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“The Unintended Consequences of the ACGME Merger”*

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I speak to you today as Norman Gevitz, PhD—a medical sociologist and historian who has researched and written about the osteopathic medical profession over a span of 40 years. I do not speak to you as a spokesman for my University. The opinions I will express here and elsewhere about the ACGME merger are my own.

*Reference sources for this oral presentation include but are not limited to: *AAMC Data Book: Medical Schools and Teaching Hospitals by the Numbers*. Washington DC: Association of American Medical Colleges (April, 2013); *Functions and Structure of a Medical School: Standards for Accreditation of Medical education Programs Leading to the M.D. Degree*. Washington DC: Liaison Committee on Medical Education (March 2014); Stephen C. Shannon, *Osteopathic Physician Supply and Distribution*. (Power Point Presentation) Chevy Chase, MD: American Association of Colleges of Osteopathic Medicine, (February, 2014); Norman Gevitz, “The Fate of Sectarian Medicine” in Barbara Barzansky & Norman Gevitz, (eds.) *Beyond Flexner: Medical Education in the 20th Century* (Westport, CT: Greenwood Press, 1992).

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In February of this year, the AOA Board and AACOM Board of Deans voted to embark on a unified graduate medical education accreditation system under the auspices of the ACGME. They did so without comprehensively considering the impact of this merged accreditation system on all the pillars of the osteopathic medical profession. These pillars include AOA board certification, AOA specialty colleges, AOA membership, and osteopathic medical colleges.

My conversations with several of the leading people negotiating this merger agreement reveal that they did not commission any independent written analysis of the consequences of the ACGME merger. This lack of a written analysis is puzzling since this proposed ACGME accreditation merger will have far reaching effects not only in the residency arena-but on the entire structural underpinnings of the osteopathic medical profession.

Briefly, I want to look at some of the likely consequences of this proposed merger on some other osteopathic pillars before turning to my main subject: the unintended impact of this merger on osteopathic medical schools.

First let me say right from the beginning that the ACGME should be congratulated in trying to develop a competency-based GME accreditation system. But let me also point out that what they are trying to accomplish is not the most pressing matter before us today in Graduate Medical Education.

The two most pressing issues facing GME today are first, developing sufficient numbers of new residency programs for all our graduates, and second, developing ambulatory-based primary care residency programs which mirror the real-life practices of family physicians,

general pediatricians, general internists and others. These two pressing issues are the ones on which the osteopathic medical profession should be primarily focused.

The ACGME Next Accreditation System fails to address these most pressing issues. Proponents of the Next Accreditation System admit that this new merger will not create a single new residency program. Not one! In addition, the Next Accreditation System does not transform the current and out-dated hospital-based residency training system for primary care practitioners. This is most disappointing.

In fact, if we go forward with the ACGME merger, our doing so will most likely reduce the number of existing OGME slots and make it more difficult for DO graduates to find PGY-1 positions.

Experienced OPTI and program directors, including those who support the merger, tell me that approximately 20% of all OGME positions do not have the requisite resources or are not otherwise structured to be able to achieve ACGME accreditation. So, if we now have 9000 slots—funded or unfunded—a 20% cut would bring the total number of OGME slots down to 7,200.

Under our current system, unfilled OGME slots provide an excellent safety net for osteopathic students who do not secure slots in either the osteopathic or allopathic match. Last year, 500 US MD graduates did not find residency positions after their scramble. By contrast, all DO graduates who wanted a residency position found a residency position because we have a safety net.

In fact, under the ACGME accreditation merger, this safety net will disappear. Both MDs and DOs will compete equally for current

osteopathic slots. Please note that if, in the event that any osteopathic-oriented programs place significant barriers or hurdles in the way of MD candidates to enter these programs because of osteopathic manipulative medicine requirements, MD candidates will sue in federal court and probably win their constitutional claim that these programs are violating the “equal protection clause” of the 14th Amendment. Most likely what will ultimately happen is that these osteopathic-oriented residency programs will simply pledge allegiance to the four osteopathic tenets and that will be the extent of the osteopathic component.

Let’s now consider AOA Board Certification and our Specialty Colleges. The ACGME merger will likely reduce to a trickle the number of individuals who will pursue AOA Board Certification. In recent years, the great majority of DOs who pursued AOA Board certification have been those individuals who have completed AOA residencies. These osteopathic residencies will now end. All of our graduates will now enter ACGME residencies.

