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Is History Repeating Itself?

JOCKEYING FOR PROFESSIONAL ACCEPTANCE, PART 1

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Here in the U.S., Oriental medicine is jockeying for professional specialty acceptance. This is not an uncommon process, as history provides a glimpse of repeating patterns. The historical relevance to this modern-day situation comes in the wake of skyrocketing medical costs, an increase in chronic public health issues and, more importantly, competition for the same patients.

Oriental medicine is the fastest growing CAM therapy due to its cost-effectiveness and decreased side effects as compared to the current pharmaceutical mainstream. This issue alone is crucial and propels Oriental medicine to the forefront from a financial perspective. It's also a reflection that the public is turning away from the complacency, distrust and tradition-instilled academic dogma within mainstream medicine. Change truly is on the horizon, not only in terms of how Oriental medicine is viewed from the outside, but also within our own profession with regard to current educational standards and fragmented unity.

If we are going to survive this transition and secure our place as a medical specialty, we really need to learn from history - the mainstream medical community has and will continue to pursue our scope of practice animatedly. History is repeating itself: homeopaths, osteopaths, chiropractors and naturopaths have all faced this exact dilemma. All were ostracized as incompetent by way of educational standards, and their respective academic philosophies differed from the popular and accepted medical belief system of the time period. Ironically, these patterns have not changed - just the faces, topics and conveniences of the generation/time period (particularly academically, socially and monetarily).

Academic arrogance has been a part of medicine on multiple levels since its beginnings in the U.S. Let's backtrack a bit and look into the historical relevance of the establishment of organized medicine, starting with a frame of reference: the first English colony, established in the U.S. in 1607 at Jamestown. Medicine primarily was carried out through medical practitioners (gentlemen and scholars), barber surgeons (usually had a stable income doing something else), apothecaries (trained by apprenticeship and in hospitals, but generally sold drugs; also considered general practitioners) and lay practitioners (folklore). Formally trained physicians from England primarily treated the wealthy and upper class here in the states.

The colonies grew in the early part of the 18th century and medical status distinction overlapped considerably, to the point of confusion and nonexistence. Most practitioners during this period were either multi-credentialed or had a good-quality folklore background; others had credentials based upon reputations for results or "cures" (clinical results) that were more established in confidence and trust, rather than academically. The time period also predisposed people to rely on treating themselves, and only in emergencies would they get medical help.[1]

A variety of "healing schools" started to emerge to try and create some structure and organization in the emerging chaos taking place during this era (called "growing pains") as more and more

colonies evolved. The American collegiate curriculum was established in 1795. This was the first medical curriculum; it was located in Philadelphia, with primarily European-trained scholars. As expected, all of the first colleges were located on the East Coast as more and more "boat people" started to occupy territories. The increase in health practitioners concentrated in a single area created expected disagreements that erupted between the different schools of thought and between physicians formally trained in the European universities versus those who were apprentice trained.[1]

The various views and educational directions of the different healing schools created a great deal of situational complications and confusion, particularly between the 18th and 19th centuries. In this era, the growth of medical schools had escalated without any regulation mandating that medical practices adhere to legislative regulations or standardization, and they all competed fiercely for students.[1,2] All the medical schools were just developing, trying to standardize disciplines and professions, basically jockeying for professional acceptance through regulation of curriculum and educational standards - with varying views of acceptance.[2]

Many of these schools started as programs termed "adult medical departments" in already established colleges and universities. These schools allowed their institutional name for degree-granting purposes in return for student recruitment and university financial gains, which created a "win-win" situation. However, the largest part of the escalated school population was comprised of independent proprietary schools, what we call private postsecondary (trade) schools today.[3] The huge profit margins gained for these institutions by providing shorter academic programs pretty much holds true in the 21st century. Historically, the trade schools, even amid turmoil, have managed to graduate superior clinicians compared to the system in place during the process. As mentioned earlier, the competition for student enrollment created a trend during this time whereby many schools waived entrance and exit requirements. Another reflection of this time period was seen at Harvard. A gentleman named Charles Eliot wanted to establish written exams for medical degrees. However, the medical school's director opposed this because a majority of the medical students in the program could not write.[2,3]

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As licensing boards started to sprout (approximately 1880-1910), they regulated not only the medical profession, but also the schools. This process started weeding out competition. The more prominent schools, such as John Hopkins University, were extremely influential.[4,5] According to the 1910 Flexner report, sponsored by the American Medical Association, "any discipline that didn't use drugs to help cure the patient was tantamount to quackery and charlatanism. Medical schools offering courses in bioelectric medicine, homeopathy or Eastern medicine, for example, were told to either drop these courses from their curriculum or lose their accreditation and underwriting support. A few schools resisted for a time, but eventually most schools fell in line or shut their doors."[4]

The success of the Flexner report was based upon comparative educational standards. "Flexner insisted they deserved to be held to the same standards."[4,5,6] Thus, this report demonstrated that many of the schools' standards were, at the time, substantially lower than that promoted by the AMA standards.[4,5,6] From this point forward, the rules were established - the territorial line of

academic "trust" recognized conventional medicine as the American Medical Association prevailing as the "holy grail," academically and clinically. However, this was not without challenges.

