

**HOD ACTION: Council on Medical Education Report 12 adopted and the remainder of the report filed.**

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 12-A-09

Subject: Recognition of Osteopathic Education and Training  
(Resolution 302, A-08)

Presented by: Claudette E. Dalton, MD, Chair

Referred to: Reference Committee C  
(Rodney G. Hood, MD, Chair)

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1 Resolution 302 (A-08), "Recognition of Osteopathic Education and Training," submitted by the  
2 American Orthopaedic Foot and Ankle Society and referred to the Board of Trustees, asked that  
3 our American Medical Association (AMA):

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5 Recognize the current similarities in the accreditation and certification systems for  
6 allopathic and osteopathic physicians and encourage greater collaboration between  
7 and mutual recognition of education, training, and board certification systems.  
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9 At Reference Committee C, testimony expressed a wide range of opinions on this resolution and  
10 described some of the complexities associated with it. This report will provide information  
11 regarding the general similarities, but also differences between allopathic and osteopathic medical  
12 education accreditation and certification systems.  
13

#### 14 ACCREDITATION SYSTEMS

##### 15 *Allopathic Medicine*

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17  
18 Since 1942, the Council on Medical Education of the AMA and the Executive Council of the  
19 Association of American Medical Colleges have sponsored the Liaison Committee on Medical  
20 Education (LCME). The LCME is recognized by each licensing jurisdiction in the United States  
21 and presently accredits the medical education programs of 130 schools of medicine. The United  
22 States Department of Education recognizes the LCME for accreditation of programs of medical  
23 education leading to the MD in the United States. For Canadian medical education programs, the  
24 LCME engages in accreditation in collaboration with the Committee on Accreditation of Canadian  
25 Medical Schools.  
26

27 Accreditation by the LCME is required for schools to receive federal grants for medical education  
28 and to participate in some federal loan programs. State medical licensing boards require that U.S.  
29 MD-granting medical schools be accredited by the LCME, as a condition for licensure of their  
30 graduates. Eligibility of U.S. students to take the United States Medical Licensing Examination  
31 (USMLE) requires LCME accreditation of their school. Graduates of LCME-accredited schools  
32 are eligible for entry into residency programs accredited by the Accreditation Council for Graduate  
33 Medical Education (ACGME).

1 *Osteopathic Medicine*

2  
3 Since 1952, the American Osteopathic Association’s Commission on Osteopathic College  
4 Accreditation (AOA COCA) is recognized by the United States Department of Education as the  
5 only accrediting agency for predoctoral osteopathic medical education in the United States. The  
6 AOA COCA currently accredits 25 colleges of osteopathic medicine.

7  
8 The COCA serves the public by establishing, maintaining and applying accreditation standards and  
9 procedures to ensure that academic quality and continuous quality improvement delivered by the  
10 colleges of osteopathic medicine reflect the evolving practice of osteopathic medicine. The scope  
11 of the COCA encompasses the accreditation of the colleges.

12  
13 *Accreditation Standards Related to the Structure and Content of the Allopathic and Osteopathic*  
14 *Educational Program*

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16 As of 2008, there were a total of 50 COCA and 131 LCME-accreditation standards. A comparison  
17 of areas covered in the LCME and COCA standards revealed that many of the same areas were  
18 addressed in both but that there were particular topics that did not appear in both sets of standards.

19  
20 Representative accreditation standards related to the structure and content of MD- and DO-granting  
21 medical schools are included as an Appendix.

22  
23 CERTIFICATION SYSTEMS

24  
25 *Allopathic medicine* – Certification is recognition by one of the 24 approved specialty boards (145  
26 specialty and subspecialties) of the American Board of Medical Specialties (ABMS) that an MD  
27 has achieved expertise in a medical specialty or subspecialty. Requirements are: graduation from  
28 an LCME-approved or COCA-accredited medical school, satisfactory completion of the  
29 appropriate full-time residency training program requirements, an unrestricted valid license in the  
30 state or region in which they wish to practice medicine, and passage of a written and/or oral board  
31 certifying examination. Certification by an ABMS specialty board is not a requirement to practice  
32 in a medical specialty.

