Unit 2: Osteopathic medicine's experiment at Los Angeles County General Hospital

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This essay is one of two second-place winners in the AOA Bureau of Osteopathic History and Identity's 2008 essay competition. This essay explores the 12th principle of the bureau's "Core Principles for Teaching the History of Osteopathic Medicine." That principle focuses on the development of the osteopathic hospital system and the importance of osteopathic hospitals in shaping DOs' practice and identity.

The bureau encourages all contestants in its annual competition to submit their entries to the AOA for consideration by *JAOA—The Journal of the American Osteopathic Association* and *The DO.*

To further the learning objectives the Bureau of Osteopathic History and Identity envisioned for the essay contestants, essays that are accepted for publication are subjected to editing to bring them into adherence with AOA publications' guidelines. In addition, the authors are asked to review and comment on the edited versions of their essays before they are published.

"Having my essay published in *The DO* was a great experience," notes Dustin Colegrove, OMS IV, the author of 2008's other second-place history essay, which was published in *The DO's* April issue. "With the encouragement and ideas of the AOA's editorial staff, the essay was further improved and refined, causing me to delve even deeper into the profession's history. The essay has definitely transformed into a publishable work, and seeing the final result is remarkable."

Abstract

This essay tracks the challenging journey of Los Angeles County Osteopathic Hospital in Los Angeles, as well as the implications of that journey on the evolution of osteopathic medicine's identity.

The osteopathic medical profession's move toward broad treatment of patients with drugs and surgery was one of the main reasons for the development of osteopathic hospitals. Another critical reason was constant discrimination from allopathic hospitals and the American Medical Association. Los Angeles County Osteopathic Hospital had the unique opportunity to demonstrate the distinctive care provided by osteopathic physicians because their outcomes were compared against those of their allopathic counterparts in the MD unit of Los Angeles County General Hospital.

County hospital patients were randomly divided between the osteopathic and allopathic units, with every 10th patient being admitted to the osteopathic unit. Data gathered from 1928 to 1933 indicate that the mortality rate and average length of stay were consistently less in the hospital's osteopathic unit than in its allopathic unit.

Considering these data, the osteopathic medical profession can currently be a driving force for improving patient care by incorporating osteopathic principles and practice into hospital settings.

The osteopathic medical profession is currently experiencing a time of rapid growth with the development of new medical schools and increasing class sizes. A total of 25 osteopathic medical schools will be accepting students in 2009.[1]

However, a large percentage of students currently entering osteopathic medical schools will serve allopathic residencies after they graduate, and the majority will not use osteopathic manipulative treatment when they enter practice.

Data on DOs who graduated in 2005 indicate that 44% matched through the AOA Intern/Resident Registration Program, better known as the AOA Match.[2] With the majority of new osteopathic physicians training in allopathic residencies, it is likely that they are being trained like their allopathic colleagues and that they are not perceiving much of a difference between the two professions. If these DOs do not perceive a difference, they are unlikely to provide unique care. This, in turn, impacts the quality of healthcare by creating a lack of significant competition, which is a force that can drive medical progress.[3]

The current biomedical model supports treating patients with high-cost technology and multiple drugs—approaches that have driven the healthcare system into a financial crisis. The distinctiveness of the osteopathic medical profession lies in its support for examining the neuromuscular system and applying manual modalities to improve the body's self-healing mechanisms. These distinctive methods have the potential for decreasing costs and improving outcomes.[4]

As the osteopathic medical profession grows, understanding its past can

help us meet and overcome new challenges. Studying the past can also help us develop appropriate strategic initiatives, add to the distinctiveness of the profession and improve the quality of care provided to patients.

Hospitals influenced profession's identity

One of the means the osteopathic medical profession has long had for being a positive force in patient care is incorporating osteopathic principles and practice into hospital settings. Unfortunately, the assimilation of osteopathic physicians into allopathic hospitals has fostered a reductionist approach to treating patients among osteopathic physicians, as well as a change in professional identity to the point that osteopathic physicians are barely distinguishable from allopathic physicians.

