

Going global with osteopathic medicine

Exciting new opportunities are presenting themselves to our profession today. Once again, I was in Geneva this spring as a delegate to the World Health Assembly, during which time I had the opportunity to speak with the various international organizations based there—and to explore our potential for involvement and collaboration. We have the chance to work with organizations such as the United Nations High Commissioner for Refugees in both a clinical and advisory capacity, if we so desire. Amongst other things, the American Osteopathic Association (AOA) has the opportunity to be a broker of services in making the introductions between our philanthropic organizations, specialty colleges, and academic institutions and the key international players.

But while this is all very glamorous, what is in it for us? Why should we invest the time, money, and effort? We have problems of our own to consider. For that matter, after more than 100 years as a profession, we are still trying to put an end to that annoying question, “What is a DO?” To add to the frustration, if you read the October 2000 issue of *The DO*, it sounds like we ourselves know less and less the answer to that question. So, altruism and warm, fuzzy feelings aside, how does going global strategically further our profession?

Does going global unite our profession?

Going global means taking a high-profile stance and doing things that are newsworthy. There is no better publicity than Tom Brokaw or Bernard Shaw reporting about the exciting new breakthrough in the treatment of malaria, made by the researchers at Ohio University College of Osteopathic Medicine today, in collaboration with their colleagues in Peru and at the World Health Organization (WHO). How about that CNN World Report affiliate in the Dominican Republic interviewing Anthony J. Silvagni, PharmD, DO, about the joint telemedicine project between Nova Southeastern University College of Osteopathic Medicine and Universidad Central del Este in providing medical education. When I hear a story like that about a school I went to, it makes me proud. Traditionally, our institutions have not been engaged in such projects and research to the same degree as our allopathic counterparts. As a result, many of our finest scientific minds have “left the profession” to work and teach at the various ivory towers. We can not blame them or call them disloyal—we simply have not had anything to offer them or with which to challenge them. And there is no incentive to join or participate in any organization unless there is a perception of personal value added.

International projects and research are a high-profile way for us to add value and pride in our profession, to strengthen the resolve of those already participating, and to recruit back to the profession those who have had to leave—not to mention the fact that it is free publicity for our profession to the public and world at large. If nothing else, it provokes the question: Who are these doctors? Obviously, they are on the cutting edge of medicine. Are there any of them around here? When patients walk into your office and recognize the name of the school on the wall, they will no doubt make some positive comment like, “Oh that’s a good school,” not because they know anything about medicine, but they have a positive association with the name. Politicians understand the value of name recognition. It is time we get our name in the news. When osteopathic physicians begin to see that the AOA and our osteopathic institutions are, with friendly aggression, moving the profession forward and adding to *their* value, we will no longer have to plead for the funds to do it.

Maturing as a profession

Going global is an opportunity for us to mature as a profession. For the first time, international health and development organizations are calling for new ideas and concepts in medical practice and healthcare delivery. Primary care is at the forefront of developmental theory in healthcare. Unfortunately, outside the United States, understanding of this concept is poorly developed and is a theoretical knowledge at best. Because we have a comparative advantage in this area, this represents a great opportunity for osteopathic medicine to distinguish itself in the world healthcare arena. We have the opportunity to be invited to participate in sociopolitical conferences like the Beijing Women’s Conference to speak and/or present position papers on the health issues to be discussed. Wouldn’t it be great to see one of the television networks interviewing our delegation regarding the ideas we presented? Do we want a voice in world health politics?

Sending a delegation is the chance for our profession to meet, greet, and influence the officials and contacts within the various ministries that we need for the projects already under way and those on which we would like to be working. Let us train and build our own diplomatic corps who understands the development jargon and is savvy enough to negotiate for the profession. In the process, we can spread the word about osteopathic medicine and the American DO.

Now we are somewhat limited by the fact that we are a

strictly an American organization. As you may know, the Council on International Osteopathic Medical Education and Affairs is working with the Caribbean Medical Council and is meeting with the Pan-American division of WHO. However, the structure of the AOA as a US-based, US-oriented nongovernmental organization composed of individual members will weaken our negotiating position as we strive for official relations and global recognition in healthcare. International organizations such as WHO, International Red Cross and Red Crescent, and the European Union prefer to associate with other organizations of like nature. They prefer international nongovernmental organizations with a federated structure made up of national or regional groups, or at the very least, having the majority of members from different countries.

