

**HOD ACTION: Council on Medical Education Report 3 adopted as amended and the remainder of the report filed.**

REPORT 3 OF THE COUNCIL ON MEDICAL EDUCATION (A-18)  
Expanding UME Without Concurrent GME Expansion  
(Reference Committee C)

EXECUTIVE SUMMARY

Over the past ten years the establishment of new medical schools and the expansion in class size of existing medical schools has helped create a growing physician workforce, which is considered essential to providing health care to a growing and aging patient population. This expansion, however, has also created a perceived “bottleneck” in the transition from medical school to residency training, as the growth of entry-level residency training positions has not been commensurate with the increase in the number of graduates. American Medical Association (AMA) Policy D-305.967 (31), “The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education,” directs our AMA to “study the effect of medical school expansion that occurs without corresponding graduate medical education expansion.” This report is in response to that directive.

Analysis of existing graduate medical education (GME) data and projections suggests that, while there will be continued growth of United States medical school graduates (USMGs), there is still substantial room for placement of USMGs into GME, with an excess of 4,500 positions relative to graduates for the next several years. Although there are more entry-level GME positions than USMGs, there are other physicians vying for these same training opportunities. Approximately half of international medical school graduates (IMGs), either U.S. citizens (US IMGs) or foreign nationals (non-US IMGs) participating in the National Resident Matching Program, successfully match into positions. As competition for the pool of positions grows, applicant behavior causes stress for both applicants and the programs to which they apply. Applicants apply to more programs, and program directors must vet an ever-increasing number of applicants.

This report:

- Provides an update on recent numbers of medical students, graduates, and residency positions
- Summarizes recent residency applicant behavior and results in terms of matching into residency programs
- Describes recent state and medical school efforts to expand GME positions
- Describes the AMA’s national SaveGME campaign

The report concludes with a discussion regarding a changing GME environment, suggestions to help allay the concerns of students about matching, and potential policy changes for medical schools to consider.

**HOD ACTION: Council on Medical Education Report 3 adopted as amended and the remainder of the report filed.**

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 3-A-18

Subject: Expanding UME Without Concurrent GME Expansion

Presented by: Lynne Kirk, MD, Chair

Referred to: Reference Committee C  
(Sherri S. Baker, MD, Chair)

---

1 INTRODUCTION

2  
3 American Medical Association (AMA) Policy D-305.967 (31), “The Preservation, Stability and  
4 Expansion of Full Funding for Graduate Medical Education,” directs our AMA to “study the effect  
5 of medical school expansion that occurs without corresponding graduate medical education  
6 expansion.” This report is in response to this directive.

7  
8 This portion of the policy was appended through Resolution 320-A-16, “Expanding GME  
9 Concurrently with UME,” which was introduced by the Resident and Fellow Section at the 2016  
10 Annual Meeting of the AMA House of Delegates (HOD). Testimony before Reference Committee  
11 C during the HOD meeting was overwhelmingly in favor of Resolution 320-A-16. Multiple  
12 individuals noted that the number of new medical schools and enrollment in existing institutions  
13 have expanded substantially of late, without a corresponding increase in the number of entry-level  
14 graduate medical education (GME) positions. Concern was voiced that the number of U.S. seniors  
15 successfully completing their undergraduate medical education (UME) at either allopathic or  
16 osteopathic medical schools likely will approach or surpass the total number of available U.S.  
17 GME positions within the next one to two decades. It was further acknowledged that the  
18 Accreditation Council for Graduate Medical Education (ACGME) is examining this important  
19 issue, with discussions that consider mitigating barriers to establishing training programs in  
20 specialties and locations that are underserved. Some testimony requested the addition of a second  
21 resolve to ask the AMA to advocate for expansion in resident and fellowship positions in  
22 proportion to expansions in medical school student populations and the health needs of the  
23 populace. Other testimony proposed limiting the number of U.S. medical school graduates  
24 (USMGs) per year. Additional discussion referenced the need for a national workforce plan that  
25 appropriately addresses specialty and geographic shortages. Testimony in opposition to the  
26 addition of the proposed second resolve focused on concerns that advocating for U.S. medical  
27 schools to limit class sizes could be construed as restraint of trade. Both the Liaison Committee on  
28 Medical Education (LCME) and the Commission on Osteopathic College Accreditation (COCA)  
29 have the authority to set standards for schools, but they must approve any school that meets those  
30 standards; they cannot arbitrarily prohibit the establishment of new schools. While medical schools  
31 may have a moral obligation to consider the issue of the narrowing gap between the number of  
32 USMGs and the number of residency positions, it is not a legal obligation.

