AOA House Defers Decision on Combined Match

Osteopathic/allopathic resident program controversy to be discussed again at next year's meeting.

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CHICAGO — The American Osteopathic Association's House of Delegates at its annual meeting agreed to keep a controversial combined osteopathic/allopathic resident match proposal on life support for 1 more year, following lengthy testimony on the concept of combining the organization's Intern/Resident Registration Program with the National Resident Matching Program.

The original resolution on a combined match, presented by the Bureau of Osteopathic Education and the AOA Council on Postdoctoral Training, called for keeping the status quo—that is, two separate matches.

The resolution was amended in deference to the position of the two largest osteopathic student organizations, the Council of Osteopathic Student Government Presidents and the Student Osteopathic Medical Association (SOMA), which back further exploration of the issue.

As passed, the resolution resolves "that the AOA, in cooperation with the American Association of Colleges of Osteopathic Medicine, conduct a thorough analysis and evaluation of the benefits, detriments, and outcomes for the profession with respect to continuing a separate match vs. adoption of a single joint match and report the findings back to the AOA House of Delegates in 2006."

Approximately half of graduating osteopathic medical students participate in the Intern/Resident Registration Program, which announces its results 1 month before the allopathic National Resident Matching Program (NRMP). Most of the remaining students apply through the NRMP to programs accredited by the Accreditation Council for Graduate Medical Education (ACGME).

Many students favor a joint match, believing the opportunity to rank osteopathic and allopathic programs simultaneously would give them additional program options without the need to choose one match or the other.

In reference committee, AOA board member and trustee Karen J. Nichols, D.O., dean of the Chicago College of Osteopathic Medicine, said a combined match would undermine the profession's "equal but separate" status, a view generally held by the AOA leadership. The existing match system provides students adequate opportunity to attain advanced placement into programs and training positions accredited by both AOA and ACGME, as well as to link from traditional internships into accredited residencies, she said.

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DR. NICHOLS

"If there are 10,000 MD graduates every year and 2,000 DO graduates every year, and you put them together, who do you think is going to be running the program? The bigger group. So basically, we would be abdicating control over a major part of our training system," Dr. Nichols said.

She reinforced her presentation with the results of two student surveys conducted this year: An AOA survey of 2,800 graduating doctors of osteopathy and her own survey of 300 students at her institution and the Arizona College of Osteopathic Medicine, conducted 1 month after completion of both match programs.

In the larger survey, 70% of students said they were in favor of a combined match. Furthermore, 75% responded that they had matched into their first-choice program, and 90% reported matching into their first- or second-choice program.

Results of the AOA survey suggested that the students who listed allopathic residencies as their first choice were most likely to add AOA positions if a combined match was offered. "If the student's first choice was an osteopathic residency, that was no problem," said Dr. Nichols. "The group we were trying to tease out were those who listed allopathic first and osteopathic second. We chose this group because we had such a high percentage of students successfully matching in their first or second choice, and this is really the only group that would have been able to add more students to osteopathic programs."

Student leaders at the meeting were unconvinced that a combined match would be a good idea. SOMA president Marty Knott said his organization believes "we don't know enough about the potential impact of a combined match, and it's hard for us as students to say how this will affect our profession."

SOMA trustee and AOA alternate delegate Sean N. Martin, with the Virginia College of Osteopathic Medicine, told FAMILY PRACTICE NEWS that the major determinants of students' residency choices are location and quality.

If students "want to remain near their families or want to live in a particular area, they should be able to do that. If we can just take all the energy that we're using on the pros and cons of a joint match and rechannel that to come up with creative ways to increase the number of residency programs or dually accredited residency programs, I think that would be . . . in the best interests of the profession," he said. ■

Other Issues at the House of Delegates

► **End-of-life care.** Delegates approved a white paper on end-of-life care and encouraged all osteopathic physicians to maintain competency in end-of-life care through educational programs such as the Web-based Osteopathic Education for Physicians on End-of-Life Care modules; to stay current with their state statues on the topic; and to engage patients and their families in discussion and documentation of advance care planning, including advance directives, hospice care, and palliative care.

► **Long-acting opioids.** Delegates passed a policy on long-acting opioid medication, stating that all patients have a basic right to medically appropriate intervention and/or treatment of acute and chronic pain and that it is "the right of all physicians to provide medically-appropriate intervention and treatment modalities that will achieve safe and effective pain control for all their patients." The action follows formal opposition by the College of Osteopathic Family Physicians Board of Governors to "any federal law or regulation that attempts to limit the ability of family physicians to legally prescribe, administer, or dispense controlled substances."

► **Counterfeit-drug education.** Delegates assented to a resolution that supports the efforts by the Food and Drug Administration to educate osteopathic physicians on how to identify counterfeit drugs, which account for "approximately 10% of the global medicine market." DOs are encouraged to report counterfeit drugs through the FDA's Counterfeit Alert Network.

► **Direct-to-consumer advertising.** Delegates voted to encourage pharmaceutical companies to stop product-specific direct-to-consumer advertising. The resolution asks governments to adopt policies or legislation to promote disease-specific public health education as the focus of such advertising.

► **Health Disparities.** Delegates adopted a position statement on minority health disparities aimed at training culturally competent physicians and "increasing representation for African Americans, Hispanic Americans, Asian Americans, Native Americans, Pacific Islanders, and individuals of disadvantaged backgrounds."

► **Electronic health records.** Delegates voted to support the implementation of electronic health records with e-prescribing capabilities and osteopathic principles and practices terminology. Delegates also backed the use of systems that meet current national standards.

Private Bounty Hunters Could Help Fight Medicaid Fraud

WASHINGTON — Private bounty hunters are one way to fight fraud in the Medicaid program, according to Stan Dorn, J.D., senior analyst at the Economic and Social Research Institute.

Successfully used by Medicare, the bounty hunter approach allows whistle-blowers to share in funds recovered through prosecutions under the False Claims Act.

According to recommendations developed by Andy Schneider, J.D., Medicaid policy expert for Taxpayers Against Fraud, Congress could bolster Medicaid whistleblower opportunities by increasing federal payments to states that enact their own False Claims Act and by offering whistle-blowers a minimum of 20% of the federal share of any recovered funds.

At a policy forum sponsored by the American Public Health Association, Mr. Dorn included enhanced fraud reduction efforts among nine budget cutting options that would trim the cost of the program without capping spending or enrollment. Congress is expected to propose Medicaid program changes this year that will result in $10 billion in reduced federal spending over 5 years.

Mr. Dorn offered other cost saving alternatives, such as improving case management for the chronically ill and implementing community-based obesity prevention strategies.

The Bush administration in its fiscal year 2006 budget proposed reducing Medicaid funding by reforming the program's drug purchasing system and limiting asset transfers that qualify seniors for long-term care.

Although limits on spending and benefits are not part of any current federal budget plans, lawmakers are looking broadly at Medicaid reform proposals this year; caps could be considered as part of those, Mr. Dorn pointed out at the forum, cosponsored by the Joint Center for Political and Economic Studies.

Not only would caps affect Medicaid recipients, but they also could prove detrimental to the economy, he said.

Since Medicaid must provide benefits to all of those eligible, the bulk of the program is economically "countercyclical," Mr. Dorn said, meaning it expands as the economy contracts. Not only does this ensure health benefits are available to low income individuals, but it also contributes to the flow of funds to health care providers and, in turn, other sectors of the economy.

To capitalize on Medicaid's stabilizing effects, Mr. Dorn suggested that federal matching rates could automatically rise when the economy slows.

—Nellie Bristol