Next Steps for Graduate Medical Education

Osteopathic Graduate Medical Education (OGME) and the Single Graduate Medical Education (GME) Accreditation System

A white paper prepared by the American Association of Colleges of Osteopathic Medicine’s Ad Hoc Committee on Graduate Medical Education Transition

Executive Summary and Recommendations  December 2014
Executive Summary

Introduction, Context and Historical Information

The U.S. healthcare system is undergoing a transformation, affecting both the training of physicians and the delivery of care. The existing system does not fully address the public’s current needs in medical education and healthcare, leading to calls for reduction or reallocation of medical education resources.

The United States is unique in having two distinct philosophical approaches to patient care with parallel systems for educating physicians. Osteopathic and allopathic medical education each have unique strengths in how they prepare physicians for practice.

The recently announced development of a single graduate medical education (GME) accreditation system will enable more collaboration between osteopathic and allopathic medicine to better meet America’s healthcare needs for the 21st century. Osteopathic philosophy, principles, and practices will be integrated in the new system, which could potentially raise awareness of the benefits of osteopathic medicine. The single GME accreditation system will also provide an opportunity for MDs to receive integrative training in osteopathic principles and practice (OPP).

Overview of DO and MD Medical Education in the U.S.

In this country, candidates interested in becoming physicians will train in one of the two pathways for undergraduate medical education: osteopathic medical or allopathic medical school. Osteopathic curricula historically provided broad-based exposure to all of the core areas of medicine. In addition, the osteopathic medical profession utilizes a distributive model of medical education and integrates the principles and practices of osteopathic medicine across all four years of undergraduate medical education.

After earning a degree from a DO- or MD-granting institution, graduates enter GME programs for concentrated training in a specialty. GME training is needed for a physician to earn full practice rights. Osteopathic medical graduates may pursue training in programs accredited by either the American Osteopathic Association (AOA) or the Accreditation Council for Graduate Medical Education (ACGME). MD graduates receive GME training in ACGME-accredited residency programs.

Traditionally, osteopathic GME has predominantly occurred in community hospitals and in the primary care specialties. In the late 1980s, when developments in healthcare economics led to the consolidation of smaller hospitals into large health systems, hospital systems and graduate medical education began to change.

In response, leaders in osteopathic medical education devised a community-based infrastructure for training DO graduates, known as Osteopathic Postdoctoral Training Institutions (OPTIs). Since 1995, all osteopathic graduate medical education (OGME) has taken place within OPTI consortia, which consist of at least one osteopathic medical college, one hospital and frequently include other healthcare facilities. Resident physicians in OPTIs often spend time in a variety of settings, from hospitals to physicians’ offices.

Challenges in the U.S. Healthcare System

American medicine is acclaimed for its clinical and scientific advances. The U.S. healthcare system has developed knowledge and tools of care that lead the world. Medical education has a critical role in setting the agenda and creating the structure for healthcare, with $15 billion dollars spent annually by the federal government to support the GME infrastructure. To reinforce these strengths while reducing

1. This executive summary does not include references though they are included in subsequent sections of the white paper.
inefficiencies, medical education must assess its vision for the future and assume a leadership role during this time of change. This will require introspection, defining the core drivers of GME and identifying outdated, redundant, or irrelevant processes.

Many strengths of OGME appear to be consistent with federal government priorities for healthcare: a focus on prevention, primary care and the underserved; training in settings similar to where one will practice; attention to patient priorities and optimizing the health of patients. Nevertheless, all aspects of GME need to be re-examined. Patient-centered care can be a challenge for resident physicians who frequently rotate from one facility to another in GME residency training. In addition, osteopathic medical students deciding between AOA-approved and ACGME-accredited residencies have to navigate disconnected systems to match into GME programs.

**Unification of GME**

The transition to a single system for accrediting GME will simplify and strengthen postdoctoral training.

To reinforce the osteopathic medical profession’s approach to care, certain measures will be put in place. The AOA and the American Association of Colleges of Osteopathic Medicine (AACOM) will become member organizations of the ACGME, and representatives from the osteopathic community will serve on the ACGME governing board and the residency review committees overseeing osteopathic training. Additionally, an ACGME Osteopathic Principles Committee (OPC) will be formed to develop standards for osteopathically-recognized programs. The ACGME will also form a new Review Committee in Neuromusculoskeletal Medicine (NMM/OMM) to oversee programs in osteopathic manipulative medicine (OMM).

