Approaching the Single Accreditation System: Curricular Variation in Allopathic, Osteopathic, and Dually Accredited Family Medicine Residency Programs

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ABSTRACT

Background With the approval of a single accreditation system for graduate medical education, allopathic and osteopathic residency programs are moving toward 1 set of accreditation standards, with full implementation planned for 2020. Minimal research has been done on the variations between allopathic and osteopathic family medicine (FM) residency programs.

Objective The aim of this study was to examine variations in allopathic, osteopathic, and dually accredited FM programs, and to allow them to be addressed.

Methods We collected information in July 2014 on faculty-to-resident ratio; number of half-days spent in clinic; and the months performing maternity, pediatric, and surgical care for each program from the American Academy of Family Physicians and the American College of Osteopathic Family Physicians. Location and number of approved positions were also obtained. Data were compared between allopathic, osteopathic, and dually accredited programs.

Results The number of approved positions was twice as large for allopathic and dually accredited FM programs (n = 24) compared to osteopathic programs (n = 12). Osteopathic FM programs offered 5 months of surgical training compared to 2 months in allopathic and dually accredited residencies, and resident stipends in osteopathic programs were about $2,000 lower than those in allopathic and dually accredited programs. All programs had similar faculty-to-resident ratios (1:2.8–3.3), and offered comparable months of maternity (3 months) and pediatric care (4 months) rotations.

Conclusions Outpatient experiences appeared similar between all types of FM residency programs. Key differences included smaller program size and more months of surgical experience in osteopathic programs. These differences may become increasingly important as osteopathic programs strive to meet accreditation requirements.

Introduction

Allopathic and osteopathic residency training programs have traditionally been affiliated with their individual accreditation bodies, the Accreditation Council for Graduate Medical Education (ACGME) and the American Osteopathic Association (AOA). In 1985, the AOA Board of Trustees agreed to allow residency programs to obtain dual accreditation from both the ACGME and the AOA as a way to increase the number of osteopathic graduate medical education training positions. More recently, the ACGME, the AOA, and the American Association of Colleges of Osteopathic Medicine approved a memorandum of understanding to transition the accreditation of current AOA-accredited programs into a single accreditation system. All programs are scheduled to be accredited via the single accreditation system beginning by 2020.[1]

Overall, the ACGME and AOA requirements for training in family medicine (FM) have an identical program length (36 months), and the requirements for the continuity of care experience stipulate a minimum of 40 weeks per year spent in the FM clinic with the expectation of 1650 patient visits. In addition, both have similar requirements regarding length of inpatient, critical care, emergency room, pediatrics, and women's health exposure. Differences exist in such areas as surgical training, where the ACGME requires only 1 month of surgical experience compared to 5 months required by the AOA. Beyond similarities and differences in the numeric requirements, there are notable differences that result from the unique, philosophical aspects of allopathic and osteopathic medicine. Minimal research currently exists on the variations between allopathic and osteopathic FM programs. These differences will need to be identified,

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reviewed, and addressed as the single accreditation system is implemented.

The aim of this study was to examine curricular variation in allopathic, osteopathic, and dually accredited FM residency programs.

Methods

A list of allopathic programs was obtained from the American Academy of Family Physicians (AAFP) Family Medicine Residency Program Directory.[2] Using this directory, we recorded educational information, such as faculty-to-resident ratio in the FM clinic; the number of half-days residents spent in the clinic each week; and the number of months spent performing maternity, pediatric, and surgical care. Program location and number of approved positions were obtained from the ACGME Accredited Programs and Sponsor Search.[3] Identical information was obtained for osteopathic residency programs through the American College of Osteopathic Family Physicians (ACOFP) Residency Finder.[4] Programs were clustered into 6 geographic regions (TABLE 1).[5–7] All data were collected during July 2014.

This study was approved as exempt research by the Medical University of South Carolina Institutional Review Board.

Descriptive statistics were used to characterize and summarize the data obtained. Tests for normality were performed on all continuous variables. Normally distributed data were compared using analysis of variance, whereas non-normally distributed data were analyzed using nonparametric analysis. Regional location was analyzed via a χ^2 test. Significance was defined as $P < .05$ level of confidence. All statistical analysis was conducted using SAS version 9.3 (SAS Institute Inc).

TABLE 1
Regional Classification

Region	States
Northwest	Alaska, Idaho, Montana, Oregon, Washington, Wyoming
North Midwest	Illinois, Indiana, Michigan, Minnesota, North Dakota, Ohio, South Dakota, Wisconsin
Northeast	Connecticut, Delaware, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont, Washington, DC
Southwest	Arizona, California, Colorado, Hawaii, Nevada, New Mexico, Utah
South Midwest	Arkansas, Iowa, Kansas, Louisiana, Mississippi, Missouri, Nebraska, Oklahoma, Texas
Southeast	Alabama, Florida, Georgia, Kentucky, North Carolina, South Carolina, Tennessee, Virginia, West Virginia

