AOA continuing medical education

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Continuing Medical Education, as the term implies, is a lifetime commitment to learning by physicians in the full recognition that the study of medicine does not end with graduation from medical school. In 1973, the American Osteopathic Association established the requirement that each member maintain a minimum number of continuing medical education credits during a 3-year period in order to continue membership in the Association. In addition, 23 states (Table 1) have established minimum CME requirements to qualify for annual relicensure and a number of specialty colleges require a minimum of CME credits in order to maintain certification.

The AOA activities in CME may be characterized as (1) the approval of general policies and guidelines that provide leadership and a national structure within which CME programs and credit may be recognized, and (2) the maintenance of a computerized CME-credit recording and notification mechanism known as Individual Activity Reports (IARs.) As in the past, experience with the program has led the AOA Board of Trustees and the Committee on Continuing Medical Education to revise certain policies and procedures. Major category changes have been implemented for this 3-year cycle in response to the needs of osteopathic physicians across the country. In addition, there is a new emphasis on documenting CME course work in physicians' primary specialties. These changes and a brief history of the program are the focus of this article.

This is the second year of the 1989-1991 AOA CME cycle. The AOA CME program has now been in existence for 17 years and five cycles have been completed; the sixth began on Jan 1, 1989.

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CME program organization and structure

The Division of Continuing Medical Education, established in 1973, is a part of the AOA Department of Education and is responsible for implementing the policies of the Board of Trustees and House of Delegates through the Committee on Continuing Medical Education. In administering the guidelines and regulations, the office disseminates information on the CME program to individual physicians and sponsors.

Sponsors may submit programs to the Division for initial approval. Each program is reviewed in accordance with guidelines approved by the Board of Trustees and the Committee and the organization or person is then notified of the hours and category of credit for which the program is approved. As requests for credit are received, the staff reviews the activity and determines eligibility, category, and credit to be granted. Any type of activity not previously considered is referred to the Committee on Continuing Medical Education for a decision.

The AOA maintains an individual computer record for each DO and, twice a year, provides each member with a report of his or her activities.

Between the first CME cycle (1973-1976) and the last 3-year cycle (1986-1988), there had been an overall increase of 3,682 physicians with a CME requirement. This was an increase of 39.9% over the 12-year period from 1976 to 1988. This trend is expected to continue.

The pattern is consistent for each 3-year cycle, with about 98% of the physician members meeting their AOA CME requirement, and about 2% of those with a requirement potentially being dropped from membership at the conclusion of each cycle. Two percent of the physicians with a requirement equates to about 0.8% of the overall AOA membership when adjusted for waivers and exclusion (Table 2).

Table 1
States With Legislation Requiring CME for
Registration of License To Practice Medicine

State	Year of legislation	CME requirement operational
Alaska	1986	Yes
Arizona	1976	Yes
Arkansas	1977	No
California	1977	Yes
Delaware	1985	Yes
District of Columbia	1985	No
Florida	1985	Yes
Hawaii	1976	Yes
Illinois	1985	No
Iowa	1979	Yes
Kansas	1978	Yes
Kentucky	1972	No
Louisiana	1987	No
Maine	1979	Yes
Maryland	1978	Yes
Massachusetts	1977	Yes
Michigan	1977	Yes
Minnesota	1977	Yes
Missouri	1987	Yes
Nebraska	1976	No
Nevada	1979	Yes
New Hampshire	1978	Yes
New Mexico	1972	Yes
Ohio	1977	Yes
Pennsylvania	1978	No
Puerto Rico	1976	Yes
Rhode Island	1977	Yes
Washington	1976	Yes
Wisconsin	1977	Yes

Trends

The total number of credit hours recorded has increased significantly each 3-year cycle. The greatest number of credits awarded in any one area has been in Category 1-A, formal osteopathic medical programs (Table 3). (Category 1-A—Formal educational programs sponsored by recognized osteopathic institutions, organizations, and their affiliates which meet the quality standards as defined by the AOA.)