33  
34 This report: 1) provides an update on recent numbers of medical students, graduates, and residency  
35 positions; 2) summarizes recent residency applicant behavior and results in terms of matching into  
36 residency programs; 3) describes recent state and medical school efforts to expand GME positions;  
37 4) describes the AMA’s national SaveGME campaign; and 5) concludes with a discussion

1 concerning a changing GME environment, recommendations to help allay student concern about  
2 matching, and potential policy changes for medical schools to consider.

### 3 4 BACKGROUND

5  
6 Concerns regarding the number of GME positions available to medical school graduates, known as  
7 post-graduate year 1 (PGY1) positions, have been increasing over the past several years.

8  
9 In 2006, the Association of American Medical Colleges (AAMC) issued a call for expanding the  
10 number of medical school graduates, due to data suggesting an imminent physician shortage. The  
11 AAMC recommended a 30 percent increase (over 2002–2003 levels) in first-year medical school  
12 enrollment in LCME-accredited schools by the 2015–2016 academic year. Using the baseline of  
13 the 2002–2003 first-year enrollment (16,488 students), a 30 percent increase corresponds to an  
14 increase of 4,946 students. The AAMC forecast in 2017 that the 30 percent goal would be attained  
15 by 2017-2018 and exceeded in future years.<sup>1</sup> Osteopathic medical schools, which are accredited by  
16 COCA, also have grown in number and in the number of enrollees and graduates.<sup>2</sup> The number of  
17 LCME- and COCA-accredited schools, first year enrollment, and corresponding allopathic and  
18 osteopathic graduates is presented in Table 1, at the end of this report.

19  
20 The rate of growth in the number of USMGs currently is greater than the rate of growth in PGY1  
21 positions. Analysis of existing data and projections suggests there is still substantial room for  
22 placement of USMGs into GME, with an excess of 4,500 positions relative to graduates, as shown  
23 in the Figure at the end of this report.<sup>3,4</sup>

24  
25 One analysis found that 99% of U.S. MD graduates ultimately do find careers in medicine.<sup>5</sup> The  
26 percent of U.S. MDs matching into PGY1 positions through the National Resident Matching  
27 Program (NRMP) has been consistently at 94% since at least 2008; only 500 to 600 U.S. MD  
28 graduates do not find a position through the NRMP's Supplemental Offer and Acceptance Program  
29 (SOAP), which assists in placing unmatched applicants into unfilled positions.<sup>6</sup> Other, infrequent  
30 opportunities exist post-SOAP for students to find positions in unfilled programs. Nonetheless,  
31 medical students continue to experience anxiety over the possibility of graduating from medical  
32 school without a training position, a necessary requirement for a clinical career in medicine.

33  
34 Although there are more PGY1 positions than USMGs, it is important to consider that other  
35 physicians also are vying for these training opportunities. Approximately half of international  
36 medical school graduates (IMGs), either U.S. citizens (US IMGs) or foreign nationals (non-US  
37 IMGs) participating in the NRMP, successfully match. A much smaller proportion find positions  
38 through SOAP.

39  
40 There are a number of reasons why USMGs do not match into PGY1 positions; the Council on  
41 Medical Education has written several recent reports on this topic (CME 3-A-16, "Addressing the  
42 Increasing Number of Unmatched Medical Students," and CME 5-A-17, "Options for Unmatched  
43 Medical Students"). One contributing factor is that not all positions are equally desirable to every  
44 applicant because of specialty and practice location preferences. For example, an average overall  
45 growth rate of two percent does not necessarily mean that there are enough positions in  
46 dermatology for all the applicants who wish to train in dermatology or wish to train in dermatology  
47 in the state of Georgia. The apprehension born of the perception of fewer available positions, often  
48 misreported in the popular press,<sup>7</sup> is coupled with a sense of increasing competitiveness, which  
49 may be caused in part by the increase in the number of DOs participating in the NRMP (in the 2013  
50 Match, DOs made up 7.9 percent of matched applicants, versus 10.6 percent in 2017 ). The number

1 of osteopathic students choosing to match into allopathic programs via the NRMP was increasing  
2 even before the transition to the Single Accreditation System, through which the ACGME will  
3 accredit both allopathic and osteopathic programs. This increase will continue during the transition  
4 of osteopathic program positions into the NRMP, which will be completed in July 2020.

