American Academy of Osteopathy®

AAO Position Paper: Recommended Knowledge Base for Entering ACGME Residencies With Osteopathic Recognition

Abstract

With the advent of the unified system for accreditation of graduate medical education (GME), health care in the United States is at a turning point that offers exciting possibilities to expand access to osteopathic care to more patients than ever before. With this opportunity for growth also comes the need to vigilantly preserve the qualities of osteopathic GME that honor our heritage and that are likely to secure our future. Regardless of whether those entering residency programs with osteopathic recognition are doctors of osteopathic medicine (DOs) or medical doctors (MDs), making sure that all of these residents begin their training with a baseline level of knowledge and skill in osteopathic medicine can only enhance the quality of these programs and the quality of the care provided by their graduates.

Background

Ensuring that MD graduates entering GME programs with osteopathic recognition accredited by the Accreditation Council for Graduate Medical Education (ACGME) have a consistent knowledge base presents an interesting conundrum, given that the curricula at the osteopathic medical colleges accredited by the American Osteopathic Association's Commission on Osteopathic College Accreditation (COCA) vary widely in the number of hours of education devoted to osteopathic manipulative medicine (OMM).

According to data from the 2012-13 academic year compiled by the American Association of Colleges of Osteopathic Medicine (AACOM), osteopathic medical students receive an average of 82 total hours of lectures on OMM during their first two years of undergraduate medical education. Depending on the osteopathic medical college, the lecture hours range from 19 to 161, with the majority of schools falling between 42 to 116 hours. In addition, first- and second-year students receive an average of 140 hours of laboratory instruction and hands-on practice in OMM. The range is even broadr for laboratory time than lecture time, ranging from 83 to 332 hours, with the majority of the colleges falling between 83 and 186 hours.[1]

In a white paper outlining its recommendations for the transition to the single GME-accreditation system, AACOM suggests that MD graduates will need a basic understanding of osteopathic philosophy and technique approaches to enter ACGME-accredited residencies with osteopathic recognition. To achieve this, AACOM is proposing that MD graduates could undergo separate training in OMM during the first year of their residency training, with the goal of reaching the knowledge and skill levels DOs have upon graduating from osteopathic medical colleges.[2]

In establishing program requirements for GME programs with osteopathic recognition, the ACGME's Osteopathic Principles Committee (OPC) outlined basic eligibility requirements for residents entering these programs.[3] Although the OPC's program requirements are all-encompassing, they are insufficiently specific to ensure that MD residents will have adequate knowledge and skill to participate in these programs in a meaningful way.

3500 DePauw Blvd., Suite 1100 • Indianapolis, IN 46268-1136
(317) 879-1881 • (317) 879-0563 (fax) • www.academyofosteopathy.org

Recognized as the "keeper of the flame of OMM" by many in the osteopathic medical profession, the American Academy of Osteopathy (AAO) determined that it should put forth its recommendations for the baseline knowledge in osteopathic medicine that DO and MD graduates should attain prior to entering ACGME-accredited residencies with osteopathic recognition, regardless of specialty.

Position

In determining its recommendations for requisite fundamentals of osteopathic knowledge, the AAO first reviewed the following documents:

- the curricula of several osteopathic medical colleges.
- the basic educational modules of the Educational Council on Osteopathic Principles, the AACOM council charged with creating guidelines for OMM instruction for all first- and second-year students at COCA-accredited colleges.[4]
- the National Board of Osteopathic Medical Examiners' testable somatic dysfunction and osteopathic technique lists.