The data indicate a steady and constant increase in the number of Category 1-A credits being awarded. Since the first 3-year cycle, there has been an overall increase of 500,000 Category 1-A credits recorded. This is an increase of 38.5% over the 12-year period from 1976 to 1988. This is by far the most utilized of the available categories.

There has also been a continuing growth in the utilization of "other" categories. The other categories include Category 1-B (formerly 1-B

through 1-F) and all Category 2 credit areas. The use of these other categories increased during the 12-year period from 1976 through 1988 from 1.2 million to 4.1 million credit hours per 3-year cycle. This increase of 2,900,000 credits represents an increase of 241%. This growth is the result of physicians seeking a variety of means to satisfy their CME obligations.

This growth also reflects AOA policy changes in recent years. It has been and will continue to be useful for physicians and CME sponsors to be knowledgeable of these changes.

It is also interesting to note that the average number of credit hours actually earned per physician of those meeting their CME requirement has consistently exceeded the base requirement of 150 credit hours (Table 4).

Recent changes in AOA CME policies

The major focus of the AOA Board of Trustees and the Committee on Continuing Medical Education during the last 3-year cycle was on the redesign of the CME program to simplify the recording of CME credits by reducing the number of subcategories from 11 to 4, and helping to focus attention on the quality and relevancy of course work taken to actual physician practice. These changes became effective with the beginning of the new 3-year cycle on Jan 1, 1989.

While physicians still are required to earn a total of 150 credits in the 3-year cycle with a minimum of 60 credits in Category 1, they may earn the remaining 90 credits in any of the remaining categories. The four newly revised categories (1-A, 1-B, 2-A, and 2-B) are summarized in Table 5.

Another major change to the CME program for the 1989-1991 cycle is the requirement that all physicians who are board certified or board eligible *must* earn a minimum of 50 credit hours or more as may be mandated by the board of their basic certification in each 3-year cycle CME period. These 50 credits may be earned in any combination of categories 1 and 2. Failure to maintain this requirement will result in loss of certification or board eligibility.

AOA members serving in the military will be exempt from the 50 credit hours in their

Table 2
Numbers of Physicians Meeting and Not Meeting CME Requirements

Three-year cycle	Number of physicians		
	With a CME requirement	Who met requirement	Dropped from membership
1973-1976	9,219	9,037 (98.0%)	182 (2.0%)
1977-1979	10,373	10,124 (97.5%)	239 (2.5%)
1980-1982	12,050	11,891 (98.7%)	159 (1.3%)
1983-1985	11,881	11,583 (97.5%)	298 (2.5%)
1986-1988	12,901	12,860 (99.7%)*	41 (0.3%)*
1989-1991	15,906		

*As of June 1, 1990.

Table 3
Total Number of CME Credits Recorded (in Millions) for Each Three-Year Cycle

Three-year cycle	Total number of credits recorded (in millions)		
	Category 1-A	Other	Total
1973-1976	1.3	1.2	2.5
1977-1979	1.4	1.3	2.7
1980-1982	1.5	1.9	3.4
1983-1985	1.5	2.2	3.7
1986-1988	1.8	4.1	5.9
1989-1991*	0.8	1.5	2.3

*As of May 5, 1990.

Table 4
Average Number of CME Credits Earned per Physician Completing His or Her CME Requirements

Three-year cycle	Average No. of credits per physician
1973-1976	277
1977-1979	267
1980-1982	286
1983-1985	319
1986-1988	469

specialty requirement when assigned to positions other than their specialty.

Also, beginning Jan 1, 1989, life members and honorary life members are no longer exempt from the AOA CME program.

These changes appear in the new AOA CME

guide (1989-1991) that was mailed to members in December 1988. The guide should be of major interest to all members and to sponsors of CME programs.

