![Alliance for Academic Internal Medicine logo]

AAIM Feedback on Preliminary CoPA Recommendations on UME – GME Transition
Submitted: May 26, 2021

On behalf of the Alliance for Academic Internal Medicine (AAIM), thank you for the opportunity to comment on the preliminary recommendations from the Coalition for Physician Accountability's (CoPA) UME – GME Review Committee (UGRC). AAIM represents educators and administrators from both undergraduate and graduate medical education, typifying the entire continuum of medical education. AAIM empowers academic internal medicine (IM) professionals through continuing education tailored to each of its constituencies and enhances health care through research and collaborative efforts with stakeholders on key issues impacting IM academia and its communities.

AAIM assembled a group of UME and GME educators whose expertise span research, faculty development, and assessment. Understanding that CoPA does not intend to make "substantive changes to the preliminary recommendations," AAIM provides insights to assist CoPA in its future endeavors to operationalize these recommendations.

Faculty Development
Faculty are essential in a trainee's pathway to independence, both influencing trainee professional identity formation (PiF) (Recommendation 12) and providing meaningful feedback in skill development across the continuum (Recommendations 9, 18, and 30). It is fundamental that the medical education community invests in faculty development (FD).

AAIM recommends the creation of FD tracks in teaching/learning, PiF, evaluation/assessment, and instructional design/ curriculum development. To expand and evolve these tracks, the medical education community must include non-physician educators and tap into their expertise to build a cadre of competent physician educators. Residency programs and medical schools can leverage these experts to assist with faculty development that could be beneficial at a national level. Institutions should be able to access these shared resources so that they can build their own tracks or so that their faculty can easily access and benefit from these national medical education programs. A shared approach will allow for greater standardization of best practices, which will benefit the overall UME to GME transition. Since the focus is on bolstering educator proficiency, the Alliance supports both didactic and peer-to-peer observations and feedback. AAIM recognizes the financial impact this commitment entails and understands that budgets vary, and some institutions would view it as an arduous undertaking; developing and sharing these tracks nationally is essential to help ease that burden.

Bias
Minimizing systemic biases (Recommendation 18) in all areas impacting the UME to GME transition is a noble pursuit that all medical education disciplines must endeavor to achieve. The medical education community should address equity from an educational, structural, and social standpoint. According to a study published in *Academic Medicine*, equity in assessments can be achieved when learners have "fair

and impartial opportunities to learn, be evaluated, coached, graded, advanced, graduated, and selected for subsequent opportunities based on their demonstration of achievements that predict future success in the field of medicine and that neither learning experiences nor assessments are negatively influenced by structural or interpersonal bias related to personal or social characteristics of learners or assessors." [i] If steps are undertaken and achieved to reduce bias, these efforts will be inherent in the UME community commitment to robust assessment tools and strategies (Recommendation 8), since assessment and feedback are part of the grading process. Reducing feedback bias will improve transparency in assessments and grades, reforming the transition process.

The AAIM clerkship director community recently put forth strategies to promote equity in clerkship assessment and grading. These best practices could be adopted to reduce bias and subjectivity in assessments.

Resource/Financial Implications
The ideal state, as described by the CoPA recommendations, will require substantial resources. Support for many changes will need to come from external sources or absorbed by programs/institutions. It is imperative that these costs are not transferred to learners. It is important to consider that all programs/institutions have different resources to support changes of this scope. Careful attention needs to be given to where financial burdens falls and how equity is addressed in implementation.

An unintended consequence, which must be absolutely avoided, is to disadvantage students and programs based on institutional resources and financial priorities. Our country needs excellent training programs for all learners so that they may fulfill their potential. Similarly, all learners need equitable opportunity to find and become part of residency programs that will allow them to fulfill their potential to become the competent, thriving physicians that our country needs. Analogous to challenges in our public school system, the medical education community needs to ensure a supportive structure so that any implemented changes need not be wholly absorbed by individual learners and institutions that are already encumbered with insufficient resources.

