‘Structure & Dysfunction’: An Open Response to the AACOM Executive Committee

Norman Gevitz, PhD

Dear Members of the AACOM Executive Committee,

I am responding to your May 19th letter.

Thank you for your communication. I believe the tide of opinion within the profession is shifting towards my position which is why you’ve decided to address some of my points in my AODME paper which I delivered in San Antonio on April 23rd—nearly a full month prior. (See “The Unintended Consequences of the ACGME Merger” to be found at www.saveogme.com)

As yours is a long letter, I want to respond to each and every point you make to allow the larger osteopathic community to compare our arguments so they can decide for themselves what is best for the osteopathic medical profession going forward. To do so, I will interpolate my responses into the narrative of your May 19th letter.

However, to reproduce your letter exactly as sent to me would pose some special difficulties for the reader. For whatever reason you decided to ‘bold’ almost all of your letter which makes it appear that you are shouting much of your response. So for the sake of reader clarity, I am removing the ‘bold’ typeface which permeates your note. I am also highlighting your letter in blue, italicizing it, indenting it, and putting it in 11 rather than 12 font to distinguish your note from mine. Readers are to note also that many of your paragraphs begin with the word FACT.

Norman Gevitz received his PhD in Sociology from the University of Chicago. He is currently Senior Vice President—Academic Affairs, AT Still University in Kirksville, MO. And Mesa, AZ. He is the chief academic officer of ATSU overseeing its six colleges including the Kirksville College of Osteopathic Medicine (KCOM) and the School of Osteopathic Medicine in Arizona (SOMA). He is the author of more than 50 publications including The DOs: Osteopathic Medicine in America. (Baltimore: Johns Hopkins University, 2nd ed. 2004) He has obtained grants from the National Institutes of Health (National Library of Medicine), the National Endowment for the Humanities, and the US Department of Education. He is the recipient of 7 honorary degrees and public service awards for his research and service to the osteopathic medical profession. Dr. Gevitz’ opinions on the proposed ACGME unification are his own and do not necessarily reflect the position of AT Still University.
For the sake of conciseness, let me reiterate my basic argument which I will expand upon in my reply.

If the Osteopathic Medical Profession proceeds with the ACGME unification or merger the following are very likely to occur:

1. The total number of current OGME slots will fall by approximately 20%
2. The resulting OGME slots which will become ACGME slots will be open equally to MDs thus making these slots far more competitive. With total slots declining and remaining slots now highly competitive, many 4th year DO students will find it more difficult securing residency positions.
3. The OGME “safety net” which currently allows all DOs who want a residency position or traditional internship to obtain one, will disappear.
4. With all graduates going into ACGME slots, the vast majority will, upon completion, pursue ABMS certification.
5. With few new residency graduates seeking Osteopathic Specialty Board certification, these specialty boards will almost exclusively serve the function of re-certifying established osteopathic specialists.
6. With few new specialists being osteopathic boarded, osteopathic specialty colleges will progressively decline in membership with aging collegians retiring or expiring.
7. AOA membership, may initially grow, but if the current percentage of less than 18% of ACGME trained DOs joining the AOA continues, the AOA will only represent less than 25% of all active DOS, fifteen years into the merger, if the annual production of DO graduates remains stable.
8. By agreeing to the proposition that one accreditation system with one common standard on the graduate medical education level through ACGME is in “the public interest”, the profession will likely be unable to offer a rational and compelling reason why one accreditation system with one common standard through the LCME is not in “the public interest” on the undergraduate level, particularly when the LCME is composed of our same partners—the AMA and the AAMC—on the graduate medical education level.
9. With the ACGME merger as precedent, the osteopathic profession admits that it cannot govern its own educational affairs, and will, sooner or later, be forced to negotiate with LCME to be part of a unified undergraduate accreditation system.
10. Given that the LCME genuinely believes that tuition-driven medical schools with few full-time faculty cannot deliver a sufficiently high quality medical education experience, many osteopathic schools—under current LCME standards and expectations which are likely to continue—will face closure or becoming small branch campuses of existing allopathic medical schools.
With my central arguments stated, I will present the complete narrative of your letter with my interpolated responses.