CME division activities

The Division of Continuing Medical Education is seeking to identify additional ways in which to serve the membership. It is seeking additional sources of CME programs for physicians who are limited by time or geographic location or both. The focus for this work is in the area of audiovisual programs and computer interactive programs, and expansion of the types of CME programs eligible for AOA Category 1 CME credit. A complete list of Category 1 sponsors recognized by the AOA is given in Table 6.

A list of AOA Category 1 CME sponsors who have agreed to make their audiovisual programs available to other facilities and individual osteopathic physicians was published in the AOA 1990 *Yearbook and Directory of Osteopathic Physicians*. Updates to the list will be published during the year in *The DO* and *JAOA*.

In addition, the AOA experimented in 1988 with videotaping a portion of the joint session of the AOA Annual Convention and made the tapes available to the general membership through announcements in *The DO* and *JAOA*. Enclosed with each set of tapes was a card that physicians could sign and return for CME credit. This program was so well received that videotapes for the joint session of the 1989 AOA Annual Convention have been made available to the membership.

Finally, basic and advanced life support courses, such as Advanced Trauma Life Support (ATLS) and Advanced Cardiac Life Support (ACLS), are now eligible for AOA Category 1 CME credit. Although these changes will benefit all DOs in general, they will be of particular benefit to DOs in the US Military and states in which there are few osteopathic physicians.

Conclusions

The Committee on Continuing Medical Education will continue to study, evaluate, and rec-

(continued on page 1025)

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Please see adjoining page for brief summary of
prescribing information.

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Considerations before you prescribe Cytotec

- Because of its abortifacient property, Cytotec should not be prescribed for women who are pregnant. Patients must be advised of the abortifacient property and warned not to give the drug to others.

- Cytotec should be used in a woman of childbearing potential only if she is using effective contraceptive measures, has received oral and written warnings concerning the hazards of misoprostol, has had a negative serum pregnancy test within two weeks prior to beginning therapy, and will begin therapy only on the second or third day of the next menstrual period.
- Some patients may experience transient diarrhea, which usually resolves in about a week, or abdominal discomfort. Abdominal discomfort may persist in the absence of gastric ulceration.

BRIEF SUMMARY

CONTRAINDICATIONS AND WARNINGS: Cytotec (misoprostol) is contraindicated, because of its abortifacient property, in women who are pregnant. (See *Precautions*.) Patients must be advised of the abortifacient property and warned not to give the drug to others. Cytotec should not be used in women of childbearing potential unless the patient requires nonsteroidal anti-inflammatory drug (NSAID) therapy and is at high risk of complications from gastric ulcers associated with use of the NSAID, or is at high risk of developing gastric ulceration. In such patients, Cytotec may be prescribed if the patient

- is capable of complying with effective contraceptive measures.
- has received both oral and written warnings of the hazards of misoprostol, the risk of possible contraception failure, and the danger to other women of childbearing potential should the drug be taken by mistake.
- has had a negative serum pregnancy test within two weeks prior to beginning therapy.
- will begin Cytotec only on the second or third day of the next normal menstrual period.

INDICATIONS AND USAGE: Cytotec (misoprostol) is indicated for the prevention of NSAID (nonsteroidal anti-inflammatory drugs, including aspirin)-induced gastric ulcers in patients at high risk of complications from gastric ulcer, eg, the elderly and patients with concomitant debilitating disease, as well as patients at high risk of developing gastric ulceration, such as patients with a history of ulcer. Cytotec has not been shown to prevent duodenal ulcers in patients taking NSAIDs. Cytotec should be taken for the duration of NSAID therapy. Cytotec has been shown to prevent gastric ulcers in controlled studies of three months' duration. It had no effect, compared to placebo, on gastrointestinal pain or discomfort associated with NSAID use.

CONTRAINDICATIONS: See boxed **CONTRAINDICATIONS AND WARNINGS**.

Cytotec should not be taken by anyone with a history of allergy to prostaglandins.

WARNINGS: See boxed **CONTRAINDICATIONS AND WARNINGS**.

