

Osteopathic graduate medical education

DIVISION OF POSTDOCTORAL TRAINING OF THE
AMERICAN OSTEOPATHIC ASSOCIATION

In 1993, the American Osteopathic Association (AOA) enacted sweeping policy reforms in the area of osteopathic graduate medical education (GME), including the streamlining of the application process for AOA-approval of allopathic GME. In 1994, the AOA focused attention on the certification process, addressing such issues as terminology, recertification, and reentry into the certification process for physicians whose board eligibility has expired.

Osteopathic internship programs and participation

Trends in enrollment

For the first time in 6 years, the number of graduates of colleges of osteopathic medicine (COMs) exceeded the number of available (funded) intern-

ship slots (*Figure 1*). This occurred as a result of a 7% increase in the number of graduates, and a simultaneous 10% decrease in the number of funded positions.

An increased number of graduates chose to enter osteopathic internships, 8% more than last year. However, for the second consecutive year, more than a quarter of all graduates chose not to enroll in osteopathic internship programs (*Table 1*).

In 1994–1995, the number of AOA-approved internship positions increased by 16%. However, despite this increase of more than 300 approved positions, the number of funded positions actually decreased by 10%. Currently, not enough training positions are available if all osteopathic medical school graduates were to desire them (*Figure 1*). This imbalance may prove especially critical

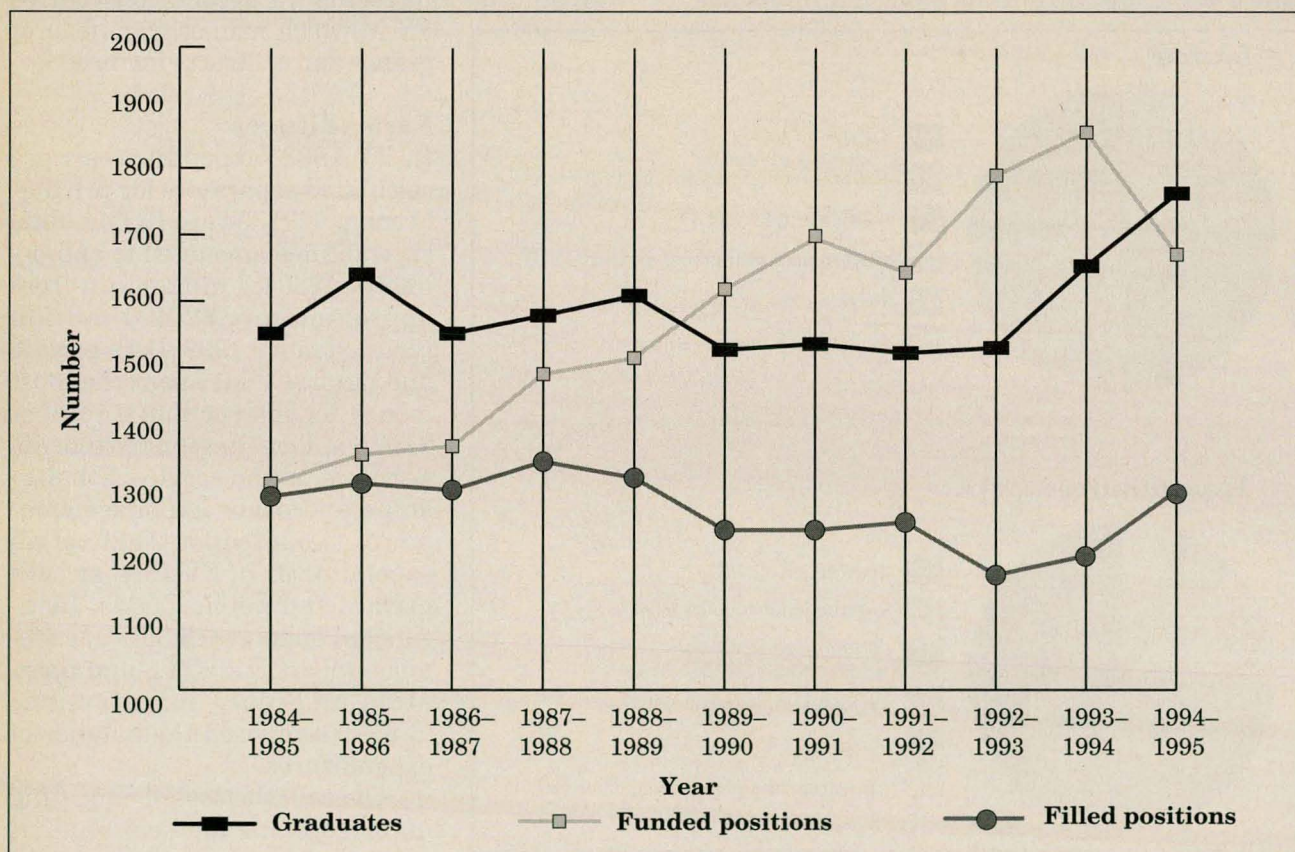


Figure 1. Number of graduates from 15 colleges of osteopathic medicine versus the number of available (funded) internship positions and the number of positions actually filled by graduates, 1984–1985 through 1994–1995. (Sources: 1984–1985 through 1993–1994: JAOA Vol 93, No. 11, November 1993, p 1154; 1994–1995: AOA Data Base.)

if the number of graduates continues to increase in the coming years with expanded class sizes and the advent of several new osteopathic medical schools.