May 19, 2014

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An Open Letter from the AACOM Executive Committee in Response to Norman Gevitz’s “The Unintended Consequences of the ACGME Merger”

Dear Dr. Gevitz,

As an established historian and sociologist with a long-standing interest in and passion for the osteopathic medical profession, we value your academic career and recognize your many credentials and achievements in our field of osteopathic medical education and practice. We also recognize that your recent communications regarding the new, single system of accreditation have been made with the best of intentions, and represented an effort on your part to help preserve and protect the profession and those who practice it, both current and future.

I believe that the AACOM Executive Committee is acting with the best of intentions. I have known several members of your Committee for decades and have always found those of you with whom I have interacted to be advocates for your respective schools and for osteopathic medical colleges in general. Our differences are professional not personal.

However, we must disagree with many of the arguments and statements made in those communications, as there are multiple errors of fact that confuse information with opinions. Most importantly, we believe that it is absolutely imperative that ANY communication during this time of change be clear, concise, and correct in terms of what is fact and what is opinion. Statements made to seem factual that are not sourced or cannot be verified create confusion and disrupt progress toward achieving consensus within our profession. This has created a great deal of confusion and fostered disunity in our profession, at a time when acting boldly and collectively is the best course of action.

Please note that I too am also trying to build consensus within the profession. This proposed ACGME merger, if followed, has significant unintended consequences which will irreparably damage this profession’s ability to survive. Most critically, this ACGME merger is dysfunctional to the fundamental institutional structures of the osteopathic medical profession. “Acting boldly
and collectively” as you say, is simply not a desirable course of action when the AOA Board and Executive Committee of the Council of Deans haven’t taken seriously the likely unintended consequences of their votes.

- **FACT:** Numerous individuals with extensive knowledge and expertise related to the nation’s medical education system, osteopathic medicine, relevant public policy, GME, the osteopathic profession’s financing and the nation’s physician self-regulatory system, spent countless hours and resources analyzing a variety of scenarios related to this effort. All along the way, a key aspect of AACOM’s deliberations centered on what would be in the best interest of the osteopathic medical students, graduates, colleges, and the profession of which we are all a part.

After I sent you and all the deans a private letter which was also posted on [www.saveogme.com](http://www.saveogme.com) I accepted Boyd Buser’s invitation at the AACOM meeting to sit down and talk with him about the negotiations process and my concern with what was happening. As you know, but perhaps some of the readers of this letter don’t, Boyd is a member of the AOA Board of Trustees as well as a member of the Deans Council and one of the negotiators of the ACGME merger. We had a good talk. I know Boyd for more than twenty-five years. Again, I have great respect for Boyd. I asked him to explain to me to what extent my concerns about the unintended consequences to the profession, particularly with respect to the schools, were considered by osteopathic medical leadership. He told me that these concerns were part of the conversations but they were not the principal subjects of focused discussions and he confirmed that no written reports on these issues were generated.

Since then, particularly since my second and longer paper entitled “The Unintended Consequences of the ACGME merger” was delivered in San Antonio, both AOA President Norm Vinn and now all of you have put forward a hyperbolic narrative about the extent of your collective research on “various scenarios.” If, as you say, “Numerous individuals…with extensive knowledge and expertise” “spent countless hours and resources…” concerned with these “various scenarios” where are your findings? Where is the written report? What outside expert or experts did you hire to consider the impact of the ACGME merger on the pillars of the profession?

If you had “numerous individuals”…“with extensive knowledge and expertise” spending “countless hours and resources” I would ask all of you and Norm Vinn (or your numerous experts) to please answer the following basic questions: How will this merger affect the number of our graduates who will a) take AOA Specialty board exams; b) join AOA Specialty Colleges, c) join the AOA, d) join state osteopathic medical societies? The AOA and AACOM leadership has, up to now, been unable to answer these questions because, “in fact” leadership did not do the necessary research. Both the AOA and AACOM leadership have not followed the most elementary of “best practices”—to generate a comprehensive study—on the likely effects of the most significant policy change facing the profession since the California merger!
FACT: There have not been enough first year osteopathic graduate medical education (OGME) positions for osteopathic medical school graduates for around 20 years, and there are no circumstances in the near future in which there will be enough positions. In 2014 the colleges of osteopathic medicine will graduate almost 5,000 DOs. The number of DO graduates is expected to increase to approximately 6,000 DOs by 2019 (the 7,000 graduates you cite in 2020 is incorrect). In the 2014 OGME match, there were 2,988 first-year funded positions, of which 529 were traditional rotating internship positions (2,064 [69%] filled as result of the match).