PRECAUTIONS:

Information for patients: Cytotec is contraindicated in women who are pregnant, and should not be used in women of childbearing potential unless the patient requires nonsteroidal anti-inflammatory drug (NSAID) therapy and is at high risk of complications from gastric ulcers associated with the use of the NSAID, or is at high risk of developing gastric ulceration. Women of childbearing potential should be told that they must not be pregnant when Cytotec therapy is initiated, and that they must use an effective contraception method while taking Cytotec.

See boxed **CONTRAINDICATIONS AND WARNINGS**.

Patients should be advised of the following:

Cytotec is intended for administration along with nonsteroidal anti-inflammatory drugs (NSAIDs), including aspirin, to decrease the chance of developing an NSAID-induced gastric ulcer.

Cytotec should be taken only according to the directions given by a physician. If the patient has questions about or problems with Cytotec, the physician should be contacted promptly.

THE PATIENT SHOULD NOT GIVE CYTOTEC TO ANYONE ELSE. Cytotec has been prescribed for the patient's specific condition, may not be the correct treatment for another person, and may be dangerous to the other person if she were to become pregnant.

The Cytotec package the patient receives from the pharmacist will include a leaflet containing patient information. The patient should read the leaflet before taking Cytotec and each time the prescription is renewed because the leaflet may have been revised.

Keep Cytotec out of the reach of children.

SPECIAL NOTE FOR WOMEN: Cytotec must not be used by pregnant women. Cytotec may cause miscarriage. Miscarriages caused by Cytotec may be incomplete, which could lead to potentially dangerous bleeding, hospitalization, surgery, infertility, or maternal or fetal death.

Drug interactions: See *Clinical Pharmacology*. Cytotec has not been shown to interfere with the beneficial effects of aspirin on signs and symptoms of rheumatoid arthritis. Cytotec does not exert clinically significant effects on the absorption, blood levels, and antiplatelet effects of therapeutic doses of aspirin. Cytotec has no clinically significant effect on the kinetics of diclofenac or ibuprofen.

Animal toxicology: A reversible increase in the number of normal surface gastric epithelial cells occurred in the dog, rat, and mouse. No such increase has been observed in humans administered Cytotec for up to one year.

An apparent response of the female mouse to Cytotec in long-term studies at 100 to 1000 times the human dose was hyperostosis, mainly of the medulla of sternbrae. Hyperostosis did not occur in long-term studies in the dog and rat and has not been seen in humans treated with Cytotec.

Carcinogenesis, mutagenesis, impairment of fertility: There was no evidence of an effect of Cytotec on tumor occurrence or incidence in rats receiving daily doses up to 150 times the human dose for 24 months. Similarly, there was no effect of Cytotec on tumor occurrence or incidence in mice receiving daily doses up to 1000 times the human dose for 21 months. The mutagenic potential of Cytotec was tested in several *in vitro* assays, all of which were negative.

Misoprostol, when administered to breeding male and female rats at doses 6.25 times to 625 times the maximum recommended human therapeutic dose, produced dose-related pre- and post-implantation losses and a significant decrease in the

number of live pups born at the highest dose. These findings suggest the possibility of a general adverse effect on fertility in males and females.

Pregnancy: **Pregnancy Category X.** See boxed **CONTRAINDICATIONS AND WARNINGS**.

Nonteratogenic effects: Cytotec may endanger pregnancy (may cause miscarriage) and thereby cause harm to the fetus when administered to a pregnant woman. Cytotec produces uterine contractions, uterine bleeding, and expulsion of the products of conception. Miscarriages caused by Cytotec may be incomplete. In studies in women undergoing elective termination of pregnancy during the first trimester, Cytotec caused partial or complete expulsion of the products of conception in 11% of the subjects and increased uterine bleeding in 41%. If a woman is or becomes pregnant while taking this drug, the drug should be discontinued and the patient apprised of the potential hazard to the fetus.