Up through the present, DOs who have pursued ACGME residencies have not generally sought certification from AOA Boards. And going forward, there will be no compelling reason for any DO to be certified by an AOA specialty board. The ABMS certifying board is all they will need for hospital affiliation, insurance, or any other requisite for acceptance. Why should we expect our graduates to expend money on a second board certification and membership in a second specialty college? Indeed, the great likelihood is that the principal function of osteopathic specialty boards will be to re-certify existing osteopathic specialists—not to test new candidates. As a consequence, Specialty

Colleges will get few new members, and over time all AOA specialty colleges will wither away as aging AOA collegians retire or expire.

ACGME specialists could still join the AOA without being AOA board certified. In fact, the AOA has previously calculated that no more than 18% of all DOs who are ACGME trained have joined the AOA. If, when all our graduates become ACGME-trained, and if this current percentage remains constant, the AOA would actually gain slightly in membership. This is because of the rapid increase in the number of osteopathic medical graduates—up to 7,000 new DO graduates a year by 2020.

But this predicted membership bump should be of small comfort. With each passing year of only 18% of our graduates joining the AOA—the absolute total AOA membership will represent an increasingly smaller percentage of all DOs in practice. Within 15 years of the merger the AOA would likely represent less than 25% of all active DOs. How then can the AOA say it represents the entire osteopathic profession?

Please keep in mind too that this just mentioned membership scenario is based on an optimistic assumption. The stability of AOA membership requires that the number of graduates from osteopathic medical schools will remain constant or grow. Under what I believe is the most likely scenario the number of osteopathic graduates in the future will fall precipitously. The rest of my paper will answer the question of why would this happen?

Since the announcement of the ACGME agreement, some of my MD friends are talking excitedly to me about the possibility of one single

undergraduate medical education accreditation system which will ensure quality training for all physicians-in training and which they say will result in improved health care for the public.

Thus, in addition to the AOA and AACOM partnering with the American Medical Association and the Association of American Medical Colleges in ACGME, the AOA and AACOM would partner with the AMA and the AAMC on the undergraduate side through the Liaison Committee on Medical Education--the LCME.

Indeed, going forward, I have no doubt that before this ACGME merger is completed by 2020, organized medicine will place growing and enormous pressure on the AOA and AACOM to join the LCME and most importantly to require osteopathic medical schools to adhere to the LCME's accreditation standards as a prerequisite for allowing their newly graduated DOs into ACGME programs.

Why would the AMA and AAMC do so?

I already mentioned to you the 500 graduates of US medical schools who could not find residency positions last year. With each passing year, the situation for newly graduated MDs will get worse. New MD schools are being established at an unprecedented pace. Since 2006, 16 new MD-granting medical schools have been established in the US. More are on the way. By 2020, there will be a minimum of 2,000 more US MD graduates per year than there are currently. At the same time, the number of annually created GME slots is widely predicted to increase by only 1% a year.

Adding to the MDs' problems is the explosive growth of DOs who are occupying slots that were originally designed for US trained and

internationally trained MDs. Where MD medical school enrollment will grow by a healthy 30% from 2002 to 2016; osteopathic medical school enrollment will jump by an amazing 125%. Although this rapid increase in osteopathic numbers of schools and graduates was initially observed with apprehension by the AMA and AAMC; their attitude towards rapid osteopathic growth is now hardening.

Osteopathic medical graduates are now increasingly being perceived by our ACGME partners as effective competitors to US allopathic school graduates in getting GME positions. There is no question that LCME-accredited medical schools want to ensure that all their graduates get GME slots going forward. Increasingly, they are realizing that the one way they can effectively do that is to have influence upon the number of osteopathic schools and their graduates. And the only way to accomplish this is through a merger of the COCA and LCME accrediting processes into an expanded LCME. This ACGME merger opens the door for them to accomplish just that.

A very polite invitation to the AOA and AACOM to become part of the LCME will come very soon from our ACGME partners—the AMA and the AAMC. Should the AOA and AACOM repeatedly refuse the invitation to join an expanded LCME, our allopathic partners will undoubtedly take their case to the Department of Education, the news media, and to the American public. Our ACGME partners will argue that it is in the public's interest that osteopathic medical schools adopt the same accreditation standards which MD schools need to meet to produce competent graduates. After all, they will argue, both types of US medical schools seek to produce "physicians and surgeons." And how, in fact, can we justify a refusal to join the LCME when we, ourselves say how beneficial it is to the public interest for us to be part of a unified GME

Accreditation System in the ACGME with these same allopathic partners?

