The number of colleges of osteopathic medicine (COMs), osteopathic medical students, and osteopathic physicians in practice has been consistently growing since the 1960s. In recent years, the growth of the profession has been exponential. Despite this growth, graduates of COMs are increasingly choosing allopathic residencies. The authors believe that this trend may stem from a lack of focus on osteopathic principles and practice in COMs, as well as geographic and specialty limitations of available osteopathic residency positions. The present article will briefly examine the history of AOA accreditation and the current accreditation process and the current state of osteopathic predoctoral education and postdoctoral training. The authors call on osteopathic physicians to help bring osteopathic distinctiveness to osteopathic predoctoral education by mentoring and volunteering at COMs. In addition, the authors urge the osteopathic profession to increase the number of osteopathic residencies to account for the number of and distribution of osteopathic medical school graduates.

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on Postsecondary Accreditation, and the Council on Recognition of Postsecondary Accreditation. The AOA has had several college-accrediting bodies throughout its history, including the Committee on Education in conjunction with the Associated Colleges of Osteopathy from 1901 until 1930, the Bureau of Professional Education and Colleges from 1930 to 1960, the Bureau of Professional Education from 1960 to 2004, and the AOA Commission on Osteopathic College Accreditation (AOA COCA) since 2004.

The AOA completed its first COM inspection in 1903; inspections have been occurring at varying intervals since then. The process of accreditation has been an important aspect of the osteopathic medical profession since its earliest days. It is only through rigorous accreditation that the public can be certain that the medical schools that are educating future physicians have implemented a standard set of academic and clinical expectations into curricula.

AOA Accreditation Process

The AOA Commission on Osteopathic College Accreditation is the current COM-accrediting body for the AOA. The Commission has 17 voting members who are appointed by the president of the AOA. These members include 1 private school dean, 1 public school dean, 2 COM educators, 1 director of medical education, 1 hospital administrator, 3 public members, and 8 members-at-large who are also members of the AOA.

A new COM must go through several steps to become fully accredited by AOA COCA. The first step is the application, during which the applicant will receive the paperwork required to earn pre-accreditation status. Pre-accreditation, the second step, requires the completed paperwork, a feasibility study by a nationally recognized accounting or management firm, and an on-site visit by AOA COCA. The applicant COM can keep pre-accreditation status for up to 5 years before completing the next step, but it cannot accept or recruit students during this time.

Provisional accreditation is the next step in the process. During this step, the applicant must submit an updated feasibility study, document adequate clinical training sites, and undergo an on-site visit by AOA COCA. At this point, the applicant school can state that it is “provisionally accredited” and can accept and recruit new students.

During the time that it is provisionally accredited, the COM must submit a self-study report and undergo on-site visits annually. Before it graduates its first class, the COM will have an accreditation visit by AOA COCA. Then, 1 of 2 things can happen: either the COM attains accreditation status, or it does not. If the former occurs, the COM’s accreditation status is reviewed on a 7-year cycle, or sooner if required. If the COM does not attain accreditation, the provisional accreditation status is ended by AOA COCA, and the COM is essentially defunct.

Osteopathic Distinctiveness

One important accreditation requirement that has been in place since the earliest days of accreditation is that each school must show osteopathic distinctiveness in its curriculum. Specifically, AOA COCA calls for COMs to “provide for integration of osteopathic philosophy, principles, and practices.” Many schools fulfill this requirement more in spirit rather than strict adherence to hard and fast rules. For example, AOA COCA requires “hands-on opportunities under faculty/preceptor supervision which include osteopathic physicians [DOs].” There are no rules regarding the ratio of DO osteopathic manipulative medicine (OMM) instructors to students. Likewise, there are no guidelines about how advanced instructors must be in OMM. This lack of structure allows for varying competency and proficiency among OMM instructors, which in turn could lead to varying comprehension and abilities among osteopathic medical students.

Osteopathic distinctiveness is the most important domain of a COM and, by extension, the most important function of AOA COCA. It is in osteopathic predoctoral education that students are taught OPP and appropriate use of OMM. Everything in osteopathic postdoctoral training is built on the 4 years of osteopathic medical school (and in the opinions of some, only the first 2 years because many schools do not have good osteopathic curricula in the clinical years). In those 4 (or 2) years, the osteopathic medical student must be exposed to the unique advantages of the osteopathic medical profession and the rationale for the osteopathic medical approach. Without such exposure, COM graduates would have no concept of the distinctiveness of the osteopathic approach and what it can accomplish.

COMs Through the Decades

The growth in the number of COMs and practicing DOs has been exponential in recent decades. In 1935, there were 6 schools and 8265 DOs in active practice. In 1955, there were still 6 schools, but the number of DOs in active practice had increased to 11,912. As Gevit noted, the California merger in 1962 was a galvanizing force in the osteopathic medical profession, causing many disparate groups to consolidate forces and establish a stronger profession. Part of this movement included establishing more COMs and thus increasing the number of DOs. In 1975, more than a decade after the California merger, there were 9 COMs and 14,321 DOs in practice.

The movement continued; in 1985, there were 14 COMs and 22,540 DOs in practice. Another wave of COM expansion began in the 1990s, when the venerable Chicago College of Osteopathic Medicine grew into Midwestern University, a health science university. Subsequently, the Arizona College of Osteopathic Medicine of Midwestern University was established. In 2005, COMs comprised 22 campuses and 25 locations. At that same time, 56,512 DOs were in practice. The growth continued. Just 4
years after that, there were 26 campuses in 32 locations and 67,167 DOs in practice. As of the 2011-2012 academic year, 26 COMs are operating in 34 locations.