The reasons behind the development of osteopathic hospitals hold many clues as to how osteopathic medicine's identity developed, as do the actual practices taught in those hospitals. Los Angeles County Osteopathic Hospital in Los Angeles played a key role in the evolution of the profession's identity because it was the first osteopathic county hospital in the country and because it provided extensive clinical experiences for osteopathic medical students, interns and residents.

In the late 19th century and early 20th century, many osteopathic physicians were drugless practitioners who mainly practiced OMT under the premises put forth by Andrew Taylor Still, MD, DO.[5] Dr Still was a major proponent of relying on natural healing and enhancing the body's self-healing capabilities through manual treatment. He accepted surgery as a valid last-resort modality for treating patients,[6] but he was against using pharmacologic medicines, which he considered to be "poisons."[5]

During Dr Still's lifetime, some of his students moved away from this strict approach and embraced a broader approach that included surgery, medication, vaccinations, and—among some DOs—other healing systems, such as naturopathy and homeopathy.[5,6] In some states, osteopathic physicians had licenses to prescribe drugs and perform minor surgical procedures, and a number of these DOs practiced in small, private hospitals that had beds for minor surgical procedures.[7]

"Unit 2 fostered tremendous growth in osteopathic graduate medical education and paved the way for equality with allopathic medicine."

When educator Abraham Flexner examined eight osteopathic medical schools in 1909, he found that few had hospitals or associations with hospitals.[7] What was then the American School of Osteopathy in Kirksville, Mo, had a 54-bed hospital, which had 20 beds in wards that were used primarily for surgical patients.[7] The Pacific College of Osteopathy in Los Angeles had 12 to 15 surgical and obstetrical beds, but they were not used for acute cases.[7] The Littlejohn College and Hospital in Chicago had a 20-bed hospital that was mostly used for surgical patients.[7]

As the osteopathic medical profession evolved and came to embrace pharmacology and germ theory, it sought equal rights with the allopathic medical profession, and DOs began to practice like MDs. The profession's move toward broad treatment of patients with allopathic medicine became one of the main reasons for establishing osteopathic hospitals.

Los Angeles County Osteopathic Hospital opened in 1928.[5] Many other osteopathic hospitals opened in the early 1930s.[6] In 1934, the American Osteopathic Hospital Association was established.[6]

As osteopathic physicians adopted contemporary scientific thought on health and disease, that thinking began to be incorporated into osteopathic medical education. This contributed to the development of osteopathic hospitals because osteopathic medical colleges needed hospitals as training sites for teaching stu-

During the AOA Bureau of Osteopathic History and Identity's meeting at the AOA's 2008 convention in Las Vegas, Kim Armenta, OMS V (left), receives a second-place award for her entry in the bureau's 2008 essay competition. Presenting the award to Armenta is the bureau's chairman, William T. Betz, DO.

Seven months later, Armenta earned her DO degree. (Photo by Michael Fitzgerald)

Early data compare Unit 2 against Unit 1

After Unit 2 of Los Angeles County General Hospital opened on Feb 16, 1928, the county hospital began collecting data on the new osteopathic unit. The data below compare the performance of Unit 1 during its first 135 days against the performance of Unit 2 during the hospital's entire 1927-28 fiscal year.

Fiscal year 1927-28	Unit 1	Unit 2	Unit 1 and 2 combined
Number of patients in each hospital unit on July 1, 1927	1,226	0	1,226
Number of patients admitted, including births	25,451	792	26,243
Number of babies born	1,512	95	1,607
Number of patients who died	2,712	65	2,777
Number of patients discharged	22,762	576	23,338
Number of patients remaining on June 30, 1928	1,203	151	1,354
Number of patients treated at each unit's clinic	161,598	5,769	167,367
Total number of patient days	455,432	12,028	467,460
Average number of patients in each unit per day	1,244.35	89.09	1,333.44
Average days until discharge, including death	17.42	13.56	17.35

Source: *Sixth Annual Report of Unit 2 (1932-33).* Located among the Louis C. Chandler papers and manuscripts (1895-1970) in the special collections at the Western University of Health Sciences College of Osteopathic Medicine of the Pacific, Pomona, Calf.

dents the contemporary, broad-based care that an increasing number of osteopathic physicians were using.

