Osteopathic graduate medical education

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This report summarizes important changes in osteopathic graduate medical education. The report also discusses the administration of graduate medical education by the AOA and presents current statistics regarding internships, residencies, and certification.

Administration of graduate medical education in the AOA

The Committee on Postdoctoral Training (COPT) was established by action of the AOA Board of Trustees in January 1968, to assure the Bureau of Professional Education, the AOA Board of Trustees, the osteopathic medical profession, and the general public that graduate medical programs were operating within approved standards, rules, and regulations, and providing educational training satisfactory to the public interest. The COPT was reorganized in 1990 and now consists of 23 members from affiliate organizations representing the major branches of osteopathic medicine, hospital administration, the uniformed services, and directors of medical education. (See Appendix I, page 1153.)

The COPT works through the Division of Postdoctoral Training of the AOA Department of Education to regulate and monitor graduate medical training in osteopathic medical institutions and evaluate graduate medical training taken in the military and approved allopathic locations. This is done through reports and inspections of training programs which are then reviewed by the Committee at its meetings in April and November each year. Recommendations from the COPT are sent to the

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Bureau of Professional Education and the AOA Board of Trustees for approval. Items that are recommended for denial by the COPT may be appealed to the Bureau of Professional Education before presentation to the Board of Trustees. The approval and appeal processes and other policies regarding graduate medical training are published annually by the AOA Department of Education and are available on request.

Osteopathic intern programs and positions

Trends in enrollment

In the early 1980s, the osteopathic profession did not have enough osteopathic intern positions to meet the needs of osteopathic graduates. In the past few years, the number of intern positions expanded, while the number of students projected as graduating each year decreased slightly. Table 1 shows the number of osteopathic intern positions and the projected number of graduates available to fill those positions. Figures 1, 2, and 3 are drawn from these data.

Figure 1 shows that the percentage of students who took internships has remained relatively stable, with about 82% of graduating students taking internships in osteopathic institutions for the past 4 years.

Figure 2 shows that the number of approved intern positions has increased 23% from 1984-1985 to 1991-1992. Similarly, the number of funded positions has increased, with a drop in number funded in 1991-1992.

Figure 3 shows the gap that resulted from the decline in graduates and increase in funded positions. In 1991-1992, only 76% of funded positions were filled, compared with 99% in 1984-1985.

Table 2 addresses concerns regarding interns who fail to honor their intern program

Table 1
Approved, Funded, and Filled Intern Positions, and
Number of Graduates Available to Fill Those Positions, 1984-1985 Through 1991-1992

	Year								% Change 1984-1985 to 1991-1992
	1984- 1985	1985- 1986	1986- 1987	1987- 1988	1988- 1989	1989- 1990	1990- 1991	1991- 1992	
Approved positions	1,579	1,643	1,660	1,774	1,845	1,859	1,859	1,942	23
Graduates	1,474	1,589	1,584	1,581	1,612	1,528	1,537	1,523	3
Funded positions	1,309	1,378	1,387	1,490	1,515	1,622	1,701	1,648	26
Filled positions	1,299	1,357	1,330	1,354	1,329	1,248	1,248	1,254	-3
Graduates taking osteopathic internships, %	88	85	84	85	82	82	81	82	
Funded intern positions that were filled, %	99	98	96	91	88	77	73	76

Figure 1. Number of osteopathic intern positions filled, and number of DOs projected to graduate each year. (Source: AOA Data Base.)

commitments. The percentage of graduates breaking contracts has continued to decline.

Table 3 lists intern positions and their geographic locations for 1989-1990 through 1991-1992. The seven states with the most positions—Michigan, Pennsylvania, Ohio, New York, New Jersey, Illinois, and Florida—con-

tain 77% of the filled intern positions. Initiatives are under way to focus expansion of intern programs on "small states" and states for which there is an unmet demand for intern positions.

The AOA approves intern programs in AOA-accredited hospitals and programs sponsored

Figure 2. Number of funded intern positions in osteopathic medical institutions, and number of AOA-approved positions. (Source: AOA Data Base.)

Figure 3. Number of intern positions filled, and number of funded intern positions in osteopathic medical institutions. (Source: AOA Data Base.)

