



**AAIM Feedback to CoPA's UGRC Request
Relating to the "Ideal State" of UME to GME Transition**
Submitted: January 8, 2021

In an ideal state, medical schools, residency programs, and fellowship programs collaborate and communicate to achieve a common goal – competent physicians who thrive in their commitment to public service. With focus on this shared goal, medical educators will be able to re-establish trust at the transition points along the continuum, specifically between undergraduate and graduate medical education. As a community, we will be successful in role modeling and instilling a set of values, behaviors, and relationships that underpin the public trust in physicians.

The Alliance for Academic Internal Medicine (AAIM) is an organization of over 10,000 members committed to education and professional development across the continuum, from medical student to practicing physician. The Alliance offers comments on the ideal state of transition from undergraduate medical education (UME) to graduate medical education (GME) within the context of the optimal medical education continuum and, most importantly, the ideal state of a learner's professional and personal growth trajectory. Without placing the future physician at the center and considering the entire continuum, we will never be able to successfully accomplish our ultimate goal -- furthering the health of the individuals and populations we serve.

Contract with Society- Public Good

In the ideal state, the responsibility of meeting the needs of the public would be owned across the medical education continuum. Appropriate workforce alignment with public needs would lessen the pressure at the point of transition for both learners and stakeholders. In addition, to ensure that the needs of the public are met, it is fundamentally necessary to ensure that medical education is addressing diversity, equity, and inclusion.

Diversity within classrooms and learning environments ensures a robust learning environment, exposing students to a broad array of ideas, experiences, and perspectives. This diversity results in a well-rounded physician – competent, compassionate, and altruistic – better equipped to meet the needs and enhance relationships with a multicultural US populace.¹ Exposure to different cultures and ethnicities will decrease health disparities.

Health professionals from underrepresented groups are more likely to work in medically underserved areas. Race concordance in patient-physician relationships results in higher patient satisfaction and trust in the health care system.

- The Association of Academic Health Centers (AAHC) relates that the medical profession and government share the responsibility of ensuring that the GME system produces an adequate number and mix of physicians with requisite competencies and skills to meet the public need. GME is largely financed by the public; hence, the responsibility for GME to meet the public good

is clear. National organizations must publicly clarify the role and mechanisms by which UME should share in this responsibility.

- Ongoing preparation of learners across the continuum should focus on value of care provided, care management, patient safety, patient- and family-centered care, and communication/teamwork/transitions of care.² Medical school graduates who are prepared to provide this type of high-quality care when they complete residency training will contribute to the overall quality of medical care within the country.
- The pool of US and international medical graduates (IMG) candidates for residency training should meet the public's needs for medical services. It is essential to ensure well-rounded physicians for all communities to mitigate health care disparities. Holistic review at every point of education and training is necessary to accomplish this goal.
- The vast disparity in physician salaries and the financial burden engendered by medical education debt drive physicians away from particular specialties and from practicing in certain communities. Efficiencies in education, such as truncated training (i.e., short-tracking), may help decrease educational cost as well as serve as a mechanism for increasing the number of needed physicians in practice. Other solutions must be developed.
- Institutional support for learners undergoing life transitions will result in a more stable physician workforce and will combat rising physician burnout and attrition from the medical field.
- Some trainees find themselves in a situation for which they need a career change. Strategies and support need to be developed for "off-ramps" at all stages of training.

Overall Transition-Transparency and Trust

Transparency and trust are essential for successful transition from undergraduate to graduate medical education. Not only must this trust exist between institutions, but must also be present between the learner and UME/GME institutions. Institutions must be trustworthy, ensuring that the needs of the public are in alignment with how educators ensure learner competency across the trajectory.

Institutions must address implicit bias, racism, and discrimination within education and assessment. Hand-off tools should also reflect clear, unbiased evaluations.

Learners must be committed to their role in serving the public good and must be honest and forthcoming regarding their own strengths and areas for growth so they may be best served by their UME and GME institutions. Learners must have realistic expectations.