Application Process
Redesigning the mechanics of the residency application process (Recommendation 28) is an ambitious undertaking. It is essential for UME and GME communities (educators, advisors, and stakeholders) to collaborate to decrease the number of applications and improve the ability of program directors to holistically assess applicants. To help applicants and programs attain this decrease, the medical education community would need to first address four areas:

- ■ Development of a comprehensive database with verifiable residency program information (Recommendation 20). This information will allow applicants to focus their application submissions, thereby decreasing the number of applications. UME and GME educators should establish a common framework and vernacular (Recommendation 7) prior to the development of any mechanism to streamline the residency application process. Residency programs would then need to specify what skills/characteristics they seek in an applicant to help align applicant goals and expectations.

- Creation of a searchable dataset of applicant characteristics (Recommendation 21), which may help decrease application submissions.
- Availability of discrete fields for both narrative and ordinal information within the MSPE (Recommendation 22).
- Enhancement of the application system's filtering options (Recommendation 23) will improve program ability to review applications holistically and efficiently.

In these efforts, both students and programs can make informed decisions, resulting in a ripple effect of successful outcomes: allowing faculty to be effective coaches, resolving application inflation, achieving more efficient matches (Recommendations 41 and 42), and resolving the growing number of unmatched applicants (Recommendation 19). These areas would need to be addressed before educators recommend that their advisees limit their number of applications. Without resolving these initial areas, applicants and programs may be unfairly categorized based on numbers and reputation of institution. Furthermore, the medical education community would potentially see fewer applications and therefore not need to implement limitations on the "number of interviews an applicant attends" (Recommendation 27), adding to the successful outcome.

As related to CoPA recommendations that touch on the recruitment cycle, including the interview and application processes (Recommendations 25, 27, 28, 41, and 42), the Alliance published guidance for the 2020 – 2021 residency application cycle in response to the pandemic. As part of the stance, AAIM suggested that innovations such as a "tiered application system, early acceptance, multiple match cycles … are worthy of exploration". [ii] Adopting any of these approaches should help inform programs of which applicants have interest in their program, while not disadvantaging any applicants. The Association of American Medical Colleges (AAMC) should consider piloting one of these areas. While implementing one of these measures would necessitate additional resources, increased costs, and compliance, the Alliance perceives these novel approaches as steps to stabilize the number of applications through new means of efficiently filtering fields of applicants (Recommendations 21, 22 and 23), leading to more holistic reviews of those learners with genuine interest in specific programs.

Streamlining Assessments and Enhancing UME – GME Relations
The clinical competency committee (CCC) is an important component of the GME evaluation process. Its role is to develop a common framework through which learners can be measured to reduce variability in assessments. Though not perfect, its formation has helped improve residency program feedback to trainees during residency as well as improved the transition to fellowship. AAIM supports the establishment of a UME panel similar to a CCC. Some schools have begun this process. To fully benefit the transition, it is essential that GME provides clarity around relative importance of various competencies to specific disciplines and programs. Without this common understanding, the risk of continued disconnect between UME and GME is high. It is incumbent for UME and GME to associate entrustable professional activities with the appropriate milestone, therefore developing competencies that span the UME – GME spheres (Recommendation 7). The establishment of a UME commission would:
- Help reduce variability in assessments (Recommendations 8 and 14), ultimately standardizing the evaluation process that would lead to objective determinations of a learner's performance (Recommendation 36).

- Assist clerkship directors aggregate data, therefore furnishing program directors with reliable information regarding competencies they most value (Recommendations 11 and 14).
- Favorably impact the trainee's evolution, as it would mitigate bias (Recommendation 18) and assist educators from UME and GME to develop a more individualized learning plan (Recommendation 35).
- Facilitate a compassionate "off ramp" for struggling learners (Recommendation 4).

In essence, the formation of a UME panel similar to the CCC has the potential to improve UME – GME communication (Recommendation 7) by refining the transition process (Recommendations 8, 28, 41 and 42). To help incoming interns determine which residency programs are within their scope (Recommendation 20), residency programs should state their application requirements commensurate with the qualitative data they seek.

