The Predicament of Osteopathic Postdoctoral Education

Mark Cummings, PhD

Abstract

The growth of colleges of osteopathic medicine (COMs) during the past 20 years has been a catalyst for change and has created new challenges in osteopathic medicine. None of these challenges is more daunting than the task of sustaining an osteopathic graduate medical education (OGME) system that has suffered during this period of rapid development. Notable trends within the osteopathic medicine community since 1990 include allopathic residency programs obtaining OGME accreditation, COM graduates bypassing OGME, repeated major changes in American Osteopathic Association (AOA) accreditation policies, a growing dependence on Accreditation Council for Graduate Medical Education programs to train osteopathic graduates, and a lessening of options for the AOA to effectively direct its OGME system. The predicament is whether COMs can continue to grow without resulting in the demise of the OGME system and a loss of professional identity.


Christopher Dickens’ opening words in A Tale of Two Cities capture perfectly the state of osteopathic medical education in the past 20 years: “It was the best of times, it was the worst of times. . . .”1 On the surface, it has been the best of times in that the osteopathic profession has witnessed unprecedented growth fueled by the development of new colleges of osteopathic medicine (COMs) and the resulting burgeoning population of medical students. In the past 20 years, osteopathic medicine has grown into a national movement and has gained greater recognition for its contributions to American health care. Individual osteopathic physicians (DOs) have ascended to leadership positions in federal agencies, the military, research institutions, and various medical organizations, resulting in a favorable halo effect on the profession. These are all signs that osteopathic medicine is moving in a positive direction.

However, there is a dark side to this rosy picture. Such enormous strides in osteopathic medicine required significant adaptations to its educational system. As originally configured, the Osteopathic Graduate Medical Education (OGME) system was held together by accreditation policies to direct COM graduates into osteopathic educational programs that would lead to osteopathic certification and eventual membership in specialty colleges, state societies, and the American Osteopathic Association (AOA). The foundation for this educational structure rested squarely on the OGME system, the loyalty of COM graduates, and limited opportunities for DOs to be accepted into Accreditation Council for Graduate Medical Education (ACGME) programs. However, during the most recent growth phase (1990–2005), COMs fractured this foundation by expanding rapidly and overwhelming the OGME system. New trends resulted, changing the face and direction of osteopathic postdoctoral education. In small yet incremental steps, the AOA was forced to reconfigure its OGME structure to cope and contend with new postdoctoral realities. At the same time, ominous trends became apparent; the osteopathic profession has yet to find an effective response to these trends, which will eventually have an enormous but unknown impact.

Trend One: Expansion Generating Dilution

As COMs spread nationally, many were started in parts of the country with shallow roots in OGME. For a variety of practical and financial reasons, these COMs found it easiest to integrate third- and fourth-year students into allopathic training sites, several of which also sponsored ACGME-accredited residency programs. Similarly, many established private COMs expanded their class sizes and adopted this same strategy.2 Few private COMs, either recent or established, undertook aggressive efforts to generate new AOA postdoctoral opportunities for their graduates. This lack of development created a wide disparity between class size and the number of positions in COM-sponsored postdoctoral programs. For example, Des Moines University’s COM has an entering class size of 205 but no OGME positions. The Arizona College of Osteopathic Medicine, founded in 1995, admits 145 students annually, yet its osteopathic postdoctoral training institution’s postdoctoral programs have only 11 first-year positions. The two Touro University COM campuses in California and Nevada together enroll 230 students each year, but their osteopathic postdoctoral training institution supports only 32 first-year positions, 19 of which are in New York.3 Not surprisingly, the lowest match rate of graduating seniors into OGME programs is found at the newest COMs and at institutions that provide clinical education in largely allopathic environments and with minimal commitments to OGME.4 Rather than bolstering the OGME system, adding new COMs and enlarging class sizes increasingly weakens the system as COM graduates become oriented toward an allopathic environment, lacking local alternatives for OGME and having few DO role models. As noted, the majority...
of them go directly into ACGME programs (Figure 1).

Generating more students has not succeeded in filling the many funded but vacant OGME positions, especially in primary care. In 2005, 925 of the 2,165 (42.7%) available positions in the AOA Match program were left unfilled (Figure 2). This anomaly of vacant OGME positions and too many DO graduates can be explained by the fact that fewer than 50% of graduating seniors from 2005 participated in the AOA match (Figure 2). Currently, the flow of graduating osteopathic medical students is bifurcated: half remain in OGME, and the other half go directly into allopathic training programs (Figure 1). Although the number of graduating DOs increases each year, the percentage of those who participate in the AOA match program continues to decline annually.

**Trend Two: The Allopathic Crossover**

Faced with a surging student population, AOA accrediting bodies decided in 1985 to allow allopathic institutions to obtain AOA postdoctoral accreditation via sponsorship by COMs. The prevailing thought at the time was that if COMs were responsible for generating more students, they would need to become proactive in the development of new postdoctoral programs. An initial flurry of activity resulted in new AOA internships that tracked DO interns into ACGME residencies, but little was done to create desperately needed OGME residency positions. The crossover trend of ACGME-accredited programs aggressively seeking osteopathic accreditation via COMs increased in the late 1990s and continues to the present (Figure 2). An ACGME-accredited program’s motives for taking on a secondary level of accreditation relate primarily to workforce issues—DOs are an important source for residents, particularly for primary care positions.

