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-16)
Addressing the Increasing Number of Unmatched Medical Students
(Reference Committee C)

EXECUTIVE SUMMARY

Policy D-310.977, National Resident Matching Program Reform, directs our American Medical Association (AMA) to "study, in collaboration with the Association of American Medical Colleges, the National Resident Matching Program, and the American Osteopathic Association, the common reasons for failures to match." This report is in response to that directive.

This report focuses on those Match participants who are U.S. medical school seniors at allopathic, MD-granting programs accredited by the Liaison Committee on Medical Education. Graduates of osteopathic medical schools (DOs) have the opportunity to participate in both the osteopathic Match as well as the NRMP Match, and as such the data available on match rates of DOs versus MDs are not comparable. In addition, match rates of International Medical Graduates (IMGs), whether U.S. citizens or foreign nationals, are not included in this report in correspondence to the scope of Policy D-310.977. The report finds long-term stability in the Match rates of U.S. medical school seniors and cites data that appear to mitigate concerns of a squeeze in the availability of graduate medical education (GME) positions.

At the same time, of course, past (or current) performance does not predict future results. This is particularly true in light of continued growth in the number of U.S. medical schools and increased enrollments in existing schools. An additional factor is limited growth in GME due to caps in federal funding. Other factors to consider in this complex matrix include 1) the significant and growing number of U.S. citizen international medical graduates (IMGs) who graduate from non-LCME-accredited medical schools and seek to enter residency programs in the United States; 2) changes in medical practice that may affect future health care workforce needs; 3) changes to government funding/reimbursement of medical training, with calls for more transparency and accountability for public funding of GME on the rise; and 4) the increased number of non-physician clinicians (physician assistants, nurse practitioners) who are providing health care and other services. In short, any of a myriad of factors could lead to an increase or decrease in the need for GME positions, and help to catalyze calls for increased or decreased funding.

The report also provides insight into the reasons why students do not match into a residency program, such as academic shortcomings and inadequate Match preparation, as well as the plans of those who do not match. Some leading strategies for those who did not match include research, re-entering the Match and applying in a different specialty, and pursuing clinical work experience. From the institutional perspective, medical schools should continue to explore strategies to enhance students' ability to match, offer options for students who do not match, and seek to better advise and counsel students.

Future study should encompass: 1) evaluation of the workforce distribution impact of the relatively static number of GME positions (barring any significant increase in this number), and the potential impact on access to care among underserved populations; 2) Match rates and helpful application (and reapplication) strategies for successful matching in a given field; and 3) the potential impact on Match rates of the unification of the GME accreditation systems for allopathic and osteopathic medicine.

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-16

Subject: Addressing the Increasing Number of Unmatched Medical Students

Presented by: Darlyne Menscer, MD, Chair

Referred to: Reference Committee C
(Albert M. Kwan, MD, Chair)

Policy D-310.977, National Resident Matching Program Reform, directs our American Medical Association (AMA) to "study, in collaboration with the Association of American Medical Colleges, the National Resident Matching Program, and the American Osteopathic Association, the common reasons for failures to match." This report is in response to that directive.

This policy was adopted at the 2015 Annual Meeting of the AMA House of Delegates. Testimony at A-15 before Reference Committee C noted that the problem of unmatched medical students was becoming more dire with the continued growth in enrollments in medical schools. Indeed, this was the topic of an educational session at A-15 hosted by the Academic Physicians Section (APS), with the goal of ensuring that medical students obtain needed guidance and counseling pre-Match and assistance with any post-Match problems, including advice on alternative career options, as needed. The AMA is committed to continued study and close monitoring of this issue—through the efforts of the Council on Medical Education and APS, among others—to ensure the highest possible return on the nation's investment in our future medical workforce.

This report focuses on those Match participants who are U.S. medical school seniors at allopathic, MD-granting programs accredited by the Liaison Committee on Medical Education. Graduates of osteopathic medical schools (DOs) have the opportunity to participate in both the osteopathic Match as well as the NRMP Match, and as such the data available on match rates of DOs versus MDs are not comparable. In addition, match rates of International Medical Graduates (IMGs), whether U.S. citizens or foreign nationals, are not included in this report in correspondence to the scope of Policy D-310.977.

BACKGROUND AND DATA

Historical Stability in Match Rates for U.S. Allopathic Medical School Seniors

Research by Sondheimer et al. in the December 8, 2015 issue of *JAMA*[1] may provide some reassurance to those who fear a rapid increase in the number of unmatched U.S. medical students. The authors note, "The percentage of US MD graduates entering GME the year of graduation has remained stable during the past decade despite an increase in the number of graduates."