Table 2 Intern Contract Releases/Violations				
	1990-1991		1991-1992	
	No.	Percent of those available to participate in the match	No.	Percent of those available to participate in the match
Contract releases by mutual consent:				
To take other DO programs	11		3	
To take allopathic programs	17		10	
To take military programs	2		0	
Reasons unknown	1		0	
Total mutual releases	31	2.0%	13	0.09%
Reported contract breaches:				
To take allopathic programs	4		5	
Reasons unknown	0		0	
Total known breaches	4	0.3%	5	0.03%
Total releases and breaches	35	2.3%	18	1.30%

Table 3 AOA-Approved Osteopathic Intern Positions, by State									
State	1989-1990			1990-1991			1991-1992		
	Approved	Funded	Filled	Approved	Funded	Filled	Approved	Funded	Filled
Arizona	40	18	13	40	27	18	26	14	12
California	66	39	32	64	49	42	59	36	26
Colorado	9	8	7	9	9	9	25	15	15
Delaware	6	6	6	6	6	3	6	6	4
Florida	112	96	82	112	98	76	113	101	70
Georgia	10	5	4	10	7	6	10	7	5
Illinois	90	87	80	90	75	56	90	86	76
Indiana	17	17	15	17	17	11	28	20	10
Iowa	28	16	15	28	21	18	17	17	10
Kansas	12	9	7	12	9	7	12	12	9
Maine	22	19	18	19	19	15	30	22	17
Massachusetts	4	4	3	0	0	0	0	0	0
Michigan	326	300	263	344	321	262	376	340	264
Missouri	86	67	57	86	65	48	86	57	39
New Jersey	124	92	86	127	110	97	142	119	109
New Mexico	0	0	0	0	0	0	0	0	0
New York	194	161	132	218	186	136	217	184	122
Ohio	198	178	164	198	171	137	198	176	131
Oklahoma	76	61	56	76	59	44	76	54	45
Oregon	7	6	6	7	6	6	7	6	6
Pennsylvania	260	213	202	260	249	179	284	250	188
Rhode Island	7	6	2	7	7	7	8	8	8
Texas	88	63	56	80	71	46	87	79	66
Virginia	0	0	0	0	0	0	11	11	5
Washington	0	0	0	0	0	0	0	0	0
West Virginia	44	35	19	44	35	22	29	23	15
Wisconsin	15	9	4	5	5	3	5	5	2
Subtotal	1,841	1,515	1,329	1,859	1,622	1,248	1,942	1,648	1,254
Military			61			45			50
Special Approvals			37			4			9
Total			1,427			1,297			1,313

by AOA-accredited institutions, in hospitals that may or may not be accredited by the AOA. As of Sept 1, 1991, there were 997 (79%) interns in programs in AOA-accredited hospitals not sponsored by colleges of osteopathic medicine (COMs); 52 (4%) in COM-sponsored programs in AOA-accredited hospitals; and 212 (17%) in COM-sponsored programs in hospitals not accredited by the AOA. Regarding the percentage of funded positions that was filled, AOA-accredited hospitals without college sponsorship had 78% filled; COM-sponsored programs in AOA-accredited hospitals had 73% filled; and COM-sponsored programs in hospitals not accredited by the AOA had 74% filled.

Specialty programs in the internship

In 1990, the AOA Board of Trustees adopted policies creating "specialty programs" within the osteopathic internship. In 1991, the Board further clarified terminology for these programs. "Specialty internships" refer to programs that may be acceptable as the first year of graduate medical training within the specialty. Such specialty internships are available in internal medicine and obstetrics and gynecology. Specialty internships must be conducted at institutions that have AOA-approved residency training in these specialties.

"Special emphasis internship" refers to concentration in a specialty, but no reduction in total number of years of training. Such programs were approved in general practice and pediatrics in 1990, and in emergency medicine in 1991. The expectation is that these curricula will both enhance the quality of specialty training and attract more students to general practice, pediatrics, and emergency medicine.

All models for the internship, including all specialty tracks, continue to include rotational requirements in general practice, surgery, internal medicine, pediatrics, and female reproductive medicine, and continue to include the requirement that osteopathic principles and practices be incorporated throughout the internship. Furthermore, an AOA-approved internship remains the basis for any further approval of graduate medical training by the AOA. If a COM graduate enters allopathic resi-

dency training directly on graduation from a COM, that residency training cannot be approved.

