

# THE JOURNAL *of the* AMERICAN OSTEOPATHIC ASSOCIATION



*The Journal of the American Osteopathic Association* (JAOA) encourages osteopathic physicians, faculty members and students at colleges of osteopathic medicine, and others within the health care professions to submit comments related to articles published in the JAOA and the mission of the osteopathic medical profession. The JAOA's editors are particularly interested in letters that discuss recently published original research.

Letters must be submitted online at <http://www.osteopathic.org/JAOAsubmit>. Letters to the editor are considered for publication in the JAOA with the understanding that they have not been published elsewhere and are not simultaneously under consideration by any other publication. All accepted letters to the editor are subject to editing and abridgment.

Although the JAOA welcomes letters to the editor, these contributions have a lower publication priority than other submissions. As a consequence, letters are published only when space allows.

## Unified Graduate Medical Education Accreditation: A Better Plow

To the Editor:

In February, the American Osteopathic Association (AOA), the American Association of Colleges of Osteopathic Medicine (AACOM), and the Accreditation Council for Graduate Medical Education (ACGME) definitively announced that they were partnering to form a unified governing body for graduate medical education (GME) in the United States.<sup>1</sup> The professional discourse within the osteopathic educational community on the subject of unification is productive for both the profession and the public. Several opinions on the topic have been published in *The Journal of the American Osteopathic Association* over the past several months.<sup>2-4</sup>

A December 2013 letter by Richard Terry, DO, titled "Osteopathic Graduate Medical Education: A Way Forward,"<sup>2,4</sup> has received some interest from osteopathic educators and the osteopathic medical profession at large. The letter offers several alternatives to a unified system of GME. In the letter, it is assumed that the current governance and structure of osteopathic graduate medical education (OGME) is adequate to lead the osteopathic medical profession into the future. There is also the presumption that the resources readily exist within the OGME community to act upon the propositions.

The potential deficit of GME positions has been well documented.<sup>5</sup> Dr Terry's math correctly suggests, based on the premise of 1 first-year OGME slot for each graduate of a college of osteopathic medicine (COM), there would be a need to double the number of first-year OGME

positions in the next 5 years (add about 500 positions per year). Much has been done by osteopathic postdoctoral training institutions (OPTIs) and others within the OGME community to increase the number of positions. Between 2009 to 2012, 1200 OGME positions were added.<sup>6</sup> Only one-third of these are first-year slots, about 130 slots annually. This growth does not account for the fact that many current positions are traditional internship slots, which do not provide a path to board certification and have been targeted for phasing out by the Council on Graduate Medical Education.<sup>7</sup> Although one could argue that there is more that could be done by the profession to grow OGME, the notion that a 4-fold, year-over-year increase could be realized is doubtful. Furthermore, the fact that many of the currently approved OGME positions are unfilled is not addressed.

The value of OPTIs has been noted.<sup>8</sup> These institutions are governed by a minimum accreditation standard by the AOA's Council on Osteopathic Postdoctoral Training Institutions (COPTI).<sup>9</sup> In spite of this governance, a great deal of heterogeneity exists.<sup>8</sup> The proposed goal that an individual OPTI, which is affiliated with an individual COM, could provide adequate OGME positions for each of the graduates seems quite difficult to measure or realize. Given students' choices for training programs, the percentage of dually accredited programs, and the overlapping geographic footprint of many OPTIs, this type of attribution is unreliable. Adding further infrastructure to require each COM to have a stand-alone OPTI is unlikely to add value and could inject unneeded costs into GME.

The promise and perils of dual accreditation have been continuously debated. History has shown that it is not the proverbial “silver bullet” to improve OGME. A vast majority of programs that are dually accredited are in family medicine, internal medicine, and pediatrics.<sup>10</sup> The only advantage to an ACGME fellowship program gaining AOA accreditation would be to fill positions with qualified candidates. However, fill rates are not a pervasive problem for ACGME fellowship programs. There are few instances in which adding AOA accreditation, even with a “facilitated process,”<sup>74</sup> would add value to an established ACGME-accredited program.

In addition, Dr Terry suggests that the osteopathic medical profession should support legal action against the ACGME aimed at the discriminatory basis of the Common Program Requirement changes.<sup>4</sup> The ACGME based the proposed changes on the need to ensure uniform competencies within ACGME training. Only training performed under the auspices of the ACGME would be acceptable for “advanced standing” into ACGME training. The use of competency-based educational prerequisite training is the same paradigm that the AOA uses to justify allowing only graduates of COMs to enter OGME programs. Consequently, litigation would be both disingenuous and highly unlikely to succeed.

It is clear that changes to the Common Program Requirements brought the AOA, AACOM, and the ACGME to the table to discuss the future of GME in the United States. If that were the only issue, a unified

accreditation system would be less attractive and would have been unlikely to be the culmination of those proceedings. The Common Program Requirements are far from the only issue. Several core challenges, including the following 4 items, restrict the potential for perpetuation of independent OGME:

■ **Governance.** The governance of OGME remains under the full auspices of the AOA. As a membership organization, this structure mandates the concurrence of the osteopathic medical profession’s delegated leaders on OGME policy, which handicaps the innovation and evolution process for OGME. Whether the question is curriculum, faculty, governance, or fees, opponents have an avenue to block change through multiple noneducational venues. The current governance structure also creates budgetary tension between OGME and other priorities of the profession.

■ **Heterogeneity.** Although the AOA maintains a centralized structure for GME accreditation, anyone who has been involved in the process knows that it is far from standardized. In addition to the noted OPTI structure, much of the accreditation work is delegated to specialty colleges. As a result, wide unjustified variation exists in standards development, deployment, and enforcement.