**Osteopathic GME and ACGME: Major Challenges**

OGME is transforming from a system of community hospitals training mostly primary care physicians to join a system that trains predominantly non-primary-care specialists. Thus, osteopathic medical educators need to give careful consideration to the aspects of osteopathic medicine and OGME that are most valuable and need to be included in all osteopathically-recognized programs, while still accommodating the unified goal of training quality physicians.

The upcoming changes require the osteopathic medical profession to codify the best characteristics of osteopathic training and establish evidence-based standards that osteopathically-recognized residencies will be expected to meet to maintain ACGME accreditation.

The agreement between the AOA, AACOM and the ACGME to unify GME accreditation includes a provision allowing MD graduates to apply to osteopathically-recognized programs. DO students receive 200 to 360 hours of instruction in OPP prior to residency. MD resident physicians will need grounding in OPP before and during residency to get the most out of osteopathically-recognized GME.

AACOM established the Ad Hoc Committee on GME Transition to offer its perspective on two important areas of consideration by the OPC: how to maintain the uniqueness of osteopathic GME and how to enable a smooth transition for MDs applying to and entering osteopathically-recognized programs. This white paper details the many considerations weighed by the Ad Hoc Committee in formulating its recommendations that were shared with the OPC for their use during deliberations on these issues, and it is now released in order to contribute to the ongoing discussions on these issues.

**Recommendations for Osteopathically-Recognized Programs**

The Ad Hoc Committee agrees that it is crucial for osteopathically-recognized programs under the ACGME to integrate osteopathic philosophy and techniques and maintain context-rich, community-based learning environments. Osteopathically-recognized residencies should have AOA board-certified program directors or co-directors as well as faculty members who can mentor and assess resident physicians in OPP. This could occur through a variety of assessments, including but not limited to objective structured clinical examinations (OSCEs), simulation-based assessments, 360-degree evaluations (student-resident, fellow-resident, resident-faculty, etc.), medical education portfolios, self-
assessment, procedure/interaction logs, and other clinical assessment metrics.

The ACGME Osteopathic Principles Committee should look toward dually accredited GME programs as a model. The flexibility and other positive features in the current dually accredited programs should be maintained in the ACGME’s osteopathically-recognized programs. The Committee recommends that residencies with dual or parallel accreditation who wish to apply for a portion of their resident cohort to be osteopathically-recognized, should be able to do so.

Although common standards must be established for all osteopathically-recognized programs by the OPC, the Ad Hoc Committee recommends that osteopathic specialty societies and each specialty’s review committee develop the specific competency milestones that their resident physicians must meet.

**Recommendations for Integrating MDs into Osteopathically-Recognized Programs**

The Ad Hoc Committee concurs that to fully realize the benefits of osteopathically-recognized training, MDs will need to have some background in OPP before starting residency and be provided with an appropriate curriculum throughout that training. The requirements for MDs should be rigorous, yet allow for flexible means of fulfillment. Residency training needs to be equivalent to what DO graduates receive, but not necessarily identical. By the end of their first year in an osteopathically-recognized residency, the Committee recommends that MDs be able to pass a performance evaluation in OPP on an equivalent level to that passed by DO students prior to their graduation from undergraduate medical school.

Beginning in undergraduate medical education, colleges of osteopathic medicine (COMs) and their OPTI partner institutions should provide opportunities for interested MD students to participate in osteopathic elective rotations in primary care and non-primary-care specialties alongside DO students. In addition to providing exposure to osteopathic philosophy and practice, these electives could serve as audition rotations for MDs considering osteopathic residencies.

Additionally, individual medical schools, AACOM, the AOA and osteopathic specialty societies can develop special courses for MDs considering osteopathically-recognized GME. MD students should be able to take online didactic classes on osteopathic principles and enroll in hands-on OMM workshops or “boot camps” that would introduce the concept of somatic dysfunction and basic OMT techniques, such as counterstrain, muscle energy, and myofascial release.

The osteopathic medical profession could use and build on OPP educational modules that have already been created by osteopathic medical schools, AACOM, the American Academy of Osteopathy (AAO), the American College of Osteopathic Family Physicians (ACOFP), and other osteopathic medical organizations.