Early on, the California osteopathic medical schools adopted many of the same requirements as did allopathic medical schools. The Los Angeles College of Osteopathy, which opened in 1905, was the first osteopathic medical college to incorporate *materia medica* into its curriculum.[7] The College of Osteopathic Physicians and Surgeons (COPS) in Los Angeles, which was created in 1914 with the merger of the Los Angeles College of Osteopathy and the Pacific College of Osteopathy, required prospective students to take premedical courses in physics, chemistry and biology. In addition, COPS required its students to take the same number of hours in pharmacology as did allopathic medical schools.[8]

Other topics shared by both osteopathic and allopathic medical schools were anatomy, physiology, pathology and psychology. However, only the curricula of osteopathic medical colleges included manipulative therapeutics.

As the education of osteopathic medical students came to parallel that of allopathic medical students, it was natural that hospitals became necessary for teaching osteopathic medical students their skills.

Discrimination sparks change

Another critical reason why osteopathic physicians developed separate hospitals was discrimination by allopathic hospitals and the American Medical Association.

Clement A. Whiting, DO, from the Pacific College of Osteopathy applied for privileges at Los Angeles County General Hospital in 1910.[9] His application was rejected. In a letter submitted to the Los Angeles County Board of Supervisors on Aug 1, 1910, a committee of the Los Angeles County Medical Association warned that if osteopathic physicians were given privileges at the hospital, allopathic physicians and surgeons from institutions of better quality would not remain at the hospital and the hospital would lose "well-educated internes."[9] The most serious opinion expressed by the committee was that osteopathic physicians would endanger the county's patients.[9]

Later that same year, Dr Whiting applied to treat a patient at the hospital who had specifically requested to be treated by an osteopathic physician, and again Dr Whiting was rejected.[9] The MDs at the hospital were very suspicious of what osteopathic medicine entailed, and they assumed that osteopathic medical schools were not of an appropriate level of quality to justify their graduates practicing alongside the MDs at the county hospital.

World War I brought a brief respite from discrimination at Los Angeles County General Hospital. Although DOs tried valiantly to assist in treating military personnel during the war, the military would not commission them as medical officers or otherwise remove restrictions against osteopathic physicians treating US soldiers, sailors and Marines.[10] This discrimination on the part of the US military in fighting a war overseas turned to the DOs' advantage at home. While the military rejected DOs, it conscripted their allopathic counterparts, effectively decreasing the number of MDs at such institutions as

Unit 2 collected data separately from Unit 1

The following data on Unit 2 cover Los Angeles County General Hospital's fiscal years 1929-30 to 1932-33.

Among the most impressive data regarding Unit 2 are statistics on length of stay. "Average bed-days per patient" were 12.75 days in Unit 2 compared with 16.60 in Unit 1 in fiscal year 1929-30; 11.84 in Unit 2 and 16.00 in Unit 1 in fiscal year 1930-31; 9.70 in Unit 2 and 17.30 in Unit 1 in fiscal year 1931-32; and 9.73 in Unit 2 and 15.80 in Unit 1 for fiscal year 1932-33.

The county hospital stopped separating the data for Unit 2 and Unit 1 in 1934. After that, the hospital combined the data for both units.