Ideal Collaboration between Medical Schools and Residency Programs:

Through ongoing collaboration to create transparent, objective, and factual assessment and transition tools, trust will be developed.

- **Ideal Assessment Tools**
 - Collaborative work must be done to develop and adopt a standardized, robust, and trusted means for evaluating competency.
 - Program director viewpoints are crucial in developing successful medical student assessments.
 - Standardized clinical assessment tools for use across the continuum must be developed and appropriate training in their use must occur. Moreover, these tools must be directed towards mitigation of bias and discrimination. This training requires substantive investment in faculty development as well as allocation of sufficient amounts of faculty time.

- These assessments should inform the Internal Medicine Summary Letter of Evaluation (IM SLOE).
- **Ideal Transition Tools**
 - The UME/GME community, with stakeholders that support their causes, should collaborate to create an “ideal standard transition tool.” Accurate Information must flow to residency programs both before and after the match. A reverse direction “ideal state transitional tool” would inform both US and non-US medical schools about the performance of their graduates. This promising communication standard could be resourced through an existing system such as ERAS. Further, this process could be utilized for residency-to-fellowship transition.
 - The Alliance acknowledges that the creation of such tools is ambitious and that the ideal for program directors to view equivalent material on both US and non-US medical school graduates is aspirational and would take a long while to implement. However, we must be steadfast in taking the necessary steps, no matter how small, since the goal is equity for all learners. Until this equity can be achieved, we acknowledge that the ideal state for tools for US graduates will be different from IMGs.
 - The UME/GME community must agree to common release dates for interview offers.

Ideal Transparency from Medical Schools and Residency Programs

Commitment to an efficient transition requires transparency from both UME and GME. These elements should be at both the programmatic and individual applicant levels.

- A central source for medical school attributes that program directors can reference for tangible, specific information – such as clinical training details, number of patients cared for by the students, a student’s level of responsibility based on a case’s complexity, etc.
- A central source for GME program attributes that students can reference to determine best program fit. This data would include deeper resident demographic information. Each discipline should determine its own data set, but some common factors would include:
 - Number of residents within program.
 - Approximation (percentage) of residents who are parents (although we acknowledge that this changes annually).
 - Geographical location of primary residence.
 - Identification with LGBTQ+ (though this information should be voluntarily disclosed by the resident).
 - Number of residents who pursue fellowship and future career decisions.
- Building a culture of trust and facilitating learner hand-off should focus on both the pre-match and the post-match transitions and include bi-directional communication in which the learner is actively engaged. Honesty (transparent, objective, and factual) during pre-match is essential. Important information may develop post-match, and it should be communicated promptly to ensure that the learner’s professional development continues at the post-match program.

Ideal Support of Learners (Applicants)

- The education community should commit to the development of transparent, easily digestible data related to the application/interview and match processes, to which applicants have direct access.
- The education community should commit to research to identify and fill gaps in knowledge related to the application/interview and match processes.

- Learners should expect consistent, fact-based advice and guidance from faculty and deans. Conversely, faculty and deans should expect that learners use facts to guide the application process to mitigate application inflation yet maximize their chances of matching.

Ideal Support for Holistic Review of Learners (Applicants)

- AAIM recommends development of options and tools for programs to conduct a holistic review of applicants. A tiered application system, early acceptance, multiple match cycles, or other innovations must be developed. Such approaches should inform programs of which applicants have sincere interest in the program.
- The transition from UME to GME is resource intensive for institutions and learners. In the ideal state, additional resources would be available to fully fund transition efforts.
 - Mentoring, coaching, and advising requires faculty skill and time. Investments, with accountability, are needed to ensure adequate support for the application process. Advising interventions should be studied to determine impact on factors, such as number of applications per learner.
 - Holistic review of applicants is time intensive and resources to support it are required. In an ideal state, technology would alleviate this burden. We suggest the development of an intelligent mapping system (perhaps an enhancement to ERAS).
 - Learners bear significant expense of application and interviews. It is imperative that UME and GME institutions work to limit the cost to learners by facilitating “best fit” information prior to the application process.