On Oct 1, 1991, there were 145 interns enrolled in specialty or special emphasis programs for the 1991-1992 internship year. Of these 145 interns, 83 were in internal medicine; 16 in obstetrics/gynecology; 40 in general practice; and 9 in pediatrics. In comparison, 64 interns completed such programs in 1990-1991, the first year of specialty and special emphasis programs, when 26 completed internal medicine; 18, obstetrics/gynecology; 16, general practice; and 4, pediatrics. No interns are currently enrolled in the new special emphasis program in emergency medicine.

In spring 1991, the Department of Education conducted a survey of directors of medical education, to which 64% of the directors responded. This survey indicated that at the conclusion of the year, 80% of those interns in the specialty intern program in obstetrics/gynecology were remaining at that institution in that specialty. In contrast, in internal medicine, 39% of the specialty interns were continuing in internal medicine residencies at the same institution. In general practice, 47% of the special emphasis interns were remaining at the institution for general practice residencies, and in pediatrics, neither of the two special emphasis interns remained for pediatrics residencies at the same institution.

Residency training policies and programs ***Enrollment in osteopathic residency training***

In 1985-1986, there were a total of 1,245 residents in programs in osteopathic medical institutions. Based on contracts received by the AOA Division on Postdoctoral Training by Sept 1, 1991, there are 1,725 residents in osteopathic medical institutions in 1991-1992. This number is a 38.6% increase for the 6-year period and an 11.2% increase from 1990-1991. Data for all residencies are shown in Table 4.

Figure 4 shows enrollment for the past 4 years for those specialties with the highest number of residents (combining all medical specialties and combining Radiology and Diagnos-

Table 4
Residency Programs in Osteopathic Medical Institutions*

Specialty	1988-1989			1989-1990			1990-1991			1991-1992		
	Pro-grams	Posi-tions	Resi-dents	Pro-grams	Posi-tions	Resi-dents	Pro-grams	Posi-tions	Resi-dents	Pro-grams	Posi-tions	Resi-dents
Anesthesiology	33	124	90	31	129	76	29	138	86	29	150	95
Dermatology	2	4	5	2	4	4	3	8	6	6	18	9
Emergency Medicine	16	123	85	16	149	119	16	174	132	19	233	198
General Practice	72	452	318	81	658	315	87	708	408	94	795	368
Geriatrics	...	...	...	...	...	...	1	4	2	1	4	2
Internal Medicine	49	358	261	45	343	214	45	365	205	45	372	218
Allergy/Immunology	0	0	0	0	0	0	0	0	0	0	0	0
Cardiology	10	27	10	12	37	13	11	36	12	13	46	20
Endocrinology	1	1	0	1	2	1	1	2	1	2	4	0
Gastroenterology	6	16	9	5	15	11	5	16	9	6	20	16
Hematology	2	6	2	1	2	1	1	2	0	1	2	0
Hematology/Oncology	2	4	0	1	2	0	1	2	0	1	2	1
Infectious Diseases	3	6	1	2	4	3	3	5	3	1	7	3
Nephrology	4	10	0	1	4	0	1	4	1	1	2	1
Oncology	0	0	0	0	0	0	0	0	0	1	2	1
Pulmonary Medicine	8	18	11	8	18	6	9	20	6	10	24	12
Rheumatology	1	1	0	1	1	0	1	1	0	1	1	0
Internal Medicine/ Emergency Medicine	...	...	...	...	...	...	...	...	...	1	8	2
Neurology	5	13	12	4	13	7	4	13	10	4	16	16
Child Neurology	0	0	0	0	0	0	0	0	0	0	0	0
Nuclear Medicine	2	3	0	0	0	0	0	0	0	0	0	0
Obstetrics/Gynecology	37	127	110	28	134	125	29	147	110	31	165	146
Maternal/ Fetal Medicine	...	...	...	...	...	...	...	...	...	1	2	0
Ophthalmology	15	41	30	16	44	32	15	42	36	16	51	38
Orthopedic Surgery	34	138	120	33	142	129	33	153	130	33	161	146
Osteopathic Principles and Practice	8	28	5	8	30	4	8	31	4	8	31	3
Otorhinolaryngology	4	8	5	2	6	4	2	6	4	2	6	6
Otorhinolaryngology/ Orofacial Plastic Surgery	16	51	36	16	54	41	16	57	46	16	57	44
Anatomic Pathology	18	43	12	8	24	6	7	22	3	8	24	3
Pediatrics	15	71	27	9	48	15	10	48	7	10	48	3
Neonatal Medicine	2	6	0	2	6	1	2	6	2	2	6	1
Public Health/Preventive Medicine	1	2	0	0	0	0	0	0	0	1	4	0
Proctology	4	6	1	3	5	1	3	5	2	3	5	4
Psychiatry	5	36	29	6	50	32	7	64	41	7	76	47
Child Psychiatry	2	4	0	2	4	0	2	4	0	3	6	1
Radiology	12	52	59	8	49	35	8	49	47	8	49	43
Diagnostic Radiology	15	72	15	14	71	36	15	63	31	15	65	61
Angiography	1	2	0	0	0	0	0	0	0	0	0	0
Neuroradiology	1	1	0	1	1	0	1	1	0	0	0	0
Nuclear Radiology	1	2	0	1	1	1	1	1	1	1	1	0
Radiation Oncology	2	4	1	2	4	1	2	4	2	2	4	1
Diagnostic Ultrasound	1	1	0	1	1	0	1	1	0	0	0	0
Rehabilitation Medicine	2	6	3	1	3	0	0	0	0	0	0	0
Surgery												
General	53	223	196	47	219	168	48	235	172	48	238	185
General Vascular	3	6	1	3	7	0	5	10	2	5	10	2
Neurological	6	14	10	8	19	9	8	19	11	8	20	10
Plastic and Reconstructive	0	0	0	0	0	0	0	0	0	1	2	2
Thoracic/ Cardiovascular	2	5	0	2	5	2	2	5	2	2	5	1
Urological	14	31	16	10	27	16	10	27	17	11	30	17
Total	490	2,146	1,480	442	2,335	1,428	453	2,498	1,551	477	2,772	1,725