What I hope all of you will appreciate is that if you embrace the concept of one unified accreditation system and standard on one end of the medical education curriculum, you are logically compelled to accept the appropriateness of one accreditation system and one single standard on the other end of the medical education continuum.

Some osteopathic college deans and other administrators have told me that the assimilation of the entire osteopathic profession is inevitable. They believe that an independent osteopathic profession cannot survive indefinitely. So for them, I'm sure this ACGME union is a natural step in the inevitable process of osteopathic medicine being absorbed into the medical mainstream.

But if these college administrators believe that in this inevitable process of absorption their colleges will seamlessly make the transition from COCA-accredited medical schools to becoming LCME-accredited medical schools they are quite mistaken.

Let me explain why?

The LCME from its' beginning has unambiguously declared, and its members genuinely and fervently believe, that any medical school which is dependent primarily upon tuition is intrinsically incapable of delivering a quality medical education to their students. Indeed, tuition counts for only 3.6% of all LCME-accredited medical school revenue. By contrast, tuition counts for 67% of all revenue in COCA-accredited medical schools.

24 osteopathic medical schools are private. Their medical education is funded primarily by tuition and they are heavily dependent upon voluntary faculty members. Despite evidence that our private schools produce a competent annual cohort of individuals well prepared for graduate medical education, the LCME finds this model utterly incompatible with its long-held standards and expectations.

6 osteopathic medical schools are state supported. In a recent AACOM Study, the six state supported osteopathic medical schools generated an average of \$117 million per annum. However, the average total annual revenue of LCME medical schools is more than \$700 million. In other words, the average revenues for public osteopathic medical schools constitute only one-sixth of the average revenues for all LCME medical schools. Thus, both our public as well as private osteopathic medical school revenue models are not in compliance with LCME standards and expectations.

Given this disparity between the financing of our schools, one of the most obvious differences between LCME- and COCA-accredited medical schools is the average full-time faculty to student ratio. There currently exists a more than 14 to 1 difference in FTE faculty per student ratio between LCME and COCA-accredited medical schools. MD schools rely on full-time clinical faculty, osteopathic schools don't, and our way of educating medical students is totally incompatible with LCME standards and expectations.

If we examine basic science faculty workforce for the first two years of medical education we also see significant differences. LCME-accredited medical schools have an average of 127 full-time basic science faculty

members. The great majority of osteopathic medical schools employ between 20 and 30.

This last gap is especially notable given the difference between the numbers of students MD and DO schools accept. MD schools have an average class size of 145. DO schools, despite having far less resources, enroll an average of 229—55% more. The average number of students that osteopathic schools matriculate, given their available resources, is completely inimical to LCME standards.

Let me be absolutely clear and unambiguous on this one point. The LCME will not establish a different standard for osteopathic medical schools from that to which their currently accredited community-based MD medical schools must adhere.

Thus, when the AOA and AACOM are either willingly or reluctantly brought into the LCME, they will be obligated—just like in the ACGME merger—to accept our allopathic partners’ standards—with some minor concessions made by the LCME that do not impair its ability to judge osteopathic schools on the same basis that they evaluate existing MD programs.

When homeopathic and eclectic medical schools reluctantly agreed to become accredited by the AMA in the first decade of the 20th century, no special accommodation was made for their schools. Indeed, the mantra—then as is now—was conformance by all medical schools of whatever type to one common standard.

In 1905, there were no less than 24 homeopathic and eclectic medical colleges. In 1935, the number of such schools shrunk to a mere 3. In that latter year, the two surviving homeopathic medical colleges were

required to drop all mention of “homeopathy” in their self-descriptions and remove any semblance of homeopathy from the required medical school curriculum. In 1939, the last surviving eclectic medical school closed its doors forever.

What would likely happen when osteopathic medical schools become subject to LCME accreditation? Based on existing LCME standards and my historical knowledge of allopathic medical school accreditation I am comfortable in predicting the following: First, all COCA-accredited osteopathic colleges would be put on probationary status; second, they would likely be required to cut their class size to an average of 100 students per year—and perhaps less; third, they would be required to support a minimum of 75 basic scientists and provide the buildings, labs, human and other resources for them to do research; fourth, each school would be required to develop multiple clinical departments and sufficiently staff them with full time faculty members; fifth, each college would need to forge formal and stronger partnerships with hospitals and other clinical sites; sixth, all schools would have to find new and enormous funding streams to support medical education; seventh, schools either would be required to award the MD degree from the beginning or our colleges will soon voluntarily adopt the MD degree as a means of reaching a wider audience and securing the revenues they need to survive; and eighth, osteopathic schools will have to subsume “osteopathy” under the heading of “physical medicine” in their curricula. Ultimately, the term “osteopathy” or “osteopathic medicine” will eventually be excised from the college curriculum and the catalog.