There is not much disagreement here except you cite lower expected graduates than I do. The discrepancy lies in the fact that AACOM uses a “static” forecasting model which counts only the number of schools and students actually approved. In its forecasting, AACOM reporting does not consider schools that are most likely to be approved in the next few years, the class size of these likely schools, or the likely requests by existing schools to expand current class size. As a consequence, AACOM data chronically undercounts schools, students, and graduates going forward. My figure of 7000 in 2020 assumes a growth in the number of osteopathic colleges in the next six years from 30 to 35. This is not unreasonable since efforts are currently underway in at least nine states (according to your own data) to establish osteopathic medical schools. As you know, within the past three weeks, COCA has approved a new school which was certainly not included in your February data set, and if their Spring accreditation visitation goes well it will admit its first class in the Fall of 2015. If just two or three more schools are approved and begin classes in the next two years and if a handful of our existing colleges successfully petition for more matriculants, the number of actual annual graduates will, in fact, approximate 7000 in 2020.

FACT: Under the standards adopted in the Accreditation Council for Graduate Medical Education (ACGME)’s Next Accreditation System, which will go into effect in 2016, unless AACOM, AOA, and ACGME join in the development of the single accreditation systems, DO graduates that choose OGME training will face extraordinary restriction of their ability to access ACGME specialty and fellowship training. Under those circumstances, DOs will have limited career pathways if they chose to become an osteopathic physician.

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1 In 1996 there were 1,877 funded AOA PGY1 positions and 1,932 osteopathic medical college graduates. GME positions from an AOA file ‘The AOA Intern Registration Program Statistics’ originally produced by AOA Department of Education, 6/23/1999 and subsequently updated. Graduate statistics from http://www.aacom.org/data/graduates/Pages/default.aspx, Graduates by Gender 1969-2012.xlsx
2 Estimate based on survey of the osteopathic medical colleges conducted in April 2014 to assess placement of current graduates in GME. Contact research@aacom.org for a copy of the report.
3 Estimate based on October 2013 survey of planned growth of current osteopathic medical colleges including new locations expected to enroll students for the first time in Fall 2015 (graduation in 2019 requires first enrollment in fall 2015). Contact research@aacom.org for a copy of the report.
5 ACMGE Common Program Requirements (effective July 1, 2016 http://www.acgme.org/acgmeweb/Portals/0/PFAssets/ProgramRequirements/CPRs_07012016_TCC.pdf
Let’s be absolutely clear on one point to all the members of the osteopathic medical profession. It is the ACGME, not the AOA or AACOM, that will restrict those DOs with osteopathic graduate medical education from entering allopathic residencies going forward. Whether or not the AOA and AACOM merge with the ACGME, all fourth year DO students who wish to do ACGME subspecialty and fellowship training will continue to have that eligibility by immediately entering an ACGME program upon graduation. So for these fourth year students, nothing changes, except the timing of when they have to make that decision.

- **FACT: ACGME is an accreditation body whose mission is to advance the quality of graduate medical education. It is not a membership organization or an advocacy body, and it is not in the business of starting residencies, just as medical college accreditation bodies (COCA and LCME) are not in the business of starting medical schools.**

Dr. Thomas Nasica MD, the Executive Director of the ACGME, on his good will visits to various osteopathic medicine groups, has raised the “supply” issue stating numerous times, with respect to the continued existence of osteopathic residency slots, that it is not in the interest of the ACGME to “reduce” the number of available residency positions. If it is in the interest of the ACGME to not “reduce” the number of slots in a time of impending shortage, it should also be in the interest of the ACGME to see the number of residency slots “grow.”

The fact is that there is a direct relationship between the “raising” of residency accreditation standards—whether through an existing accrediting body, or by joining another accrediting body with different standards—and the availability of residency training positions. We see that most acutely and painfully today in the podiatric medicine profession. In part, to raise the status of podiatric medicine, its accrediting body adopted more rigorous standards governing podiatric residencies. The unintended consequence is that during each of the past two years, 14% of all podiatric medicine graduates who have passed all their required tests cannot now find residency positions. Despite the podiatric profession placing a moratorium on new schools and restricting the ability of existing schools to add new matriculants, this awful problem has not been solved. Indeed, this problem may soon extend to our DO graduates.