Which COM graduates attended is a strong predictor of whether they will seek an osteopathic internship. *Table 2* shows the participation rate of 1994 graduates in the AOA's Intern Registration Program ("the Match"). The Philadelphia College of Osteopathic Medicine had the highest match rate, with 95.6% of its graduates attaining osteopathic internship programs. Conversely, the College of Osteopathic Medicine of the Pacific and the University of North Texas Health Sciences Center at Fort Worth/Texas College of Osteopathic Medicine had the lowest match rates of 44.6% and 54.9%, respectively.

Geographic availability of funded internship positions accounts for some of these differences. *Table 3* shows the distribution of funded AOA-approved internship positions, by state. Much of the overall 10% decrease in funded internship positions evidenced in 1994–1995 can be attributed to reductions in states where COMs are located (Florida, Illinois, Michigan, Missouri, New Jersey, New York, Pennsylvania, and Texas). Yet, in each of these states, some funded positions remained unfilled.

AOA approval of allopathic internship training

Since July 1989, the Council on Postdoctoral Training (COPT) has considered 334 applications for AOA internship approval of allopathic postgraduate year 1 (PGY1) training. The number of applications considered annually continues to

rise, from 27 in 1990–1991, to 79 in 1992–1993, and 102 in 1993–1994. (These figures do not include the numbers of requests for approval of military internship, 77 in 1993–1994.)

An AOA-approved internship is required for licensure in several states, and for eligibility to sit for all osteopathic medical certification examinations.

For allopathic PGY1 training to be eligible for AOA approval as an internship, applicants must meet two conditions: They have to have had "special circumstances" that necessitated the taking of allopathic GME rather than available osteopathic GME; and the training taken has to meet the rotational requirements of AOA-approved osteopathic internship programs.

If the applicant is judged by the COPT to meet special circumstances, the training taken is then examined for equivalency of rotations. Thus, COM graduates immediately entering, for example, an allopathic surgery residency program, will likely not meet the rotational requirements of an osteopathic internship, and thus will not receive approval, even if special circumstances exist.

Because of the steady annual increase in the number of special-circumstances internship applications received, the COPT revised the application process such that applications will only be reviewed once the applicant has actually begun training in the program.

Specialty internships

To help make osteopathic GME more attractive, and to retain DOs in osteopathic residency programs after internship, in 1990 the AOA created approved *specialty-track* and *special-empha-*

Table 1
Approved, Funded, and Filled Intern Positions, and
Number of Graduates Available To Fill Those Positions, 1987–1988 Through 1994–1995

	1987– 1988	1988– 1989	1989– 1990	1990– 1991	1991– 1992	1992– 1993	1993– 1994	1994– 1995	% Change 1993–1994 to 1994–1995
Approved positions	1,774	1,845	1,859	1,859	1,942	2,156	1,994	2,311	+16
Graduates	1,581	1,612	1,528	1,537	1,523	1,531	1,658	1,771	+7
Funded positions	1,490	1,515	1,622	1,701	1,648	1,799	1,866	1,676	–10
Filled positions	1,354	1,329	1,248	1,248	1,260	1,198	1,208	1,309	+8
Graduates taking osteopathic internships, %*	86	82	82	81	83	78	73	74	
Funded intern positions that were filled, %*	91	88	77	73	77	67	65	78	

*Percentages are rounded off to the next highest number.

Table 2
Original Intern Registration Program Participation and Match Rates
by College of Osteopathic Medicine for 1994-1995 Intern Class Year*

College	Graduates matched, %	Graduates not participating, %
■ Philadelphia College of Osteopathic Medicine, Philadelphia, Pa	95.6	3.4
■ University of Medicine and Dentistry of New Jersey School of Osteopathic Medicine, Stratford, NJ	93.9	3.0
■ Michigan State University College of Osteopathic Medicine, East Lansing, Mich	91.0	9.0
■ Ohio University College of Osteopathic Medicine, Athens, Ohio	90.8	7.1
■ Oklahoma State University College of Osteopathic Medicine, Tulsa, Okla	85.9	14.1
■ Nova Southeastern University College of Osteopathic Medicine, North Miami Beach, Fla	82.9	11.7
■ New York College of Osteopathic Medicine of New York Institute of Technology, Old Westbury, NY	81.0	19.0
■ West Virginia School of Osteopathic Medicine, Lewisburg, WV	79.0	17.7
■ Kirksville College of Osteopathic Medicine, Kirksville, Mo	75.8	22.6
■ University of New England College of Osteopathic Medicine, Biddeford, Me	66.7	27.8
■ Chicago College of Osteopathic Medicine of Midwestern University, Downers Grove and Chicago, Ill	66.1	33.1
■ University of Osteopathic Medicine and Health Sciences College of Osteopathic Medicine and Surgery, Des Moines, Iowa	65.3	30.1
■ University of Health Sciences/College of Osteopathic Medicine, Kansas City, Mo	61.5	32.9
■ University of North Texas Health Sciences Center at Fort Worth/Texas College of Osteopathic Medicine, Fort Worth, Tex	54.9	37.4
■ College of Osteopathic Medicine of the Pacific, Pomona, Calif	44.6	47.3

*Not shown: Percentage of students with military obligations (3.4% total of all graduates) and percentage of students not matching (3.0% of all graduates). These figures are the results of the computer run of the match and subsequent adjustments (for example, nonparticipants entering internship programs, and participants who requested and obtained releases from their match obligations, and who may or may not have enrolled in other AOA-approved internship programs).