Unit 2	1929-30	1930-31	1931-32	1932-33
Applications for admission	7,294	9,863	12,984	16,476
Patients cared for on wards	4,960	6,764	8,633	9,234
Daily average number of ward patients	140.04	177.06	195.27	210.36
Rate of bed-space occupancy	85.39%	107.90%	119.10%	128.27%
Births	357	823	1,196	1,419
Discharges, including deaths	4,008	5,624	7,425	8,046
Mortality rate, including newborns	5.94%	5.56%	5.36%	4.48%
Average bed-days per patient	12.75	11.84	9.70	9.73
Autopsy rate for patients who died	57.56%	64.89%	71.86%	71.19%
Surgical procedures	1,860	3,577	4,950	6,542
Outpatient department visits and treatments	51,889	65,498	90,968	116,181
Physiotherapy treatments	27,096	36,661	37,735	39,218
Laboratory tests and determinations	43,341	51,030	60,777	68,870
Roentgenological findings	19,264	21,438	20,556	22,593
Held in outpatient department	2,508	3,013	4,573	6,932
Placed on wards	3,320	4,446	6,101	6,701
Referred to other institutions	1,476	2,404	2,310	2,843

Source: *Sixth Annual Report of Unit 2 (1932-33).* Located among the Louis C. Chandler papers and manuscripts (1895-1970) in the special collections at the Western University of Health Sciences College of Osteopathic Medicine of the Pacific, Pomona, Calf.

Los Angeles County General Hospital.

In 1916, Los Angeles County General Hospital accepted four COPS graduates as interns.[9] By 1919, 10 of the hospital's 31 interns were COPS graduates.[9] DO graduates continued to obtain training as interns at Los Angeles County General Hospital through 1921.[9]

As soon as MDs returned home from the war, trouble began again for osteopathic physicians. In 1919, Neal Narramore Wood, MD, the hospital's first assistant superintendent and the county's first assistant superindendent of charities, received a letter from the AMA threatening to rescind the hospital's accreditation if it kept DOs as interns.[9]

California's board of medical examiners, in turn, decided not to accredit COPS as a medical college, which meant that COPS's graduates were not allowed to sit for the state's licensing examination.[9] At its Oct 20-23, 1919, meeting, the licensing board rejected a motion that would have permitted COPS graduates to be qualifying applicants for the state's physician and surgeon certificate.[9]

An Oct 27, 1919, letter to Norman Martin, the county hospital's superintendent and the county's superintendent of charities, stated that COPS was no longer on the list of schools approved by the board of medical examiners as qualifying applicants to take the written examination for the physician and surgeon certificate.[9]

The County Civil Service sent a letter to Martin on Nov 19, 1919, that stated: "We are in receipt of an opinion from the County Counsel dated November 14, in which he holds that we are not permitted to admit, or after admission, to consider, candidates for positions as Interne who are not graduates of a medical institution, and in which he further holds that graduates of a college of Osteopathy are not graduates of a medical institution. This opinion is given in confirmation of the order given by the State Board of Medical Examiners."[9]

COPS took legal action against the licensing board and won in June 1921, forcing the state licensing board to allow COPS graduates to sit for California's licensing exam.[9,11]

Nonetheless, the county hospital accepted no new osteopathic interns from 1919 until 1928.[9]

The blatant discrimination sparked California's osteopathic physicians to request their own state licensing board. In addition, DOs applied to the Los Angeles County Board of Supervisors, which oversaw the county hospital, to obtain equal privileges as MDs at Los Angeles County General Hospital.[9]

In November 1922, California voters passed Proposition 20, which allowed osteopathic physicians to have their own licensing board and which authorized that board to grant physician and surgeon certificates to DOs.[9]

The 1922-23 president of the California Osteopathic Association, H.W. Forbes, DO, along with Dain L. Tasker, DO, and Norman F. Sprague, DO, asked the Los Angeles County Board of Supervisors to have a separate DO staff at the county hospital.[9]

Much debate ensued regarding integrating DOs into the hospital. The DOs fought for the right to practice alongside MDs at the hospital, but as the discussions progressed, it became apparent that the only solution that would be accepted would be for osteopathic physicians to practice in a separate building and operate separately from the county hospital's allopathic physicians.[9]