Teratogenic effects: Cytotec is not fetotoxic or teratogenic in rats and rabbits at doses 625 and 63 times the human dose, respectively.

Nursing mothers: See *Contraindications*. Cytotec should not be administered to nursing mothers because the potential excretion of misoprostol acid could cause significant diarrhea in nursing infants.

Pediatric use: Safety and effectiveness in children below the age of 18 years have not been established.

ADVERSE REACTIONS: The following have been reported as adverse events in subjects receiving Cytotec:

Gastrointestinal: The most frequent gastrointestinal adverse events were diarrhea and abdominal pain. The incidence of diarrhea ranged up to 40% but averaged 13% in clinical trials.

Diarrhea was dose related and usually developed early in the course of therapy (after 13 days), usually was self-limiting (often resolving after 8 days), but sometimes required discontinuation of Cytotec (2% of the patients). Rare instances of profound diarrhea leading to severe dehydration have been reported. Patients with an underlying condition such as inflammatory bowel disease, or those in whom dehydration, were it to occur, would be dangerous, should be monitored carefully if Cytotec is prescribed. The incidence of diarrhea can be minimized by administering after meals and at bedtime, and by avoiding coadministration of Cytotec with magnesium-containing antacids.

Gynecological: Women who received Cytotec during clinical trials reported the following gynecological disorders: spotting (0.7%), cramps (0.6%), hypermenorrhea (0.5%), menstrual disorder (0.3%) and dysmenorrhea (0.1%). Postmenopausal vaginal bleeding may be related to Cytotec administration. If it occurs, diagnostic workup should be undertaken to rule out gynecological pathology.

Elderly: There were no significant differences in the safety profile of Cytotec in approximately 500 ulcer patients who were 65 years of age or older compared with younger patients.

Additional adverse events which were reported are categorized as follows:

Incidence greater than 1%: In clinical trials, the following adverse reactions were reported by more than 1% of the subjects receiving Cytotec and may be causally related to the drug: nausea (3.2%), flatulence (2.9%), headache (2.4%), dyspepsia (2.0%), vomiting (1.3%), and constipation (1.1%). However, there were no significant differences between the incidences of these events for Cytotec and placebo.

Causal relationship unknown: The following adverse events were infrequently reported. Causal relationships between Cytotec and these events have not been established but cannot be excluded: aches/pains, asthenia, fatigue, fever, rigors, weight changes, rash, dermatitis, alopecia, pallor, breast pain, abnormal taste, abnormal vision, conjunctivitis, deafness, tinnitus, earache, upper respiratory tract infection, bronchitis, bronchospasm, dyspnea, pneumonia, epistaxis, chest pain, edema, diaphoresis, hypotension, hypertension, arrhythmia, phlebitis, increased cardiac enzymes, syncope, GI bleeding, GI inflammation/infection, rectal disorder, abnormal hepatobiliary function, gingivitis, reflux, dysphagia, amylase increase, glycosuria, gout, increased nitrogen, increased alkaline phosphatase, polyuria, dysuria, hematuria, urinary tract infection, anxiety, change in appetite, depression, drowsiness, dizziness, thirst, impotence, loss of libido, sweating increase, neuropathy, neuritis, arthralgia, myalgia, muscle cramps, stiffness, back pain, anemia, abnormal differential, thrombocytopenia, purpura, ESR increased.

Important note: Complete prescribing information should be consulted prior to use.

DOSE AND ADMINISTRATION: The recommended adult oral dose of Cytotec for the prevention of NSAID-induced gastric ulcers is 200 mcg four times daily with food. If this dose cannot be tolerated, a dose of 100 mcg can be used. Cytotec should be taken for the duration of NSAID therapy as prescribed by the physician. Cytotec should be taken with a meal, and the last dose of the day should be at bedtime.

Renal impairment: Adjustment of the dosing schedule in renally impaired patients is not routinely needed, but dosage can be reduced if the 200-mcg dose is not tolerated.