Grafting an OGME program onto an ACGME residency creates parallel accredited programs, but not parity. The number of DO positions in ACGME/AOA programs is usually no more than 25 to 33% of the ACGME-approved total for the entire program. The osteopathic faculty is generally a minority component as well. Overall educational leadership rests in the hands of the allopathic program director and director of medical education, whose primary attention is directed toward maintaining ACGME accreditation requirements. The DOs are integrated into ACGME programs and, as such, routinely take allopathic in-service training examinations and American Board of Medical Specialties (ABMS) certifying board examinations. Although DOs in ACGME/AOA-accredited programs obtain osteopathic approval, distinctions that differentiate an ACGME from an ACGME/AOA residency program are minimal. The OGME system made accommodations for ACGME programs, with the unintended consequence of a diminution in osteopathic educational leadership, effective role models, and training in osteopathic medicine.

**Trend Three: Pressure for Conformity**

As the door to ACGME programs opened for DOs, AOA accreditation policies changed in ways that mirrored those of the ACGME. The first major adjustment occurred with the osteopathic internship, a required one-year program that serves as a foundational experience before the start of residency training. In ACGME/AOA programs, the internship year also counted as the first year of an ACGME residency program. As a result, ACGME/AOA programs (with the exception of family medicine) were consistently one year shorter than the OGME sequence. Thus, in 1990, the OGME system of track and emphasis internship programs was introduced to achieve parity in the number of years of training for osteopathic and allopathic residency programs. One year of postdoctoral training was eliminated from the OGME system, and the osteopathic internship was retained in name only. The end result is that the AOA first-year experience now emulates the educational content of an ACGME PGY-1 year.

Leaders in the OGME community introspectively examined the reasons for the departure of osteopathic graduates from the osteopathic educational system. The AOA had begun to operate under the assumption that students perceived the AOA-accredited programs as not measuring up to the quality of ACGME-accredited programs. To improve its qualitative image, the AOA started to incorporate common features of ACGME accreditation, such as general competencies, the concept of the designated institutional official, the internal review system, policies to limit work hours, and the formulation of
institutional standards for sponsors of accredited programs. Recent discussions resulted in an accreditation pathway that allows osteopathic hospitals to apply for ACGME institutional accreditation to enhance their status. Although these shifts in the accreditation of OGME programs were intended to improve educational quality, they mirror ACGME initiatives and minimize differences between AOA and ACGME accreditation. Such changes smooth the way for the development of ACGME/AOA programs, yet all the AOA accreditation revisions to date have been one-sided, reflecting the actions of a minority medical profession seeking to appear similar to the majority medical profession.

**Trend Four: Independence versus Dependence**

From its origins, the OGME system was a self-contained, independent entity that received little or no support outside the network of osteopathic hospitals. It was designed to provide for its own graduates. As COMs expanded rapidly, the ACGME programs initially served as a safety valve to absorb excess numbers. Now the ACGME safety valve is a necessary fixture for the postdoctoral training of DOs (Figure 1). The ACGME does not have a formal role in the OGME system, although its extensive influence and control may warrant such consideration. With more than one half of the osteopathic graduates from 2005 going directly into allopathic residencies and another significant portion committed to ACGME/AOA programs, more than two thirds of this class are training in ACGME programs. The osteopathic profession is already far down the road to outsourcing its postdoctoral education system to the ACGME programs.

OGME independence has become dependence on ACGME programs; this state will only increase when 500 or more COM students enter the postdoctoral pipeline in the next three years. By default, and through no effort of its own, the ACGME has garnered significant but quiet influence over OGME. The AOA accreditation bodies can no longer consider policy changes without gauging their impact on ACGME programs. The AOA must assess policies that are too far-reaching or too costly to determine which of these policies might lead ACGME/AOA programs to drop their osteopathic accreditation. On the other hand, the ACGME has complete freedom of action in decision making and policy setting in their programs, over which the osteopathic profession has no control. DOs, like international medical graduates, are invited guests in the allopathic postdoctoral educational system; as such, they must abide by the rules created by those who run and operate their accreditation system. Any sort of new policy that adversely affects DOs would have devastating consequences for the osteopathic profession and its OGME system.

**Conclusions: Impacts on the Osteopathic Profession**

It should not be assumed that a single trend is a good predictor of the future. Reliability increases when there are several related trends all pointing in the same direction. The trends displayed in Figures 1 and 2 cover several years, show little variability in terms of volatility, and include a dynamic and growing COM system, the significant role of allopathic programs in the OGME system, osteopathic graduates bypassing OGME, accommodations made in AOA accreditation policies, increased dependence on ACGME programs, and...
the declining ability of the AOA to effectively control OGME.

