



Allopathic and Osteopathic Medicine Unify GME Accreditation: A Historic Convergence

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BACKGROUND AND OBJECTIVES: In 1968, the American Medical Association resolved to accept qualified graduates of osteopathic medical schools into its accredited Graduate Medical Education (GME) programs. An equally momentous decision was arrived at in 2014 when the Accreditation Council for Graduate Medical Education (ACGME), the American Osteopathic Association (AOA), and the American Association of Colleges of Osteopathic Medicine (AACOM) resolved to institute a single unified GME accreditation system by July 1, 2020. As envisioned, the unified accreditation system will all but assure system-wide consistency of purpose and practice in anticipation of the Next Accreditation System (NAS) of the ACGME. Governance integration replete with AOA and AACOM and osteopathic representation on the ACGME Board of Directors is now well underway. What is more, osteopathic representation on current Review Committees (RCs) and in a newly established one with an osteopathic focus has been instituted. Viewed broadly, the unification of the GME accreditation system goes a long way toward recognizing the overlapping characteristics in the training and practice of allopathic and osteopathic medicine. As such, this momentous development represents the latest, indeed boldest leap toward convergence between the two historic branches of American medicine. In this Health Policy Analysis we seek to place the impending unification of the GME accreditation process in its historical context, delineate its near-term impact, and discuss the potential long-term implications thereof.

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On February 26, 2014, the Accreditation Council for Graduate Medical Education (ACGME), the American Osteopathic Association (AOA), and the American Association of Colleges of Osteopathic Medicine (AACOM) resolved to institute a single unified accreditation system for Graduate Medical Education (GME) by July 1, 2020.¹ The product of 2-year long discussions, this “watershed moment for medical education” seeks nothing

less than to afford all future allopathic and osteopathic physicians with a “uniform path of preparation for practice” and to establish consistency in the “evaluation of and accountability for... competency... across all programs.”¹ Arguably the most significant modification of GME since the institution of the Resident Duty Hour reform, this agreement rewrites the status quo yet again by standardizing GME accreditation in the United States.^{1,2} Concurrently,

this latest development redefines the allopathic-osteopathic interface in a manner reminiscent of the historic 1968 decision of the American Medical Association (AMA) to accept qualified graduates of osteopathic medical schools into AMA-accredited GME programs.³

Osteopathic Medicine and the ACGME

Central to this transition is the designation of the AOA and AACOM as member organizations of the ACGME and their representation on the ACGME Board of Directors. Subject to this new governance structure, the expanded ACGME will assume the additional responsibility of accrediting the more than 1,000 osteopathic (heretofore AOA-accredited) GME programs.^{1,4} In so doing, the ACGME will be guided by osteopathic representation on current Review Committees (RCs) as well as by a newly established osteopathic-focused RC.^{1,4} In each and every case, the ACGME will be applying its Next Accreditation System (NAS), the full implementation of which went into effect on July 1, 2014.⁵ It follows that the all-important NAS imperatives—innovation,

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tracking of outcomes, measurement of milestones, ongoing quality improvement, and the clinical learning environment—stand to impact more GME programs than originally envisioned.^{4,6} Notwithstanding the forgoing, great care will be exercised to preserve and codify the “unique principles and practices of the osteopathic medical profession” by way of a “Recognition Committee” tasked with defining an “osteopathic recognition” designation to be conferred upon qualified GME programs.^{1,4,7} Similar commitments have been made to maintain osteopathic signature GME programs, the oversight of which will rest with a dedicated Osteopathic Neuromusculoskeletal Medicine Review Committee (ONMM RC).^{1,4}

Going forward, AOA-accredited GME programs are to apply for ACGME accreditation and, if desired, for the “osteopathic recognition” designation between July 1, 2015, and June 30, 2020.^{1,4} Upon entering the ACGME accreditation process, AOA-accredited GME programs are to be assigned a “pre-accreditation” status.⁴ Starting July 1, 2016, eligibility for all advanced residency positions will require completion of prerequisite training in a program accredited by the ACGME, the Royal College of Physicians and Surgeons of Canada (RCPSC), or the College of Family Physicians of Canada (CFPC). Residents in or entering existing AOA-accredited GME programs with ACGME “pre-accreditation” status during the 5-year transition period who are seeking training in ACGME-accredited residency and fellowship programs, will be subject to the eligibility standards (per specialty) that were in effect June 30, 2013 or July 1, 2016, whichever is less restrictive.⁸ Throughout this transitional interval the AOA will continue to exercise its accreditation authority over osteopathic GME programs.⁴ However, at the conclusion of this period, on or before June 30, 2020, the AOA will cede its accreditation authority to the ACGME.⁴ The AOA Board of Trustees also approved a standard

that states that “AOA programs that do not apply for ACGME accreditation cannot accept new trainees after July 1 of the year in which the resident can complete their training by June 30, 2020.” As such, this measure assures resident applicants that any program they enter will retain its accreditation through the completion of their training.⁹

As of August 14, 2015, the ACGME Review Committees of most (21 of 23) applicable specialties resolved to assure further allopathic-osteopathic equity by abandoning the prior requirement of an American Board of Medical Specialties (ABMS)-certified co-program director.⁹⁻¹¹ These specialties include allergy and immunology, anesthesiology, dermatology, diagnostic radiology, emergency medicine, family medicine, general surgery, internal medicine, neurology, obstetrics and gynecology, ophthalmology, orthopedic surgery, otolaryngology, osteopathic neuromusculoskeletal medicine, pathology, pediatrics, physical medicine and rehabilitation, plastic surgery, preventive medicine, psychiatry, and thoracic surgery. Identical arrangements will apply to for Transitional Year programs. In contrast, the ACGME Review Committees of the specialties of urology and neurosurgery will, for now, continue to require an “ABMS-certified co-program director.”^{9,10} Given the absence of osteopathic counterparts to the specialties of colon and rectal surgery, medical genetics, nuclear medicine and radiation oncology, these programs will continue to rely on an “ABMS-certified co-program director.”^{9,10}