Therefore, what is needed—and expected—is a World Federation or World Congress, if you will, of Osteopathy and Osteopathic Medicine. I include both *Osteopathy* and *Osteopathic Medicine* because DOs around the world are not alike. So it becomes essential for us to have what strategic marketing folks call a clear “brand identity.” Rather than trying to change world understanding of the osteopathic establishment, let us build on it! What we need is to identify the concept of “osteopathic medicine.” Rather than alienating our greatest allies in this endeavor, let us work with our colleagues in osteopathy. Let us use this synergism in marketing both aspects of the profession.

One of the classic examples of using synergism in advertising was the campaign by Hershey’s in marketing Mounds and Almond Joy. When the company struck on its now famous catchy jingle, its marketing problem was solved. And even 20 years since the jingle was last used, when a consumer sees one candy bar, he automatically thinks of the other and remembers the difference. Perhaps most important, he still bases his purchasing decisions on that information. Rather than worldwide competition, let there be distinction and enhancement between the osteopathic and osteopathic medical professions. Going global under this umbrella will allow us to maximize our impact, adding to our negotiating power in approaching international organizations, influencing policies and procedures, negotiating agreements, establishing terms of partnership, and identifying potential areas of joint activities.

Institution building

Another reason we may wish to enter the international arena is the opportunity to build our osteopathic institutions and academic centers. This is closely tied to the first point I mentioned: our taking a high-profile stance.

Our institutions may wish to become official “WHO Collaborating Centers” and involve themselves in various WHO high-priority research projects around the world. The collaborating center designation will no doubt add to the stature and prestige of the school receiving it. Besides research opportunities, we may want clinical affiliations overseas so that we will have training opportunities for our own students in environments with diseases rarely, if ever, seen in the states. Practicing in the developing world puts a new spin on the concept of rural health care and diagnosis.

Perhaps most important from an administrative standpoint, there is money in international development consulting and in the proposal- and grant-writing process. If the participants are familiar with the process, it can be profitable for the institutions involved. Emory University and the Centers for Disease Control and Prevention typically charge 60% and 40% overhead, respectively, on the total value of any project. This gives them the freedom to hire additional consulting talent and professional staff to get the job done right. Make no mistake: these professors also have teaching responsibilities and are expected to initiate other proposals and seek out additional grant money. The resources are then available to build the special institutes, research facilities, and other needed infrastructure to support that effort. This is how the ivory towers are built and maintained. Why not build our own ivory towers? While the specifics of the process are outside the realm of this article, we are certainly capable of doing it. The bottom line is that the more prestige we add to our institutions, the easier it will be to recruit the best researchers, teaching staff, and choicest students.

Future of osteopathic medicine

I want you to expand your mind for a moment and consider this with me. It is 15 to 20 years from now and we have done all of these things. We made the commitment and moved the profession into the global arena. The Federation is in place and we have good relationships with all our international osteopathic colleagues. The AOA, our specialty colleges, our educational institutions, and our individual physician members are all steadfastly united. Each of our academic institutions is now an ivory tower. We have ongoing projects, collaborative efforts, and joint ventures all over the world. We have the connections to do anything, anywhere, and the financing to do so is readily available—or subject to minor delays at worst. We have the highest respect from our medical colleagues here and abroad, and the public no longer asks, “What is a DO?” They now know we are really bright doctors.

I propose to you that even when we reach this point, if

this is *all* we do, we will not have truly succeeded. What will we have added that will be uniquely different? What will distinguish us?

Manual medicine is currently practiced in various places and to various degrees around the world. Perhaps it is not quite as integrated a curriculum as we have made it, but can it be much longer before it is? The University of Arizona began an alternative medicine residency approximately three years ago that teaches its residents manipulation. The University of New Mexico School of Medicine is currently offering continuing medical education in myofascial release.