5  
6 One of the unintended consequences of this perceived bottleneck is that residency applicants have  
7 increased their number of program applications in an attempt to improve the likelihood of receiving  
8 an invitation to interview and eventually secure a residency. Table 2, at the end of this report,  
9 provides the average number of program applications per applicant through the Electronic  
10 Residency Application Service (ERAS) and the average number of applications received by  
11 programs. An NRMP analysis of U.S. MD seniors participating in the 2017 Match in the 20 largest  
12 specialties found that MD seniors who ultimately successfully matched applied to a median number  
13 of 35 programs, resulting in a median number of 16 offered interviews. MD seniors who ultimately  
14 did not match applied to a median number of 54 programs, resulting in a median number of six  
15 offered interviews.<sup>8</sup> Data from the 2013 Match shows comparable numbers: successfully matched  
16 MD seniors applied to a median number of 29 programs, yielding 15 interview offers. Unmatched  
17 MD seniors applied to a median number of 50 programs, yielding seven interview offers.<sup>9</sup> These  
18 data suggest that simply applying to more programs does not necessarily result in more interview  
19 opportunities. In addition, analyses by the AAMC provide information on the point of diminishing  
20 returns in the number of applications sent by U.S. MD applicants, by USMLE Step 1 score and  
21 specialty.<sup>10</sup>

## 22 23 STATE AND MEDICAL SCHOOL EFFORTS

24  
25 Recently, some individual schools, medical systems, and states have begun to address the  
26 discrepancy between rapidly expanding UME enrollment and GME expansion, often in tandem  
27 with efforts to meet the health care needs of local populations.

### 28 29 *Texas*

30  
31 In 2017, the Texas state legislature passed Bill 1066, “Requirement to Plan GME Needs in  
32 Conjunction with Medical School Planning,” which requires that all new public allopathic and  
33 osteopathic medical schools in the state provide to the Texas Higher Education Coordinating Board  
34 an assessment of the adequacy of the projected number of first-year residency positions that may be  
35 available for graduates of the new medical school. If a shortage is projected, the medical school  
36 will be required to submit a plan to increase the number of PGY1 positions in the state to  
37 reasonably accommodate the number of graduates from all MD and DO medical school programs  
38 in Texas and “provide adequate opportunity for those graduates to remain in the state for the  
39 clinical portion of their education.” Submission of the assessment, and, if necessary, the plan to  
40 increase PGY1 positions, is a prerequisite for the board’s approval of the medical school.<sup>11</sup>

41  
42 Not only does this bill serve Texas’s needs by ensuring UME expansion within the state is coupled  
43 with GME expansion, allowing newly graduated physicians the opportunity to remain in Texas for  
44 their training, but it also establishes a legislative strategy to assure UME expansion is coupled with  
45 corresponding GME expansion so that the newly admitted medical students have the theoretical  
46 opportunity to complete GME training in the state. It does not, however, address the expansion of  
47 already existing medical schools. The law also does not affect future planned private medical  
48 schools. In addition, although the plan must specify that there will be adequate PGY1 positions in  
49 the state, the proposed medical school itself is not required to sponsor the GME programs. The plan  
50 regards total state numbers, not type of program or location, and is not specific to an institution. If

1 the state's total number of existing residency positions is expected to meet the needs of the total  
2 number of medical school graduates, the medical school does not have to submit a plan for  
3 developing additional GME positions.

4  
5 The Texas Medical Association (TMA) is working to address a loophole in the current law. New  
6 medical schools are required to submit a GME plan to demonstrate the projected availability of  
7 training positions for the total number of students in the inaugural class. Most schools, however,  
8 start with a relatively small number in the inaugural class, with plans to expand the class size after  
9 achieving full accreditation status. The result is that the full GME needs of their students are  
10 neither identified nor planned for from the beginning. The TMA will likely consider a proposed  
11 amendment that would stipulate that medical schools must submit a plan to meet the GME needs  
12 for the school's planned target class-size.