Source: AOA Intern Registration Program Data Base. Figures are as of May 25, 1994.

sis internship curricula, in addition to the traditional osteopathic rotating internship.

Specialty-track internships, in which the trainee is granted both internship and first-year residency credit (thus reducing the total years of training by 1) are available in internal medicine and obstetrics and gynecology, and can be offered only by institutions with existing AOA-approved residencies in these specialties.

Special-emphasis internships focus the first year of training in a particular specialty, but do not reduce the total number of years of GME. Such programs may be offered in the areas of pediatrics, emergency medicine, family practice, and psychiatry.

The availability of these programs did not have an overall positive effect on the percentage of COM graduates choosing osteopathic internships (*Table 1*) and, in fact, the proportion of graduates entering internships has decreased since specialty internships were introduced.

Tracking the progress of specialty-track interns through internal medicine or obstetrics and gynecology residencies has proved to be difficult. Preliminary figures, along with anecdotal evidence gathered by the AOA, point to many internal medicine trainees taking the internship/first-year residency in an AOA-approved program, but then completing their remaining 2 years in an allopathic internal

Table 3
AOA-Approved, Funded, and Filled Internship Positions

State*	1992-1993			1993-1994			1994-1995		
	Approved	Funded	Filled	Approved	Funded	Filled	Approved	Funded	Filled
Alabama	4	4	4	4	4	0	4	4	4
Arizona	36	20	10	34	26	24	37	32	29
Arkansas	4	4	2	4	4	3	4	4	4
California	63	45	25	67	45	33	77	50	30
Colorado	25	15	15	25	15	14	25	15	15
Delaware	6	6	3	6	6	2	6	6	6
Florida	131	114	66	121	111	73	132	96	81
Georgia	10	9	7	6	6	1	16	6	3
Illinois	90	86	71	90	83	75	90	70	64
Indiana	17	17	12	19	19	6	19	14	8
Iowa	30	22	12	22	22	16	30	18	14
Kansas	12	12	8	12	12	4	12	8	8
Maine	40	32	14	28	19	10	34	19	14
Massachusetts	24	12	0	20	17	9	20	15	11
Michigan	377	342	254	376	354	239	418	328	249
Missouri	79	56	25	65	65	25	79	35	30
New Jersey	156	129	106	134	125	98	145	110	105
New York	323	238	137	286	270	133	402	247	148
Ohio	213	191	134	190	188	136	222	195	166
Oklahoma	76	47	44	59	59	53	64	57	45
Oregon	7	6	4	6	6	5	7	5	5
Pennsylvania	290	271	190	279	279	180	311	246	201
Rhode Island	7	7	3	7	7	1	0	0	0
Tennessee	0	0	0	18	18	0	18	0	0
Texas	80	69	36	68	65	49	78	54	42
Virginia	11	6	5	13	10	1	13	7	2
West Virginia	41	34	9	30	26	18	43	32	23
Wisconsin	5	5	2	5	5	0	5	3	2
Subtotal	2,157	1,799	1,198	1,994	1,866	1,208	2,311	1,676	1,309
Military			57			45			61

*No internship slots are approved in the following states: Alaska, Connecticut, Hawaii, Idaho, Kentucky, Louisiana, Maryland, Minnesota, Mississippi, Montana, Nebraska, Nevada, New Hampshire, New Mexico, North Carolina, North Dakota, South Carolina, South Dakota, Utah, Vermont, Washington, Wyoming.

Sources: 1992 through 1994, *JAOA* Vol 93, No. 11, November, 1993; 1994-1995, unverified data from AOA Intern Registration Program Data Base as of July 6, 1994 (May 25, 1994 for 1994-1995 Military).

Numbers do not include special approvals of allopathic OGME year 1 training.

medicine training program, or switching to another specialty. For example, of the 102 internal medicine specialty-track interns in 1992-1993, only 53 entered AOA-approved internal medicine residency programs in 1993-1994. Thus, the specialty-track goal of retaining DOs in osteopathic residency programs after internship may not be being attained.

Osteopathic residency training policies and programs

Traditionally, only a portion (92% in 1994-1995 vs 88% in 1992-1993) of residency positions approved for osteopathic GME are actually funded by the sponsoring institutions and therefore available. In the 1994-1995 training year, 1,802 (only 61%) of these funded positions were filled with residents (*Table 4*). This number represents

Table 4
AOA-Approved Residency Programs by Specialty,
1991-1992 Through 1994-1995