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6 [http://www.acgme.org/acgmeweb/tabid/121/About/MissionVisionandValues.aspx](http://www.acgme.org/acgmeweb/tabid/121/About/MissionVisionandValues.aspx)

Since the announcement of the first proposed MOU in 2013, I have had the opportunity to speak to OPTI executive directors, osteopathic DMEs and program heads—both supporters and opponents of the unified accreditation system, asking them to estimate how many of our existing programs, based upon the current ACGME standards and expectations, are unlikely to achieve ACGME accreditation based on program size or resources or other factors, and the figure of 20% was mentioned by several respondents. I might add that no one in the audience at the AODME meeting where I presented, including Drs. Boyd Buser and Steve Shannon, then took issue with this estimate. If we have approximately 3000 first year slots—which you don’t dispute—a 20% reduction would leave our graduates with 600 less positions. Furthermore, under the ACGME merger, US, Canadian, International and Caribbean medical students would have equal opportunity to enter the remaining 2400 slots—thus making competitive—positions that were once devoted exclusively to DO graduates. By agreeing to this ACGME merger, we will, in fact, be disadvantaging osteopathic medical graduates in two distinct ways—first, we will be cutting the overall supply of “osteopathic” residencies; and second, we will be making the remaining “osteopathic” residency positions far more competitive to enter. In a time of an impending residency shortage, why would the AACOM Executive Committee Deans vote to make it more difficult for their own osteopathic medical students to find residency positions?

- **FACT:** The assertion that “osteopathic residencies will now end” will be true only if our profession elects to let that happen—this statement can be a self-fulfilling prophecy. The single accreditation system establishes a mechanism and set of processes and standards within ACGME by which osteopathic programs will continue and can expand. Not only can current osteopathic programs maintain that status if they continue to meet appropriate standards established by a new Osteopathic Principles Committee established within ACGME by the agreement (and consisting of 13 out of 15 members nominated by the AOA), but existing ACGME programs can also seek that recognition. Such activity has already been occurring, with numerous reports from many states of hospital systems and individual programs interested in affiliation with our COMSs in order to prepare for that eventuality. Given that these programs will also admit MDs, it is worth considering the following: “What MD seeking to become a primary care physician would not consider the advantages of dual-certification with osteopathic credentials as well as allopathic credentials—credentials that will distinguish their training, attributes and skills, as well as justify billable activity in Osteopathic Manipulative Medicine?”

First, there can be no “osteopathically-oriented” residency programs if there are no osteopathic program directors. Perhaps the most unconscionable provision of this ACGME-merger which the AOA Board of Trustees and the AACOM Executive Committee of Deans agreed to permit the diminishment of all those DOs who are currently AOA-board certified specialists. The AOA and

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8 [AACOM.org, Single GME Accreditation System: Answers to FAQs](http://www.aacom.org/news/latest/Pages/SingleGME_FAQs.aspx)
AACOM leadership signed on to and now actively promote an MOU which puts AOA-boarded PDs in the situation where they will become “junior partners” to ACGME-trained PDs. Under the ACGME merger, our AOA-board certified specialists in applying for acceptance as program directors will be treated much like “immigrants” applying for a “green card” in order to continue their livelihood! The fact is there is no guarantee that AOA Board-certified specialists will be approved as Program Directors and in all likelihood those who will be, are going to be “short-timers”—continuing to work where they are at presently until they leave to be replaced by someone that is ABMS-certified.

Second, since the AOA and AACOM did no comprehensive analysis of the unintended consequences of the merger, none of the leading proponents have any idea how many hospitals who currently offer AOA-accredited residency programs will be interested in maintaining “osteopathically-oriented GME programs. Don’t you all think that at the very least the AOA and AACOM leadership should have polled the hospitals to have estimated that number before you all signed on to the MOU? The fact is that with so many AOA-accredited programs being dual-accredited, it very likely that their sponsoring hospitals will want consolidated programs to commit to one set of standards, and one residency director per program who is ABMS-credentialed in order to save money and avoid duplication of record-keeping.