Two health care professions that challenged the AMA to drive an end to professional discrimination were the osteopathic and the chiropractic professions. During the 18th century, both were establishing themselves as pioneering medical professions. Both professions also were caught up in the AMA's mistrust of anything not understood as the accepted "norm." The osteopathic profession was conceived by A.T. Still in 1874; of course, his viewpoints were not accepted and he was labeled irrational and a quack. But his beliefs were strong and persistent, and by 1897, he had established the American Association for the Advancement of Osteopathic Medicine, which became the American Osteopathic Association (AOA) in 1901. In 1876, the first licensing legislation was passed in Vermont. The Flexner report anticipated the elimination of osteopathic schools. However, with quick thinking and by anticipating the next play, the opposite happened. Through a series of internal revolutions, the AOA brought its surviving schools in line with Flexner's recommendations, both validating the profession's claims to independent equality and ensuring its continuance in the future.[2,3,4]

The Flexner report introduced the concept of minimum requirements for school admissions to medical schools (high-school diploma and two years of college/university-level science); recommended medical school for four years (two years science and two years clinical); and changed the structure for the financing of medical education, because the cost of satisfactory training was too high for most stand-alone institutions. (Flexner suggested the closure or incorporation of "proprietary" schools into universities.)[4] Formal recognition was not established until the 1950s through a landmark court decision, which said doctors of osteopathy (DOs) could practice in public hospitals and be recognized as physicians in Audrain County, Mo. This set a precedent and more hospitals began opening their doors to DOs on a state-by-state basis. However, mainstream status was not granted until 1952, when the osteopathic profession was accredited.

During this same time period, osteopaths served in two wars and were drafted, but not recognized, as medical officers. The osteopaths were able to get a hearing before the U.S. Senate through the Armed Services Subcommittee. It was not until 1967 that DOs were accepted as equals to MDs in the military, approximately 10 years after the fact. Each state had legislative recognition of some form for DOs. It was not until six years later that DOs finally gained the right to have a full practice. By 1998, after a four-year transition period, professional licensing requirements evolved into osteopathic postdoctoral training institutions (OPTI), as opposed to residencies and internships.[7] Currently, curriculum emphasis in most osteopathic schools is identical to conventional medicine standards, with additional education in musculoskeletal diagnosis and training.

Chiropractic faced this same dilemma, but the challenge from the medical profession was much more brazen. Daniel David (D.D.) Palmer developed chiropractic in 1895; the first school opened in 1897. Palmer's son, Bartlett Joshua (B.J.) Palmer, carried on his father's legacy in 1913, making chiropractic a licensed profession 17 years after osteopaths achieved licensure. Chiropractic had its first association, called the International Chiropractic Association, in 1926. B.J. Palmer died in 1961. It was at this time that the AMA established the Committee on Quackery in order to discredit the profession, and by 1966, it had mandated that the communication with "unscientific practitioners" in any form by medical doctors was unethical, basically labeling chiropractic an "unscientific" cult. This professional alienation was fierce, denouncing chiropractic as quackery even within the academic curriculum.

Four years later, in 1976, hospitals that allowed doctors of chiropractic (DC) to be on staff were rescinded their accreditation from the Joint Commission on Accreditation of Hospitals. This professional boycott provoked a group of DCs, headed by Chester A. Wilk, to challenge the AMA, the American Hospital Association, as well as others, for conspiring to eliminate DCs in this fashion, saying it was a violation of sections 1 and 2 of the Sherman Antitrust Act. In 1987, the AMA was charged with professional boycott and a permanent injunction was put in place that prevented the AMA from excluding its members from associating with DCs. Of course, the AMA appealed this decision.[9] It also should be noted that the premise of the AMA in court was concern over a lack of the scientific method used for patient care. The court decision mentioned that the AMA and the Committee on Quackery identified some evidence that they also were motivated by economic concerns. It was not until 1990 that the AMA lost its appeal in the U.S. Court of Appeals.[10] A position paper written shortly after this decision and presented by the American College of Surgeons recognizes that the medical and chiropractic professions are seen as working together. This curbed public attacks on chiropractors from the AMA.

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