It is truly a staggering achievement for the osteopathic medical profession to have added so many schools and physicians within a few decades. In roughly 4 decades, the osteopathic profession has added approximately 4 times the number of COM locations than existed in 1935. In comparison, no allopathic medical schools opened in the US in the 1980s or 1990s.

### Osteopathic Postdoctoral Training Through the Decades

Where are all of these new COM graduates going for osteopathic postdoctoral training? For many decades, a majority of DOs would complete the traditional osteopathic rotating internship and then go into practice as a general practitioner. In 1950, a survey published by JAOA—The Journal of the American Osteopathic Association revealed that 13% of osteopathic medical students intended to enter a residency program after the internship year. Twenty-five percent intended to seek board certification in a specialty.

In 2010, there were 792 AOA-approved residency programs. In 2009, 5399 DOs were in AOA-approved residencies and internships. However, 7237 DOs were in Accreditation Council for Graduate Medical Education (ACGME), or allopathic, residency programs. Not surprisingly, many of the ACGME positions filled by DOs were specialty positions that were limited in availability in AOA-approved residencies. One good example of this is in pediatrics. In the 2008-2009 academic year, there were 171 funded positions in AOA residency programs, of which 130 were filled, in addition to 40 “specialty track” interns. At the same time, there were 656 DOs in ACGME residencies. Likewise, there were 52 funded neurology positions in AOA residencies and 31 neurology residents compared with 114 DOs in ACGME residencies.

Interestingly, some AOA-approved residency specialties have a surplus of positions. Internal medicine, for example, had 1128 funded positions in 2008-2009 in AOA residencies. However, only 672 residents and 214 specialty-track interns filled the positions. In comparison, 1296 DOs filled ACGME internal medicine residencies during the same period. Family practice is another example; out of 1836 funded positions, 1298 were filled, 221 of which were filled by specialty track interns. In ACGME family practice residencies, 1374 DOs held positions, roughly equivalent to the total number of DOs in AOA residencies.

There are several important questions germane to osteopathic postdoctoral training, including “Why do many COM graduates choose ACGME residencies?” One important factor is geographic; 10 states have 83% of the AOA-approved residency spots, thus limiting geographic diversity. A recent survey of fourth-year osteopathic medical students demonstrated that the top 2 reasons for residency choices were related to geography and the least important factors were regarding prestige and research opportunities. Although it was a limited study based on a sample size of 159, larger studies may yield similar results.

Other factors might be the limited number of AOA-residency spots or the perceived lack of prestige of AOA residencies. A 2004 survey revealed that 66% of fourth-year osteopathic medical students chose to practice allopathic or governmental residencies. The reasons this group gave for choosing a nonosteopathic residency included the following: better training (40%), osteopathic program not available in preferred geographic area (33%), more career opportunities (30%), family considerations (26%), specialty training not available in an osteopathic program (25%), and shorter training period (13%).

Another question regarding osteopathic postdoctoral training is, “Why do many osteopathic residencies in family practice and internal medicine have fewer residents than they have funded spots?” In addition to the reasons cited in the 2004 study, especially in internal medicine with its emphasis on fellowships, a graduate from an AOA-approved residency might have less perceived “market value” than one from an ACGME-approved residency. In a survey of second-year DO residents, 31% of those in ACGME-accredited residencies reported the reputation of the institution as a factor in their decision, compared with 12% of DOs in AOA-accredited residencies.

In a survey of osteopathic medical students and residents, Teitelbaum found that those who chose to go into osteopathic residencies were substantially more likely to report having a DO role model. Not surprisingly, these residents were also more likely to value OPP. These findings suggest that osteopathic residencies are more desirable to COM graduates who value OPP. Osteopathic medical schools need to improve the way in which they present OPP to students to make osteopathic residencies more appealing to COM graduates.

### Call to DOs

Osteopathic physicians have the opportunity to help bring osteopathic distinctiveness to the forefront of osteopathic predoctoral education. What osteopathic distinctiveness means varies from individual to individual. To start exploring these issues, we suggest that DOs talk to and volunteer with students, be active in local osteopathic organizations, and give talks at COMs. We encourage DOs to find out what is going on in schools and to get involved. Although cultural gaps exist among the generations of osteopathic physicians and students, students still require models of physician behavior to understand what it means to be an osteopathic physician. This one-on-one experience and mentorship simply cannot be replicated with any form of technology.

The profession should also put a priority on creating new osteopathic residency positions in different locations. Two
reasons most frequently cited by COM graduates for not choosing osteopathic residencies are limitations in where residencies are available and a lack of residency positions that are not internal medicine or family medicine. Osteopathic medical school graduates may be more interested in osteopathic residencies if residencies are offered in all specialties and available in a variety of locations throughout the United States.

Conclusion
The ability of the AOA to accredit COMs and to make osteopathic residencies appealing is crucial to the cohesiveness of the profession. At the college level, much of the foundation for OPP is established. Osteopathic postdoctoral training and practicing osteopathic medicine are based on the education one receives at COMs. The AOA COCA is the official accrediting body of COMs, but each osteopathic medical student, resident, and physician is unofficially partially responsible for making sure the standards of the profession are being met. Becoming a role model or mentor for osteopathic medical students is 1 way DOs can fulfill this responsibility. In addition, the profession should make osteopathic residency positions in all specialties available in more locations. Making osteopathic residencies more attractive to COM graduates is a way that the profession can fulfill its obligation to its vital resource, its future. As the osteopathic oath reads, “To my college I will be loyal and strive always for its best interests and for the interests of the students who will come after me.” To us, this oath does not refer to a specific school of osteopathic medicine or specialty college, but rather the “College of Osteopathic Medicine” in the broadest sense.

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