**Looking Ahead**

The unification of GME accreditation into a single system will be a transformational change for graduate medical education, one in sync with efforts to streamline healthcare. During this transition, the osteopathic medical profession has the opportunity to share the benefits of osteopathic principles and practice with a wider audience. At the same time, the Ad Hoc Committee believes that the ongoing need for further research into the outcomes of OPP will be enhanced by these developments.

The Ad Hoc Committee on GME Transition hopes that its recommendations will become a part of the dialogue in the medical education community, and a context for discussions related to the implementation of the standards developed by the OPC for osteopathically-recognized program accreditation and the admission and training of MD graduates in these programs. The Ad Hoc Committee supports the maintenance of what is best about osteopathic GME: continued honing of osteopathic manipulative treatment (OMT) skills; focus on compassionate, whole-patient care; and community-based learning environments. With adequate preparation and ongoing additional training, MDs will be able to thrive in osteopathic GME programs, thereby expanding the influence and reach of osteopathic medicine.
Recommendations

The work of AACOM’s Ad Hoc Committee on GME Transition is reflected in the following recommendations. These recommendations were developed as a perspective for consideration by the ACGME Osteopathic Principles Committee (OPC), which establishes standards for osteopathically-recognized ACGME programs that educate graduates of U.S osteopathic (DO) and allopathic (MD) medical schools.

I. Recommendations for Osteopathically-Recognized Programs

1. Infrastructure

   a. The consortium model of training should be maintained. Resident physicians should be exposed to a diversity of clinical experiences in hospitals, ambulatory sites and other settings, especially environments resembling where the graduates will practice. Graded levels of contextual experience should be provided to resident physicians in order to produce learners capable of applying knowledge and skills to a broad range of clinical presentations, including the application of osteopathic principles in diagnosis and treatment.

   b. An osteopathic learning community should incorporate such factors as (a) membership or affiliation within the academic structure provided by an osteopathic postdoctoral training institution; (b) sponsorship by a college of osteopathic medicine (COM); and (c) presence of an adequate number of DO faculty within the program.

   c. All programs should have osteopathically trained (U.S. DO or MD) “core faculty” as defined by ACGME and an AOA board-certified program director, the minimum proportion of DO faculty members determined by each specialty.

   d. ACGME specialty programs should be able to pursue osteopathic recognition for a portion of their training cohort, i.e., an osteopathically recognized track within a larger program that includes a non-osteopathic track as well. Current dually accredited ACGME-AOA programs can provide a model for shaping such standards.

   e. Resident physicians should have ample and clinically relevant opportunities for supervised and independent hands-on OPP training and access to adequate facilities and resources, including OMT tables, osteopathic medical literature, etc.

   f. Electronic health records (EHRs) and other types of clinical records used in programs should include sections for documenting the rationale and clinical context for the integration of the osteopathic structural examination in the patient management routine, from screening to specific segmental dysfunction, as well as the application of specific OMT techniques.

   g. Resident physicians should engage in publishable research or scholarly activities that should be shared in a peer-reviewed manner. The resources necessary to pursue research/scholarly activities on osteopathic principles and practice should be available. Results of research should be prepared in line with the standards for publication in the Journal of the American Osteopathic Association, Osteopathic Family Physician, or other appropriate venues.
2. Curriculum

a. All programs should integrate the four tenets of osteopathic medicine, with resident physicians understanding the whole patient approach to care; the impact of body, mind and spirit on health; the body’s self-healing and self-regulatory properties; and the interrelationship of structure and function.

b. Resident physicians should be able to demonstrate knowledge of the osteopathic medical profession’s history, understanding the context in which osteopathic medicine emerged and evolved since its founding. The Ad Hoc Committee agrees that the continuity between undergraduate osteopathic medical education and osteopathically focused GME should be maintained.

c. Resident physicians should be able to integrate at least three of the seven major OMT modalities into the care of patients and be familiar with all seven major OMT modalities (see appendix: Core OMT/OMM modalities): counterstrain; high-velocity, low-amplitude thrust; lymphatic; muscle energy; myofascial release; osteopathic cranial manipulative medicine; and soft tissue.

d. Programs in all specialties should meet core-competency standards for OPP. Programs should ensure progressive proficiency in specific OPP competencies as demonstrated by Entrustable Professional Attributes (EPAs) toward the achievement of osteopathic milestones over time. The ACGME Osteopathic Principles Committee (OPC) should consult the modality guidelines developed by AACOM’s Educational Council on Osteopathic Principles (ECOP) and the competency milestones being developed by the AOA Council on Postdoctoral Training (COPT). The input from each osteopathic specialty college/society and its educational committees should determine any additional competencies and program requirements.

e. Resident physicians should be able to demonstrate the skillful use of their hands in the total assessment and management of a patient, including a specific and presentation-directed osteopathic structural approach for diagnosis and treatment.