Driving this decision was the fact that the hospital would have lost its accreditation from the AMA and the American College of Surgeons if MDs and DOs practiced together.[9]

On May 21, 1923, the Los Angeles County Board of Supervisors authorized the superintendent of the county hospital to divide the institution into two units.[9,12] The osteopathic unit opened in a seven-story structure on Feb 15, 1928.[12]

Unit 2's beginning

The MD unit at the county hospital was called Unit 1, and the DO unit was called Unit 2. Also known as Los Angeles County Osteopathic Hospital, Unit 2 started out with a maximum capacity of 196 beds.[9] Every 10th patient was admitted to Unit 2 because there were 10 times more MDs than DOs in Los Angeles County.[9] In 1956, the unit moved into a 600-bed facility.

From 1928 until 1962, osteopathic physicians treated patients at Los Angeles County Osteopathic Hospital, and osteopathic residents, interns and medical students trained there.

COPS students rotated through Unit 2 until 1962, when COPS became the California College of Medicine,[9] which is now the University of California, Irvine School of Medicine. By 1940, COPS students spent their entire fourth year in the unit.[13]

The hospital went from having approximately 10 interns in 1919 to 235 in 1940, fostering tremendous growth and opportunity in osteopathic graduate medical education and paving the way for equality with allopathic medicine.[13]

Training students in a hospital reinforced the trends within the profession to adopt a "broad approach" to osteopathic medicine and to diminish OMT's role. Students rotated through Unit 2's urology, infectious disease, and obstetrics and gynecology services. As osteopathic medical students increased their clinical skills and gained biomedical knowledge, the emphasis on OPP declined at the hospital.

Forest J. Grunigen, DO, a 1931 COPS graduate who would exchange his DO degree for an MD degree in 1962, complained about the lack of OMT provided in the hospital.[14] However, G.W. Woodbury, DO, the superintendent of the osteopathic unit, was quoted in the Oct 11, 1931, issue of the *Los Angeles Times* as saying that every patient in Unit 2 received some form of OMT.[15] On the other hand, Dr Woodbury noted that one reason for Unit 1's longer average length of stay may have been related to the number of chronic cases that unit had.[15]

In addition to providing OMT to hospitalized patients, Unit 2 had an ambulatory OMT clinic, and patients could follow up with DOs after discharge to obtain more OMT.[16]

Problems did not disappear when Unit 2 was established. On Sept 8, 1928, only a few months after Unit 2 opened, the American College of Surgeons sent a threatening letter to the chief of staff at Los Angeles County General Hospital.[9] The American College of Surgeons had learned that an underground corridor linked the two units so that janitors and maids could travel between the buildings, and it had learned that the heads of the two units reported to the same chief for the entire county hospital.

Despite great protest from Unit 1's attending staff, the American College of Surgeons withdrew the county hospital's accreditation in 1929 and withheld it until 1936. In 1936, a new Unit 1 was constructed, and the two units were completely separated physically, administratively and professionally.[9]

Unit 2 measured the difference

Discrimination against osteopathic physicians based on poor healthcare was unsubstantiated, as hospital data from 1928 to 1933 demonstrate.[16]

As reported in the December 1932 issue of *JAOA—The Journal of the American Osteopathic Association*, Unit 2 handled cases similar in range, variety and seriousness to those handled by Unit 1.[17] In fiscal year 1931-32, nearly 50% of the patients admitted to Unit 2 "came into the hospital as stretcher cases," meaning they were brought in by ambulance.[17] By fiscal year 1930-31, Unit 2 was handling one-seventh of the total admissions to the county hospital because the osteopathic unit was discharging patients at a faster rate than was the allopathic unit.[17] Unit 2 also handled more than one-third of the hospital's obstetrical cases because it had a large obstetrical ward.[17] While Unit 1 had 1,751 births in fiscal year 1931-32, Unit 2 had 1,196 births.[17]

Despite the increasing number of patients treated every year in Unit 2, the mortality rate and the average length of stay of patients treated in Unit 2 dropped between 1928 and 1932, while

Inpatient data show lower mortality rate, shorter length of stay for Unit 2

The data below are from two of the last fiscal years in which Los Angeles County General Hospital compared the performance of Unit 2 against that of Unit 1.