Third, if this ACGME merger goes forward, it would be most interesting to see how much the “Osteopathic Principles Committee” can infuse OPP into those limited number of programs that wish to be “osteopathic”. 4th year MD students must be treated equally in applying for what are now AOA-accredited residency programs. If barriers are erected which “discourage” MD candidates from gaining entry into these programs because of “limitations” in their training as MD students—such as basic competence in manipulative medicine—programs could well face a constitutional challenge based on class discrimination under the “Equal Protection clause” of the 14th Amendment. To expect these 4th year MD students to take an OMM course of several months lengths before they are “eligible” for candidacy to the program, or have that course added on top of whatever else they are expected to be competent in under the ACGME next accreditation system is problematic. Most likely, this “Osteopathic Principles Committee will only be able to incorporate the four philosophical tenets of osteopathic medicine into program requirements, declare “victory”, and call it a day.

Fourth, almost all DOs who currently complete singly-accredited AOA residency programs obtain AOA-specialty board certification and join AOA Specialty Colleges. Under the MOU, this annual cohort will now disappear. Going forward, there is no compelling reason why DOs (let alone MDs!) in ACGME programs would become dually-boarded or join two specialty colleges. The financial burden to individual DOs to do so are considerable and ABMS certification is sufficient for hospital affiliation, insurance, and any other requisite to practice. We already know that the vast majority of DOs who complete an ACGME program apply for ABMS-certification only. In recent years, no more than 18% of DOs with ACGME training even apply for AOA membership. Given these figures, our specialty boards will soon only function as
re-certifying bodies for existing osteopathic specialists, our specialty colleges will wither away as members retire or expire, and the AOA and State Societies will represent an annually decreasing percentage and eventually total number of osteopathic physicians. Any independent analyst which the AOA Board of Trustees could have hired—but didn’t—could have projected the rates of decline in these institutional structures which constitute the foundations of the profession.

One of the main assertions in your paper is the claim of an alignment between AMA and AAMC to use the ACGME to force Commission on Osteopathic College Accreditation (COCA)-accredited osteopathic medical schools to seek Liaison Committee on Medical Education (LCME) accreditation, thus resulting in fewer DO graduates to compete with US MD graduates for residency positions. We believe this is without merit, evidence, or logic and undermines honest, rational debate.

In my first letter to the Deans and thereafter, I asked all of you who support the ACGME merger a fundamental question which none of you have yet to satisfactorily answer. Let me restate the question for the whole osteopathic profession to reflect upon. The question is this:

“If unification and one common standard with the ACGME (with the AMA and AAMC as our partners) is desirable for the osteopathic profession and in the public interest with respect to graduate medical education, what is the compelling and rational reason for the AOA and AACOM to not join with the LCME (also with the AMA and AAMC as our partners) in one unified undergraduate medical college accreditation system with one common standard?”

All of the leaders, including yourselves, who publically support the ACGME merger continue to avoid or deflect my question. I believe it is because you have no logical or credible answer. If you have no logical or credible answer, you have no logical or defensible position.

- FACT: There have been no discussions of any change in accreditation status of osteopathic medical schools, either as a part of the ACGME discussions—from which that topic was specifically excluded—or by the AMA, AAMC, or other organizations independently with AACOM. COCA is deemed to have the authority to accredit osteopathic medical schools by the U.S. Department of Education as a result of a public process, and any attempt to subject that process to political pressures would be unwelcome.

By agreeing to a “unified” graduate medical education accreditation system with partners that include the American Medical Association and the Association of American Medical Colleges, the AOA has severely undermined, indeed “stepped on,” its long-standing rationale for being the single authority deemed by the US Department of Education to accredit undergraduate osteopathic medical schools.
The AOA has declared that this ACGME “unification” is in the “public interest” and is an important vehicle to assure quality. Since both allopathic and osteopathic medical schools produce the same category of health care practitioners—physicians & surgeons—who now will enter one unified accredited graduate medical education system—the Department of Education is most likely to look upon with favor and in “the public interest” a comparable “unified” system of undergraduate accreditation. For the AOA to continually and repeatedly say “We’re not interested” to the Liaison Committee on Medical Education (LCME) when it has already agreed to the precedent of medical education accreditation unification is logically inconsistent and hardly a compelling argument for the US Department of Education, when it considers re-authorization of the AOA’s authority to accredit osteopathic schools.