If in the unlikely, but best, scenario that all formerly DO-granting medical schools survive this process of becoming LCME- accredited

colleges, the number of graduates they produce –which is currently expected to approximate 7,000 by 2020, will be dramatically reduced thereafter. Assuming a total of 35 osteopathic medical colleges in 2020, the number of total graduates would be cut by one half to no more than 3,500 per year.

This means that under “the best” of scenarios, there will be 3,500 less of our graduates a year to compete with “congenital” MD graduates for scarce GME positions. Please note that this dramatic drop in our graduates would go a long way in solving the residency slot shortage for future graduates of congenital allopathic medical schools.

The far more likely scenario is worse, however. In this scenario the great majority of private osteopathic medical schools, particularly those without a strong alumni base and endowment, would cease to be free-standing medical colleges. Some private schools, because of their geographical location and rural mission may become small, branch campuses under the auspices of existing allopathic medical colleges. Some formerly osteopathic medical schools may use their facilities and faculty members to either create or expand other graduate-level health programs such as for physician assistants or nurse practitioners. Some of their existing school facilities might be retrofitted for non-educational uses such as nursing homes, office buildings, or shopping centers.

Publically-funded osteopathic medical schools would also face continuing challenges to survive. All of our state osteopathic medical schools have faced periodic legislative scrutiny and some, on occasion, have had to mobilize their supporters to combat serious efforts by cost-conscious lawmakers to close them down.

State-supported osteopathic schools on average generate only 16% of the average revenues of LCME-based schools. How these public osteopathic colleges would obtain the needed revenues to make the grade to continue as fully operational medical schools is unclear given the tight fiscal situation many of their respective state governments now face. State governments could simply decide it would be more cost effective for them to just close these osteopathic colleges down and expand enrollment at other state allopathic medical schools.

In this more likely and bleak scenario, the number of annual graduates from what were formerly “osteopathic” medical schools, may drop to 1,000 to 1,500 per year. This decline would be even better news for congenital MD-granting medical schools in guaranteeing their graduates an ACGME residency position.

The AMA and the AAMC –our proposed partners in the ACGME unification—would no doubt proudly trumpet the demise of “osteopathic” medical schools as being in the public’s interest. Their argument always has been and will always be—one profession of medicine—one standard of medical education—and one medical degree to signify “physician and surgeon”. This has been and always will be their genuine and firmly-held belief.

As for the AOA and AACOM being members of both the ACGME and LCME, that will end after this process of college assimilation is completed as there will be no “osteopathic” medical schools, per se, whose undergraduates or graduates these all but defunct associations can legitimately represent.

I believe, as I think most in this room believe that the loss of osteopathic medical schools would not be in the public interest. First, osteopathic medical schools despite their limited resources produce uniformly qualified candidates for graduate medical education; second, osteopathic medical schools educate a higher percentage of future primary care physicians than do allopathic medical schools; third; graduates of osteopathic medical schools 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 graduate medical education; 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.

Let me conclude. The ACGME plan will transform graduate medical education for newly-minted DOs. But it will do far more. It will unintentionally weaken and irreparably damage the other pillars of the osteopathic profession including its specialty boards, its specialty colleges, and the AOA.

If the ACGME merger goes forward, there will be no compelling and rational argument against osteopathic medical colleges NOT being accredited under the auspices of the LCME. And if the LCME makes no allowances for the vastly different financial models of osteopathic medical colleges—which it most assuredly won't—then this profession

will lose its schools, and will see every pillar that holds up the edifice of the osteopathic medical profession collapse.

All of you need to closely question your leadership as to the wisdom of the path they are on. And quite frankly, the leadership needs to step back, pause, and comprehensively consider the unintended consequences of the path they are now on—before going forward. They also need to stop saying “We have no Choice.” You have a choice!

I am one with the current leadership on one important point. They say “the status quo is unacceptable.” I absolutely agree. But I am convinced that following the ACGME route is not the solution to addressing any of the difficult challenges the osteopathic medical profession faces now or in the future.