The first section of this table provides the cumulative data on inpatient services provided by each unit in fiscal years 1931-32 and 1932-33. The next four sections break down the cumulative data into the subsets of medical, obstetrical, natal and surgical services.

The comparative data show that across the board, Unit 2 had a lower inpatient mortality rate and a shorter average length of stay than did Unit 1.

	Fiscal year 1931-32		Fiscal year 1932-33	
	Unit 1	Unit 2	Unit 1	Unit 2
Total of all services (medical, obstetrical, natal and surgical)				
Number of cases, including newborns and infants	35,039	7,415	38,144	7,994
Average number of patient days	17.3	9.7	15.8	9.7
Mortality rate, excluding newborns	9.4%	4.3%	9.3%	4.2%
Autopsy rate for patients who died	49.4%	71.9%	53.1%	71.0%
Medical services, including contagious, psychopathic, tuberculosis and other special services				
Number of patients	14,849	1,679	17,962	1,679
Average number of bed-days per patient	16.4	9.7	14.4	9.9
Mortality rate	13.6%	10.0%	12.7%	12.1%
Autopsy rate for patients who died	44.8%	65.4%	47.0%	67.3%
Obstetrical services				
Number of patients discharged, including deaths	3,405	1,624	3,796	1,891
Average number of bed-days per patient	10.1	9.4	–	9.5
Mortality rate	2.0%	0.7%	1.2%	0.2%
Therapeutic abortions	37	3	–	–
Infants				
Delivered in the hospital	1,759	1,187	2,134	1,422
Mortality rate for hospital deliveries	10.8%	9.5%	8.5%	5.1%
Surgical services				
Number of patients	13,133	2,567	13,583	2,836
Average number of bed-days per patient	17.2	8.1	16.5	8.4
Average number of postoperative days per patient	18.9	9.5	17.5	9.1
Mortality rate	5.9%	2.3%	6.4%	2.0%
Mortality rate following surgery	6.5%	3.5%	6.7%	2.7%
Autopsy rate for patients who died	58.3%	73.3%	33.4%	67.7%

Source: *Sixth Annual Report of Unit 2 (1932-33).* Located among the Louis C. Chandler papers and manuscripts (1895-1970) in the special collections at the Western University of Health Sciences College of Osteopathic Medicine of the Pacific, Pomona, Calf.

these measures remained comparatively higher in Unit 1.[16]

For fiscal year 1930-31, Unit 2's mortality rate was 5.53% excluding infant deaths, while Unit 1's was 9.78%.[15,16,17] For fiscal year 1932-33, Unit 2's mortality dropped to 4.20%, while Unit 1's was 9.30%.[16]

For fiscal year 1930-31, Unit 2's average length of stay was 11.84 days, while Unit 1's was 16.00 days.[15,16,17] By fiscal year 1932-33, Unit 2's average length of stay was 9.73 days, while Unit 1's was 15.80 days.[16]

According to the hospital's sixth annual report on Unit 2, "The staff of the hospital attributes the constantly decreasing average hospital days per patient to the adherence to osteopathic principles and practices in the Unit. The steady decrease in death rate in the Unit is attributed to the same cause and attention is called to the growing number of patients."[16]

The same Oct 11, 1931, article in the *Los Angeles Times* in which Dr Woodbury was quoted focused on

patients staying an average of four fewer days in Unit 2 compared with the entire hospital, saving the county $30 per patient.[15]

Despite evidence that indicated that osteopathic medical care at the county hospital was superior in terms of mortality rate and length of stay compared with allopathic medical care at the hospital, the AMA continued to make slanderous statements about the osteopathic medical profession.