These conclusions were emphasized in an interview with the lead author, Henry Sondheimer, MD.[2] "[I]n spite of the growth in U.S. MD graduates, the percent of graduates not beginning their GME the year they graduated has remained very stable around 3%." He adds that, after following the graduates for eight to 10 years after graduation, "more than 99% enter GME or begin practice in

some other way"—for example, those with a joint medical/dental degree may obtain a dental residency slot versus a similar position in a medical residency.

The noteworthy long-term stability of Match rates for U.S. medical school seniors is corroborated with data presented by Geoffrey Young, PhD, at the APS meeting in June 2015 in Chicago.[3] Dr. Young, senior director, student affairs and programs, Association of American Medical Colleges (AAMC), noted that historical Match rates over the previous five years, 10 years and 30 years are 94.2%, 93.8%, and 93.4%.

As with any numbers, however, Match data can be misinterpreted and may lead to false conclusions and perpetuate misperceptions if not analyzed in the proper context. A recent Associated Press article, for example, titled "More Doctors Fail to Land Residency Positions After School," states that "Most doctors who apply to participate in residency programs are matched with particular hospitals or health care providers, but the percentage remaining unmatched has risen faster over the past decade than the percentage placed in residency programs."[4] The article fails to note, however, that the 75.2% overall Match rate [in 2015] is the highest since 2006, according to NRMP data, and that U.S. seniors generally match at 94%, as noted above. The majority of the 25% not matching are IMGs. In short, the article implies one quarter of U.S. medical school graduates cannot find a position, even though the Match rate for this segment is essentially stable and very high.

Further data that mitigate concerns of a GME squeeze come from a 2015 perspective piece in the *New England Journal of Medicine* authored by Mullan et al. of the George Washington University Health Workforce Institute.[5] Their analysis suggests that a continued surplus of GME positions versus U.S. medical school graduates—a total of 4,500 positions—is likely through 2023-2024. The authors note, "Although that figure represents a decrease in the gap between GME positions and graduates from 21.7% in 2014–2015 to 13.5% in 2023–2024, the number of GME positions available will continue to substantially exceed the number of U.S. medical graduates seeking them. This enduring gap suggests that any current or foreseeable failure of U.S. graduates to obtain residency positions is not attributable to a lack of positions." They go on to state, "The primary goal of public GME support . . . is to produce trained physicians to meet the country's health care needs and not to fulfill the personal preferences of individual graduates for the specialties of their choice. Although the GME gap will narrow slowly, it appears likely that there will be ample positions for all U.S. graduates over the next decade, assuming that this group will be given priority in residency selection. It would seem difficult to argue that Congress should fund more GME positions in order to create a larger margin for U.S. graduates." The authors also note, "Greater competition for residency opportunities may challenge U.S. medical students' traditional assumptions about specialty selection and give new importance to the advice about appropriate specialties provided by medical school faculty and advisors."

Future Shock? The Complexity of Health Care Workforce Needs

In spite of these data, it is important to remember that past (or current) performance does not predict future results. This is particularly true in light of continued growth in the number of U.S. medical schools (both allopathic and osteopathic) and increased enrollments in existing schools. An additional factor is limited growth in GME due to caps in federal funding. Accordingly, the AMA and other organizations, such as the Association of American Medical Colleges, support legislation to increase federal funding of GME. A list of current proposed legislation to increase the number of federally funded residency slots is available via the AAMC website at aamc.org/advocacy/campaigns_and_coalitions/355904/gmebills.html.

Despite the cap, financial support of GME has continued over the last two decades from a number of sources, writes Edward Salsberg in a recent *Health Affairs* blog, "including funding from the Health Resources and Services Administration for primary care programs, new teaching hospitals eligible for Medicare GME, expanded funding for GME through the Veterans Health Administration, state funding, and hospital self-funded positions." He notes that "this growth has included entry positions into pipeline programs that lead to initial board certification. However, by percentage most of the growth in GME positions has been in hospital-based specialty and subspecialty continuing programs, where teaching hospitals have self-funded additional GME positions 'over the cap.'"[6]

Other factors to note include the significant and growing number of U.S. citizen international medical graduates (IMGs) who graduate from non-LCME-accredited medical schools and seek to enter residency programs in the United States—along with foreign national IMGs (although, as noted in the introduction, this report does not address this issue). Further, changes in medical practice may affect future health care workforce needs. In addition, changes to government funding/reimbursement of medical training may occur, with calls for more transparency and accountability for public funding of GME on the rise.[7] An increased number of non-physician clinicians (physician assistants, nurse practitioners[8]) are providing health care and other services, and the pace of medical practices hiring such clinicians has increased recently.[9] In short, workforce prediction is an inexact science (or art), due to the complexity and number of moving parts. Any of a myriad of factors could lead to an increase or decrease in the need for GME positions, and help to catalyze calls for increased or decreased funding.