33  
34 *Osteopathic medicine* – Certification is recognition by one of the 18 AOA approved specialty  
35 boards (88 specialties and subspecialties) that a DO has achieved expertise in a medical specialty or  
36 subspecialty. Certification by an AOA approved board is not a requirement to practice in a medical  
37 specialty. Certification requirements vary by specialty. At a minimum, all AOA Board-certified  
38 physicians must have graduated from an AOA COCA accredited medical schools, be accepted as a  
39 registrant by the appropriate AOA specialty board, satisfactorily completed an AOA-approved  
40 internship and the practice requirement and of an AOA-approved residency or preceptorship  
41 program if applicable, and are active and remain in good standing with the AOA. DOs can receive  
42 certification through one of the member boards of the ABMS by meeting the requirements of that  
43 ABMS Board.

44  
45 AMA POLICY

46  
47 AMA policy supports equal access to licensure for graduates of US MD- and DO-granting schools.  
48 Policy H-295.995 [27] (AMA Policy Database) “recommends to state medical licensing authorities  
49 that they require individual applicants, to be eligible to practice medicine, to possess the degree of  
50 Doctor of Medicine or its equivalent from a school or program that meets the standards of the  
51 LCME or accredited by the American Osteopathic Association....”

1 Existing AMA policy also considers only Doctors of Medicine (MD) and Doctors of Osteopathic  
2 Medicine (DO) to be termed “physicians and surgeons” (Policies H-405.989, H-405.976). AMA  
3 policy also supports equal access to educational opportunities for students at MD- and DO-granting  
4 schools. Policy H-295.876 [1] states that our “AMA, in collaboration with the American  
5 Osteopathic Association, discourages discrimination against medical students by institutions and  
6 programs based on osteopathic or allopathic training.”  
7

## 8 SUMMARY AND RECOMMENDATIONS 9

10 As described there are many similarities in the structure and content of educational programs  
11 leading to the MD- and DO-degrees. AMA policy fully supports the concept that both individuals  
12 with MD and DO degrees be termed “physicians” and also supports the participation of individuals  
13 with DO degrees in the membership of the AMA and in the Federation (Policy G-635.053).  
14

15 While informal communications occur at many levels, there are, however, limited mechanisms for  
16 formal dialogue between the allopathic and osteopathic medical education communities. The  
17 Council on Medical Education, therefore, recommends that the following be adopted in lieu of  
18 Resolution 302 (A-08) and that the remainder of this report be filed.  
19

20 That our American Medical Association explore the feasibility of collaborating with other  
21 stakeholder organizations and funding agencies to convene leaders in allopathic and  
22 osteopathic medicine responsible for undergraduate and graduate medical education,  
23 accreditation and certification, to explore opportunities to align educational policies and  
24 practices. (Directive to Take Action)

Fiscal Note: \$10000 for meeting costs and staff time for report preparation.

APPENDIX  
SELECTED ACCREDITATION STANDARDS FOR THE EDUCATIONAL PROGRAM

*Relevant LCME Accreditation Standards*

1. General Design of the educational Program

ED-4. The program of medical education leading to the MD degree must include at least 130 weeks of instruction.

ED-5. The medical faculty must design a curriculum that provides a general professional education, and that prepares students for entry into graduate medical education

ED-5-A The educational program must include instructional opportunities for active learning and independent study to foster the skills necessary for lifelong learning.

ED-6. The curriculum must incorporate the fundamental principles of medicine and its underlying scientific concepts; allow students to acquire skills of critical judgment based on evidence and experience; and develop students' ability to use principles and skills wisely in solving problems of health and disease.

ED-7. It must include current concepts in the basic and clinical sciences, including therapy and technology, changes in the understanding of disease, and the effect of social needs and demands on care.

ED-8. There must be comparable educational experiences and equivalent methods of evaluation across all alternative instructional sites within a given discipline.

ED-9. The LCME must be notified of plans for major modification of the curriculum.