Based on its assessment of those documents' strengths and weaknesses, the AAO proposes that all DOs and MDs entering ACGME-accredited residencies with osteopathic recognition receive both didactic and practical education in the following 22 areas:

1. osteopathic history
2. osteopathic philosophy and tenets
3. applied anatomy and physiology
4. surface anatomy focused on landmarks used for structural diagnosis
5. palpation of landmarks, as well as skin, fascia, muscle, and bone
6. anatomy of the musculoskeletal, neurologic, and visceral systems
7. principles of somatic dysfunction, including barrier concepts
8. biomechanics of spinal movement and extremities
9. dysfunction of axial, appendicular, and visceral structures
10. cranial anatomy and basic strain pattern dysfunctions
11. basic principles of manipulation, including indications, contraindications, and integration with standard medical care
12. five models of osteopathic manipulative treatment (OMT)
13. specifics of OMT techniques, including the physiologic mechanisms and palpatory diagnosis related to the following techniques:
    a. soft tissue
    b. myofascial release
    c. lymphatic
    d. muscle energy

e. high-velocity, low-amplitude thrust
f. articulatory
g. strain-counterstrain
h. indirect, including balanced ligamentous tension, functional, facilitated positional release, and Still
i. osteopathic cranial manipulative medicine
j. visceral

14. concepts of facilitation and viscerosomatic, somatovisceral, viscerovisceral and somatosomatic reflexes

15. Chapman reflexes

16. posture, gait, and motor function

17. exercise prescription

18. Use of OMM in all patient populations, especially the following:
    a. pediatric patients
    b. adults
    c. obstetrical patients
    d. geriatric patients
    e. postoperative and hospitalized patients

19. Use of OMM in treating patients for systemic illnesses of all body systems, especially the following:
    a. cardiovascular
    b. upper and lower respiratory
    c. gastrointestinal
    d. genitourinary
    e. neurologic
    f. musculoskeletal

20. Use of OMT for treating patients for all common clinical problems and syndromes related to all anatomic regions, especially the following:
    a. cranium
    b. cervical spine
    c. thoracic spine
    d. lumbar spine
    e. sacrum
    f. innominates
    g. rib cage, sternum, and thoracic contents
    h. upper extremities
    i. lower extremities
    j. abdomen, as well as abdominal and pelvic contents

21. research on OMT

22. OMT coding and billing

The AAO recommends that COCA-accredited osteopathic medical colleges review their curricula to ensure that all of the topics above are covered so that DO graduates meet all of the prerequisites to enter ACGME-accredited residencies with osteopathic recognition.

For residents who did not attend COCA-accredited colleges, the AAO believes this knowledge could be obtained through multiple formats. Several of the topics, for example, could be learned through self-study of recorded lectures and learning modules, which would allow MD students and residents to fit this additional training into their busy schedules. However, palpation and training in OMT techniques clearly would require in-person education and practice time. The AAO advocates that the OPC specify a minimum number of hours of hands-on education for applicants to residency programs with osteopathic recognition.

The AAO further recommends that throughout the education process for baseline knowledge in OMM, periodic assessments be conducted to demonstrate competency. A summative assessment is recommended at the end of this training so that residency directors have a high level of confidence in accepting MDs who have completed the training.

This training could be separated into the last year of medical school and the first year of residency. Because the first year of most current osteopathic GME programs is very similar to the transitional year in ACGME-accredited residencies, it would be possible for MD residents to use this year to catch up with DO residents in terms of OMM training. Regardless of whether MDs complete this baseline training before entering residencies or split the training between their last year of medical school and their first year of residency, the critical goal is that MDs and DOs enter the second year of their residencies with equivalent backgrounds on which to build their osteopathic specialty training.

Conclusion

The AAO believes that the unified GME-accreditation system provides the best opportunity to date for realizing the dream of Andrew Taylor Still, MD, DO, that all patients are treated osteopathically. The new GME system also has great potential for advancing the Academy's new vision statement: "All patients are aware of and have access to osteopathic medical care and osteopathic manipulative medicine for optimal health."[5]

Considerable care, however, must be taken in determining what constitutes the appropriate level of OMM education for MDs so that the essence of osteopathic care remains consistently excellent and true to the spirit of our founder's vision. The AAO supports rigorous, comprehensive, documented education in OMM for all MDs prior to beginning specialty training in ACGME-accredited residencies with osteopathic recognition.

References

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Adopted July 2015
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