1/23/90 • P90-R114V

Address medical inquiries to:

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Medical & Scientific Information Department
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Table 5
Recent Changes in the Guidelines and Summary of
AOA Continuing Medical Education Program

Total Requirement		CME content by category	Credit limits per 3-year period	
Maximum of 150 credits per 3-year period			1986–1988	1989–1991
Not applicable	50 credits must be in primary specialty			
1986–1988	1989–1991			
1-A	1-A	CATEGORY 1—Minimum of 60 hours Formal education programs sponsored by recognized osteopathic institutions, organizations, and their affiliates that meet the definition of “osteopathic” CME	No limit	No limit
1-B	1-B	Development and publication of scientific papers and electronically communicated programs	No limit	90 hours
1-C	1-B	Osteopathic medical teaching	45 hours	90 hours
1-D	1-B	Conducting osteopathic hospital inspections and certifying boards’ examinations (5 credits per inspection or examination)	30 hours	90 hours
1-E	1-B	AOA-accredited and/or approved hospital committee and departmental conferences concerned with the review and evaluation of patient care	60 hours	90 hours
1-F	1-B	Other CME activities and programs approved for Category 1 credit by AOA Committee on Continuing Medical Education	30 hours	90 hours
2-D	2-A	CATEGORY 2—Maximum of 90 hours allowed Formal education programs sponsored by recognized institutions, organizations, and agencies	90 hours	90 hours
2-A	2-B	Non-AOA—Accredited and/or approved hospital committee and departmental conferences concerned with the review of patient care		
2-B	2-B	Home study	90 hours	90 hours
2-C	2-B	Scientific exhibits	30 hours	90 hours
2-E	2-B	Other CME activities and programs approved for Category 2 credit by AOA Committee on Continuing Medical Education	30 hours	90 hours

commend revisions to the AOA guidelines. The number of recognized programs and recorded credit will grow in the next few years as greater numbers of osteopathic physicians graduate and enter practice. The AOA CME program will be directed toward awarding

credit in a wide diversity of activities while remaining primarily concerned about patient care and clinical education. The Committee on Continuing Medical Education and the AOA office may be contacted at any time to assist with your questions or concerns.