*This table reports on residency programs, approved positions, and resident training in osteopathic medical institutions. These data, current to Sept 1, 1991, reflect only those residency contracts received to that date.

Figure 4. Enrollment in osteopathic residencies, selected specialties, ordered by enrollment in 1991-1992. (Source: AOA Data Base.) *Does not include 2 residents in combined internal medicine/emergency medicine programs in 1991-1992. (Key: GP = general practice; G IM = general internal medicine; EM = emergency medicine; Surg = general surgery; OrtS = orthopedic surgery; OBG = obstetrics and gynecology; Rad/D = radiology and diagnostic radiology [combined]; Anes = anesthesiology; IM Sp = internal medicine specialties other than general internal medicine; Psy = psychiatry; OFPS = orofacial and plastic surgery; Opht = ophthalmology.)

tic Radiology). These data show a distressing drop in the number of general practice residents. For general practice, 1990-1991 was the first year of the requirement of a second year of this residency, so a stable rate of enrollment would have resulted in a doubling of the numbers in this residency program. Instead, these data show only a slight increase in 1990-1991, followed by a 10% drop for the current year. Furthermore, pediatrics (combined in the "other" statistics in this illustration) continued its decline in enrollment, with 27 residents in 1988-1989; 15 in 1989-1990; 7 in 1990-1991; and only 3 in 1991-1992.

Most other areas, however, show an increase. Internal medicine specialties showed a 69% increase from last year, with increases from 12 to 20 residents in cardiology; 9 to 16 in gastroenterology; and 6 to 12 in pulmonary medicine. Enrollment in emergency medicine increased 50% in the year, through both new

programs and increases in the size of existing programs, to now be the profession's third largest residency area.

Obstetrics and gynecology programs gained 33% this year. Some of this increase may be attributable to residents who had previously served in a specialty internship in obstetrics/gynecology. (Specialty interns are included in intern data, but not in residency data.) General internal medicine, the other specialty that had a specialty internship that could count as the first year of residency, showed an 8% gain.

Enrollment in allopathic residency programs

Table 5 and Figure 5 compare enrollment in osteopathic residency programs with enrollment in allopathic residency programs. In 1987-1988, 39% of the DOs in residency training were in osteopathic residency programs. In 1988-1989, that percentage rose slightly to