Specialty	1991-1992			1992-1993			1993-1994				1994-1995*			
	Pro-grams	Posi-tions	Resi-dents	Pro-grams	Posi-tions	Resi-dents	Pro-grams	Posi-tions	Fund-ed	Resi-dents	Pro-grams	Posi-tions	Fund-ed	Resi-dents*
Anesthesiology	29	150	95	28	137	88	27	145	121	85	28	147	122	53
Dermatology	6	18	9	8	23	16	10	23	21	18	13	36	28	20
Emergency Medicine	19	233	198	21	253	192	26	385	337	230	27	433	354	173
Emergency Medicine/ Internal Medicine	1	8	2	5	24	9	7	32	31	15	7	44	36	16
Family Practice	94	795	368	101	903	379	101	962	828	430	102	1011	848	464
Family Practice/ Emergency Medicine	...	...	...	...	...	...	...	...	...	...	1	4	4	4
Adolescent Medicine in Family Practice	...	...	...	1	6	0	1	4	4	0	1	6	0	0
Sports Medicine in Family Practice	...	...	...	2	4	2	1	2	2	1	...	...	...	...
Geriatrics	1	4	2	2	8	5	3	10	10	6	3	10	10	1
Internal Medicine	45	372	218	44	385	221	44	412	355	176	42	391	340	163
Cardiology	13	46	20	14	57	42	11	62	57	39	9	54	48	37
Critical Care Medicine	...	...	...	1	2	0	2	2	2	0	4	8	8	2
Endocrinology	2	4	0	3	5	3	2	4	4	2	3	6	4	1
Gastroenterology	6	20	16	6	21	19	6	23	21	20	7	28	27	23
Hematology	1	2	0	1	2	1	2	3	3	0	1	2	2	0
Hematology/Oncology	1	2	1	1	2	0	1	2	2	1	1	2	2	0
Infectious Diseases	1	7	3	4	8	5	2	7	7	6	2	7	7	0
Nephrology	1	2	1	4	11	1	4	6	6	0	4	8	6	1
Oncology	1	2	1	1	2	1	1	2	1	0	1	2	1	0
Pediatrics	...	...	...	...	...	...	...	...	...	...	1	2	2	4
Pulmonary Medicine	10	24	12	9	20	14	8	20	16	13	9	28	25	8
Pulmonary/ Critical Care	...	...	...	...	...	...	1	6	6	0	...	...	...	...
Rheumatology	1	1	0	...	...	...	...	...	...	...	1	2	1	0
Neurology	4	16	16	5	17	17	5	24	22	21	5	24	22	15
Obstetrics/Gynecology	31	165	146	28	178	165	31	200	188	160	32	225	203	173
Maternal/Fetal Medicine	1	2	0	1	3	0	...	...	...	...	...	...	...	...
Ophthalmology	16	51	38	15	50	38	14	46	44	38	13	49	46	33

Source: 1991-1992 through 1993-1994, *JAOA*, Vol 93, No. 11, November 1993, pp 1158-1159.

*1994-1995 based on contracts received by the AOA as of August 16, 1994.

a decrease of 4% in the actual number of DO residents enrolled in osteopathic GME programs over the previous year.

The 61% fill rate of all available osteopathic residency slots varies considerably by specialty. For example, osteopathic specialties filling a high proportion of their positions include orthopedic surgery (91%), obstetrics and gynecology (85%), and general surgery (79%). In contrast, the primary care specialties had comparatively low fill rates: family practice (55%), internal medicine (48%), and pediatrics (33%).

The number of residents enrolled in osteopathic internal medicine residency programs decreased by 7% in the 1994-1995 training year from the previous year, and by 26% since 1992-1993. This phenomenon is possibly due to

a combination of factors, including trainees who took the specialty-track internship in internal medicine completing their residency training a year early and, as discussed earlier, specialty-track interns entering allopathic residency programs after completion of their internship year, or switching to another specialty.

AOA approval of allopathic residency training

Until 1990, more osteopathic medical school graduates received their training in AOA-approved osteopathic internship and residency programs than in allopathic GME programs (*Figure 2*). However, beginning in the 1990-1991 training year, this trend reversed. A contributing factor to this phenomenon is the fact that in 1989, the

Table 4, Continued
AOA-Approved Residency Programs by Specialty,
1991-1992 Through 1994-1995

