In 1996, the Wilson Family Practice Residency program (Wilson Memorial Regional Medical Center, Johnson City, NY), accredited by the Accreditation Council for Graduate Medical Education (ACGME), became approved by the American Osteopathic Association (AOA). The first class completed osteopathic medical training in 1998.

This combined osteopathic and allopathic family medicine residency is used here to illustrate key issues and trends facing dually accredited family practice residency programs and osteopathic graduate medical education.

Trends in Family Practice Residency Training
In the past 5 years, there has been a significant decline in the number of graduates of both osteopathic and allopathic medical schools in the United States who pursue family practice residency training programs.

The number of ACGME-accredited family practice residency training positions has decreased from 3293 in 1998 to 2983 in 2002. Despite this, only 79% of the positions were filled.1 The number of AOA-approved family practice residency training positions available in 2002 was at an all-time high of 1552, yet only 50% of the positions were filled.2

There were 2569 graduating students from colleges of osteopathic medicine in the United States in 2002. Only 53% of the graduating students participated in the AOA Intern Resident Registration Program,1 with the highest percentage of participants from states where an osteopathic rotating internship is required for licensure (ie, Pennsylvania, Michigan, Florida, Oklahoma, West Virginia). In 2002, a total of 261 osteopathic medical school graduates chose matriculation directly into allopathic family practice programs.3

According to data provided by the AOA Department of Medical Education in 2003, preliminary results from the 2003 AOA intern match indicate that 47% of 2650 projected graduates participated. Of that number, 338 internships were linked to osteopathic family practice residencies, with 215 positions filled.

In 2002, only 59% of ACGME-accredited positions were filled by graduates of allopathic medical schools in the United States; 11.1% were filled by graduates of osteopathic medical schools.3 Currently, 11% of graduates of osteopathic medical schools are training in allopathic family practice residency programs.2

There are 132 AOA-approved family practice residency programs and 497 ACGME-accredited family practice programs in the United States, while there are only 22 dually accredited programs, most of which have been dually accredited for less than 5 years.

We polled dually accredited programs as to the number of years they have been accredited by both organizations and the number of prospective osteopathic medical school graduating students. We also inquired as to the percentage of osteopathic medical school graduates who took the American Osteopathic Board of Family Physicians’ (AOBFP) certification examination and the American Board of Family Practice’s (ABFP) certification examination. Noting that such data are not tracked, all dually accredited programs reported that all of their osteopathic medical graduates had taken the ABFP examination, and approximately 50% of all osteopathic graduating students completed both examinations.

Rationale for Dually Accredited Programs
According to responses to a survey regarding graduate medical training issued by an AOA/ACGME Collaboration Task Force in 2002, osteopathic medical school students prefer a dually accredited residency program (80%) to programs approved only by the AOA, with 77% of those polled stating that they would choose a dually accredited program over an ACGME-only accredited program.4

Further, the survey responses revealed that the overwhelming perception among students is that allopathic residency programs are of higher quality and offer better educational opportunities than osteopathic residency programs. In addition, 79% of directors of osteopathic medical education indicated that dual accreditation would enhance the competitiveness of their program, and most reported that it would also increase the overall quality and prestige of osteopathic residency programs.4

There are an insufficient number of AOA-approved family practice residency positions available should all graduating

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Terry • Special Communication

JAOA • Vol 103 • No 8 • August 2003 • 367
osteoPATHIC medical students choose AOA-approved residencies. In the past 5 years, many smaller osteopathic medical hospitals have either closed or amalgamated with larger allopathic medical institutions, resulting in further decline in osteopathic residency training positions. This trend, combined with the increased number of osteopathic residency medical school graduates, has created a shortfall of osteopathic training positions and a geographic maldistribution of existing positions.

According to John B. Crosby, JD, Executive Director of the AOA, to the Council on Medical Education Testimony regarding the financial situation of teaching hospitals, osteopathic family practice residency programs are poorly funded, compared with their allopathic counterparts, who receive greater reimbursement for graduate medical education. This funding inequity results from the previous model used for osteopathic postgraduate residency training in family medicine, which was based on a preceptorial, apprenticeship model. In many cases the faculty volunteered their time without pay to the residency program while trying to run a full-time practice.

All of these factors have served to undermine osteopathic medical postgraduate residency training in family medicine, reinforcing the perception among osteopathic medical school students and residents that allopathic medical residency training is superior to osteopathic medical residency training. And student perception rapidly translates into reality when choosing a residency.