#### 13 14 *Kaiser Permanente*

15  
16 Kaiser Permanente, a large, integrated, population-based health care delivery system in the Western  
17 U.S., has been one of the largest private contributors to GME funding through its integrated  
18 residency programs. Kaiser currently hosts residency positions in five regions (Northern and  
19 Southern California, the Pacific Northwest, Colorado, and Hawaii). These collective programs  
20 support 900 full-time equivalents of residents in over 30 specialties. Residents in the Kaiser  
21 Permanente system are hosted primarily through Kaiser itself (600 residents), but affiliate programs  
22 also send residents to train within the Kaiser system for some duration of time. In total, 3,000  
23 individuals per year rotate through the Kaiser system for training.<sup>12</sup> Kaiser has been very successful  
24 in retaining trainees following completion of residency training, with one-third to one-half of  
25 trainees staying and practicing in the Kaiser system. Savings on physician recruitment are then  
26 used to support Kaiser's resident complement.<sup>13</sup>

27  
28 Following its success in establishing diverse and sustainable residency training positions, Kaiser is  
29 building a medical school in Southern California. The inaugural class of 2019 is expected to have  
30 48 students, with a full complement of 192 enrolled by 2022. Initial plans for student education  
31 include early exposure to patients and integration into the robust network of clinical opportunities  
32 available within the Kaiser system.<sup>14</sup>

#### 33 34 *Local assistance*

35  
36 Creating a new GME program from scratch is a daunting process, but more information has  
37 become available about the process. Consultants with GME experience are available to assist. One  
38 institution recently published a plan for starting a new residency program, with step-by-step  
39 guidelines.<sup>15</sup> The state of Indiana has worked with at least two consultant groups to develop its plan  
40 to expand GME.<sup>16</sup>

#### 41 42 **SAVEGME CAMPAIGN**

43  
44 The AMA has long advocated for both the preservation of GME funding and additional monies to  
45 support future physician workforce needs, as noted in, for example, Council on Medical Education  
46 Report 5-A-16, "Accountability and Transparency in Graduate Medical Education Funding." The  
47 SaveGME website ([savegme.org](http://savegme.org)), originally oriented toward medical students and physicians, was  
48 revamped with a public-facing aspect in 2017. The revitalized website was then shared across  
49 social media platforms and various advocacy groups including the Patients Action Network and the  
50 Physicians Grassroots Network. This campaign emphasized the value of residents to patient care,

1 including the provision of 40 percent of charity care nationwide as well as the importance of  
2 residency programs to innovations in health care delivery and patient safety initiatives. The new  
3 website includes videos, statistics, demographics, and other material to support the SaveGME  
4 campaign. From March through October 2017, there were 78,827 visits to the SaveGME.org  
5 website and 1,816,821 video views. Social medial platforms proved useful in spreading the  
6 message, with over 12.5 million impressions on Facebook and Twitter. Over 2,300 letters were sent  
7 via the site to legislators by 720 individuals, representing a 16-fold increase compared to the year  
8 prior in communication to legislators.<sup>17</sup>

9  
10 CURRENT AMA POLICY

11  
12 Currently, the AMA has several policies or directives that concern the lack of appropriate growth  
13 in GME positions; these are listed in the Appendix.

14  
15 SUMMARY

16  
17 Without expansion in the number of PGY1 positions available to recently minted medical school  
18 graduates, eventually the number of USMGs seeking positions will exceed what is available.  
19 Lacking this expansion, some potential applicants likely will seek training elsewhere. Non-US  
20 IMGs, a group that long has trained in the U.S. and greatly added to the U.S. physician workforce  
21 in numbers and diversity, as well as specialty and geographic focus, may choose to train in other  
22 countries where there are more opportunities and fewer immigration barriers (CME Report 3-I-17,  
23 “Impact of Immigration Barriers on the Nation's Health”). The reduction in the size of one  
24 applicant pool likely will prolong the period during which there is increasing competition for  
25 positions, but still more available positions than USMGs. Despite this temporary reprieve, medical  
26 students perceive increasing competition and suffer anxiety engendered by the risk of graduating  
27 with substantial educational debt but without a residency position. Medical schools should increase  
28 their efforts to guide students concerning educational debt, specialty choice, and potential career  
29 paths, in order to better prepare students entering a physician workforce that may have constraints  
30 in its capacity to grow. In this context, and in anticipation of this country’s future health care needs,  
31 efforts to expand UME without thoughtful provision of GME opportunities is careless at best and  
32 negligent at worst.