LCME unified accreditation will come with consequences. As all of you well know, COCA-accredited osteopathic medical schools are differently structured and financed than medical schools accredited through the LCME. The members of the LCME truly believe that medical schools that rely heavily on tuition (67% for DO schools and less than 4% for MD schools); have few full-time faculty members (MD schools have an average full-time faculty-student ratio 18 times greater than DO schools); and despite limited financial resources, enroll far more students than MD schools (an average of 55% more) cannot possibly provide students with a quality undergraduate medical education. If osteopathic medical schools are evaluated under current LCME standards, (and these standards are unlikely to substantially change with unification) what do you believe are our colleges’—indeed your colleges’—chances for obtaining LCME accreditation? You or your colleagues have never addressed this issue because the AOA never hired anyone to do an impact study of the ACGME merger!

- **FACT:** The graduates of osteopathic medical schools are valued by residency programs, both OGME and ACGME—they are recruited and have a near complete placement rate (in 2013 it was about 98.5% and so far in 2014 it is over 99%). LCME school placement rates are slightly lower, and their leadership describes those from their system who are not successful as having unreasonable expectations about their specialty choices or training locations.

First, I have stated in my paper that “osteopathic medical graduates are now increasingly being perceived by our ACGME partners as effective competitors to US allopathic school graduates in getting GME positions” We have no disagreement here.

Second, in 2013, 528 MD graduates could not find residency positions. This year, it was somewhat better—412 MDs could not find residency slots. You note that allopathic leadership states that some of their 4th year students had “unreasonable expectations” about their “specialty

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9 Estimates based on surveys of the osteopathic medical colleges conducted in April 2013 and April 2014 to assess placement of current year graduates in GME. Contact research@aacom.org for a copy of the report.
choices” or “training locations.” What about our 4th year osteopathic students? They don’t have these same problems? Of course they do! But here’s the difference between the allopathic and osteopathic worlds. We currently have a reserve of OGME first year spots—whether traditional rotating internships or residencies. Thus, all our graduates who want to participate in graduate medical education can do so. Those who do a traditional rotating internship can hopefully find the residency position of their choice the following year. This institutional “safety net” will now end.

- **FACT:** The osteopathic medical education system is valued on state and federal policy levels for the graduates and physicians it produces, as well as the health care services it provides to the population. The DO graduates’ affinity for primary care, specialty care, community-based training, service to underserved populations, relative efficiency and less-costly infrastructure is well known, recognized, and celebrated. We are not aware of any policy maker or body that supports an effort to decrease those results.

We are in apparent agreement as to the social value of osteopathic medical schools. Please note that in my “Unintended Consequences” paper I argued that osteopathic medical schools serve the public interest in six significant ways: First, osteopathic medical schools despite their limited resources produce uniformly qualified candidates for GME; second, osteopathic medical schools educate a higher percentage of future primary care physicians than do allopathic medical schools; third, DO school graduates are more likely to serve in rural areas where they are needed; fourth, osteopathic medical graduates are trained in distinctive diagnostic and therapeutic means not taught in MD-granting schools and these means provide DO graduates with an additional set of competencies to provide quality patient care; fifth, osteopathic schools provide a challenge to conventional allopathic wisdom as to how much and what type of resources are actually needed to prepare competent individuals for GME; and sixth, osteopathic medical schools have the capacity to swiftly develop and institute innovative programs to educate their students and to better serve the underserved. Indeed AOA President Norm Vinn has prominently repeated my six arguments in his letter to the AOA Board of Trustees.

That some prominent policy makers agree is undoubtedly valuable in making our case for independence but their support will not be determinative as it will be the US Department of Education that will have the final say in who accredits osteopathic medical schools and whose standards will be operational with respect to educating “physicians and surgeons.” However much some policy makers agree with my six aforementioned arguments as to why osteopathic

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10 Opening Keynote Address, AACOM Annual Conference, April 2014: The Patient-Centered Medical Home, Paul Grundy, MD, MPH, Global Director of IBM Healthcare Transformation, IBM Corporation


12 Mary K. Wakefield, PhD, RN, Administrator for the Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services, [http://www.aacom.org/resources/e-news/ome/archives/2012/2012-01/Pages/hpfseminar.aspx](http://www.aacom.org/resources/e-news/ome/archives/2012/2012-01/Pages/hpfseminar.aspx)
medical schools serve the public interest, none of these arguments go to the heart of the question of whether there shall be one or two agencies that accredit schools that produce candidates for graduate medical education.

