional career. Calabrese points out a number of interesting personal parallels between Osler and Still, including the fact that both had fathers who were clergymen, both had a commitment to patient care, both held general practitioners in high regard and, finally, both developed critical postures toward the heroic medical practices (eg, bleeding, blistering, and purging) of their time.

The parallels end abruptly here, however. When these personal details are viewed in their proper historic context, the two men actually had more differences than commonalities.

Although their fathers were indeed both clergymen, the backgrounds of Osler and Still in historic context are quite disparate. The rigorous formal seminary education, professionalized pastoral training, and social standing of a Canadian Anglican rector is a far cry from that of a Methodist circuit-riding preacher in the American South. Indeed, the early education and the nature of the pathways to physicianship of Osler and Still could also hardly be more incongruous—and roughly parallel the paths their fathers took in the life of the church.

As in our comparison of Still’s ASO and the Mayo brothers’ institute, an easily demonstrable feature of the disparity between Osler and Still is readily appreciated when one takes an historic view of the famous institutions to which these men are most closely associated.

While Osler’s Johns Hopkins Hospital and Medical School in Baltimore, Md, was under construction—with $7 million of donated money (ie, the equivalent of $140 million in 2005)—Still founded the ASO in a modest, 16 ft by 22 ft frame house by cobbling together money from his personal savings and a bank loan.2–4

Although both men were critical of contemporary heroic medical practices and remedies, Still abandoned their use almost completely. Still also resisted the expansion of the ASO curriculum as advocated by William Smith, DO, and the Littlejohn brothers.5 Although it is also not understood if Still ever accepted the germ theory of disease, he explicitly rejected inoculation and vaccination.3

Osler, though arguably nihilistic about most medical therapies, continued to advocate for the “judicious” use of bleeding and calomel (mercurous chloride), a chalky purgative, throughout his career.4

In addition, as medical educators, Still and Osler could hardly have been more dissimilar. Aside from the scope of their training backgrounds, Still’s style of teaching and writing was circuitous, cumbersome, and liberally sprinkled with folksy analogy and parable.6 Still was almost completely dependent upon the skills of his early British faculty to articulate his concepts in language that most students could understand and accept.6,7

Osler’s erudition in writing and in lecture halls—and his inspired skills at bedside clinical instruction are legendary. Indeed, it makes for an interesting exercise in counterfactual speculation to imagine what Osler and Still’s reactions to one another might have been had they actually met. Based on what we know about these two men, I would assert that such a meeting would have been awkward at best and, ultimately, they most likely would have had little to say to one another.

Drs Calabrese and Orenstein are clear that modern practitioners of osteopathic medicine would be wise to reflect upon the teachings of the Mayo brothers and Osler and to create within osteopathic medicine’s current expansion a culture of investigative curiosity, uncompromising academic rigor, and passionate humanism.

Rogers’ Analysis of Approach
Dr Rogers offers a thoughtful analysis of debates that are current and ongoing within the osteopathic medical profession, offering a provocative challenge with regard to the question of osteopathic distinctiveness.

On an anecdotal level, many osteopathic practitioners know that if one were to ask six osteopathic physicians to define the osteopathic difference, one is likely to receive six different responses. Rogers adds his voice to that of others
throughout the history of the profession, however, in arguing that in spite of a difference of approach to the profession’s fundamental challenge, there are indeed abiding and overlapping philosophical tenets and traditions of clinical practice on which consensus can be reached.

Rogers has described and named the three main approaches leaders and spokespersons for the profession have taken toward osteopathic medicine’s crisis of identity: fundamentalist, traditional, and progressive.

Rogers disputes the fundamentalist view, which he asserts has been generally uncritical of professional claims for distinctiveness, given this group’s belief that a structure-function paradigm and the use of osteopathic manipulative treatment (OMT) are sufficient for establishing osteopathic distinctiveness.

Rather than develop a culture that fostered interrater reliable findings and consistently reproducible improvements in patient-care outcomes, those with a fundamentalist view of osteopathy have sometimes settled for expansion of technique based on uncritical acceptance—and at times even on the charismatic appeal of personalities—contributing to delays in developing consensus on the use of specific osteopathic terminology.

Dr Rogers’ identification of the progressive position includes those both within and outside of osteopathic medicine attempting to promote what they believe is a more comprehensive view for the profession’s future.