33  
34 RECOMMENDATIONS

35  
36 The Council on Medical Education therefore recommends that the following recommendations be  
37 adopted and the remainder of this report be filed.

- 38  
39 1. That Policy D-305.967 (31), “The Preservation, Stability and Expansion of Full Funding  
40 for Graduate Medical Education,” be rescinded, as having been fulfilled by this report.  
41 (Rescind HOD Policy)  
42  
43 2. That our American Medical Association (AMA) encourage all existing and planned  
44 allopathic and osteopathic medical schools to thoroughly research match statistics and  
45 other career placement metrics when developing career guidance plans. (Directive to Take  
46 Action)

- 1       3. That our AMA strongly advocate for and work with legislators, private sector partnerships,  
2       and existing and planned osteopathic and allopathic medical schools to create and fund  
3       graduate medical education (GME) programs that can accommodate the equivalent number  
4       of additional medical school graduates consistent with the workforce needs of our nation.  
5       (Directive to Take Action)  
6
- 7       4. That our AMA encourage the Liaison Committee on Medical Education (LCME), the  
8       Commission on Osteopathic College Accreditation (COCA), and other accrediting bodies,  
9       as part of accreditation of allopathic and osteopathic medical schools, to prospectively and  
10      retrospectively monitor medical school graduates' rates of placement into GME as well as  
11      GME completion. (Directive to Take Action)

Fiscal note: \$1,000.

TABLE 1. MEDICAL SCHOOLS, FIRST YEAR ENROLLMENT, GRADUATES, AND TRAINEES IN FIRST YEAR POSITIONS FOR ACADEMIC YEARS 2012-2013 THROUGH 2017-2018

|  | 2012-13 | 2013-14 | 2014-15 | 2015-16 | 2016-17 | 2017-18 |
|--|---------|---------|---------|---------|---------|---------|
| Number of allopathic medical schools†          | 136     | 140     | 141     | 142     | 145     | 147     |
| Number of colleges of osteopathic medicine‡    | 26      | 29      | 29      | 30      | 36      | 48      |
| MD 1 <sup>st</sup> -Year Enrollment†           | 20048   | 20583   | 20608   | 21128   | 21396   | 21338*  |
| DO 1 <sup>st</sup> -Year Enrollment‡           | 5986    | 6636    | 7012    | 7219    | 7575    | 8113    |
| MD Graduates†                                  | 18147   | 18057   | 18668   | 18820   | 19402¥  |         |
| DO Graduates‡                                  | 4806    | 4997    | 5323    | 5472    | 6038    |         |
| Total U.S. Graduates                           | 22953   | 23054   | 23991   | 24292   | 25440   |         |
| Annual Graduate Growth Rate (%)                |         | .44     | 4.06    | 1.25    | 4.72    |         |
| PGY1 Applicants Matched in NRMP∞               | 25246   | 25687   | 26252   | 26836   | 27688   | 29040   |
| Residents in ACGME PGY1 Positions£             | 26018   | 26649   | 27122   | 27949   | 28658   |         |
| Annual ACGME PGY1 Growth Rate (%)              |         | 2.42    | 1.77    | 3.05    | 2.54    |         |
| Applicants Matched in NMS (Osteopathic Match)§ | 1891    | 2022    | 2135    | 2206    | 2162    | 1640    |
| Annual Osteopathic Match Growth Rate (%)       |         | 6.93    | 5.59    | 3.32    | -1.99   | -24.14  |

† LCME database, includes schools with first year enrollment.

‡ AACOM data, includes branch campuses and remote teaching sites with first year enrollment: <http://www.aacom.org/docs/default-source/data-and-trends/AppEnrollGrad2011-2016.pdf?sfvrsn=39>. Accessed December 21, 2017; [http://www.aacom.org/docs/default-source/data-and-trends/2016-17\\_FYEnroll\\_Gender\\_RE\\_COM.pdf?sfvrsn=12](http://www.aacom.org/docs/default-source/data-and-trends/2016-17_FYEnroll_Gender_RE_COM.pdf?sfvrsn=12). Accessed December 21, 2017; [https://www.aacom.org/docs/default-source/data-and-trends/2017\\_fall\\_enrollment\\_report.pdf](https://www.aacom.org/docs/default-source/data-and-trends/2017_fall_enrollment_report.pdf). Accessed December 21, 2017.

