The Six Osteopathic Educational Virtues and the Accreditation of Osteopathic Medical Schools

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In 2020, there exist thirty nine osteopathic medical schools in the United States. These colleges annually graduate approximately 25% of all US medical students enrolled in all MD- and DO-granting medical schools combined. The first osteopathic school, now known as the Kirksville College of Osteopathic Medicine, a component of AT Still University of Health Sciences, produced distinctive practitioners who spread across the continent with a few opening other schools. The biggest growth in colleges, however, has occurred in recent decades. In 1960, there were but five colleges, in 1980; fourteen, in 2000, nineteen, and twenty additional schools have originated since. All osteopathic medical schools are separately accredited by the Commission Osteopathic College Accreditation (COCA). In an era where, it is widely perceived the United States has a significant physician shortage, the osteopathic profession has far exceeded the allopathic medical profession in producing additional qualified individuals to enter graduate medical education and meet this need. Recent developments, however, threaten the autonomy of osteopathic medical school accreditation and the future of osteopathic schools to continue their mission.

The US Department of Education awards deeming status to COCA to accredit osteopathic schools every five years. It may be the next cycle in 2021, or 2026, or 2031, or later, but the American Medical Association (AMA), the Association of American Medical Colleges (AAMC), and other allopathic organizations will likely be making a concerted effort to incorporate osteopathic medical schools into the ranks of institutions subject to accreditation by the Liaison Committee on Medical Education (LCME). Their rationale will likely note that as both allopathic and osteopathic schools produce individuals qualified for graduate medical education as physicians and surgeons, there should be one body to determine standards for all. The groundwork and pathway for this hypothetical consolidation has already been carefully laid by the MD and DO proponents of the “Single Accreditation” graduate medical education system.

Under the agreement which created the “Single Accreditation System” for Graduate Medical Education, whose process commenced in 2015, the American Osteopathic Association would no longer accredit its own graduate programs in 2020. The AOA, along with the American Association of Colleges of Osteopathic Medicine (AACOM) would gain representation on the Board of the Accreditation Council on Graduate Medical Education (ACGME). DOs would become represented, in some cases more than proportionately represented, on Residency Review Committees (RRCs) for each specialty. In addition, the ACGME agreed to preserve “osteopathic distinctiveness” by agreeing to the formation of a new specialty area in “Osteopathic Neuromuscular Medicine” which would be composed of formerly AOA-only accredited residency programs in Osteopathic Manipulative Medicine. Finally, the agreement allowed all ACGME-accredited programs to have the option of achieving what is called “Osteopathic Recognition” status.

Overall, the five-year process worked as intended. In June, 2015, there were 998 listed AOA-only accredited programs, some of which were by then inactive. Of this total number, (as of September 28, 2020), the ACGME reports, 683 currently have ACGME “initial” or “Continued” Accreditation status (68%). A total of 242 osteopathic (and some traditionally allopathic) programs have sought and received “osteopathic recognition” status and there are 28 ACGME-accredited programs in osteopathic neuromuscular medicine. In 2020, the first year without an AOA match process, 90.7% of all osteopathic seniors matched, compared to 93.7% of all allopathic seniors. This performance result by DO seniors is a testament, in part, to better faculty advising but especially to the excellent qualifications of the osteopathic pool of candidates.

At the time the Single Accreditation System was developed, both MD and DO proponents, argued that this combination of two accrediting bodies into one was “in the public interest” and would guarantee the same high standards in all such singly accredited graduate medical education programs. Given the outcomes of the first full year of the single accreditation system, osteopathic proponents have argued it is highly successful.

Nevertheless, one question I posed to the entire AOA and AACOM leadership in 2014 and 2016 has never been satisfactorily addressed by osteopathic

proponents, namely “If a single accreditation system on the graduate medical education level is in the public’s interest, why wouldn’t a single accreditation system on the undergraduate level also be in the public’s interest?”