Specialty	1991-1992			1992-1993			1993-1994				1994-1995*			
	Pro-grams	Posi-tions	Resi-dents	Pro-grams	Posi-tions	Resi-dents	Pro-grams	Posi-tions	Fund-ed	Resi-dents	Pro-grams	Posi-tions	Fund-ed	Resi-dents*
Orthopedic Surgery	33	161	146	30	170	141	29	190	182	157	29	213	191	174
Osteopathic Manipulative Medicine	8	31	3	10	39	10	8	28	19	10	8	36	17	9
Otolaryngology	2	6	6	2	7	4	1	3	3	0	2	5	4	5
Otolaryngology/Facial Plastic Surgery	16	57	44	17	65	43	19	73	61	45	17	67	62	49
Anatomic Pathology	8	24	3	9	28	1	6	20	13	3	6	20	13	2
Pediatrics	10	48	3	13	61	8	9	57	44	9	10	59	43	14
Neonatal Medicine	2	6	1	2	6	0	1	2	0	0	1	2	0	0
Preventive Medicine/ Public Health	1	4	0	1	4	0	1	4	4	0	1	4	0	0
Occupational	...	...	...	...	...	...	1	2	0	0	1	2	0	0
Proctology	3	5	4	4	8	2	2	4	3	2	1	4	4	1
Psychiatry	7	76	47	7	70	38	6	67	62	43	7	76	60	31
Child Psychiatry	3	6	1	1	2	1	0	2	2	1	1	2	2	1
Radiology	8	49	43	...	...	...	...	...	...	...	...	...	...	...
Diagnostic Radiology	15	65	61	24	141	105	20	156	136	103	20	137	131	98
Nuclear Radiology	1	1	0	1	1	0	...	...	...	...	...	...	...	...
Radiation Oncology	2	4	1	2	4	0	2	4	2	1	1	2	1	1
Rehabilitation Medicine	0	0	0	1	2	0	1	12	12	0	1	2	2	2
Surgery														
General	48	238	185	46	266	200	41	245	226	197	38	253	234	186
General Vascular	5	10	2	6	11	2	5	7	5	5	5	9	7	2
Neurological	8	20	10	11	26	12	8	21	21	16	8	22	22	12
Plastic/Reconstructive	1	2	2	2	5	2	2	6	6	3	1	6	2	4
Thoracic/ Cardiovascular	2	5	1	2	5	3	2	5	5	3	1	3	3	0
Urological	11	30	17	12	32	17	11	26	25	19	11	30	26	20
Total	478	2,772	1,726	508	3,074	1,807	485	3,316	2,919	1,878	487	3,483	2,970	1,802

Source: 1991-1992 through 1993-1994, *JAOA*, Vol 93, No. 11, November 1993, pp 1158-1159.

*1994-1995 based on contracts received by the AOA as of August 16, 1994.

AOA enacted new policies allowing for AOA approval for training taken in allopathic residency programs, along with the creation of the special-circumstances policy for approval of allopathic internships discussed earlier. In 1992, the residency approval application fee was eliminated and, in 1994, the application process was streamlined to encourage more residents to take advantage of the opportunity for approval.

Residents currently in allopathic residency training now simply register their application for approval with the AOA, then, for the duration of their training, correspond directly with their specialty college. The specialty college then reviews these residents' annual reports, logs, and scientific papers, where appropriate. When the specialty college notifies the AOA that these

residents successfully completed their training and are recommended as "training complete," the AOA grants the approval.

As of August 1, 1994, a total of 731 DOs who are either currently in or who have recently completed allopathic residency training have active applications for AOA approval in process. Although the approval process has been streamlined in the past year, with the expectation of more applications, this figure is changed little from the 691 applications in process 1 year earlier.

In 1993-1994, there were 3,296 DOs in allopathic GME programs (including 45 in "transitional year" programs). Thus, only approximately a fifth of DOs in allopathic GME programs apply for AOA approval of their training. This