The 1924-50 editor of *JAMA: The Journal of the American Medical Association*, Morris Fishbein, MD, questioned the data from Unit 2 in his book *Fads and Quackery in Healing: An Analysis of the Foibles of the Healing Cults, With Essays on Various Other Peculiar Notions in the Health Field*.[18] Although Dr Fishbein cited no data to support his viewpoint, he boldly asserted that the osteopathic unit had a shorter average number of bed days because the unit sent all seriously ill patients to Unit 1.[18] In actuality, the osteopathic unit sent less than 1% of its patients to Unit 1.[19]

The MDs at the county hospital were unwilling to acknowledge that osteopathic medical care was superior to allopathic medical care. After 1934, the county hospital combined data for the entire hospital, and no longer kept individual data on Unit 2.[3]

Building on Unit 2's accomplishments

An important lesson to be learned from the data from Los Angeles County Osteopathic Hospital is that OMT can be a key factor in improving the care of patients. This early randomized, clinical assessment of osteopathic versus allopathic medical care at a large metropolitan county hospital clearly demonstrated that osteopathic medical care was safe and effective even in its infancy. Not only did osteopathic medical care decrease mortality and morbidity rates, but it also decreased the costs to county taxpayers.

Modern studies are generating results akin to the data from Unit 2.

References

1. Member colleges. American Association of Colleges of Osteopathic Medicine's Web site. Available at http://www.aacom.org/people/colleges/Pages/default.aspx. Accessed May 12, 2009.

2. Obradovic JL, Winslow-Falbo P. Osteopathic graduate medical education. *J Am Osteopath Assoc.* 2007;107:57-66. Available at http://www.jaoa.org/cgi/content/full/107/2/57. Accessed May 12, 2009.

3. Gevitz N. *The DOs: Osteopathic Medicine in America.* 2nd ed. Baltimore: Johns Hopkins University Press; 2004.

4. Blackstone E. Competition within the physicians' services industry: Osteopaths and allopaths. *Am J Law Med.* 1982;8(2):137-150.

5. Gamber R, Holland S, Russo DP, Cruser DA, Hilsenrath PE. Cost-effective osteopathic manipulative medicine: A literature review of cost-effectiveness analyses for osteopathic manipulative treatment. *J Am Osteopath Assoc.* 2005;105:357-367. Available at http://www.jaoa.org/cgi/content/full/105/8/357. Accessed May 13, 2009.

6. Baer HA. Divergences in the evolution of osteopathy in four anglophone countries: The United States, Canada, Britain, and Australia. In Oths KS, Hinojosa SZ, eds. *Healing by Hand: Manual Medicine and Bonesetting in Global Perspective.* Walnut Creek, Calif: AltaMira Press; 2004.

7. Flexner A. *Medical Education in the United States and Canada: A Report to the Carnegie Foundation for the Advancement of Teaching.* Bulletin No 4. New York City: Carnegie Foundation for the Advancement of Teaching; 1910.

8. College of Osteopathic Physicians and Surgeons' information pamphlet. Located among the Louis C. Chandler papers and manuscripts (1895-1970) in the special collections at the Western University of Health Sciences College of Osteopathic Medicine of the Pacific, Pomona, Calf.

9. Martin HE. *The History of the Los Angeles County Hospital (1878-1968) and the Los Angeles County-University of Southern California Medical Center (1968-1978).* Los Angeles: University of Southern California Press; 1979.

10. Gevitz N. The sword and the scalpel—The osteopathic 'war' to enter the military medical corps: 1916-1966. *J Am Osteopath Assoc.* 1998;5:279-86. Available at http://www.jaoa.org/cgi/reprint/98/5/279. Accessed May 12, 2009.

11. *The College of Osteopathic Physicians and Surgeons of Los Angeles v Board of Medical Examiners,* 53 Cal App 138,199 P 1093 (1921).