Noting that instituting a comprehensive UME panel is complex, a first step is initiating a grading committee for clerkships and subinternships. In reconsidering the structure of the medical student performance evaluation (MSPE) (Recommendation 10), the medical education community should consider including more specific subinternship (or other advanced clinical rotations) data into the fold. Recognizing that it is an aspirational feat, the medical education community should nonetheless take steps to integrate this training phase into the available data since it reflects a learner's interpersonal/communication skills, professionalism, and patient care proficiency.[iii] Given the challenges regarding timing of these experiences and timing of MSPE formation, allowing separate structured evaluative letters (SELs) to come from departments/subinternships based on departmental UME panels could be an initial step.

Structured Evaluative Letters (SELs)
AAIM supports CoPA's recommendation to eventually replace letters of recommendation (LoRs) with SELs (Recommendation 13). However, while many LoRs are not helpful and may even be counterproductive, the medical education community should not uniformly discount LoRs as an invaluable source of information for some applicants.

In response to the LoR challenge, AAIM established a group of clerkship and program directors tasked to further enhance last year's AAIM IM SEL template. To accommodate candidates whose schools do not have LoRs, to include international medical graduates (IMGs) and osteopathic medical students, FAQs for the AAIM SEL will provide guidance on how best to complete the document. While AAIM and other disciplines work to augment their respective SELs, LoRs should not be eliminated. LoRs provide a balanced and in-depth perspective on a trainee that may not be represented in assessment or grading. Until other UME to GME transition materials allow for holistic review, LoRs should remain in place.

Virtual Interviews
The Alliance will advise its membership that virtual interviews (Recommendation 26) for the 2021-2022 academic season is the most equitable approach. Once COVID-19 has subsided, programs should assess if a hybrid technique is the most reasonable way for learners to sufficiently gauge institutional culture and their own ability to thrive.

Recognizing that a hybrid approach could potentially induce bias, residency programs should make a concerted effort to not rank candidates based on their decision and ability to visit. Recognizing the complexities of such an approach, the most transparent means would be for programs to complete their rank lists prior to opening site visits and for students to complete their rank lists after site visits, if they elect to visit programs. This change may require an alteration of deadlines within the Match process. If the Match timeline cannot be altered – and the Alliance is aware of the intricacies involved – it is imperative that residency programs be transparent with its applicants that site visits are optional and whether interactions and observations from these visits will influence their application review.

Student Advising, Policy, Faculty Support Resources, and Research
Continued research on quality improvement of the transition system (Recommendations 1, 40, and 41), funding possibilities/opportunities (Recommendation 40), enhanced counseling for trainees (Recommendations 2, 3, 5, and 6), and faculty support resources (Recommendations 29 and 30) are important components to address. Producing career advice resources for faculty and staff (Recommendation 5), increased diversity, equity, and inclusion professional development offerings (Recommendation 30), and counseling on alternative career pathways (Recommendation 4) are potential domains that can be addressed in a shorter timeframe by an institution. Resident support resources for program directors and designated institutional officials (Recommendation 29), the development of a single electronic resource for students (Recommendation 3), and efforts towards standardizing the credentialing process (Rec. 39) would require significant funds and a longer period to execute.

It is prudent to consider prospectively the effect that feasibility will have on implementing these recommendations– particularly with regard to purview, resources, funding, and time frame. In the end, we all have a common goal: streamlining the transition from UME to GME to the benefit of learners, educators, and stakeholders. The Alliance seeks to support CoPA in its efforts to take the first steps to operationalize these recommendations. This is no easy feat. AAIM thanks you for the opportunity to comment. Please direct any questions to educationandresearch@im.org.

References

[i] Lucey C, Hauer K, Boatright D, Fernandez A. Medical education's wicked problem: Achieving equity in assessment for medical learners. *Acad Med.* 2020; 95 (12): 98-108.

[ii] Chretien K, Raj J, Abraham R, et. al. AAIM Recommendations for the 2020 – 2021 Internal Medicine Residency Application Cycle in Response to the COVID-19 Pandemic. *Am J Med.* 2020; 133 (10): 1223 – 1226.

[iii] Angus S, Vu R, Halvorsen A, et. al. What Skills Should New Internal Medicine Interns Have in July? A National Survey of Internal Medicine Residency Program Directors. *Acad Med.* 2014; 89: 432 – 435.