■ **Relevance.** A majority of COM graduates choose ACGME training and have for many years.<sup>6,11</sup> This fact

exists in the face of numerous open OGME positions. Some may argue that this fact is irrelevant because the interest of OGME is training those who desire distinctive osteopathic training. The maintenance of a unique infrastructure to provide training for a minority of the osteopathic medical profession is not constructive to either the profession or the public.

■ **Resources.** Although the previous concerns are daunting, they may be surmountable if substantial resources existed to effect change. Changes in the fee structure and additions of educationally warranted changes that require resources are frequently met with resistance. Examples are system changes such as independent site reviewers and the Performance-Based Accreditation System, or standards changes such as duty hours, service caps, and program director stipends. In the current governance structure, OGME competes for a finite portion of the AOA’s budget. The size of OGME and its limited potential for substantial growth inhibit the ability to reach needed economies of scale that could temper this issue.

Creation of a unified accreditation system will ensure that the governance of GME in the United States is overseen by a body separate from membership organizations. Both the AOA and AACOM will partner with 5 other similar organizations in nominating members to the ACGME board. In this role, leaders in the osteopathic medical profession will play an

integral part in shaping GME policy for the entire system—more than 110,000 trainees—rather than maintaining the AOA's exclusive oversight of about 6% of that number. A unified system will offer greater potential to decrease heterogeneity both in the osteopathic community and the nation. While some of this will be driven by the unification itself, a vast array of educational resources will become available to the current OGME community with this new partnership. These resources will bring changes, but with those changes comes the opportunity to innovate without the handicap of a lack of human and monetary capital.

Relevance is a topic on the mind of many. The answer to the relevance question depends on one's opinion of the current state of OGME. Regardless, for the reasons noted, the ability of the AOA to change the tide, build a new system, and reform OGME from within is limited. Consequently, the path to relevance for OGME and the osteopathic medical profession will need to include new paradigms. As has been noted, the osteopathic profession plays an important role in providing medical care in the United States, particularly in primary care.<sup>4</sup> Although unification of GME is not an endeavor that should be entered into lightly, the ability to lead change, rather than have it forced upon us, exists today for OGME. It may not exist in the future.

Andrew Taylor Still, MD, DO, said, "My father was a progressive farmer and was always ready to lay aside an old plow if he could replace it with one better constructed for its work. All through life, I

have ever been ready to buy a better plow."<sup>12</sup>(p42) The AOA and AACOM becoming partners with other national bodies in the accreditation of GME replaces the current OGME system with one better constructed for its work. (doi:10.7556/jaoa.2014.064)

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Dr Bulger is a member of the AOA-ACGME Joint Task Force and is the former chair of the AOA's Program and Trainee Review Council.

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## Moving From EBM to EBOM: An Osteopathic Perspective on Evidence-Based Medicine

### To the Editor:

As I was drinking my morning tea and reading a POEM (Patient Oriented Evidence that Matters) by Allen Shaughnessy, PharmD (POEM Research Summaries listserve, December 11, 2013), one of my mentors and a US leader in evidence-based medicine (EBM), it occurred to me that EBM is not entirely concurrent with osteopathic philosophy. The POEM by Shaughnessy asked the clinical question, "Do lifestyle interventions decrease adverse clinical outcomes in patients with, or at high risk for, type 2 diabetes?" In short, Shaughnessy said the answer was no. This conclusion was largely reached because the concept that if the evidence does not show how an intervention can

prolong life or decrease morbidity or mortality, then the evidence base does not support its use.

I propose that because the osteopathic philosophy is fundamentally different from that of allopathic medicine, it is incumbent on us osteopathic physicians to apply our philosophy to the evidence and use what I would like to call “evidence-based osteopathic medicine” (EBOM). The fundamental difference from EBM is that EBOM includes optimum health as a central theme. The third edition of our profession’s textbook, *Foundations of Osteopathic Medicine*, highlights that “Health is the adaptive and optimal attainment of physical, mental, emotional, and spiritual well-being.”<sup>1</sup> Never in the history of

osteopathic medicine has the central theme stopped at managing disease. As osteopathic physicians, we have always sought optimum health for our patients.

Evidence-based medicine is an important contribution to the practice of medicine, and I believe all physicians need to make decisions based on EBM. Practicing EBM means that we apply our clinical expertise to the clinical state of the patient while paying particular attention to the patient’s preferences and belief systems and integrating that information with the research evidence to create unique, evidence-based treatments. However, as osteopathic physicians we have the added responsibility to ask if the evidence has a positive or negative impact on our

patient’s abilities to achieve optimum health. Osteopathic medicine has always been about offering something more, and I believe that tradition should continue with EBOM—our approach to EBM. (doi:10.7556/jaoa.2014.047)

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## Correction

The authors regret an error that appeared in the following article:

**Brumm LF, Janiski C, Balawender JL, Feinstein A. Preventive osteopathic manipulative treatment and stress fracture incidence among collegiate cross-country athletes. *J Am Osteopath Assoc*. 2013;113(12):882-890. doi:10.7556/jaoa.2013.066.**

The authors neglected to cite the funding source in their article. The following statement should have appeared on page 882: “Support: This study was supported by a grant from the Health Resources Services Administration Academic Administrative Unit—awarded in 2001 and 2004—and the Department of Family and Community Medicine at Michigan State University, under Department Chairs Margaret Aguwa, DO, and Carol Monson, DO, respectively, each the chair at the time of each grant approval.”

This change will be made to the full text and PDF versions of the article online.