\*AAMC matriculant data: <https://www.aamc.org/download/321442/data/factstable1.pdf> 2017-2018. Accessed February 12, 2018. 1<sup>st</sup> year enrollment data include students repeating the first year, as opposed to matriculant data.

¥ LCME database; schools estimated the number of graduates in February 2017.

∞ National Resident Matching Program, Results and Data: 2017 Main Residency Match®. National Resident Matching Program, Washington, DC. 2017, and Advance Data Tables: 2018 Main Residency Match <http://www.nrmp.org/main-residency-match-data/> Applicants match during the current academic year to become first year residents in the following academic year.

£ Brotherton SE, Etzel SI. Graduate Medical Education, 2016-2017. JAMA. 2017;318(23):2368-2387. doi:10.1001/jama.2017.16203

§ National Matching Service. May include those with prior training. Applicants match during the current academic year to become first year residents in the following academic year. <https://natmatch.com/aoairp/aboutstats.html>. Accessed February 13, 2018.

TABLE 2. AVERAGE NUMBER OF APPLICATIONS THROUGH ERAS FOR ACADEMIC YEARS 2013-2014 THROUGH 2017-2018

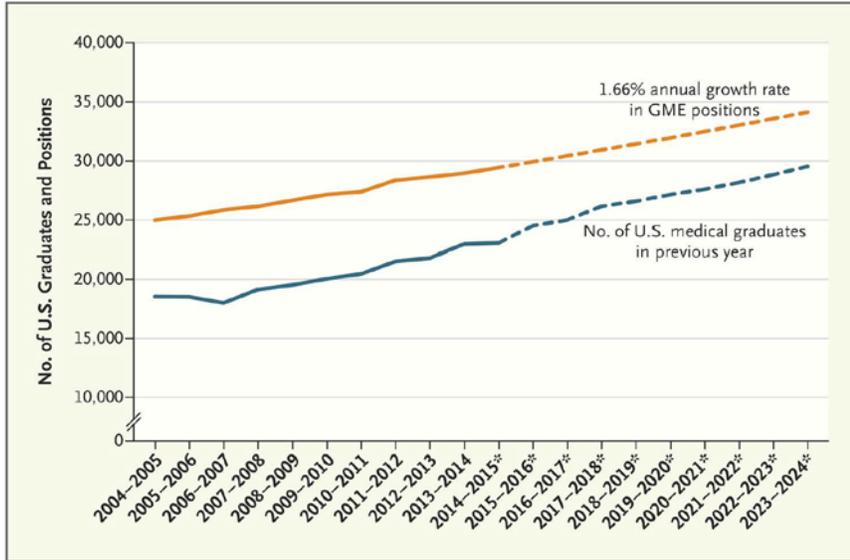
| Average number of applications sent by applicant*    | 2013-2014 | 2014-2015 | 2015-2016 | 2016-2017 | 2017-2018 |
|--|-----------|-----------|-----------|-----------|-----------|
| USMG   | 43.8      | 47.2      | 49.3      | 55.0      | 58.0      |
| IMG  | 113.4     | 119.1     | 123.1     | 131.5     | 135.5     |
| All applicants                                       | 74.3      | 78.6      | 80.7      | 87.7      | 90.1      |
| Average number of applications received by program** |           |           |           |           |           |
| USMG   | 285.9     | 306.6     | 327.9     | 367.2     | 386.8     |
| IMG  | 576.6     | 601.5     | 606.3     | 654.3     | 639.5     |
| All applicants                                       | 862.2     | 907.8     | 933.9     | 1021.1    | 1025.7    |

\*<https://www.aamc.org/download/359232/data/all.pdf> Accessed August 15, 2017. USMG includes U.S. MDs and DOs, of any graduating class.

\*\*<https://www.aamc.org/download/359236/data/all.pdf> Accessed October 13, 2017. USMG includes U.S. MDs and DOs, of any graduating class.