Results

The respective directories identified 321 residency programs accredited by the ACGME, 145 programs accredited by the AOA, and 118 dually accredited programs. While the ACGME listed 471 accredited FM programs, only 439 (93.2%) programs provided corresponding curricular information in the AAFP Family Medicine Residency Program Directory. The largest percentages of both osteopathic and dually accredited residencies were located in the Northeast (6.5% and 6.4%, respectively) and north Midwest (5.6% and 6.7%, respectively). The number of approved resident positions was also approximately twice as large for allopathic and dually accredited programs (n = 24) compared to the osteopathic programs (n = 12). Resident stipends in osteopathic programs were approximately $47,800, or about $2,000 less than in allopathic and dually accredited programs (TABLE 2). All programs had similar faculty-to-resident ratios in the FM clinic (1:2.8–3.3), and offered a comparable number of months of rotations in maternity care (3 months) and pediatrics (4 months). However, osteopathic programs offered a median of 5 months of surgical training, compared to 2 months in allopathic and dually accredited programs. Residents also devoted a similar number of half-days in the FM clinic during the years of training: 1 half-day during the first year, 3 half-days during the second year, and 4 half-days during the final year (TABLE 2).

Discussion

Our results reveal several differences between allopathic and dually accredited FM residency programs and osteopathic programs. The most noteworthy of these is the considerable differences in program size. Allopathic and dually accredited residencies operated with a median of 24 approved positions, compared with the 12 positions observed in osteopathic programs. A likely reason is that current AOA/ACOFP program requirements for FM stipulate a minimum of 6 residency positions, and the ACGME requires a minimum of 12 positions. The median number of approved positions in osteopathic programs just meets the minimum requirement by the ACGME. This may result in smaller osteopathic

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TABLE 2
Family Medicine Residency Program Characteristics by Accrediting Body

	ACGME Accredited	AOA Accredited	Dually Accredited
Residency programs, N (%)	321 (55.0)	145 (24.8)	118 (20.2)
Regional location, n (%)			
Northwest	17 (3.0)	6 (1.1)	7 (1.2)
North Midwest	70 (12.4)	32 (5.6)	38 (6.7)
Northeast	50 (8.9)	37 (6.5)	36 (6.4)
Southwest	60 (10.6)	10 (1.8)	7 (1.2)
South Midwest	67 (11.9)	17 (3.0)	9 (1.6)
Southeast	57 (10.1)	25 (4.4)	20 (3.5)
Approved positions (median)	24.0	12.0	24.0
Salary (mean ± SD)	$47,576.41 ± $3,680.62	$45,780.49 ± $4,015.86	$47,800.76 ± $3,475.73
Ratio faculty:residents (median)	1:3.3	1:2.8	1:3.0
Obstetrics-gynecology months (median)	3.0	3.0	3.0
Pediatric months (median)	4.0	4.0	4.0
Surgery months (median)	2.0	5.0	2.0
PGY-1 half-days per week in FM clinic (median)	1.0	1.0	1.0
PGY-2 half-days per week in FM clinic (median)	3.0	3.0	3.0
PGY-3 half-days per week in FM clinic (median)	4.0	4.0	4.0

Abbreviations: ACGME, Accreditation Council for Graduate Medical Education; AOA, American Osteopathic Association; PGY, postgraduate year; FM, family medicine.

programs seeking to increase their resident complement to achieve accreditation under the new system. It is worth noting that a number of currently accredited allopathic FM programs have a resident complement that is below the ACGME required minimum. Still, program size may pose substantial challenges to smaller programs that wish to increase their resident complement, as increasing available positions will require a corresponding increase in patient volume, faculty numbers, and funding support. In addition, smaller programs have been shown to be less successful in resident recruitment and have lower board pass rates, which may further add to their burden.[5,8,9]

While many similarities exist in curricular content and educational experiences, the primary curricular variation noted was in months of surgical care experience. While the variation is likely due to differences in surgical requirements between programs, it could prove to be a defining characteristic of FM programs in the future, as applicants could view the additional months of surgical experience as an advantage or disadvantage, depending on their individual preferences. In addition to the impact on the program itself, these differences will likely affect graduates and their scope of practice.

Limitations of this study include the accuracy and descriptions of the self-reported data contained in the AAFP Family Medicine Residency Program Directory and ACOFP Residency Finder. Curriculum comparisons were made on a quantitative basis, and no assessment of curriculum quality or patient diversity or complexity could be made. Additionally, no verification was obtained to confirm the accuracy of the self-reported data.

While this study provides an initial evaluation of curricular variation in FM residency education, additional differences may exist between allopathic and osteopathic programs that were not addressed in this article. Future studies should address added areas of program accreditation, including characteristics of assessments, use of milestones and entrustable professional activities, and faculty development. In addition, programs currently accredited by the AOA may be concerned about a loss of their osteopathic identity as they seek ACGME accreditation. To address this issue, the ACGME is developing an Osteopathic Principles Committee whose responsibility will be "to establish standards and evaluate program compliance in the Osteopathic Principles dimension of residency training."[10]

Conclusion

Outpatient continuity care experiences appeared similar between all types of FM residency programs.

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Key differences included smaller program size, lower resident stipends, and more months of surgical experience in osteopathic residency programs. These variations may become increasingly important under the single accreditation system as programs strive to substantially meet requirements.

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