Table 5
DOs in Allopathic or Osteopathic Graduate Medical Training

Year and program	DOs				No. of interns plus residents	% of all trainees in osteopathic programs
	Residents	% of residents in osteopathic programs	Rate of increase	Interns*		
1985–1986						
Osteopathic†	1,245	49%	...	1,299	2,544	67%
Allopathic‡	1,277					
1986–1987						
Osteopathic†	1,250	45%	0.4%	1,357	2,607	63%
Allopathic‡	1,543		20.8%			
1987–1988						
Osteopathic	1,290	39%	3.2%	1,330	2,620	56%
Allopathic§	2,031		31.6%			
1988–1989						
Osteopathic†	1,480	41%	14.7%	1,354	2,834	57%
Allopathic§	2,150		5.9%			
1989–1990						
Osteopathic†	1,430	37%	–3.4%	1,329	2,759	53%
Allopathic§	2,449		13.9%			
1990–1991						
Osteopathic†	1,551	35%	8.5%	1,248	2,799	49%
Allopathic	2,872		17.3%			
1991–1992						
Osteopathic†	1,725	...	11.2	1,244	...	...
Allopathic	...	...	...	...	...	...

*New graduates in osteopathic medical institutions.

†Source: AOA Data Base.

‡Source: *JAMA* annual education issue, vol 258, No. 8, Aug 28, 1987, p 1040.

§Source: *JAMA* annual education issue, vol 264, No. 7, Aug 15, 1990, p 832.

||Source: *JAMA* annual education issue, vol 266, No. 7, Aug 21, 1991, p 942.

41%, and the last report places it at 35%. Please note that allopathic residency statistics include both residents who first completed an osteopathic internship and those who entered allopathic residencies directly upon graduation. They also include residents in military programs that are approved by both the AOA and the Accreditation Council for Graduate Medical Education (ACGME). The statistics reported for osteopathic residents do not include any interns, even those in specialty internships. Note that overall these data show increases in the numbers of residents for both osteopathic and allopathic residency programs, but that the rate of increase has been less for osteopathic residency programs.

Figure 6 shows the number of residents in allopathic residencies in selected specialties, as reported in the annual "education issue" of

JAMA. The primary care specialties all show a linear increase in DOs in allopathic programs.

The AOA policies for approval of allopathic residency training were changed in 1988, to no longer require applicants to document that osteopathic residency positions were not available. Table 6 shows the number of DOs in allopathic or military residency training who completed AOA-approved internships and are seeking AOA approval of subsequent residency training. Figure 7 shows that in many specialties the number of residents seeking approval of training immediately increased, particularly in those specialties that had denied most previous applications (notably general practice and internal medicine). However, for the 1991–1992 training year, these data tend to show a decline in applications for AOA approval,

Figure 5. DOs in residency training in osteopathic and allopathic institutions. (*Sources: AOA Data Base, and the annual education issue of JAMA, most recent edition, vol 266, No. 7, Aug 21, 1991; vol 264, No 7, Aug 15, 1990; and vol 258, No. 8, Aug 28, 1987.)

Figure 6. DOs in allopathic residency programs, by specialty. (Sources: The annual education issue of JAMA, most recent edition, vol 267, No. 7, Aug 21, 1991; and vol 264, No. 7, Aug 15, 1990.)

Table 6
Nonosteopathic and Military Residents in AOA-Approved Programs
(as of Sept 1, 1991)

Program	1988-1989	1989-1990	1990-1991	1991-1992
Aerospace Medicine	7	2	5	3
Allergy/Immunology	0	0	0	1
Anatomic Pathology	1	1	1	1
Anesthesiology	11	20	21	24
Angiography	1	1	0	0
Cardiology	14	9	7	5
Child Neurology	...	1	1	0
Child Psychiatry	2	1	2	4
Critical Care Medicine	...	3	2	2
Dermatology (residency training)	3	2	1	12
Dermatology (preceptorship)	21	10	36	28
Diagnostic Radiology	3	4	6	4
Diagnostic Ultrasound	0	0	1	0
Emergency Medicine	13	10	9	7
Endocrinology	2	2	0	2
Gastroenterology	2	3	1	0
General Practice	9	32	78	61
General Vascular Surgery	1	1	2	2
Geriatrics	...	2	1	0
Hematology	1	0	1	0
Hematology/Oncology	6	6	4	3
Infectious Diseases	2	3	1	2
Internal Medicine	5	24	53	31
Maternal and Fetal Medicine	0	0	0	0
Medical Diseases of the Chest (1991 changed to Pulmonary Medicine)	3	5	1	1
Neonatology	1	2	2	3
Nephrology	5	4	0	3
Neurological Surgery	1	1	0	1
Neurology	24	28	18	12
Neuroradiology	2	2	2	1
Obstetrics/Gynecology	6	7	16	11
Occupational Medicine	7	5	4	2
Oncology	0	4	2	1
Ophthalmology	2	2	0	0
Orthopedic Surgery	2	1	2	3
Other Specialty*	13	6	3	2
Otorhinolaryngology	2	2	2	2
Pathology	2	4	14	11
Pediatric Allergy/Immunology	...	...	1	0
Pediatrics	2	9	18	13
Plastic/Reconstructive Surgery	4	4	4	4
Preventive Medicine	4	3	4	0
Proctology (residency)	0	0	2	0
Proctology (preceptorship)	0	0	0	1
Psychiatry	39	23	27	18
Public Health	0	0	0	0
Radiation Oncology	2	2	2	1
Radiation Therapy	0	1	1	0
Radiology	2	2	3	4
Rehabilitation Medicine	28	26	22	19
Reproductive Endocrinology	...	...	2	2
Rheumatology	3	2	3	1
Surgery (General)	2	5	4	7
Thoracic/Cardiovascular Surgery	4	7	11	6
Urological Surgery	1	1	2	2
Totals	265	295	406	323