FIGURE

**Actual and Projected Growth in Numbers of U.S. Medical School Graduates and Graduate Medical Education (GME) Entrants, Based on 1.66% Annual Growth in GME Positions.**



Mullan F et al. N Engl J Med 2015;373:2397-2399.



From the New England Journal of Medicine, Mullan F, Salsberg E, Weider K, Why a GME Squeeze Is Unlikely. Volume No. 373, Pages 2397-2399. Copyright 2018 Massachusetts Medical Society. Reprinted with permission from Massachusetts Medical Society.

#### APPENDIX: RELEVANT AMA POLICY

D-305.967, “The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education”

Our AMA will: (3) Actively seek congressional action to remove the caps on Medicare funding of GME positions for resident physicians that were imposed by the Balanced Budget Amendment of 1997 (BBA-1997); (4) Strenuously advocate for increasing the number of GME positions to address the future physician workforce needs of the nation; (8) Vigorously advocate for the continued and expanded contribution by all payers for health care (including the federal government, the states, and local and private sources) to fund both the direct and indirect costs of GME; (15) Encourages the ACGME to reduce barriers to rural and other underserved community experiences for graduate medical education programs that choose to provide such training, by adjusting as needed its program requirements, such as continuity requirements or limitations on time spent away from the primary residency site; (17) Work with interested state and national medical specialty societies and other appropriate stakeholders to share and support legislation to increase GME funding, enabling a state to accomplish one or more of the following: (a) train more physicians to meet state and regional workforce needs; (b) train physicians who will practice in physician shortage/underserved areas; or (c) train physicians in undersupplied specialties and subspecialties in the state/region; (18) Supports the ongoing efforts by states to identify and address changing physician workforce needs within the GME landscape and continue to broadly advocate for innovative pilot programs that will increase the number of positions and create enhanced accountability of GME programs for quality outcomes; (26) Encourages insurance payers and foundations to enter into partnerships with state and local agencies as well as academic medical centers and community hospitals seeking to expand GME.

D-305.958, “Increasing Graduate Medical Education Positions as a Component to any Federal Health Care Reform Policy”

Our AMA will: (2) Work with the Centers for Medicare and Medicaid Services to explore ways to increase graduate medical education slots to accommodate the need for more physicians in the US; (3) Work actively and in collaboration with the Association of American Medical Colleges and other interested stakeholders to rescind funding caps for GME imposed by the Balanced Budget Act of 1997; (4) Actively advocate for expanded funding for entry and continued training positions in specialties and geographic regions with documented medical workforce shortages; (5) Lobby Congress to find ways to increase graduate medical education funding to accommodate the projected need for more physicians.

H-310.917, “Securing Funding for Graduate Medical Education”

Our AMA: (4) Encourages entities planning to expand or start GME programs to develop a clear statement of the benefits of their GME activities to facilitate potential funding from appropriate sources given the goals of their programs.

H-305.988, “Cost and Financing of Medical Education and Availability of First-Year Residency Positions”

Our AMA: (2) In studying the financing of medical schools, supports identification of those elements that have implications for the supply of physicians in the future.

H-465.988, “Educational Strategies for Meeting Rural Health Physician Shortage”

Our AMA: (2) Encourage medical schools to develop educationally sound primary care residencies in smaller communities with the goal of educating and recruiting more rural physicians.

H-200.954, "US Physician Shortage"

Our AMA will: (8) Continue to advocate for funding from all payers (public and private sector) to increase the number of graduate medical education positions in specialties leading to first certification; (9) Work with other groups to explore additional innovative strategies for funding graduate medical education positions, including positions tied to geographic or specialty need.

D-310.977, "National Resident Matching Program Reform"

Our AMA: (11) Will work with the Association of American Medical Colleges (AAMC), American Osteopathic Association (AOA), American Association of Colleges of Osteopathic Medicine (AACOM), and National Resident Matching Program (NRMP) to evaluate the current available data or propose new studies that would help us learn how many students graduating from US medical schools each year do not enter into a US residency program; how many never enter into a US residency program; whether there is disproportionate impact on individuals of minority racial and ethnic groups; and what careers are pursued by those with an MD or DO degree who do not enter residency programs; (15) Encourages the Association of American Medical Colleges to work with U.S. medical schools to identify best practices, including career counseling, used by medical schools to facilitate successful matches for medical school seniors, and reduce the number who do not match.

