CORR Curriculum — Orthopaedic Education

CORR® Curriculum – Osteopathic and Allopathic Residency Education: Why Not the Same Standards?

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There are two different accreditation pathways for orthopaedic surgery residency programs. One pathway is designed for doctors of osteopathic medicine (DO) and the other pathway is intended for allopathic medical school graduates (MD). But earlier this year, Dr. Thomas J. Nasca, Chief Executive Officer of the Accreditation Council on Graduate Medical Education (ACGME), outlined an unprecedented and historical shift in the way graduate medical education (GME) will be pursued. A tentative agreement among the three

governing boards – ACGME, American Osteopathic Association (AOA), and the American Association of Colleges of Osteopathic Medicine – will give the ACGME sole responsibility for the accreditation of training for all residency programs, both allopathic and osteopathic.

In order to implement this new agreement, which Dr. Nasca described as “a major event in American medicine” in a March 13 open letter to the GME community, osteopathic programs must comply with the ACGME standards for institutional accreditation

(Fig. 1). Osteopathic programs may apply for ACGME accreditation beginning in 2015 and they are expected to complete the application for accreditation by 2020 (Fig. 2).

But questions still remain. How will the ACGME, AOA, and the American Association of Colleges of Osteopathic Medicine structure this new agreement? Will a cohesive and shared interdependency on the best and most creative training and certification elements, currently existing in both ACGME and AOA systems, really work?

Prior to this agreement, the ACGME provided accreditation for orthopaedic residency programs and physicians who became board certified by the American Board of Orthopaedic Surgery (ABOS). The AOA provided accreditation for osteopathic residency programs, as well as a training pathway for DOs. The ACGME-accredited programs, on the other hand, are specifically designed for MDs. Crossover can and does occur when a DO graduate takes the United States Medical Licensing Examination, and completes an ACGME approved residency. The DO graduate is then eligible for taking the ABOS certifying examinations. The reverse does not happen;

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Fig. 1 This flow chart shows the present system of Allopathic (MD) and Osteopathic (DO) education.

allopathic medical school graduates do not apply for osteopathic residency programs.

Currently, there are 39 osteopathic and 162 allopathic orthopaedic surgery residency programs in the United States [3, 5]. While their goals are the same – produce competent and safe orthopaedic surgeons – how osteopathic and allopathic programs obtain those goals are quite different (Table 1). Osteopathic programs have the initial years at the primary institution, then residents rotate at other institutions for more specialized rotations. For the last year of training,

6 months must be spent at the primary institution. Because of this, the osteopathic programs generally have a more “community” feel to them, with competence gained in areas of general orthopaedic surgery. The programs often are dependent on the strength of other institutions to provide the subspecialty rotations. The subspecialty rotations have a minimum number of cases or length of rotation time required.

Allopathic programs tend to be more subspecialty-based, with rotations based on each subspecialty (spine, orthopaedic trauma, hand

surgery). The adult-education principle favoring subspecialty rotations is believed to provide the best learning environment. However, increasingly, graduates seem to be taking postresidency fellowships to make up for perceived deficiencies in education – to subspecialize in an area, and/or to enhance their “marketability”. Very few graduates use the extra training as a means to get an academic job. Most graduates, postfellowship, go to a general practice with a subspecialty interest. This trend is occurring when the need for general orthopaedic surgeons is expected to increase [4].

While the goal of providing a single GME accreditation system is laudable, program directors and others who are expected to implement these changes have raised concerns. First, there are concerns that some osteopathic programs could close if they cannot meet the ACGME standards quickly enough, therefore losing a program which may have been producing safe clinicians for a number of years. The ACGME has indicated its interest in preventing program losses and assisting smaller programs. The 5-year transition period (2015 to 2020) will permit multiple program reviews if necessary without additional costs beyond the initial ACGME application fee. This will allow for examination of a program over time to ensure an adequate educational environment.

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Fig. 2 This flow chart shows the proposed changes for accreditation in Graduate Medical Education.