Parallel Training Tracks

In 1874, Andrew Taylor Still, MD, DO, gave rise to the clinical principles that launched the osteopathy movement.¹² Special focus has been placed on the import of holistic prevention and on the relationship between the musculoskeletal system and health and disease. However, since its inception, osteopathy has struggled to achieve parity with

the allopathic enterprise.¹³⁻¹⁸ Key milestones in the hard-fought progression to parity included the recognition of osteopathy as a distinct medical education track, the establishment of a distinct board of examiners, and the right to prescribe drugs.^{13,14,17} Amended state laws permitting the licensing of osteopathic practitioners followed suit.¹⁹ Additional progress was evident in the wake of the Flexner Report with osteopathic medicine gaining entry into the United States Military Medical Corps and into AMA-accredited GME programs.^{3,20,21} However, it was not until the recent unification of GME accreditation that allopathic and osteopathic medicine have converged in a manner heretofore unlikely.²²⁻²⁶

In the eyes of many, the distinction between allopathic and osteopathic disciplines has become increasingly nuanced.²³ Absent the osteopathic emphasis on the primacy of the musculoskeletal system in human health and disease, primary care-focused training,²⁷⁻²⁹ and an emphasis on a holistic approach to patient care, the two disciplines are similar.^{23,30} Drawing on an overlapping applicant pool, both the allopathic and osteopathic medical education enterprises follow the well-trodden track from undergraduate to graduate to postgraduate training. In 2013, osteopathic medical schools were home to 21.2% of all actively enrolled medical students.³¹ Both require a pre-med orientation and the Medical College Admission Test (MCAT) as conditions for entry into a 4-year undergraduate medical education program. Both subscribe to similar curricular and accreditation standards. Both pursue similar licensing and specialty certification milestones that are all but uniformly recognized by state-licensing boards as well as by public and private payers. Both enjoy a comparable scope of practice as well as eligibility for membership with many of the same professional organizations. And all but one state (PA) share the same licensing boards. In this regard,

the joint commitment of allopathic and osteopathic medicine to establish a single unified GME accreditation system goes a long way toward acknowledging the tenuous premise of what some view as a persistent artificial divide.²³ After all, 60% of all the graduates of osteopathic medical schools are presently being trained in ACGME-accredited programs (51% in ACGME-accredited programs; 9% in ACGME/AOA dually-accredited programs).^{23,32,33}

Implications for American Medicine

The consequences of this new steady state are far-reaching. First, qualified graduates of either allopathic or osteopathic medical schools will be eligible to apply for residency training with all future ACGME-accredited programs.⁴ This development is of significance to graduates of allopathic medical schools who were previously precluded from applying to AOA-accredited GME training programs. Under such scenario, graduates of allopathic medical schools may be required to demonstrate competencies in Osteopathic Principles for programs with Osteopathic Recognition.⁴ Second, residents in training will be in a position to transfer from one ACGME-accredited program to another absent the imposition of additional educational requirements and of Medicare GME funding shortfalls.⁴ It also follows that the adaptive yet costly notion of “dually accredited” allopathic and osteopathic medical residency training programs will be rendered obsolete.⁴ Third, qualified graduates of allopathic and osteopathic residency training programs will be eligible to apply for advanced fellowship training with all ACGME-accredited programs.⁴ Additionally, as has been noted in the course of medical student clerkships, joint training of students of allopathic and osteopathic medicine is bound to prove mutually enriching.³⁴⁻³⁶ Finally, the effects of this merger on the number of residency programs available to qualified medical and osteopathic

graduates is difficult to ascertain. Pre-accreditation of programs does not guarantee final accreditation, a point of concern to students entering such programs. Institutional and program-specific requirements for accreditation by the ACGME has already resulted in the closing of some programs. The number and nature of programs that will close is uncertain. However, the unification of accreditation also promises that all programs remaining will meet a minimum standard of quality.

It is not beyond the realm of possibility that the establishment of a single unified GME accreditation system may further accelerate the process of convergence of allopathic and osteopathic medicine. Given a single pool of ACGME-accredited GME programs, it is tempting to speculate that the distinct digital processes of matching allopathic (National Resident Matching Program) and osteopathic (National Matching Services Inc.) medical student applicants with corresponding GME programs may be consolidated. A similar rationale could apply to the prospect of streamlining—if not unifying—the specialty board certification process of qualified graduates of GME training programs. With the advent of universal and uniformly accredited GME programs, the notion of separate and parallel specialty board certification by the American Board of Medical Specialties and the AOA could potentially be revisited. Finally, consideration could be given to consolidating the parallel testing requirements of allopathic and osteopathic trainees. These presently consist of the USMLE (United States Medical Licensing Examination) and the COMLEX-USA (Comprehensive Osteopathic Medical Licensure Examination of the United States of America) licensing examinations. The institution of a single unified GME accreditation system marks a transformation for the American medical education enterprise. If nothing else, this development stands to unify and thus materially strengthen ongoing advocacy efforts

intended to reverse the “GME Bottleneck.”^{37,38} In addition, however, this development does its part to further highlight some of the seemingly outdated distinctions between the two historic branches of American medicine.²³ Indeed, with a single unified GME accreditation system in place, compelling arguments can be made in support of common matching, licensing, and certification paradigms. In the final analysis, the main beneficiary is the American public whose social compact has just been revised to state that the training and evaluation of all future physicians in the United States will be unified, consistent, and accountable to the same governing organization.

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