Curriculum Integration
With a few exceptions, the ACGME-accredited family practice curriculum is similar to the AOA-approved family practice curriculum. Historically, the osteopathic family practice residency was a 2-year program (a rotating AOA-approved internship followed by 2 years of family practice residency), compared with the 3-year allopathic family practice residency program. Recent changes instituted by the ACOFP integrate the postgraduate year (PGY) 1 curriculum as part of the family practice residency training. At this time, the AOA still requires a separate internship inspection.

In the Wilson Family Practice Residency program, we were able to integrate the ACOFP and ACGME requirements with minor curricular changes. Both osteopathic and allopathic medical residents matriculate through the same rotations. We added a second-year emergency medicine rotation and a third-year acute ambulatory care rotation to fulfill ACOFP requirements for emergency medicine.

Core rotation requirements are also similar (Table). The AOA requires three emergency medicine rotations, while the ACGME requires one. The ACGME has specific time requirements (ie, hours required) in specific rotations: otorhinolaryngology, ophthalmology, and sports medicine. The AOA has no specific time requirements in these areas and includes surgery subspecialties as part of the total requirement for general surgery.

Further, the AOA curriculum allows for a more elective experience than the ACGME curriculum. The ACGME requires that individual clinic patient contacts be tracked (ie, 140 hours for PGY 1, 500 hours for PGY 2, and 1000 hours for PGY 3). The ACOFP requires 312 clinic half-days total, not including the internship year (minimum of 6 patient contacts per session for PGY 2 and 10 for PGY 3).

Osteopathic Manipulative Treatment Training in Allopathic Residencies
Osteopathic manipulative treatment training in dually accredited programs is essential for osteopathic medical residents so they may enhance their skills and maintain their osteopathic medical identity. Allopathic medical faculty have varying degrees of exposure and comfort with OMT, as most are not trained in OMT and may not be competent in supervising osteopathic medical residents in this area.

The first step to remedy this is to establish an OMT clinic. At least one examination room should be designated as the OMT room and should be equipped with a manipulation table. The clinic should be held a minimum of once per week, and an osteopathic physician faculty member competent in OMT should supervise.

The OMT clinic (1) establishes OMT as a distinct entity within the family practice center; (2) serves as a referral clinic for patients within the family practice clinic; and (3) serves as an osteopathic medical education resource for osteopathic medical students and residents.

By no means should the OMT clinic preclude osteopathic medical residents from practicing OMT on their other family care patients. This should be encouraged. However, as OMT skills vary greatly among osteopathic medical residents, the clinic allows for a trainer to assess each resident’s manipulation skills before allowing him or her to practice OMT independently. The osteopathic postdoctoral training institution (OPTI) affiliate may also provide educational opportunities in osteopathic medicine within the family practice residency.

Resident Outcome
Curriculum in the Wilson Family Practice Residency program is fully integrated, with osteopathic and allopathic residents completing all of the same rotations. Osteopathic medical residents are required to participate in the osteopathic medical education clinics and thereby become credentialed to practice OMT independently during their first year.