ED-10. The curriculum must include behavioral and socioeconomic subjects, in addition to basic science and clinical disciplines.

ED-11. It must include the contemporary content of those disciplines that have been traditionally titled anatomy, biochemistry, genetics, physiology, microbiology and immunology, pathology, pharmacology and therapeutics, and preventive medicine.

ED-12. Instruction within the basic sciences should include laboratory or other practical opportunities for the direct application of the scientific method, accurate observation of biomedical phenomena, and critical analysis of data.

ED-13. Clinical instruction must cover all organ systems, and include the important aspects of preventive, acute, chronic, continuing, rehabilitative, and end-of-life care.

ED-14. Clinical experience in primary care must be included as part of the curriculum.

ED-15. The curriculum should include clinical experiences in family medicine, internal medicine, obstetrics and gynecology, pediatrics, psychiatry, and surgery.

ED-16. Students' clinical experiences must utilize both outpatient and inpatient settings.

ED-17. Educational opportunities must be available in multidisciplinary content areas, such as emergency medicine and geriatrics, and in the disciplines that support general medical practice, such as diagnostic imaging and clinical pathology.

ED-17-A. The curriculum must introduce students to the basic principles of clinical and translational research, including how such research is conducted, evaluated, explained to patients, and applied to patient care. [New standard approved by the LCME in February 2007; effective July 1, 2008.]

ED-18. The curriculum must include elective courses to supplement required courses.

ED-19. There must be specific instruction in communication skills as they relate to physician responsibilities, including communication with patients, families, colleagues, and other health professionals.

ED-20. The curriculum must prepare students for their role in addressing the medical consequences of common societal problems, for example, providing instruction in the diagnosis, prevention, appropriate reporting, and treatment of violence and abuse.

ED-21. The faculty and students must demonstrate an understanding of the manner in which people of diverse cultures and belief systems perceive health and illness and respond to various symptoms, diseases, and treatments.

ED-22. Medical students must learn to recognize and appropriately address gender and cultural biases in themselves and others, and in the process of health care delivery.

ED-23. A medical school must teach medical ethics and human values, and require its students to exhibit scrupulous ethical principles in caring for patients, and in relating to patients' families and to others involved in patient care.

ED-26. The medical school faculty must establish a system for the evaluation of student achievement throughout medical school that employs a variety of measures of knowledge, skills, behaviors, and attitudes.

ED-27. There must be ongoing assessment that assures students have acquired and can demonstrate on direct observation the core clinical skills, behaviors and attitudes that have been specified in the school's educational objectives.

ED-28. There must be evaluation of problem solving, clinical reasoning, and communication skills.

ED-29. The faculty of each discipline should set the standards of achievement in each course and clerkship.

ED-30. The directors of all courses and clerkships must design and implement a system of formative and summative evaluation of student achievement in each course and clerkship.

ED-31. Each student should be evaluated early enough in a unit of study to allow time for remediation.

ED-32. Narrative descriptions of student performance and non-cognitive achievement should be included as part of evaluations in all required courses and clerkships where teacher-student interaction permits this form of assessment.

*Relevant COCA Accreditation Standards*

General Requirements

6.1 The College of Medicine (COM) must develop and implement curricula designed to achieve its mission and objectives.

6.1.1 The minimum length of the osteopathic medical curricula must be at least four academic years or its equivalent as demonstrated to the COCA.

Guideline: The curriculum should provide at least 130 weeks of instruction.

6.2 The COM must develop and implement ongoing review and evaluation of the curricula, and demonstrate application of the findings towards improvement of the educational program.

6.3 The COM must provide for integration of osteopathic philosophy principles and practices throughout the entire curricula, including its clinical instruction.

6.4 A COM may offer a portion of its curricula at affiliated or educational clinical sites not owned or operated by the COM.