If the AOA and AACOM, osteopathic schools, faculty, students, and graduates cannot offer a reasoned answer to this question to the US Department of Education, health policy makers, and legislators, then there is no reasoned imperative why a merger of the two undergraduate medical education accreditation bodies should not occur.

The effects of such a merger would likely have a significant impact on the future of osteopathic medical schools. Anyone examining the most recent LCME and COCA sets of standards can see that there is very little difference in the language between the respective standards. However, it is not the standards that would be problematic for osteopathic medical schools but the different “expectations” as to what is necessary to meet each accrediting body’s standards. Although many AOA-only accredited residency programs were able to secure the additional funding and full-time workforce in order to achieve ACGME accreditation expectations; the order of magnitude private osteopathic schools will need in resources is so many times greater to meet LCME expectations. Many osteopathic medical schools given their current annual funding, total number of students in each class, and faculty-student ratios, will not likely fare well in LCME inspections.

I have elsewhere argued that AOA accredited osteopathic schools serve the public interest in six significant ways: First, osteopathic medical schools, despite their limited resources, produce uniformly qualified candidates prepared for graduate medical education; 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 physicians are in shortage; fourth, osteopathic medical students 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 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

implement innovative programs to educate their students and better prepare them for serving the underserved.

The question is: Do these particular educational “virtues” justify the existence of a separate undergraduate medical school accrediting body? The answer, I think, is not necessarily, particularly if we look at them singly rather than collectively.

As to most osteopathic medical school “virtues”, it is only a matter of degree on a continuum, not any fundamental difference that separates allopathic and osteopathic schools in producing graduates who go into primary care or rural medicine. With respect to monetary resources, mission, and finances, allopathic community medical schools look more similar to private osteopathic medical colleges than they do with respect to Ivy League allopathic medical schools. With respect to innovation, neither profession has a monopoly on developing unique educational models.

Even the key “distinctiveness” element in the aforesaid list—Osteopathic Manipulative Medicine (OMM) was reasonably accommodated in the ACGME merger with the establishment of a new type of residency program—Osteopathic Neuromuscular Medicine, and the creation of the status of “Osteopathic Recognition” for those AOA and other programs that wish to maintain an osteopathic focus or identity. There is every likelihood that in possible negotiations between osteopathic and allopathic parties that the persistence of osteopathic diagnostic and therapeutic measures in the school curriculum would be vouchsafed in an agreement with the LCME. As far as the allopathic profession is concerned, “osteopathic manipulative medicine” is analogous to, if not a part of the larger field of “physical medicine” which though not generally a part of undergraduate allopathic training, is nonetheless a traditional residency option.

However, taken collectively, these six educational virtues, explicated with facts and figures from osteopathic medical schools, can provide a reasoned rationale to internal and external audiences to justify continued independent accreditation—at least in the short term, as they serve the “public good”.

I emphasize short term because powerful forces have and will continue to draw members of the osteopathic profession and its institutions into assimilating into the allopathic medical world. The single accreditation system, no matter how well it will work on a practical level, still represents a loss of osteopathic autonomy.

However, it is only the most recent example. Over the decades, by adopting standards and practices similar to those embraced by MD practitioners and institutions; we've seen the complete absorption or loss of all osteopathic hospitals, the number of independent osteopathic licensing boards has declined, allopathic membership associations have increasingly drawn DOs into their ranks; MDs and DOs practice together; and osteopathic graduates are seeking allopathic board certification and joining allopathic specialty colleges.

In addition, fewer DO graduates are incorporating distinctly osteopathic diagnostic and therapeutic tools in their armamentarium. Osteopathic distinctiveness in diagnosis, treatment, and overall management of the patient, were at the center of the osteopathic profession. By moving distinctiveness to the periphery, osteopathic institutions and practitioners have obtained greater acceptance by the allopathic community, but as a result they have made themselves vulnerable to those, both in and outside the profession, who wish to see complete absorption of the profession into allopathic medicine.

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