Remember, it is 20 years from now. The baby boomers are retiring. There is a smaller population base working to support the entitlement programs needed. People are living longer, but chronic diseases and comorbidities still abound. What will the practice environment be like? By now, some of you are saying to yourselves, "I am glad I will not be practicing medicine then. It is tough enough getting authorization for things now, by then it will be a nightmare." Maybe you are hoping to be one of those retirees, and hoping that perhaps somebody somewhere will have finally figured out something that works with regard to healthcare.

Consider this—when A.T. Still began digging up those old Indian graves to study the musculoskeletal system, it was because he knew that the leeches and most of the other "medicines" of his day were useless, if not harmful. He was searching for a *better method of practicing medicine*.

Do we practice medicine better because we are osteopathic physicians?

A study from the 1996 Colorado Workers Compensation Claims shows medical costs for musculoskeletal injuries by providers—be they nonsurgical allopathic physicians, allopathic surgeons, osteopathic physicians, or chiropractors. This study demonstrates that osteopathic physicians are the most cost-effective providers of healthcare. There are a small handful of studies like this. What if in the process of building our ivory towers, we mandate studies like this to compare the cost-effectiveness of osteopathic medicine across the spectrum of diseases? What would it do to our credibility if we found out this was true across the spectrum of diseases and we indeed are the best providers of healthcare? Would insurance companies and managed care organizations be giving discounts to patients of osteopathic physicians? If we are not as good as we need to be in certain areas we would have solid evidence of where we need to beef up our undergraduate, postgraduate, and continuing medical education programs.

Now let us take this one step further. What if we con-

tinued this analysis across the spectrum of disease, working with the assistance of our colleagues across the industrialized world? While there is a certain level of care that makes a country industrialized, there are cultural biases that affect the way we practice medicine. While we spend more money per capita on healthcare and two to three times as much as the next most expensive industrialized country, the Netherlands, we ranked No. 24 in overall attainment of health and No. 37 in overall health system performance. There are definitely areas in which we have room for improvement. We need to examine who has the best patient outcomes, who gets the patient well the quickest. Then, among those with similar outcomes, who is the most cost-effective and why—looking at length of stay, treatment protocols, resources used, ancillary services, home health, etc. Now what if we made recommendations based on our studies and integrated those best practices into our medical school curriculum and medical education programs? We would truly be integrating the healthcare system with patient care. We could publish this information on our Web site or whatever the latest technology of the day is. Instead of having our patients held hostage by the actuaries that dictate managed care, we would empower our physicians with the statistical evidence to demand the resources needed to treat their patients properly.

According to its mission statement, the AOA is to advance the philosophy and practice of osteopathic medicine by promoting excellence in education, research, and the delivery of quality, cost-effective healthcare in a distinct, unified profession. This is our opportunity to meet the ultimate mission of the AOA.

The bottom line *is* the bottom line. I propose that if we do this, every medical center worth its salt around the world will be beating a path to our door to find out what it takes to become an osteopathic medical institution, because the osteopathic medical profession has realized and actualized the concept of physician-driven continuous quality improvement in healthcare.

We *can* revolutionize healthcare delivery! The public and world is paralyzed by fear, desperately looking for solutions to the crisis in healthcare, and they are terrified that there may be none. We have the answer! The opportunity awaits us. And more than any other group, we, as physicians, have the moral obligation to take our rightful position to lead and direct the Quality Revolution! Yes, going global will take time, money, commitment, and a lot of hard work from everyone involved to make it a reality. And perhaps there would be some that would think it just too long a process, but what is the alternative? In the words of my grandfather, "Too

Editorial continued

often people limit themselves from achieving the ultimate success in life they might have had, because they think it will take too long to get there; and so they settle for far less.”

We have the talent pool—medical schools, universities, schools of public health, business and health administration programs, and more than 45,000 physicians in practice. (On hearing this, one of the Assistant Director-Generals at WHO commented, “That’s more than most regions of the world!”) We have the resources to grab hold of the vision and carry it on to victory.

We can not and must not be fainthearted in seizing the opportunity to establish the osteopathic medical profession as the “standard of care” by which the world measures all others. Let us join hands in the spirit of A.T Still and find a better way to provide healthcare for the world in our day!

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