*Other specialty classification is given to specialty areas where no currently approved AOA standards exist.

Figure 7. DOs seeking AOA approval of allopathic or military programs, by specialty, selected specialties. (Source: AOA Data Base.)

from approximately 17% of DOs in allopathic residencies to approximately 11% seeking such approval. The proportion of residents taking allopathic graduate medical education programs who are seeking "double boarding" appears to be relatively small, and may be decreasing.

Policies regarding general residency training

During the past year, the AOA approved several policies that had an impact on general residency training.

The Committee on Postdoctoral Training directed each specialty affiliate to address the issue of resident work hours in its programs. In the past year, this task has been accomplished in many of the training areas, and is expected to be instituted in all specialty and subspecialty areas by the end of the 1991-1992 training year.

Policy was adopted to prevent residents who unilaterally break contracts with osteopathic graduate medical training programs from gaining approval of any subsequent nonosteopathic

graduate medical training. This policy will prevent physicians who have arbitrarily broken contracts with osteopathic graduate medical programs from entering into the approval process for nonosteopathic residency training programs.

The Board also adopted a policy recommending (but not requiring) financial compensation of residency program directors. This compensation is meant to stabilize the position of the residency program director and acknowledge the physician's expertise in patient care and resident education.

New residency documents and policies

Changes in terminology have converted the name of previously approved programs in *medical diseases of the chest* to *pulmonary medicine*, and modifications in the curriculum and faculty requirements of radiology have caused programs to change to *diagnostic radiology* programs.

Policies have been adopted in dermatology which will recognize only new *residency* programs and prohibit the approval of any *pre-*

Table 7
Physicians Receiving Certification 1987 to 1991
(as of Aug 1, 1991)

	1987	1988	1989	1990	1991		1987	1988	1989	1990	1991
Allergy and Immunology	0	0	0	0	0	Orofacial Plastic Surgery	0	2	0	0	0
Anatomic Pathology	3	2	4	2	2	Orthopedic Surgery	20	21	24	30	26
Anatomic Pathology and Laboratory Medicine	0	0	1	0	2	Osteopathic Manipulative Medicine, Special Proficiency	0	3	1	3	24
Anesthesiology	19	14	32	22	30	Otorhinolaryngology	0	2	2	4	1
Cardiology	13	8	12	15	19	Otorhinolaryngology and Orofacial Plastic Surgery	7	7	8	12	8
Child Neurology	1	0	0	0	0	Pediatrics	20	16	12	15	8
Child Psychiatry	1	1	1	0	4	Plastic and Reconstructive Surgery	0	0	1	1	0
Dermatology	3	7	5	5	9	Preventive Medicine/ Aerospace Medicine	1	2	3	3	2
Diagnostic Radiology	16	25	16	17	15	Preventive Medicine and Public Health	4	0	5	3	1
Emergency Medicine	38	30	34	40	51	Preventive Medicine/ Occupational Medicine/ Environmental Medicine	5	6	5	4	6
Endocrinology	1	2	1	1	0	Proctology	2	1	0	2	2
Gastroenterology	7	5	4	9	9	Psychiatry	8	8	11	10	16
Gynecologic Oncology	0	1	0	0	0	Pulmonary Medicine (Pre-1991—Medical Diseases of the Chest)	...	...	...	...	9
General Practice	285	384	497	478	289*	Radiation Oncology	1	1	0	0	2
General Vascular Surgery	0	9	6	4	3	Radiology	2	2	0	1	0
Hematology	2	0	2	2	2	Rehabilitation Medicine	4	6	11	7	6
Hematology and Oncology	0	0	0	0	0	Reproductive Endocrinology	0	2	3	0	1
Infectious Disease	1	2	1	1	5	Rheumatology	0	1	6	3	0
Internal Medicine	78	80	69	94	70	Surgery (General)	17	9	19	23	24
Laboratory Medicine	2	1	2	0	3	Thoracic/Cardiovascular Surgery	4	5	3	0	4
Maternal and Fetal Medicine	0	1	1	0	1	Urological Surgery	6	6	6	7	9
Medical Diseases of the Chest (1991 changed to Pulmonary Medicine)	7	7	6	7	...	Total number of physicians per year	613	714	854	879	729*
Neonatology	1	1	0	2	0						
Nephrology	4	4	2	4	3						
Neurological Surgery	0	0	1	5	1						
Neurology	3	6	6	9	13						
Nuclear Medicine	0	1	2	0	1						
Obstetrics and Gynecology	11	13	15	22	25						
Oncology	4	2	2	1	7						
Ophthalmology	12	8	12	11	16						