However, Rogers’ case for the further elaboration, clarification, and refinement of the traditional view is convincing. The traditional viewpoint is one that argues that OMT in and of itself has never been the exclusive defining feature of osteopathic medicine—although it is its most obvious and concrete methodology.

Inclusive in this philosophical distinctiveness are tenets that include, but are not limited to, emphasis on the care of the “whole person,” disease prevention, promotion of health and fitness, and an understanding of the major role of the musculoskeletal system in health and illness.

Rogers is among a number of thoughtful and reflective osteopathic physicians who have been engaged in efforts to further elaborate the traditional viewpoint and place it before the profession for further scrutiny. He expresses concern that these efforts have not generated more vigorous discussion and debate both within and outside the profession.

The unifying feature of Rogers’ analysis with the pieces written by Drs Orenstein and Calabrese is Rogers’ challenge to create within our expanding profession a culture that embraces research and systematically demonstrates the efficacy of our distinctive form of medical care using outcome-based studies.

Rogers’ most important point is that the further implementation of our philosophy to advance our treatment goals is necessary—but it is still not sufficient on its own to support continued claims of distinctiveness.

The purpose of the refinement and articulation of osteopathic philosophy in documents such as the 2002 Proposed Tenets is expressly to inform and guide how the profession develops more sophisticated and distinctive diagnostic and treatment modalities.

Rogers also provides important recent public health data that are sobering with regard to general health status within the United States. As a cardiologist, Rogers is especially qualified to point out the numerous overlapping risk factors so prevalent in our society, factors that make cardiovascular disease the greatest threat to mortality and morbidity for the foreseeable future. Basic science research has demonstrated that muscular activity itself controls the expression of a number of genes involved with several of the risk factors discussed by Rogers.

Truly, the best opportunity for the osteopathic profession to prove its claim of distinctiveness lies in the opportunities provided by these public health data.

Opportunities abound to systematically test the outcomes of osteopathic care compared with conventional care in randomly assigned, double-blind clinical trials for a range of chronic illnesses.

Dr Rogers acknowledges the recent establishment and efforts of the Osteopathic Research Center at the University of North Texas Health Science Center at Fort Worth—Texas College of Osteopathic Medicine, but begs the question, “What about the other 20 osteopathic medical schools?”

Other arenas ripe for robust osteopathic medical research involve the educational and social sciences.

Comment

It is clearly within the capabilities of the osteopathic medical profession to continue testing the nature of specific physician-patient interactions, which are widely considered to be a distinctive feature of osteopathic care.

Imagine the added support to our claim of distinctiveness if it can be consistently demonstrated that osteopathic physicians address broad issues of prevention and health promotion more often than do allopathic physicians during patient interactions. Imagine also what it would mean for the promotion of our profession if independent reviews of clinical outcomes data of matched samples of patients of osteopathic and allopathic physicians revealed consistently superior results for those receiving osteopathic medical care.

Dr Rogers challenges osteopathic physicians regardless of their specialty orientation to take immediate advantage of the opportunities to deliver patient care consistent with long-established osteopathic tenets and to develop methodologies to test these clinical outcomes.

The call for the development of a culture of research within the osteopathic profession is not new. What the three authors in this special focus issue of JAOA now emphasize is the urgency with which the profession must address and positively respond to this unresolved issue.
The most challenging barrier to the profession’s ability to conduct useful outcomes-based research today is just how we might expeditiously remedy more than a century of neglect.

Prevailing explanations about the osteopathic medical profession’s uphill political struggles to survive, economic disadvantages, and social invisibility because of its traditional emphasis on general practice are true and accurate—but only to a point.

Given the explosive expansion of the profession since the early 1970s—especially with the development of osteopathic medical colleges by large state-funded universities—these explanations have become excuses. The remarkable successes of the osteopathic medical profession over the past 40 years—especially as seen in the high quality of osteopathic graduates—are beyond dispute. These graduates have found themselves in increasing numbers being recruited into competitive graduate medical training programs and assuming positions of importance in many respected allopathic institutions.

The question remains, however: To what extent is the distinctive osteopathic identity alive, well, and clinically demonstrable?

Cultural shifts are indeed difficult to initiate, but the expeditious development of a healthy culture of continuous critical inquiry within our representative educational and training institutions is vital to resolving the lingering questions about osteopathic distinctiveness and the so-called “paradox of osteopathy,” for which this special focus issue of JAOA is named. Isn’t it time we take this challenge seriously?

References