6.5 The COM must stipulate specific educational objectives to be learned in its educational program.

6.5.1 At minimum, a graduate must be able to:

1. Demonstrate basic knowledge of osteopathic philosophy and practice and osteopathic manipulative treatment;
2. Demonstrate medical knowledge through one or more of the following: passing of course tests, standardized tests of the NBOME, post-core rotation tests, research activities, presentations, and participation in directed reading programs and/or journal clubs; and/or other evidence-based medical activities;
3. Demonstrate interpersonal and communication skills with patients and other healthcare professionals;
4. Demonstrate knowledge of professional, ethical, legal, practice management, and public health issues applicable to medical practice;
5. Demonstrate basic “basic support skills,” as assessed by nationally standardized evaluations.

6.6 The COM must define, publish, and implement educational outcomes, based on its own educational objectives that will prepare students for osteopathic graduate medical education.

6.6.1 The COM must establish clinical competencies and a methodology to ensure they are being met.

Guideline: Osteopathic medical students should have the basic skills and competencies defined by COM faculty as the prerequisites to osteopathic graduate medical education. Integration of basic skills and competencies should be developed through the use of standardized patients, skills testing, and clerkship training.

The COM should, at minimum, consider the Seven Core Competencies required of all AOA-accredited postdoctoral training programs. The seven competency areas include: medical knowledge; osteopathic philosophy and osteopathic manipulative medicine; patient care; professionalism; interpersonal & communication skills; practice-based learning and improvement; and systems based practice.

6.7 A longitudinal record marking the career tracks, choices, and achievements of the graduates must be included in an assessment system.

6.8 The COM must develop and publicize a system, in keeping with the COM's mission and objectives, to assess the progress of each student toward acquiring the competencies essential to effective performance as an osteopathic physician.

6.8.1 All students must take and pass the National Board of Osteopathic Medical Examiners, Inc. (NBOME) Comprehensive Osteopathic Medical Licensing Examination COMLEX-USA Level 1 prior to graduation. All students must take COMLEX-USA Level 2 Cognitive Evaluation (CE) and Performance Evaluation (PE) components prior to graduation. All students who enter in the 2004-2005 academic year, and all students who graduate after December 1, 2007, must also pass NBOME Cognitive Evaluation (CE) and Performance Evaluation (PE) components of COMLEX-USA Level 2 prior to graduation. (Students graduating prior to December 1, 2007 must take COMLEX-USA Level 2 CE and PE prior to graduation.

6.8.2 A component of this assessment must include the student performance and the COM's overall performance on the NBOME COMLEX-USA Levels 1 and 2.

6.8.3 The COM must track COMLEX-USA Levels 1 and 2 results as part of a process to determine how well students accomplish the COM's educational goals.

**Comparable Accreditation Standards**

<b>AOA Language</b>	<b>LCME Language</b>
<p>3.3. The learning resources of all campuses and affiliated teaching sites must be reviewed by the COM to ensure delivery of the curriculum.</p>	<p>ED-39. The medical school's chief academic officer must be responsible for the conduct and quality of the educational program and for assuring the adequacy of faculty at all educational sites.</p>
<p>6.8. The COM must develop and publicize a system, in keeping with the COM's mission and objectives, to assess the progress of each student toward acquiring the competencies essential to effective performance as an osteopathic physician.</p> <p>6.8.1. All students must take and pass the National Board of Osteopathic Medical Examiners, Inc. (NBOME) Comprehensive Osteopathic Medical Licensing Examination (COMLEX) Level I prior to graduation. All students must take COMLEX Level II Cognitive Evaluation (CE) and Performance Evaluation (PE) components prior to graduation. All students who enter in the 2004-2005 academic year, and all students who graduate after December 1, 2007, must also pass NBOME Cognitive Evaluation (CE) and Performance Evaluation (PE) components of COMLEX-USA Level II prior to graduation.</p> <p>6.8.2. A component of this assessment must include the student performance and the COM's overall performance on the NBOME COMLEX Levels I and II.</p> <p>6.8.3. The COM must track COMLEX Levels I and II results as part of a process to determine how well students accomplish the COM's educational goals.</p> <p>6.7. A longitudinal record marking the career tracks, choices, and achievements of the graduates must be included in an assessment system.</p>	<p>ED-47. In assessing program quality, schools must consider student evaluations of their courses and teachers, as well as a variety of other measures.</p> <p>ED-48. Medical schools must evaluate the performance of their students and graduates in the framework of national norms of accomplishment.</p>
<p>6.2. The COM must develop and implement ongoing review and evaluation of the curricula, and demonstrate application of the findings towards improvement of the educational program.</p>	<p>ED-33. There must be integrated institutional responsibility for the overall design, management, and evaluation of a coherent and coordinated curriculum.</p> <p>ED-46. A medical school must collect and use a variety of outcome data, including national norms of accomplishment, to demonstrate the extent to which its educational program objectives are being met.</p>