Instead of having an educational system that takes individuals through a step-by-step process from medical school to postdoctoral training and, eventually, to certification (as in the allopathic profession), disruptions at the OGME level now disperse DOs in a number of directions. DOs coming out of COMs make choices that affect the vitality of the osteopathic profession downstream. It is given that the 50% of DOs graduating in 2005 who went directly into ACGME programs will earn their certifying boards from the ABMS. Mindful of recertification requirements, how many of these DOs will voluntarily take osteopathic certifying boards and participate actively as members of an osteopathic specialty college, state society, and/or the AOA, having lost contact with the osteopathic profession after the second year of medical school? The same question can be asked of those DOs who commit to an ACGME/AOA-accredited program.

If the experiences of internal medicine apply to other osteopathic specialties, only 2% to 3% of those who initially pass the ABMS certifying board go on to obtain osteopathic certification.\(^4\) From its membership data, the AOA acknowledges that DOs certified by the ABMS are much less likely to become members of the AOA.\(^7\) Relying on the ACGME to train the majority of its graduates places the osteopathic profession in a vulnerable position. Any number of scenarios, both good and bad, can play out in the future, but the AOA dependency on the ACGME is such that, regardless of what actually happens, it will invariably put the AOA in a reactive position with few choices.

As AOA accreditation policies continue to follow the lead of the ACGME, the differences in these accreditation systems become less apparent. Despite the AOA’s dogged efforts to emphasize educational quality, the association has made little difference in graduating students’ tendencies to give primary consideration to ACGME programs. DO students themselves are promoting policies within the profession, such as the development of a uniform AOA and national residency matching program that will blur the distinctions between the osteopathic and allopathic educational systems.\(^9\) OGME is experiencing an identity crisis among osteopathic students in that the system does not stand out in contrast to the ACGME. Students find the most value in the OGME system’s nonprimary care specialty residency programs that cannot readily be obtained in the ACGME system.\(^8\) It was easier for the osteopathic profession to forge a sense of unity when doors for outside educational opportunity were closed and its OGME system was a homegrown product. To a great extent, DOs have entered the mainstream and many ACGME programs have opened up, allowing the next generation of DOs to enter in large numbers. As a consequence, the OGME system has been marginalized.

Are there any viable options to get out of this quagmire? The choices are few, dwindling, and unpalatable. Slowing the pace in the development of new COMs can only happen if stricter accreditation policies are implemented as a logical first step. With a tighter hand on the spigot controlling the flow of new DOs, an opportunity is created to focus directly on OGME concerns. Current barriers are daunting. Creating a revamped and more robust OGME system is not going to happen under current federal policies linked to the funding of OGME. Expanding existing ACGME/AOA programs into centers of osteopathic education is an unlikely scenario. Revising postdoctoral accreditation standards to include more osteopathic-centered policies may drive ACGME/AOA programs away. As long as ACGME programs keep the doors open to DOs, osteopathic students will continue to pursue their preferred choice of allopathic training. Not only are COMs opposed to policies that curb their potential for growth, there is no consensus within the osteopathic community that its OGME system is progressively declining. By not addressing this issue directly, the AOA may eventually seek accommodations for its postdoctoral programs under the ACGME and begin to function as a separate osteopathic residency review committee, marking the end of its own OGME system.

The osteopathic profession is caught in a dilemma. Efforts to expand COMs at the current or an accelerated rate will continue to have a deleterious impact on the OGME system. By ignoring this postdoctoral issue, the osteopathic profession is poised with a COM model that is able to respond quickly to the anticipated physician shortage and to bring osteopathic medicine further into the mainstream of American medicine.\(^2\) At stake here are issues of osteopathic distinctiveness, professional identity, and the viability of an OGME system. The question is no longer whether the osteopathic profession recognizes the precariousness of its postdoctoral predicament but, rather, whether it still has the ability to steer current trends in a different direction.

---

References


3. Class size for COMs mentioned is found at (www.aacom.org/colleges/dmuomc.asp); (www.aacom.org/colleges/kcumcom.asp); and (www.aacom.org/colleges/tucam.asp).


As of January 1, 2006, the AOA Council on College Accreditation has granted applicant status to three new COMs: Touro University College of Osteopathic Medicine, NY, NY; Lincoln Memorial University College of Osteopathic Medicine, Harrogate, TN; and A. T. Still College of Osteopathic Medicine, Mesa, AZ. Initiatives to open new COMs are underway that could see even more institutions applying for applicant status in the near future.


Greenwald B. At the crossroads: should the match “tradition” be maintained? The DO. 2005;9:23–29.

---

Did You Know?

In 2003, with funding from the National Institutes of Health, researchers at Brigham and Women’s Hospital determined that high levels of C-reactive protein (an indicator of inflammation) are associated with an increased risk of developing high blood pressure in women.

For other important milestones in medical knowledge and practice credited to academic medical centers, visit the “Discoveries and Innovations in Patient Care and Research Database” at (www.aamc.org/innovations).