- **FACT:** For several years, AACOM has partnered with AAMC to provide increased access by 4th year DO students to elective clinical rotations in LCME schools and hospital affiliates. This system has worked well, enabling thousands of DO students to rotate in locations where they were seeking residency training, and access within that system has continued to increase for DO students with no evidence of any retrenchment. AAMC’s reason for doing this has been stated as helping them find the “best” students in the most efficient way for their programs. This system is not open to IMGs.

We need to avoid “static” forecasting in considering the future. Between 2002 and 2016 MD medical school enrollment is increasing a healthy 30%. By comparison, DO medical school growth is increasing an incredible 125%. Where our prospective allopathic partners—the AMA and in particular the AAMC, looked at the early years of this growth with apprehension, their attitude towards new osteopathic medical schools and our increased number of matriculants is now hardening. All of our allopathic and especially our osteopathic schools are struggling with finding clinical rotations. With 16 new MD schools being established with more on the way, you need to ask yourselves how long is it before the “era of good feelings” between AACOM and AAMC comes to an end as our respective member schools compete with each other for limited spots while having to face the challenge of Caribbean schools paying hospitals an enormous premium to secure slots for their students?

- **FACT:** There are enough GME positions for all US MD and DO school graduates now, with over 6,000 to spare that are currently filled by IMGs. Despite growth of both MD and DO schools, there will continue to be several thousand more GME slots than US MD and DO graduates for at least the next decade.13

These two aforementioned sentences, one after another, are logically inconsistent. In the first sentence, you consider all GME aspirants including IMGs, (and I would add Canadian and US citizens in Caribbean schools); in the second sentence you only consider US DOs and MDs. What happened to the IMGs, Canadian and US citizens who graduate from Caribbean schools? They haven’t magically disappeared. Of what value is it to include in your residency supply calculation only two of five groups seeking GME?

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13 Health Affairs Blog, The 2014 GME Residency Match Results: Is there Really a “GME Squeeze?”
In addition, these numbers you use are the product of your “static” forecasting model which underestimates the number of DO graduates if the schools remain COCA accredited through 2020 and beyond. In addition you do not consider the loss of 20% of OGME positions in your data. Let’s not present data to our US students—osteopathic and allopathic—that all is well in the near future for them to be guaranteed accredited residencies. Unless otherwise addressed legislatively, international medical graduates, Caribbean graduates and Canadian graduates will continue to be significant part of the US graduate medical education workforce.

- **FACT:** GME is a publicly funded resource. To date, there have not been any stated policy justifications that would warrant the closure of the very schools that policy makers have recognized are producing the type of physicians that the nation needs, especially when they are less costly to taxpayers and recognized as a real benefit to the communities in which they serve. The osteopathic profession today is in a much more advanced state of political presence than it was a century ago, and is recognized as a successful and valued resource. It would be very surprising, and highly self-defeating, for the AMA and the AAMC to challenge the value of osteopathic medical schools as a resource in this country.

It is not primarily a question of “health policy” rather it is more a question of “educational accreditation policy”. The distinction is very important. Under the Obama administration the Department of Education is being charged with looking carefully at the accreditation standards maintained by various types of agencies that oversee different types of educational institutions including professional schools. The DOE is questioning the redundancy of some accreditation bodies and asking why there are multiple accreditation bodies for the same or similar types of practitioners. The DOE wants to know why these multiple accrediting bodies have different criteria and standards. By our leadership embracing the ACGME merger and the principle of “one common standard” for all physicians and surgeons in training, osteopathic medicine has significantly undermined its justification for retaining its deemed accrediting authority over its undergraduate schools.

- **FACT:** Under the implemented single accreditation system, AACOM and AOA will hold eight seats on the governing board of ACGME, which is 28% of the governing board members from sponsoring organizations (AAME, AMA, CMSS, AHA, and ABMS). DOs are 7-8% of the practicing physicians in the U.S., and DO graduates are rapidly approaching 20% of all U.S. medical school graduates. In this circumstance, how likely is it that ACGME’s board would vote to limit access to their programs to only LCME graduates? If such limits were even considered, wouldn’t it be more likely to occur if AOA and AACOM were not member organizations and had no presence within the organization.