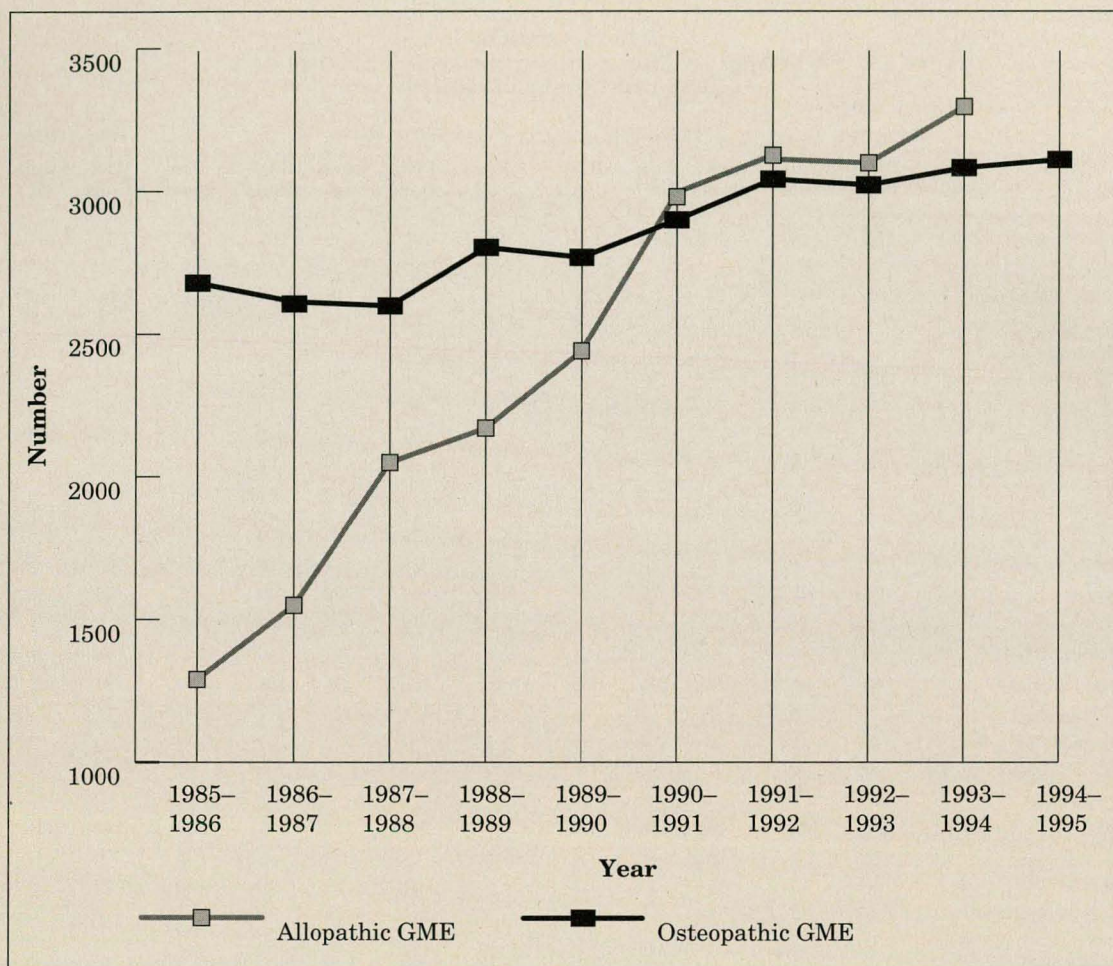


Figure 2. Number of DOs in GME programs in osteopathic (AOA-approved) and allopathic (Accreditation Council for Graduate Medical Education [ACGME]-approved) institutions. (Sources: AOA Data Base and the annual education issue of JAMA, most recent edition, Vol 272, No. 9, September 7, 1994, pp 725-726.)

figure varies slightly by specialty. For example, while roughly 38% of pathology and general surgery residents apply, only about 15% of family practice and obstetrics/gynecology residents so choose. Other comparatively high-applicant specialties include orthopedic surgery (47%), rehabilitation medicine (36%), and diagnostic radiology (28%), while emergency medicine (14%) and pediatrics (10%) approval applications are relatively low.

Figure 3 compares the number of DOs in osteopathic and allopathic residency programs in selected specialty areas. In the primary care specialties of family practice, general internal medicine, and pediatrics, the number of DOs taking allopathic residency training far exceeds the number enrolled in osteopathic residency programs. It should be noted, however, that the allopathic residency figures include some first-year trainees who would

be considered interns if they were training in osteopathic GME programs. Many of these trainees likely are in family practice or internal medicine residency programs.

Certification

As of September 1994, a total of 10,109 DOs are actively certified by the AOA, and hold a combined total of 11,872 certificates. For the third consecutive year, a record number of DOs received certification from the AOA through its 18 certifying boards. To date in 1994, a total of 1,143 certificates were awarded in specialty and subspecialty areas (Table 5). In addition, 117 certifications of added qualifications were awarded, 105 of which were in geriatric medicine from the American Osteopathic Boards of Family Practice (93) and Internal Medicine (12).

Substantial increases were seen in the number of DOs becoming certified in special profi-