## REFERENCES

- <sup>1</sup> Association of American Medical Colleges. 2017. Results of the 2016 Medical School Enrollment Survey. Washington, DC.
- <sup>2</sup> American Association of Colleges of Osteopathic Medicine. [https://www.aacom.org/docs/default-source/data-and-trends/2017\\_fall\\_enrollment\\_report.pdf](https://www.aacom.org/docs/default-source/data-and-trends/2017_fall_enrollment_report.pdf). Accessed December 21, 2017
- <sup>3</sup> Mullan F, Salsberg E, Weider K. Why a GME Squeeze Is Unlikely. *N Engl J Med* 2015; 373:2397-2399. Available at: <http://www.nejm.org/doi/full/10.1056/NEJMp1511707> Accessed November 5, 2015.
- <sup>4</sup> NRMP. First-Year Graduate Medical Education in the United States: 2002-2016. <http://www.nrmp.org/wp-content/uploads/2017/02/First-Year-GME-in-the-US-2016.pdf>. Accessed December 31, 2017.
- <sup>5</sup> Sondheimer HM, Xierali IM, Young GH, Nivet MA. Placement of US Medical School Graduates Into Graduate Medical Education, 2005 Through 2015. *JAMA*. 2015;314(22):2409-2410. Available at: <http://jama.jamanetwork.com/article.aspx?articleid=2474417>. Accessed December 16, 2015.
- <sup>6</sup> NRMP Update. Group on Student Affairs, April 2017.
- <sup>7</sup> Bailey, M. Looming question for medical students: Will they be shut out of advanced training? *STAT*, March 17, 2016. <https://www.statnews.com/2016/03/17/medical-students-match-day/>. Accessed August 25, 2017.
- <sup>8</sup> NRMP, Data Release and Research Committee: Results of the 2017 NRMP Applicant Survey by Preferred Specialty and Applicant Type. National Resident Matching Program, Washington, DC. 2017
- <sup>9</sup> NRMP, Data Release and Research Committee: Results of the 2013 NRMP Applicant Survey by Preferred Specialty and Applicant Type. National Resident Matching Program, Washington, DC. 2013.
- <sup>10</sup> Association of American Medical Colleges. <https://students-residents.aamc.org/applying-residency/article/apply-smart-data-consider/> Accessed March 6, 2018.
- <sup>11</sup> Texas S.B. 1066. Relating to meeting the graduate medical education needs of new medical degree programs offered by public institutions of higher education and to the employment status of certain residents participating in certain graduate medical education programs. <https://legiscan.com/TX/bill/SB1066/2017>. Accessed September 9, 2017.
- <sup>12</sup> Roemer BM, Azevedo T, Blumberg B. Looking at graduate medical education through a different lens: a health care system's perspective. *Acad Med*. 2015;90(9). doi: 10.1097/ACM.0000000000000828.

<sup>13</sup> Spero J C et al. 2013. GME in the United States: A Review of State Initiatives. The Cecil G. Sheps Center for Health Services Research. [http://www.shepscenter.unc.edu/wp-content/uploads/2013/09/GMEstateReview\\_Sept2013.pdf](http://www.shepscenter.unc.edu/wp-content/uploads/2013/09/GMEstateReview_Sept2013.pdf). Accessed April 10, 2015

<sup>14</sup> Henry J. Here's what Kaiser Permanente is planning for its Pasadena school. The Pasadena Star News. March 21, 2017. <https://www.pasadenastarnews.com/social-affairs/20170321/heres-what-kaiser-permanente-is-planning-for-its-pasadena-school>. Accessed September 18, 2017.

<sup>15</sup> Barajaz M, Turner T. Starting a new residency program: a step-by-step guide for institutions, hospitals, and program directors. Med Educ Online. 2016;21: 32271. <http://dx.doi.org/10.3402/meo.v21.32271>

<sup>16</sup> <https://www.in.gov/che/4612.htm>. Accessed February 4, 2018.

<sup>17</sup> American Medical Association. Final Report: Implementation of Resolution 902-I-15. AMA Enterprise Communications and Marketing. November 2017.