*Requirements for certification in general practice were expanded to require 2 years of residency training rather than 1 year. During this transition, few residents completed programs and, therefore, few applicants were available for certification in general practice in 1991.

ceptorship programs. This change will not affect currently approved preceptorship programs, but it will prevent establishment of any preceptorship programs under the direction of new preceptors.

New standards have been approved for training in combined emergency medicine/internal medicine; sports medicine; and surgical critical care. Standards were also approved in general practice in the fields of interest areas of adolescent and young adult medicine, and osteopathic sports medicine.

Certification

Specialty certification is awarded by the AOA Board of Trustees through the appropriate specialty boards and on recommendation from the Advisory Board for Osteopathic Specialists.

The Advisory Board was established in 1939 by action of the AOA Board of Trustees to meet the needs resulting from the growth of specialization in the osteopathic medical profession. The Advisory Board is composed of one representative from each of the 18 specialty boards, one representative from the Bureau of Professional Education, and a chairman and vice chairman appointed by the president of the AOA. One affiliate has nonvoting representation.

In addition to making recommendations to the Board of Trustees concerning certification of physicians, the Advisory Board makes recommendations concerning the rules, regulations, and procedures established by the specialty boards. The Advisory Board is also charged with providing recommendations con-

cerning the establishment of new certifying boards and the assignment or transfer of specialty and/or subspecialty jurisdiction.

Action by the Board of Trustees in July 1991, clarified terminology regarding certification. "Certification" will be used for certification in a specialty or subspecialty and for certification of special proficiency in Osteopathic Manipulative Medicine, and the only other term that will be used by the AOA and the Advisory Board is "certificate of special recognition." The term "subspecialty" will refer only to areas eligible for certification, and "field of interest" will be used for training in areas not leading to certification. Documents using the terms "certificate of added qualification" or "certificate of competence" will be brought into compliance with this policy.

To respond to concerns about the length of the interval between the time a candidate completes requirements for certification and the date of final certification action by the AOA board of Trustees, policies were changed to make certification effective as of "the date of verification of successful completion of all specialty board requirements" by the respective specialty boards.

The Advisory Board has also been directed by the AOA Board of Trustees to further ex-

amine the recertification process, with a goal of developing a uniform recertification process applicable to all specialties. This process is currently under way.

Other policy action, passed by the AOA House of Delegates, establishes a task force to study issues in graduate medical education, and places a moratorium on documents relating to issues of certification, new specialties, and the approval process and impact of approving new allopathic training programs for osteopathic graduate medical education, until this report is received in 1992. This resolution does not affect programs currently in place and any adjustments made to those programs.

Table 7 shows the number of physicians certified for the past 4 years. The table shows a temporary decline in the number of physicians certified in general practice, resulting from implementation of the requirement of a 2-year residency in general practice and therefore few physicians meeting the requirements for certification during this transition.

Summary

Osteopathic graduate medical education is still in transition. The AOA Department of Education will continue to monitor and report on the impact of these changes.