AOA Language	LCME Language
6.4. The minimum length of the osteopathic medical curricula must be at least four academic years or its equivalent as demonstrated to the AOA Commission on Osteopathic Accreditation (COCA).	ED-4. The program of medical education leading to the MD degree must include at least 130 weeks of instruction.
6.1.1. The curricula must include basic biological, behavioral, and clinical sciences to prepare the graduate for postgraduate training.	ED-10. The curriculum must include behavioral and socioeconomic subjects, in addition to basic science and clinical disciplines.
6.5. The COM must stipulate specific educational objectives to be learned in its educational program.	ED-1. The medical school faculty must define the objectives of its educational program. The objectives must serve as guides for establishing curriculum content and provide the basis for evaluating the effectiveness of the educational program.
6.11. All instruction at the affiliated or educational sites must be conducted under the supervision of COM academically credentialed or approved faculty.	ED-25. Supervision of student learning experiences must be provided throughout required clerkships by members of the medical school's faculty.  ER-10. In the relationship between the medical school and its clinical affiliates, the educational program for medical students must remain under the control of the school's faculty.
6.12. Planning and implementation of instruction at affiliated or educational sites must be a cooperative activity between COM academically credentialed or approved faculty at those sites and the administration and faculty at the COM.	ED-41. The faculty in each discipline at all sites must be functionally integrated by appropriate administrative mechanisms.

**Similar but Partly Distinct Standards**

<b>AOA Language</b>	<b>LCME Language</b>
<p>1.3. The COM must connect its learning outcomes assessment to mission plans and objectives in order to continuously improve the educational quality of its osteopathic medical education program.</p> <p>1.3.1. The planning processes must incorporate formative and summative reviews of student achievement including, but not limited to: COMLEX I and II passage rates; licensure, geographic area of practice, obtainment and completion of a postdoctoral program, and AOA or ABMS board certification.</p>	<p>ED-47. In assessing program quality, schools must consider student evaluations of their courses and teachers, and an appropriate variety of outcome measures.</p> <p>IS-1. Each medical school must engage in a planning process that sets the direction for the institution and results in measurable outcomes.</p>
<p>6.8. The COM must define, publish, and implement educational outcomes, based on its own educational objectives, that will prepare students for osteopathic graduate medical education.</p> <p>6.6.1. The COM must establish clinical competencies and a methodology to ensure they are being met.</p>	<p>ED-1-A. The objectives of the educational program must be stated in outcome-based terms that allow assessment of student progress in developing the competencies that the profession and the public expect of a physician.</p>
<p>6.13. The COM must develop and implement an assessment process that reviews student achievement in the clinical education program at its affiliated or educational sites to ensure that these programs meet the COM's mission and objectives.</p>	<p>ED-8. There must be comparable educational experiences and equivalent methods of evaluation across all alternative instructional sites within a given discipline.</p> <p>ED-42. There must be a single standard for promotion and graduation of students across geographically separate campuses.</p>
<p>6.14. The COM must develop a process that evaluates the clerkship in regard to meeting the COM's mission and objectives.</p>	<p>ED-37. The faculty committee responsible for the curriculum must monitor the content provided in each discipline so that the school's educational objectives will be achieved.</p> <p>ED-39. The medical school's chief academic officer must be responsible for the conduct and quality of the educational program and for assuring the adequacy of faculty at all educational sites.</p>