Second, we are concerned that the American Board of Medical Specialty, which is an ACGME member organization, does not currently recognize the AOA board certification of faculty members or program directors of osteopathic programs. Faculty for ACGME-accredited programs must be ABOS certified. Those who have been program directors under the AOA system do not meet this requirement because current AOA rules require an American Osteopathic Board of Orthopaedic Surgery (AOBOS) certified surgeon. In fact, the current AOA

guidelines require a program director who is at least 3 years post-AOBOS certification. Clearly, there are well-qualified educators under the osteopathic system, some of whom have considerable educational and clinical experience. While some leeway presently exists in the language for qualified orthopaedic surgery faculty, the orthopaedic surgery Residency Review Committee adjudicates whether a program director has “specialty qualifications that are acceptable to the review committee” [2] if non-ABOS certified. To expect the qualified

AOBOS surgeon to return and repeat board certification, especially after years of practice, may be onerous. Program directors for DO programs who are non-ABOS certified should be individually assessed by the Residency Review Committee with regards to leadership, clinical ability, and educational track record.

The American public demands increased accountability (documentation and records) of doctors in practice. It seems intuitive that the same standards should apply to any orthopaedic surgeon (DO or MD) who practices in

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the United States. While there is emphasis on integrating osteopathic principles, philosophy, and practice (treating the “whole patient” and use of “manipulative techniques”) to differentiate osteopathic doctors, the reality is that osteopathic orthopaedic surgeons are engaged in the same

practices as allopathic doctors. Ultimately, they do have the same standards for care of patients with osteoarthritis, ACL deficiency, or a hip fracture. An “osteopathic principles” focus may be separately incorporated into programs as an option for its residents.

Having one accreditation body for the residency programs is a logical step in the right direction. It also makes sense that the certification process is based on unified education standards. Osteopathic program directors, who are non-ABOS certified, should be individually evaluated by

Table 1 Current education standards for allopathic and osteopathic orthopaedic residency programs

	Allopathic programs (months)	Osteopathic programs (months)
PGY 1 year	Orthopaedic surgery (6) General surgery specialties (trauma, plastics, burn) (3) Anesthesia, emergency medicine, surgical skills, neurosurgery, radiology (3)	Internal medicine (2) Emergency Medicine (1) General orthopaedic surgery (3) Nonorthopaedic surgical rotation-general, urology, plastic surgery, trauma, burn (2) Family Medicine (1) Electives to include orthopaedic surgery subspecialties, anesthesia, radiology, neurology, neurosurgery, rehabilitation (3)
PGY1 surgical skills	(see above) Structured surgical skills curriculum to provide education and assessment in basic surgical skills [1].	No required structured surgical skills curriculum
PGY2-5 rotations	Must satisfy: Case log minimums and milestones procedures Must have experience in: Hand Spine Adult Reconstruction Foot and Ankle Sports Trauma Musculoskeletal oncology Amputations and Prosthetics Rehabilitation	Must have procedure log with a minimum 400 arthroscopy cases. 100 cases or 3 month rotation in each of the following: Hand Trauma Foot and Ankle Pediatric 50 cases or 3 months in Spine
Assessment	Milestones evaluations with 18 topics	No required topic assessments as milestones, but see above.

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the orthopaedic surgery Residency Review Committee, based on individual qualification, accomplishments, program history, and leadership ability in determining program director status, rather than which agency issued the program director's certification.

A transition plan, in which the AOBOS certification is deemed acceptable for program directors given the above criteria, would allow for a period of time to adjust the Board Certification status. The transition plan might include a time limit of perhaps 10 years to 15 years, in which program directors and faculty are all expected to be ABOS certified. This will allow for a smooth transition. Those who originally certify with AOBOS should be allowed to recertify after the time limit under the ABOS.

The orthopaedic community should take this opportunity to review all aspects of medical education standards. A good example might be

review of the Milestones topics, and decide if there is evidence to support the present specific topics as representative of general orthopaedic surgery, and modifying the topics if necessary. A second example might be reviewing the minimal cases numbers required for education from the AOA and ACGME and deciding which might be optimal. With an agreement in place, there is a window to combine the best available standards from both the AOA and ACGME programs, and if the ACGME can properly execute this agreement, our patients will benefit.

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