This issue includes two messages regarding the AOA/ACGME single residency accreditation agreement–one from the OFP Journal Editor in the Editor's Message relating information from interviews, and one from ACOFP President Dr. Carol Henwood relating issues from the 2014 ACOFP Congress of Delegates in Philadelphia, Pennsylvania. Dr. Henwood invites the members to submit opinions and questions via e-mail at president@acofp.org.
*- Amy J Keenum, PharmD, DO, Associate Editor*

# Editor's Message

## Then How the Reindeer Loved Him

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The story of Rudolph is a familiar one: a member of the community, once ostracized, demonstrates that he has a unique and special skill and is consequently welcomed into the fold as an important contributor. We never hear any follow up verse in which Rudolph moves on from what could certainly be a bit of resentment, after having spent some important years being marginalized and ridiculed, only to be redeemed when his peers find him useful. In the television version, though, young Rudolph appears delighted to return from exile on the Isle of Misfit Toys, and to be given a place at the front of Santa's sleigh. Santa and his lead reindeer coach also appear to be ready to let bygones be bygones as well.

Even as a second grader, I remember thinking that Rudolph was a much better sport than I would have been. Shouldn't he have been treated with respect even if the more mainstream reindeer HADN'T found a use for him? Is he supposed to have such a short memory that he can completely disregard the fairly caustic treatment he received at the hands (or hooves) of his now-teammates? Is he supposed to relax and just assume his space on the team is forever secure? I'm from New England. We know how to hold a grudge.

I've been thinking a lot about Rudolph as the two parallel residency systems in the United States unveil a plan for unified accreditation. On the one hand, recognition that we are just as good as the "big boys" is appealing. On the other hand, I'm a little paranoid. I like the specialness of being a DO and do not want so see my identity diluted as our post graduate education merges in to a larger pool. Another part of me is annoyed that it took so long.

Discussion with my osteopathic colleagues suggests they also need some explanations and reassurance. A conversation among the national members of the Association of Osteopathic State Executive Directors revealed a list of concerns and questions that had been generated by the membership.

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Fortunately, one of the many marvelous aspects of our profession is that the leadership is perennially accessible and communicative. OFP had the good fortune to bring some of these questions to two important leaders of the osteopathic educational world. One was Steve Shannon, DO, president and CEO of the American Association of Colleges of Osteopathic Medicine. The second was Boyd Buser, DO, an AOA Trustee, Vice President for Health Affairs, and the Dean of Pikeville College of Osteopathic Medicine.

"Part of the frustration people have is that they want answers which we don't have yet," explained Dr. Shannon. "We are still working this out."

Both DO's made clear that the plan to develop a single accreditation system came out of several years of work and consideration, and was not done capriciously. The drive for a common system of evaluation of arose from the particular environment in which physicians are trained in the United States.

With the new universal standards of quality metrics, patient safety standards, etc, as Dr. Shannon remarked, "we are all very confident that we are doing a good job, but we need to be able to demonstrate it in ways we haven't had to demonstrate it before. We also need to demonstrate that there is a level playing field for quality metrics that is easy and understandable. We expect that we will be under microscope more than we are now, because we are the only country in the world that does not have government oversight of our GME system, and the more we can demonstrate that the way we measure it is the way other people measure it, the simpler it will be for people to understand our system. "

Dr. Buser adds, "Back about a year ago, we arranged meetings between the representatives of our specialty evaluating committee and the corresponding Residency Review Committees, or RRCs, which include obstetrics, surgery, orthopedics, etc. At those meetings were three representatives from each faction. The purpose was to review the crosswalk of

the standards between ACGME and AOA. And to determine if there were 'red light' issues, ie, would our programs be at risk. What we found generally were that there were not many red light issues."

What about the concern that increased cost for ACGME accreditation will be beyond the budget for some OGME hospitals? Won't those programs be forced to close?

Dr. Shannon doubts it. "If a hospital does not value medical education and residency training in their system, it's always questionable, but I couldn't imagine a change in fee structure being a decision maker in this. "

Buser is careful to assert, "I don't want to say that there is no impact here. When you look at the per-resident amounts for Medicare, a lot of the osteopathic programs were set at a lower per resident amount, so they were not getting as much as a larger ACGME program in a big academic medical center. But is it going to cause programs to close? It didn't seem like it from those committee meetings. If anything, there will be advocacy to level those amounts. ACGME is going to want all of the programs to have the resources they need to succeed. "

Dr. Buser was asked about some members' concerns that a hospital which had two parallel accredited programs might now be moved to discontinue the AOA track. He does not think this is a real concern. "A hospital has a cap for Medicare graduate medical education funding and a certain amount of FTE's for the staff, regardless of whether they are ACGME or AOA positions. The fact that both are now ACGME shouldn't lead that hospital to want to ditch a bunch of doctors or to reduce the amount of residents they train. That number would remain constant."

Dr. Shannon agrees that a unified system actually will incentivize more access to programs for DO applicants. "Assuming this happens the way we believe it will, you will go into a single match, have a whole group of residencies to pick from in the specialty you want…if you want to do more after that, you will have access to fellowship training that you wouldn't have access to before. After 2016, in the original plan, residents who had training in AOA programs would not receive advanced credit for that training. You couldn't get credit for a traditional rotating internship. Now you can. When you complete a recognized orthopedic program, there will be no difference in fellowship opportunities based on your training, as in "we are only taking two DO's this year."

So how is this different from total assimilation? How can we be assured our osteopathic identity is being preserved?