Table 6
Category 1 Sponsors Recognized by the AOA

Divisional Societies		
1. Arizona Osteopathic Medical Association	Phoenix, Ariz	
2. Eastern Regional Osteopathic Convention	Trenton, NJ	
3. Iowa Osteopathic Medical Association	Des Moines, Iowa	
4. Kentucky Osteopathic Association	Louisville, Ky	
5. Maine Osteopathic Association	Augusta, Maine	
6. Michigan Center for Continuing Education in Osteopathic Medicine	Pontiac, Mich	
7. Mississippi Osteopathic Medical Association	Meridian, Miss	
8. Missouri Association of Osteopathic Physicians and Surgeons	Jefferson City, Mo	
9. New England Osteopathic Assembly	Warwick, RI	
10. Ohio Osteopathic Association	Columbus, Ohio	
11. Osteopathic Physicians and Surgeons of California	Sacramento, Calif	
12. Pennsylvania Osteopathic Medical Association	Harrisburg, Pa	
13. Texas Osteopathic Medical Association	Fort Worth, Tex	
14. Washington Osteopathic Medical Association	Seattle, Wash	
15. West Virginia Society of Osteopathic Medicine	Charleston, WV	
Practice Affiliates		
1. American Academy of Osteopathy	Newark, Ohio	
2. American College of Osteopathic Internists	Washington, DC	
3. American College of Osteopathic Obstetricians and Gynecologists	Pontiac, Mich	
4. American College of Osteopathic Surgeons	Coral Gables, Fla	
5. American Osteopathic Academy of Sclerotherapy, Inc	Alpine, Calif	
6. American Osteopathic College of Radiology	Milan, Mo	
7. American Osteopathic College of Allergy and Immunology	West Bloomfield, Mich	
8. American Osteopathic College of Anesthesiologists	Lee's Summit, Mo	
9. Midwest Osteopathic Society of Anesthesiologists	Columbia, Mo	
Osteopathic Foundations		
1. Colorado Springs Osteopathic Foundation	Colorado Springs, Colo	
2. Tucson Osteopathic Medical Foundation	Tucson, Ariz	
Military		
1. Navy Health and Sciences Education and Training Command—US Navy	Besthesda, Md	
Colleges of Osteopathic Medicine		
1. Chicago College of Osteopathic Medicine	Downers Grove, Ill	
2. College of Osteopathic Medicine of Oklahoma State University	Tulsa, Okla	
3. College of Osteopathic Medicine of the Pacific	Pomona, Calif	
4. Kirksville College of Osteopathic Medicine	Kirksville, Mo	
5. Michigan State University—College of Osteopathic Medicine	East Lansing, Mich	
6. New York College of Osteopathic Medicine of New York Institute of Technology	Old Westbury, NY	
7. Ohio University College of Osteopathic Medicine	Athens, Ohio	
8. Philadelphia College of Osteopathic Medicine	Philadelphia, Pa	
9. Southeastern University of Health Sciences College of Osteopathic Medicine	North Miami Beach, Fla	
10. Texas College of Osteopathic Medicine	Forth Worth, Tex	
11. University of Health Sciences, College of Osteopathic Medicine	Kansas City, Mo	
12. University of Medicine and Dentistry of New Jersey—School of Osteopathic Medicine	Stratford, NJ	
13. University of New England College of Osteopathic Medicine	Biddeford, Maine	
14. University of Osteopathic Medicine and Health Sciences College of Osteopathic Medicine and Surgery	Des Moines, Iowa	
15. West Virginia School of Osteopathic Medicine	Lewisburg, WV	
Osteopathic Hospitals		
1. Botsford General Hospital	Farmington Hills, Mich	
2. Carson City Osteopathic Hospital	Carson City, Mich	
3. Still Regional Medical Center	Jefferson City, Mo	
4. Community General Osteopathic Hospital	Harrisburg, Pa	
5. Community Hospital of Lancaster	Lancaster, Pa	
6. Des Moines General Hospital	Des Moines, Iowa	
7. Detroit Osteopathic Hospital	Detroit, Mich	
8. Doctors Hospital	Columbus, Ohio	
9. Garden City Osteopathic Hospital	Garden City, Mich	
10. Grandview Hospital	Dayton, Ohio	
11. Hospital of Philadelphia College of Osteopathic Medicine—Parkview Campus	Philadelphia, Pa	
12. Lansing General Hospital	Lansing, Mich	
13. Massapequa General Hospital	Seaford, NY	
14. Memorial Hospital	York, Pa	
15. Metropolitan Hospital	Grand Rapids, Mich	
16. Metropolitan Hospital	Philadelphia, Pa	
17. Michiana Community Hospital, Inc	South Bend, Ind	
18. Michigan Health Center	Detroit, Mich	
19. Osteopathic Hospital of Texas	Fort Worth, Tex	
20. Pacific Hospital of Long Beach	Long Beach, Calif	
21. Parklane Medical Center	Kansas City, Mo	
22. Parkview Hospital	Toledo, Ohio	
23. Phelps County Regional Medical Center	Rolla, Mo	
24. Pontiac Osteopathic Hospital	Pontiac, Mich	
25. Riverside Hospital	Wilmington, Del	
26. Springfield Hospital	Springfield, Pa	
27. Suburban General Hospital	Norristown, Pa	
28. Sun Coast Osteopathic Hospital	Largo, Fla	
29. Traverse City Osteopathic Hospital	Traverse City, Mich	
30. Tri-City Health Centre	Dallas, Texas	
31. Tulsa Regional Medical Center	Tulsa, Okla	
32. Warren General Hospital	Warren, Ohio	