The 6/7th ACGME rule will have no impact on any determination by the US Department of Education that osteopathic medical school accreditation should be under the auspices of the LCME. The requirement that all “osteopathic” entrants to ACGME programs must be graduates of LCME schools shall be a product of a Department of Education determination—not from ACGME itself.
As you are a sociologist and historian, we are surprised that your presentation and communications on this important issue do not reflect upon similar crossroads in the evolution of osteopathic medical education, and the methods by which those challenges were overcome. To look back and highlight what brought about collective unity of purpose and ultimately success during similar periods of challenge/opportunity could have provided very valuable insight and helped to create positive momentum going forward. This was a sadly missed opportunity, in our view.

Collective unity of purpose on a plan of action not well thought out in the first place is no virtue. My role over the last four decades in researching on and writing about the osteopathic medical profession is to tell the profession and the outside world both the strengths and weaknesses of the profession over time. I have endeavored to pull no punches. If you examine the reviews of my book The DOs: Osteopathic Medicine in America, (Baltimore: Johns Hopkins University Press, 1st ed. 1982, 2nd ed. 2004), you will see that it is widely regarded as objective and balanced. I write history—not hagiography and I am no apologist. In my articles, I have sharply critiqued how this profession has performed with respect to osteopathic research, the teaching of OPP, social visibility, promoting distinctiveness, and raising educational standards. Some of you have asked me “Why am I doing this?” as if I have not asked probing questions about the profession or its policies through the entirety of my relationship with osteopathic medicine. Certainly, I am not in the business of ratifying any group’s decision-making, if that decision-making is incomplete or flawed.

During this time of change and challenge we must focus on what really defines ANY profession. According to most modern day definitions of a profession, a universal criterion that appears repeatedly across all professions is that of self-governance. How do we create an open, honest, and productive dialogue around this challenging issue, one that crosses all of our separate but related associations, societies, and interest groups? How do we make sure that all voices are heard? How do we go about achieving consensus and making decisions? What is it that we need to pursue in the interest of the greater good? These are the questions that we need to ask and to develop answers as a unified body, and we need to do it sooner rather than later.

The ACGME merger seriously undermines the autonomy of the osteopathic medical profession. AT Still noted of the osteopathic profession that “It can paddle its own canoe” With this merger, you are saying it can’t. This policy change has consequences which you unfortunately have not foreseen or taken seriously.

Let’s not proclaim that the sky is falling before we have a chance to pursue a common vision of where our profession can go. Let us do what those in our profession have done before us: Positively and productively pursue change that benefits the health of our citizenry and defines us as a caring and enlightened group of professionals who can police themselves and act in the collective best interest of the American public. If we cannot do that, then we can rest assured that someone will surely step in and do it for us.

The “sky is not falling”! This ACGME agreement instead will likely create “an ever widening and deepening sink hole” into which the institutional structures of the osteopathic medical profession will collapse.
As a result of “unification”, our students will face a more competitive environment for obtaining residency positions. Our osteopathically-boarded Program Directors will undergo a humiliating and uncertain test of their credentials. Our specialty boards will diminish in their function. Our specialty college membership will not be replenished. The AOA will represent a progressively decreasing percentage of active DOs. A “unified” LCME will sooner or later replace COCA as our college accrediting body. Many of our schools will close or become small branch campuses of existing allopathic medical schools.

My sincere hope is that given the risks I have identified to your schools and to the profession in general, all of you will step back, pause, and seriously reconsider where you leading the osteopathic medical profession.

I would urge all of you—given these very real risks—to put in place a one year moratorium on taking any further steps in the fulfillment of any aspect of the MOU.

You can use the year to do “due diligence.” What harm can there be of you—and the AOA Board—hiring outside independent contractors to consider the risks, benefits, and yes, the unintended consequences of unification.

To proceed now without the benefit of written analyses unnecessarily jeopardizes this profession we all want to see thrive.

In the time between now and the AOA House of Delegates, you have the opportunity to demonstrate real professional courage.

I call upon all of you—and the AOA Board of Trustees—to temporarily halt this process. By doing so, you can ask the tough and necessary questions that need answers. And once you have the answers, this profession can move forward—in whatever direction—that is truly best for the members of the profession and in the public interest.

The future is in your hands.

Sincerely,

Norman Gevitz, PhD

Sincerely,

Executive Committee of the AACOM Board:

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William Strampel, DO, Chair of the AACOM Assembly of Presidents and Board of Deans
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cc: AACOM Board of Deans
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