12. Litton HE. History of College of Osteopathic Physicians and Surgeons. *Western Alumnus.* Nov 19, 1940. Located among the Louis C. Chandler papers and manuscripts (1895-1970) in the special collections at the Western University of Health Sciences College of Osteopathic Medicine of the Pacific, Pomona, Calf.

13. Faires LB. The Los Angeles County Osteopathic Hospital. *Western Alumnus.* Nov 19, 1940. Located among the Louis C. Chandler papers and manuscripts (1895-1970) in the special collections at the Western University of Health Sciences College of Osteopathic Medicine of the Pacific, Pomona, Calf.

14. Grunigen D, O'Connell J. *A Strength Born of Giants: The Life and Times of Dr Forest Grunigen.* Raven River Press: Van Nuys, Calif; 2002.

15. Osteopathy unit saves per patient: County hospital figures show average case on books four days less. *Los Angeles Times.* Oct 11, 1931.

16. *Sixth Annual Report of Unit 2 (1932-33).* Located among the Louis C. Chandler papers and manuscripts (1895-1970) in the special collections at the Western University of Health Sciences College of Osteopathic Medicine of the Pacific, Pomona, Calf.

17. Osteopathic versus medical hospital efficiency. *J Am Osteopath Assoc.* 1932;32(4):144-145.

18. Fishbein M. *Fads and Quackery in Healing: An Analysis of the Foibles of the Healing Cults, With Essays on Various Other Peculiar Notions in the Health Field.* New York City: Blue Ribbon Books; 1932.

19. Misrepresenting Los Angeles Hospital conduct. *J Am Osteopath Assoc.* 1932;32(4):145-146.

20. Noll DR, Shores JH, Gamber RG, Herron KM, Swift J Jr. Benefits of osteopathic manipulative treatment for hospitalized elderly patients with pneumonia. *J Am Osteopath Assoc.* 2000;100:776-782. Available at http://www.jaoa.org/cgi/reprint/100/12/776. Accessed May 12, 2009.

21. Radjieski JM, Lumley ML, Cantieri MS. Effect of osteopathic manipulative treatment on length of stay for pancreatitis: A randomized pilot study. *J Am Osteopath Assoc.* 1998;98:264. Available at http://www.jaoa.org/cgi/reprint/98/5/264. Accessed May 19, 2009.

A study on the effects of OMT on elderly patients with pneumonia showed that subjects who received OMT needed fewer antibiotics than did subjects in the study's control group.[20] A study on OMT in hospitalized patients with pancreatitis demonstrated that OMT shortened length of stay.[21] These and other studies indicate how effective osteopathic medical care is both in terms of providing quality healthcare and decreasing costs.

Using palpatory diagnosis and OMT in the care of all patients, as Unit 2 did, would give the osteopathic medical profession a huge competitive edge by allaying some of the financial costs of healthcare today. In addition, the number of osteopathic medical students picking AOA-approved internships and residencies might increase substantially if students believe that the profession's reputation is improving because the public is realizing that DOs provide cost-effective, quality care.

If we remember all the struggles that Unit 2's founders endured to advance our profession, we may find the courage to pursue change and progress in the face of such modern challengers as powerful pharmaceutical companies, private third-party payers, and federal and state government programs. The osteopathic medical profession has an important contribution to make to society in the form of our unique philosophy and practices. Let us honor OPP by putting it into practice. AOA

Acknowledgments

I would like to acknowledge Michael A. Seffinger, DO, for opening my eyes to this rich episode in osteopathic medicine's history, for steering me to papers that were sources of countless hours of research, and for offering guidance and editorial assistance to me during the writing process.

I would also thank Raymond J. Hruby, DO, for our discussions about the osteopathic medical profession's identity and for his editorial assistance.

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About the author

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In addition to sharing the second-place honors in the AOA Bureau of Osteopathic History and Identity's 2008 essay competition, Dr Armenta took third place in the bureau's 2007 competition.

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