   Resident physicians should be able to think critically in the process of individualized patient care, including the appropriate use of osteopathic concepts and rationale in the total patient-management routine.

f. Resident physicians should be able to perform, document, and rationally integrate the findings arising from the osteopathic structural screening examination as it applies to total patient care. After the screening examination, resident physicians should be able to engage in further segmental diagnosis and application of osteopathic manipulative treatment.

3. Outcomes

a. Graduates of osteopathically-recognized programs, DOs and MDs, who successfully complete all of the osteopathic requirements for the “osteopathic focus” of the residency program should receive certificate/diploma indicating additional training in OPP applicable to their specialty as granted by an OPTI, a college of osteopathic medicine or other qualified academic sponsor.

b. All graduates of osteopathically-recognized programs should be well-prepared to pass the AOA board-certification examination for their specialty. The passage of these certifying examinations will be one outcome measure used by the Osteopathic Principles Committee and the specialty-specific Review Committee (RC) to assess the program.

c. Graduates of osteopathically-recognized programs should be practice-ready, equipped with the clinical knowledge, procedural skills, and management acumen to succeed in their specialty, including a detailed knowledge base of the indications, contraindications and specific application criteria of OPP to the individual patient’s presentation.
d. Programs must provide the structure and opportunities for the experiences that would allow the first year of the residency to meet the requirements for DOs to be licensed in those states that require successful completion of one year of OGME, currently: Michigan, Pennsylvania, Oklahoma, and Florida.

II. Recommendations for Criteria for MDs Pursuing Osteopathic GME

1. Requirements Prior to Matriculation
   a. MDs pursuing osteopathically-recognized GME should have instruction in osteopathic philosophy and techniques in manipulative medicine—120 hours minimum. This foundation in OPP need not be completed before an MD student or graduate applies for residency. The Ad Hoc Committee recommends a flexible, hybrid approach that includes MD student access to introductory OPP courses while in medical school, OPP orientation prior to beginning residency, and ongoing training throughout the osteopathically-recognized residency.
   b. Osteopathic medical schools and their OPTI partner institutions should facilitate elective rotations or other educational experiences for MD students alongside DO students in OPP, primary care and non-primary-care specialties. Electives can serve as audition rotations for MDs desiring osteopathic training in a specific program.
   c. Osteopathic program directors should consider MD candidates for entry into osteopathically-recognized GME based on a number of factors, such as completion of OPP courses at an osteopathic medical school, performance on audition elective rotations, a convincing personal statement explaining their interest in an osteopathically-recognized program, letters of recommendation, and personal interviews.

2. Requirements for Completing DO Programs
   a. A single consistent standard is needed for MDs entering and completing osteopathically-recognized residencies. A single source for record keeping and assessment of standards should be encouraged.
   b. By the end of their first year in an osteopathically-recognized residency, MD resident physicians should be required to take a performance evaluation (PE) equivalent to that taken by DO students prior to their graduation from undergraduate medical school, e.g., Level 2-PE of the National Board of Osteopathic Medical Examiners' Comprehensive Osteopathic Medical Licensing Examination of the United States (COMLEX-USA), and/or the appropriate Comprehensive Osteopathic Medical Achievement Test(s) (COMAT). Additional alternatives could include other standardized examinations and/or institutionally specific evaluation programs.
   c. MD and DO graduates of osteopathically-recognized programs should complete the AOA board-certification examination in their specialty, with the results of such examinations utilized in program assessment by the OPC. MDs and DOs who desire can also sit for board certification by the American Board of Medical Specialties (ABMS).

2. The Ad Hoc Committee on GME Transition’s consensus is that MDs should have a minimum of 120 hours of instruction to adequately learn and apply OPP/OMT in an osteopathically focused residency program.