Dr. Shannon explained that there will be a special recognition committee will be established, consisting of 15 members, 13 of whom will be DO's, two of whom will be recommended by ACGME. They will be empowered to set the standard by which all ACGME specialty training will be recognized as osteopathic. This will provide continuity beyond medical school, and into residency and fellowship training. In addition to that, the committee will include any ACGME program which wants to seek that recognition. "Right now," Shannon points out, "we have 60% of our graduates leaving osteopathic programs to go to ACGME. If anything, this might extend the presence of the osteopathic identity further. Expand our influence further. They will have to earn it, it won't be a rubber stamp."

And this is something that the ACGME cares about?

"We have heard a great deal of interest on the part of the ACGME, they see it as something special," replies Dr. Shannon. Dr. Buser agrees. "One of the overarching things here besides preserving access for future training is that under this new system, osteopathic principles are recognized and codified in it. It is not insisting on our unique features going away, they are including them explicity. That's where we see a real opportunity."

Then how the reindeer loved him. This is, if everything goes according to plan and if the current ACGME programs function the way they say they will. What if there is discrimination anyway? What recourse would a DO have?

Buser replies, "There is not a simple answer. Traditionally osteopathic programs that have mostly DO faculty and so forth will probably continue to prefer to accept DO's as candidates that are likely to fit in well and meet the goals of the program. MDs will be eligible to enter programs with osteopathic recognition as well, although there may be additional training required for those MDs who want to. The ACGME already has situations like this; anyone who wants to do a neurosurgery residency has to attend certain other residencies first to demonstrate certain competencies.

"There may be a number of ACGME programs that say, 'we like to take applicants from Ivy League schools and that's what we prefer. ' Where does preference cross the line into discrimination? Not an easy thing to adjudicate. From the AOA's perspective, you'd handle it the same way we do now."

Dr. Buser tells the story of a DO graduate in Maine who finished an ACGME family medicine program, and a hospital residency wanted to hire her but according to existing bylaws, they couldn't allow her to be credentialed. The program had AOA accreditation but the hospital would not accept her staff privileges. "We are hoping that the unification will actually preclude this kind of thing because we will all have the same standards. The perception that we don't have quality programs will go away because we all have the same requirements."

Many hospitals sponsor DO medical student clerkships as they have osteopathically accredited GME programs and view students as recruitment candidates. How will these clerkships be retained now that hospitals can recruit all students?

From Dr. Shannon's perspective, "Clinical training for our students is a core aspect of what we do. This is a very important question for us. We think there are more opportunities for us now that this is happening. All of our students are very attractive in the GME world, our match rate keeps going up. Programs like our students. All of our colleges create their training systems based on not only the GME component but a bunch of other factor community based vs hospital training, etc. Some training may not even be at a place that has a residency. That said, our students won't get in to hospitals unless they have a chance to check them out. There will be competition always. We will be monitoring closely."

Dr. Buser acknowledges that competition will exist. "There will be clerkships that are now open to everyone in terms of 4th year rotations for sure. But I don't see that MD students are suddenly going to come in and replace DO students in the clerkships. More than worrying about each other, both groups are worried about the International Medical graduate competition."

How about those in leadership at these residencies? One change is that under the ACGME accreditation standards, the position "DME" does not even exist — there are only Designated Institutional Officials. DIO's do not need to be board certified ; in fact, they do not even need to be physicians. Most of them are, but it's not a requirement.

The greater concern might be for program directors. Could AOA certification now make it easier for a physician to be excluded from opportunities?

Dr. Buser doubts it. "This is not about whether the board certification has legal standing. It has more to do with if you understand the process of how an ACGME program is accredited, and in that case, obviously having been through one would be helpful. But it is not true that osteopathic board certification is not acceptable. And it will be within the ability of the Residency Review Committee to accept that certification. The RRC will look at the quality of the program and the extent to which the program is meeting that standard. The real question: are the program directors going to be treated fairly, and evaluated according to what they have done and the quality of their program, not according to some kind of litmus test like ACGME vs AOA. That discretion is built into the agreement and the RRC, and there is an existing committee, the RRC monitoring committee, made up of members of the ACGME board. Both AOA and ACGME will have representation on that committee. The joint task force has been working on this for the past two years and is explicit that this will remain in place."

So there is the possibility that a person who is board certified through the AOA may be acceptable. Why is it not automatically acceptable?

Dr. Shannon admits, "We wrestled with that. Bear in mind that ACGME is governed by 5 membership organizations. They are: the AMA, American Hospital Association; American Medical Colleges, the Council of Medical Specialty Societies, and the American Board of Medical Specialties. ABMS is the assumed certification organization. It was hard to affect that standard, but there were four things that occur which are protective: 1) there are a number of program directors who are not ABMS specialties but are AOA certified, for example emergency medicine, FP…some already exist; 2) the RRC does have the power to provide exceptions to people who aren't ABMS certified; 3) for those programs in which there is an issue, there could be co-program directors; 4) the only way we can continue to change this recognition is that we are part of the organization which sets the standards. Which we now are becoming."

Buser adds, "There will undoubtedly be rough spots. You can't just flip a switch and expect it will all be perfect. We were assured explicitly that we will be involved in the operations of this system as it unfolds. "

Dr. Shannon hopes that the involvement includes the AOA membership as well as the leadership. "There are many allies for osteopathic medicine within the allopathic world in the ACGME system. We find a great deal of respect, and even more now that we are working within the system. If it's good for us, it should be good for anyone.

"I also recognize and respect those who are questioning why this was done, and how it will work, and this is a natural and appropriate attitude to have. I would ask those who are wondering this, how will they judge what is working? What will you be looking back on to figure out if it worked or not? We want to have ongoing education and revision."

Dr. Shannon also hopes that our DO graduates under the new ACGME system remain, "not just one more fish in a big pond, but a goldfish in a big pond."

Or, one might say, the red nosed reindeer at the front of the pack.

Special thanks to Dr. Boyd Buser and Dr. Stephen Shannon for their participation.