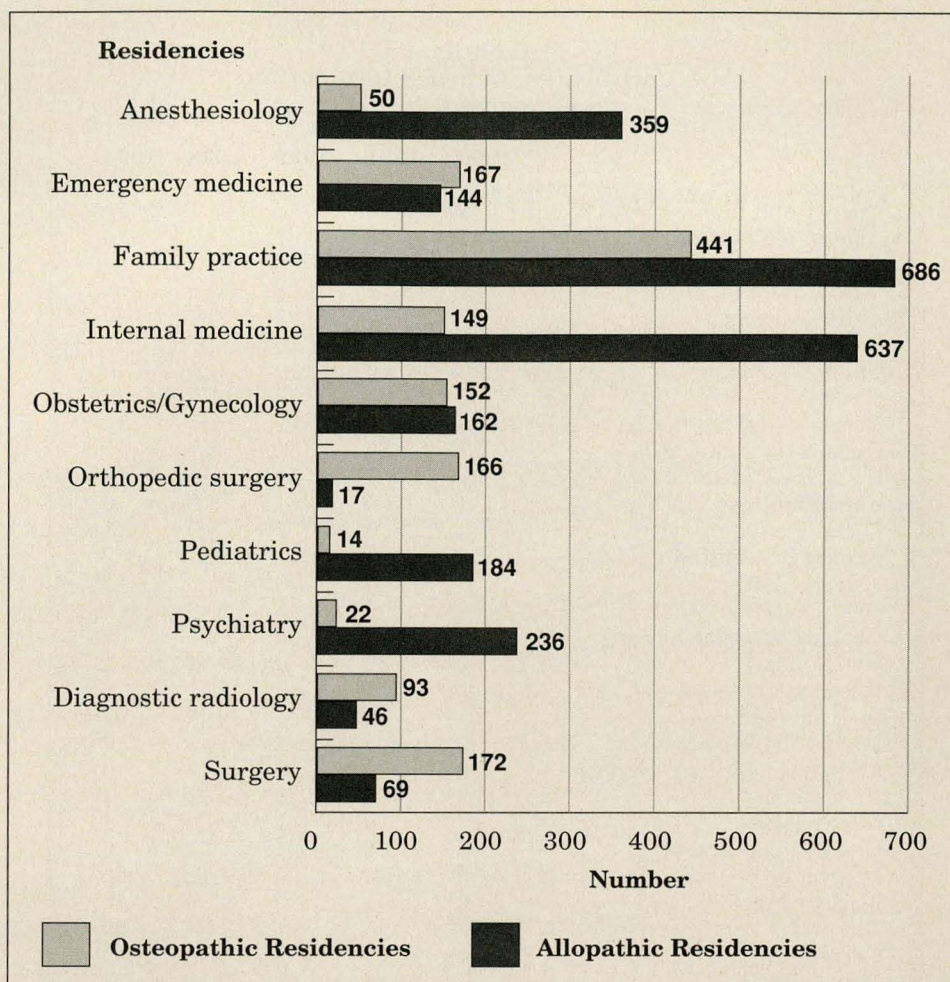


Figure 3. Comparison of number of DOs in osteopathic (AOA-approved) and allopathic (Accreditation Council for Graduate Medical Education [ACGME]-approved) residencies, by selected specialties, 1993–1994. (Source: AOA Data Base and the annual education issue of JAMA, most recent edition, Vol 272, No. 9, September 7, 1994, pp 725–726.) Note: The figures for osteopathic residencies contain only years GME2 and above, whereas the figures for the allopathic residencies include GME1.

ciency in osteopathic manipulative medicine, and in family practice.

New certification terminology

In February 1994, the AOA Board of Trustees adopted the following standardized definitions of certification, and eliminated certificates of special recognition.

General Certification (formerly “Primary Certification”): The primary certification conferred on diplomates who meet the requirements in a specified field of medical practice under the jurisdiction of a certifying Board. General certification represents a distinct and well-defined field of osteopathic medical practice. Certificates read, “Certified in [general field].”

Certification of Special Qualifications (for-

merly “Secondary Certification”): Subspecialty certification conferred by a certifying Board in a specific subspecialty area of the field to which that Board certifies. It requires prior attainment of general certification. Certificates read, “Certified in [subspecialty field].”

Certification of Special Qualifications indicates the possession of knowledge, skill, training, and successful examination in a subspecialty field over and above that required for general certification. Certification of Special Qualifications designates additional abilities in limited areas of the general specialty field represented by that Board. For example, Cardiology is a limited area within the field of Internal Medicine for which physicians may earn special qualification certification.

Certification of Added Qualifications (formerly “Certificate of Added Qualifications”): Consti-

Table 5
AOA Certification Awarded 1990 to 1994
(as of August 1, 1994)

	1990	1991	1992	1993	1994
Allergy and Immunology	0	0	0	1	0
Anatomic Pathology	2	2	1	2	5
Anatomic Pathology and Laboratory Medicine	0	2	2	0	0
Anesthesiology	22	30	47	61	50
Cardiology	15	19	10	8	12
Child Neurology	0	0	0	0	0
Child Psychiatry	0	4	0	5	2
Dermatology	5	9	12	17	10
Diagnostic Radiology	17	15	31	27	15
Emergency Medicine	40	51	54	39	78
Endocrinology	1	0	1	0	0
Facial Plastic Surgery	0	0	0	0	1
Family Practice*	478	289†	444	494	552
Forensic Pathology	0	0	0	0	2
Gastroenterology	9	9	5	6	12
General Vascular Surgery	4	3	4	1	7
Hematology	2	2	4	2	1
Infectious Diseases	1	5	3	1	5
Internal Medicine	94	70	84	108	97
Laboratory Medicine	0	3	1	1	0
Maternal and Fetal Medicine	0	1	0	1	0
Neonatology	2	0	0	7	4
Nephrology	4	3	5	0	2
Neurological Surgery	5	1	1	1	3
Neurology	9	13	5	12	10
Nuclear Medicine	0	1	0	0	0
Obstetrics and Gynecology	22	25	27	24	39
Oncology	1	7	5	6	5
Ophthalmology	11	16	8	16	21

*Before July 1993, certificates were issued as General Practice.
†Requirements for certification in family 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 this specialty

tutes a modification of a general certificate or certificate of special qualifications to reflect additional training of at least 1 year in length and satisfactory completion of a certifying examination in that field. The training required for added qualifications must incorporate a specific and identifiable body of knowledge within the broader practice of the general specialty. For example, a physician can hold general certification in Family Practice, with added qualifications in Geriatric Medicine. Certificates read, "Certified in [general field], with Added Qualifications in [added field]."

When the identifiable body of knowledge for certification of added qualifications overlaps more than one specialty or subspecialty area, a conjoint examination program may be developed by the corresponding certifying Boards. Certification of added

qualifications requires maintenance of valid general or special qualifications certification from which the added qualification was modified.

Recertification in areas of added qualifications requires maintenance of valid general or special qualifications certification from which the added qualification was modified.

Reentry into the certification process

In February 1994, the AOA Board of Trustees directed all certifying boards to establish a mechanism for reentry into the certification process no later than January 1, 1995, for those physicians whose board eligibility has expired. Such a reentry process may include, for example, the completion of a specified amount and type of continuing medical education credit before being

Table 5, Continued
AOA Certification Awarded 1990 to 1994
(as of August 1, 1994)

