Introducing Osteopathic Medical Education in an Allopathic Residency

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Osteopathic medicine’s tradition in family medicine is not surprising, considering that the osteopathic principles are very similar to the core values of family medicine. For example, one of the basic principles of osteopathic medicine is that the person is a unit of body, mind, and spirit. Similarly, family medicine aims to “integrate the biological, clinical, and behavioral sciences.” According to the American Osteopathic Association (AOA), the majority of graduates of colleges of osteopathic medicine (COMs) are “family-oriented, primary care physicians.”

As the percentage of allopathic medical school graduates choosing family medicine declines, COM graduates have been increasingly entering allopathic family medicine residency programs. In 2004 and 2005, more than 12% of all family medicine residents in programs approved by the Accreditation Council for Graduate Medical Education (ACGME) were osteopathic physicians (DOs)—an 8% increase from 1995 and 1996. Likewise, the percent of COM graduates entering allopathic family medicine residency programs has steadily increased from 15.8% in 1998 to 18.5% in 2005.

However, ACGME-accredited residencies often lack the appropriate faculty, curricula, and resources to enable osteopathic residents to continue practicing osteopathic manipulative medicine (OMM). Allee and colleagues studied DOs in family medicine residencies and found that respondents anticipated they would practice similar amounts of OMM, regardless of the type of residency program. However, compared with residents from AOA-accredited programs, those in allopathic programs were less likely to exercise “frequent” OMM and reported that they lacked adequate facilities and mentors to effectively practice OMM.

In response to the increasing number of osteopathic graduates attending allopathic residencies, the AOA passed a resolution (Resolution 42 [A/2000]—Approval of ACGME Training as an AOA-Approved Internship) allowing residents who trained in ACGME-accredited postgraduate training programs to apply for AOA approval of their internship or first postgraduate year. As described in the resolution, osteopathic residents who completed allopathic internships before July 1, 2008, are required to participate in at least one osteopathic educational activity, such as attending the AOA Annual Convention and Scientific Seminar or preparing and conducting an osteopathic clinical presentation to the ACGME-accredited program.
In 2004, the ACGME-accredited family medicine residency program at the Warren Alpert Medical School of Brown University in Providence, RI, noted increasing numbers of COM graduates entering their program. Many of these residents and applicants expressed a desire to continue the practice of OMM and identified a need for an osteopathic curriculum. Although the residency administrators decided that dual accreditation was not financially feasible, they wanted to meet the osteopathic residents’ educational needs.

In the present study, we describe the development, implementation, and evaluation of an osteopathic curriculum at the Brown Family Medicine Residency Program. Improvements made to the program since the osteopathic curriculum’s inception are also described.

Methods

Brown University’s family medicine residency is an ACGME-accredited program and the only family medicine residency in Rhode Island.10 In the 2004-2005 academic year, 8 of 39 residents were osteopathic physicians, 4 of whom were in their first year of postgraduate training. Although two community preceptors were DOs, there was no core osteopathic faculty.

Although many of the osteopathic residents wanted to practice OMM, the community and faculty preceptors were uncomfortable supervising procedures in which they were not trained. Therefore, in the fall of 2004, the residency director and the medical director of the outpatient residency practice identified an osteopathic resident “leader” (A.R.) to explore ways to enable osteopathic residents to practice OMM within the residency practice. The osteopathic resident leader and the other osteopathic residents then identified two primary goals for the project: (1) creating an osteopathic clinic and (2) promoting osteopathic educational activities. The group identified learning goals and objectives and developed interventions to meet those needs, as outlined in the Figure.

Creation of the Osteopathic Clinic

In developing the osteopathic clinic, staff had to consider the available resources, from staffing to appropriate equipment. Osteopathic residents and one allopathic resident with previous OMM training comprised the available staff for the clinic. Residents were scheduled to work the OMM clinic two evenings per month in the residency practice. The sessions were scheduled during an existing evening clinic to avoid the need for additional nursing and office staff. The residency had three adjustable tables appropriate for the practice of OMM.

The osteopathic residents identified many of their own patients that could benefit from OMM at the clinic. In fact, even before the osteopathic clinic was finalized, some allopathic residents and faculty began referring patients to the osteopathic residents for OMM consultation. To limit the number of patients presenting to the osteopathic clinic, the osteopathic resident leader provided information on appropriate referrals through written memos to all physicians and through presentations at monthly practice meetings and at a resident conference. The leader reviewed the referral volume and resident availability and determined that four to six 30-minute appointments would be offered during each session.

Osteopathic Educational Activities

To promote osteopathic educational activities, the residents created an osteopathic interest group, which was open to both osteopathic and allopathic physicians. The objectives of the interest group were to review OMM techniques, discuss osteopathic publications, and allow residents to provide case reports of patients with uncommon or interesting presentations. The 8 osteopathic residents were to collect resources from their Osteopathic Principles and Practice courses, articles from JAOA—The Journal of the American Osteopathic Association, and osteopathic textbook chapters for discussion.

Each of these monthly sessions were to include two “educational interventions.” First, a resident would present a case and invite the other participants to share techniques that they might use in their approach to the patient. The OMM techniques would have to be supported with the previously described materials. Residents would then discuss a selected journal article or textbook chapter and describe how they intended to incorporate its contents into their practice.