IMG Considerations:

- Ideally, the medical education community and the associations representing their interests should develop official statements of support for IMGs, to include requesting inclusivity in creating policies.
- Costs and other financial challenges IMGs face should be addressed.
- Advocate for institutions to follow a standardized means of support for IMGs. This system would ensure IMGs have a voice and are welcome, without repercussions, to offer feedback.
- In an ideal state, once a trainee is accepted in a residency program, they should be able to complete their proposed trainee timeline. Any major updates in law regarding visas would go through a separate physician task force. GME trainees should be categorized as essential workers, which would ensure additional protection should visa requirements change.

Professional Identity Formation

Professional identity formation addresses the maturation of professionalism, well-being, growth mindset, resilience, mindfulness, and an understanding of equity. Learners during transition from medical school to residency, residency to fellowship, and from trainee to independent practice are also entering a period of new *personal* identity formation, which includes new socialization as well as increased financial responsibility and personal health care needs. These high-risk periods of transition can impact learner academic performance, professional behaviors, and wellness.

Ideal State: Across the Medical Education Continuum

- The development of professional values, actions, and aspirations should be the backbone of medical education. Professional identity formation must be acknowledged as a fundamental educational objective throughout the medical education continuum.³
- Faculty are responsible for a trainee’s continued maturation, to include their personal progression to becoming a partner, parent, and caregiver. Physicians spend many of their prime

child-bearing years in residency and fellowship.⁴ Healthy physicians with a thriving family generate career satisfaction and a work-life balance, creating a ripple effect of wholeness and strength that affect not just their families, but patient care and, ultimately, our nation.⁵

- There should be a minimum amount of guaranteed parental leave.
- Educators must take care to not indirectly instill a culture of compartmentalization and delay.
- Academia should pay particular attention to underrepresented minorities (URM) and the LGBTQ+ communities, who may face additional challenges in professional and personal identity formation due to lack of role models and appropriately-trained mentors and coaches.⁶⁻⁷ These individuals may also face macro- and micro-aggressions.⁸ To that end, the medical education community should create and sustain an environment that allows continued holistic development of the physician and person.
 - It is vital to develop and support faculty to provide mentorship and coaching to URM and trainees in the LGBTQ+ communities.
 - It is vital to provide “upstander” training for all faculty, staff, and learners to sustain a supportive and transparent relationship.
- Institutions should instill a culture conducive to academic success for women.⁹
 - This support includes institutional backing (parental leave, family leave program, work schedule flexibility, etc.) for pregnant residents, partners of expectant mothers, and adoptive foster parents.¹⁰
 - Institutions should establish on-site childcare.
 - Parental leave policies must be transparent and communicated effectively.
 - Address potential impact of leave on board eligibility, job options, and salary.
 - Communicate the institution’s stance on returning to full-time, unadjusted work schedule, post-maternity leave.

Ideal State: UME to GME Transition

- The transition from medical school to residency must be recognized as a time of high risk. It is a disorienting period, during which learners navigate large discontinuities in roles along with the cognitive and emotive stances they are expected to assume.
- UME and GME faculty require acknowledgement and support for important role modeling, mentorship, and coaching to ensure continuity of purpose and identity.
- Learners in this transition period require easy access to primary care physicians for basic preventative health advice and support.
- Learners in this transition period require easy access to mental health services for either continued or initiating care.

The pathway to becoming an independent physician is difficult. Though strenuous at times, it is a necessity to evolve a learner into the physician that communities need. As such, it is incumbent on UME and GME faculty to develop physicians with excellent clinical and interprofessional skills. To achieve this, UME and GME should make concerted efforts to unify and resolve areas of mistrust. After all, a trainee’s evolution and the medical education continuum are intertwined. In an ideal state, medical schools, residency programs, and fellowships collaborate and communicate to achieve that ultimate common goal – a competent, well-rounded, independent physician thriving in his/her commitment to public service.

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