	1990	1991	1992	1993	1994
Orthopedic Surgery	30	26	21	39	33
Otorhinolaryngology	4	1	1	4	2
Otorhinolaryngology and Facial Plastic Surgery	12	8	12	16	24
Pediatrics	15	8	15	19	14
Plastic and Reconstructive Surgery	1	0	2	5	3
Preventive Medicine/ Aerospace Medicine	3	2	0	1	2
Preventive Medicine and Public Health	3	1	0	2	0
Preventive Medicine/Occupational Medicine/Environmental Medicine	4	6	1	5	14
Proctology	2	2	1	1	1
Psychiatry	10	16	10	18	22
Pulmonary Diseases (Pre-1991: Medical Diseases of the Chest)	7	9	8	9	8
Radiation Oncology	0	2	2	2	2
Radiology	1	0	0	...	...
Rehabilitation Medicine	7	6	1	10	9
Reproductive Endocrinology	0	1	0	0	1
Rheumatology	3	0	0	3	4
Special Proficiency in Osteopathic Manipulative Medicine	3	24	20	13	32
Surgery (General)	23	24	25	36	31
Thoracic/Cardiovascular Surgery	0	4	9	3	3
Urological Surgery	7	9	6	9	5
Total number of certificates per year	879	729†	888	1,035	1,143
*Before July 1993, certificates were issued as General Practice. †Requirements for certification in family 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 this specialty in 1991.					

allowed to sit for certification examination, and will differ by Board. This process will not reestablish board eligibility status, but simply allows physicians to meet the requirements for sitting for certification examination.

Conjoint examinations

In July 1993, the AOA Board of Trustees directed the AOA Executive Director, in conjunction with the Bureau of Osteopathic Specialists (the Bureau), to study the issue of creating a mechanism for the formation of conjoint boards in areas of overlapping specialties. This action was prompted by an application for the formation of a conjoint board of Sports Medicine.

In its discussions, the Bureau noted that

over time, there likely will emerge new areas of overlapping jurisdiction in osteopathic medicine in addition to sports medicine, and that the formation of a new certifying board each time would not be practical. Instead, it was recommended that a mechanism for creating conjoint examinations be formed, that would allow all appropriate specialty boards to participate if they so desire. The Board of Trustees accepted this recommendation in February 1994, and approved the mechanism for creating conjoint examinations.

The Sports Medicine Conjoint Examination Committee was formed in June 1994, and consists of representatives from the AOA certifying Boards of Emergency Medicine, Family Practice, Internal Medicine, Pediatrics, Pre-

Table 6
Current Status of Certificate Time-Limiting by the American Osteopathic Boards

Board	Certificate time limit	Beginning date
■ American Osteopathic Board of Anesthesiology	None	...
■ American Osteopathic Board of Dermatology	None	...
■ American Osteopathic Board of Emergency Medicine	10 years	January 1, 1994
■ American Osteopathic Board of Family Practice	None	...
■ American Osteopathic Board of Internal Medicine	10 years	January 1, 1993
■ American Osteopathic Board of Neurology and Psychiatry	10 years	January 1, 1995
■ American Osteopathic Board of Nuclear Medicine	10 years	January 1, 1995
■ American Osteopathic Board of Obstetrics and Gynecology	None	...
■ American Osteopathic Board of Orthopedic Surgery	10 years	January 1, 1994
■ American Osteopathic Board of Special Proficiency in Osteopathic Manipulative Medicine	10 years	January 1, 1995
■ American Osteopathic Board of Ophthalmology and Otorhinolaryngology	None	...
■ American Osteopathic Board of Pathology	10 years	January 1, 1995
■ American Osteopathic Board of Pediatrics	7 years	January 1, 1995
■ American Osteopathic Board of Preventive Medicine	10 years	January 1, 1994
■ American Osteopathic Board of Proctology	None	...
■ American Osteopathic Board of Radiology	None	...
■ American Osteopathic Board of Rehabilitation Medicine	7 years	June 1, 1995
■ American Osteopathic Board of Surgery	None	...

ventive Medicine, Rehabilitation Medicine, and Special Proficiency in Osteopathic Manipulative Medicine, and the American Osteopathic Academy of Sports Medicine.

The conjoint mechanism allows diplomates (those holding general certification) from participating Boards to establish eligibility to sit for examination in sports medicine. The first conjoint examination for certification of special qualifications in sports medicine is scheduled for May 1995.

Recertification

Effective January 1, 1995, every AOA certifying Board must offer a recertification mechanism to its diplomates. In conjunction with implementation of the recertification process, numerous Boards have instituted time-limiting of their certificates (that is, new certificates are issued with an expiration date). If a Board does not time-limit its certificates, then the certification is valid for life. Similarly, certificates issued before the implementation of time-limiting are valid for life. All diplomates are eligible to sit for recertification examinations, even if they hold a life certificate.

Table 6 summarizes the current status of certificate time-limiting by the AOA boards.

Psychometric assistance

Beginning in January 1994, the AOA began providing psychometric services to assist osteopathic certifying Boards in the validation of their certification examinations. Certification is especially crucial for healthcare practice today because it is usually required for obtaining hospital privileges and participating in a managed care environment. Since certification is so consequential, the certification process must be legally justifiable and valid in order for credentialers to accept it.

To this end, the AOA provides consultation and data analysis services to certifying Boards and assists them in creating, scoring, and analyzing their examinations. These services provide psychometric guidance to a Board in any step of the examination process, whether for a written, oral, or practical examination. Currently, the Boards of Family Practice, Internal Medicine, Ophthalmology, Proctology, Rehabilitation Medicine, and Surgery have used the AOA's psychometric services.