In addition, each osteopathic resident was encouraged to make a formal presentation on osteopathic philosophy and techniques at a residency conference in order to fulfill the AOA’s osteopathic educational activity requirement.

Evaluation

The osteopathic clinical experience was evaluated using the modified nominal group technique.11 As described by Dobbie et al,11 this evaluation technique elicits positive and negative feedback from participants in an inclusive and nonjudgmental atmosphere in which each participant contributes equally to the feedback.

The first step in the process is to present evaluation questions to the respondents—in this case, the osteopathic residents. The following two questions were used to elicit feedback on our curriculum: (1) What are the strengths of the osteopathic clinic? And (2) what are the clinic’s weaknesses or your suggestions for improvement? Second, each group member silently wrote down their five personal responses to each question. Third, with the whole group, the items were pooled, clarified, and edited into themes, with the most popular items listed first. Then, from the pooled list, each group member ranked their top responses. In the present study, participants were asked to rank their top five items, awarding 5 points to the most important item, 4 points to the next, and so forth down to one. Finally, points were tallied, resulting in a rank-ordered, weighted list of the group’s collective opinions.

Success of the educational activities was based on whether osteopathic residents were able to obtain AOA approval of their first postgraduate year.
Osteopathic Clinic

The clinic was implemented in August 2004 and has since occurred once every 2 weeks. A month before the first clinic session, the osteopathic resident leader approached two community osteopathic preceptors, who both agreed to precept once or twice a month on a volunteer basis. Each session has been staffed by at least 2 osteopathic residents and 1 osteopathic preceptor, treating up to 6 patients in a 2.5 hour session.

In April 2005, 5 of the 7 osteopathic residents who participated in the clinic took part in a 3-hour evaluation session. The resident leader served as the facilitator for the group discussion but did not contribute answers. Using the modified nominal group technique previously described, the osteopathic residents identified 10 strengths and 8 weaknesses (Table). The top three strengths of the clinic were (1) maintaining OMM skills, (2) benefits to patients, and (3) integration of OMM. The top three weaknesses were (1) need for more structured didactics, (2) lack of compensation for their time, and (3) need for more varied preceptors.

Osteopathic Educational Activities

All osteopathic and allopathic residents were invited to an osteopathic interest group meeting, at which 3 residents—2 osteopathic and 1 allopathic—participated. No additional group meetings were held. However, 3 osteopathic residents presented osteopathic topics during residency conferences.

Between 2004 and 2006, 4 osteopathic residents graduated from the residency program. Of the 3 osteopathic residents who presented osteopathic topics, 2 applied for and received AOA approval of their first postgraduate year. The other 2 first-year osteopathic residents did not apply for AOA approval because they did not intend to practice in states that require it for osteopathic medical licensure.

Comment

As noted by Burkhart and Lischka, AOA-approved internships and residencies have made modest gains in the number of osteopathic graduates entering their programs. However, nearly half of osteopathic graduates enter ACGME-accredited programs. Factors such as location, curriculum, and reputation may be just a few of the reasons some COM graduates opt to participate in ACGME programs.

Dually accredited residencies (ie, programs accredited by both the AOA and the ACGME) can take advantage of the resources of their Osteopathic Postdoctoral Training Institutions when creating osteopathic curricula, and affiliation with a COM provides osteopathic faculty for didactics and precepting. However, allopathic residencies such as the one at Brown University may not seek dual accreditation. Potential barriers for such residency programs include accreditation fees, administration burden, and a lack of osteopathic faculty to meet the requirements of the AOA Program and Trainee Review Committee.

Although the small population size limits the strength of the present study’s results, an osteopathic curriculum was successfully implemented into an allopathic family medicine residency, enabling osteopathic residents to maintain and develop their practice of OMM. In fact, the participants rated the maintenance of their OMM skills to be the clinic’s greatest strength, thereby meeting one of the curriculum’s key objectives.

Allee and colleagues suggest that osteopathic residents training in allopathic programs are less likely to practice frequent OMM because they lack adequate osteopathic mentors and equipment. By providing resources for osteopathic resi-
In 2007, the total number of osteopathic graduates exceeded 3000 for the first time.12 With new COMs and increased enrollment at several existing COMs, the number of osteopathic grad-

Table

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* Each participant chose the clinic’s top five strengths and weaknesses and rated them in order of greatest (score of 5), second greatest (score of 4), and so on. Therefore, 25 points was the maximum any strength or weakness could receive.
† Participants were asked to either identify weaknesses of the clinic or make suggestions for improvements.

**Abbreviations:** AOA, American Osteopathic Association; DO, osteopathic physician; OMM, osteopathic manipulative medicine; OMT, osteopathic manipulative treatment.

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uates will only continue to increase. However, it remains to be seen whether COM graduates will opt for osteopathic or allopathic family medicine residencies in the coming years, particularly with the implementation of the restructured traditional osteopathic internship that went into effect in July.12

Conclusion
As indicated in the present study, an osteopathic clinic staffed by osteopathic residents and at least two preceptors can be a simple and sustainable way to allow osteopathic residents to maintain and further develop their osteopathic skills within the context of their required residency curriculum. Further research should address the long-term effects of such a program, both on COM graduates’ continued use of OMM and the influence of an osteopathic curriculum on allopathic colleagues.

References