We have graduated 32 osteopathic medical residents since 1998, 30 of whom have taken and passed the ABOFP certification examination and 22 of whom have also taken the ABFP examination, with 21 passing on the first attempt. Results of our phone survey of dually accredited family practice programs indicate that less than half of osteopathic medical graduates sit for both the allopathic and osteopathic certification examinations; however, most do take the AOBFP examination and become certified.
<table>
<thead>
<tr>
<th>Rotation</th>
<th>AOA/ACOFP Curriculum</th>
<th>ACGME Curriculum</th>
<th>Key Differences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pediatrics</td>
<td>4.5 months</td>
<td>4 months</td>
<td>AOA requires 6 weeks in the OGME 1</td>
</tr>
<tr>
<td>Obstetrics and gynecology</td>
<td>4 months (1 month required for obstetrics; 1 month must be completed in the first postgraduate year)</td>
<td>2 months obstetrics; 140 hours gynecology</td>
<td>AOA requires more gynecology exposure</td>
</tr>
<tr>
<td>Internal medicine</td>
<td>6 months required</td>
<td>8 months required, at least six inpatient and one in critical care</td>
<td>ACGME requires &quot;structured experience in cardiology&quot;; AOA requires 2 months of general internal medicine in the OGME 1 year</td>
</tr>
<tr>
<td>General surgery</td>
<td>5 months required (at least 1 month required in each year)</td>
<td>2 months required (structured requirement in general surgery)</td>
<td>AOA requirement includes the surgical subspecialties as well as general surgery</td>
</tr>
<tr>
<td>Emergency medicine</td>
<td>3 months (1 required in first year)</td>
<td>1 month</td>
<td>AOA 3 months; ACGME 1 month</td>
</tr>
<tr>
<td>Sports medicine/orthopedics</td>
<td>No specific time requirement for orthopedics or sports medicine; may be included in the general surgery requirement</td>
<td>No time requirement for sports medicine, but must be in addition to the 140 hours required for orthopedics</td>
<td>ACOFP has no specific time requirement for orthopedics</td>
</tr>
<tr>
<td>Geriatrics, community medicine and behavioral science</td>
<td>Same required exposure</td>
<td>Required exposure</td>
<td>Most ACGME programs have specific rotations in each. The ACOFP programs do not.</td>
</tr>
<tr>
<td>Surgical subspecialties (otorhinolaryngology, urology, ophthalmology)</td>
<td>No specific requirement for each discipline</td>
<td>“Structured experience” required in otorhinolaryngology, urology, and ophthalmology. Time requirement not specified.</td>
<td>ACOFP allows the surgical subspecialties to be included in the surgery requirement of 5 months</td>
</tr>
<tr>
<td>Electives</td>
<td>Minimum of 5 months and maximum of 7 months (1 month required in first postgraduate year and at least 2 months each in second and third postgraduate years)</td>
<td>Minimum of 3 months, maximum of 6 months</td>
<td>ACOFP requires more elective rotations</td>
</tr>
<tr>
<td>Practice management</td>
<td>Required exposure but no specific time requirement</td>
<td>60 hours formal instruction in practice management</td>
<td>ACOFP does not have a specific hourly requirement</td>
</tr>
</tbody>
</table>

AOA indicates American Osteopathic Association; ACOFP, American College of Osteopathic Family Physicians; ACGME, Accreditation Council for Graduate Medical Education; OGME, Osteopathic Graduate Medical Education.

(Compiled from the AOA and ACOFP Basic Standards for Residency Training in Osteopathic Family Practice and Manipulative Treatment, 3/2002 and the ACGME Program Requirements for Residency Education in Family Practice, 2002)
SPECIAL COMMUNICATION

The Way Forward
A critical examination of problem areas in the osteopathic medical profession should result in the following changes:

- As the osteopathic internship has been so scaled down that it is no longer a relevant entity, it is time for the AOA to abolish this requirement and allow the family practice residency program to become a seamless 3-year curriculum accountable to the education body of the ACOFP, as well as the AOA. This will end the confusion for students and allow osteopathic medical programs to compete directly with ACGME-accredited programs.

- The ACOFP and the AOA must either strengthen or close weak osteopathic family practice residency programs. Many other programs could be marketed as showcase programs. Further, OPTIs need to provide the educational resources that many of our smaller osteopathic residency programs require to be competitive.

- The AOA must aggressively develop more dually accredited programs. This process needs to be facilitated. Osteopathic postdoctoral training institutions could provide ACGME-accredited residency programs that elect to become approved by the AOA the osteopathic medical faculty necessary. This ensures that osteopathic principles and practice are taught and is a way of welcoming back osteopathic medical faculty to the osteopathic medical profession. The current process by which allopathically trained osteopathic family practitioners attain osteopathic certification needs to be facilitated.

- Colleges of osteopathic medicine must expand in a responsible manner. No new college should matriculate students, and no existing college should expand class size until sufficient osteopathic medical teaching institutions are secured for both undergraduate and osteopathic residency teaching (not just intern positions) for all graduates. Colleges of osteopathic medicine must continue to emphasize family practice in their undergraduate curriculums.

Conclusion
Unless more dually accredited family practice positions are created or there is a significant change in osteopathic medical school students’ perception of AOA-approved family practice residency education, osteopathic medical students will preferentially choose allopathic family practice training programs over osteopathic programs. This will ultimately weaken the profession and lead to a new generation of osteopathic family physicians who lack exposure to the unique approach that osteopathic medicine exemplifies.

We are already seeing the trend in graduates seeking more career flexibility, higher earning potential, and the increased prestige perceived by osteopathic students to be associated with allopathic and subspecialty professions.

We need to critically examine the osteopathic medical profession and make necessary changes to ensure that osteopathic family practice residency programs are both comparable and competitive with our allopathic counterparts.

References