Why Students do not Match

Data from the Liaison Committee on Medical Education (LCME) provide insight into the reasons provided by medical schools as to why their students did not match into a residency program. The LCME Part II Annual Medical School Questionnaire from 2014-2015 (with responses from 141 schools) shows that academic shortcomings and inadequate Match preparation are two key reasons for failure to match.

> 8c. For each student identified in Q8b who sought but did not find a residency position, select the main reason. (Select one reason for each student.)
>
> Students who did not find a residency position:

#	%	Reason
174	51.3%	The student's academic performance (eg, clinical grades) and/or USMLE scores were below the norm
77	22.7%	The applications were limited to one specialty and did not include backup plans ("plan B" specialty)
66	19.5%	Reason unknown by school
22	6.5%	The number of applications was (relatively) limited

Not having a backup plan ("plan B" specialty) may result from candidates' failure to fully and realistically evaluate their chances for matching into a given specialty field and/or residency program. Certain specialty fields of medicine offer attractive compensation and "controllable lifestyle," and as such are valued by medical school graduates as inviting career options. These fields also may have a limited number of positions, making them more competitive. The large and increasingly burdensome debt load many medical graduates face may also play a role in students' decisions. Competition for placement into such fields is intense. Students who have not achieved

high United States Medical Licensing Examination (USMLE) scores or class ranking may not be competitive applicants for such programs, and are likely to remain unmatched if their rank order lists include only highly competitive specialties.

In response to student concerns about the availability of positions, the number of residency programs that the average student applies to has risen precipitously over the last few years, notes Fitzhugh Mullan, MD, in a post in the *Medical Education Futures Study* newsletter. "The idea that we are running out of residency positions has become a popular and fear-invoking belief in medical schools with the result that senior medical students are applying to more and more residencies in the hope of not becoming losers in the perceived game of GME musical chairs." He adds that the average U.S. senior "applied to 47 (forty-seven!) residencies in 2015, up 20% in the last five years."[10]

Student fears of not matching and desire for a residency in a remunerative and/or lifestyle-friendly field are two causes of this applications approach—despite research that this practice is not effective.[11] This in turn forces program directors to resort even more to using USMLE scores, grades and other quantitative criteria as a numeric cutpoint—rather than perform an in-depth review of every application, even though the USMLE score alone is not predictive of success in residency.[12] Students then react by submitting even more applications, and the situation continues to spiral.

Another key source of data on unmatched medical students is the National Resident Matching Program (NRMP). A 2015 NRMP survey of Match applicants, presented at the 2015 AAMC Annual Meeting,[13] notes the following behaviors by unmatched U.S. MD seniors as compared to those who matched; these data show how unmatched students were less likely to engage in recommended strategies for matching and more likely to engage in counterproductive strategies when developing their rank order lists of programs:

Matched	Unmatched	Behavior
92%	81%	Ranked programs in order of preference
68%	77%	Ranked all programs where they interviewed
77%	64%	Ranked all programs willing to attend
65%	43%	Ranked a mix of programs
48%	24%	Ranked "safety-net" programs
2%	8%	Ranked programs where they did not interview

A third data source is the 2015 Match/SOAP (Supplemental Offer and Acceptance Program) Survey administered by the AAMC to 141 student affairs deans after the 2015 National Resident Matching Program (NRMP) Match. A total of 97 of 141 schools (69%) completed the survey, which collected data on the following three groups who participated in the 2015 Match and SOAP:

1. 2015 U.S. MD seniors;
2. 2014 U.S. MD seniors who did not match in 2014 and delayed graduation until 2015; and
3. U.S. MDs who graduated between 2009 and 2014.

For the first group (2015 U.S. MD seniors), student affairs deans reported that 527 of 10,515 (7%) were unmatched to first-year GME positions by noon on March 16, 2015, and 254 of these remained without a position by March 27. Of the 254, 110 (46%) were previously discussed in a promotions committee during their time in medical school. Indeed, for those students, medical schools "may need to re-examine their promotions standards, which may be a tough discussion," as

described in an *AMA Wire* article.[14] "'At some point, you need to help a student make an exit plan [from medical school]'," said Dr. Young during his APS presentation, as quoted in the *AMA Wire* article.

Additional survey data from the AAMC, as presented by Dr. Young, show the following reasons for failure to match:

1. Low scores on a USMLE exam;
2. Not competitive for first choice specialty;
3. Did not have an appropriate backup/alternate plan;
4. Did not follow guidance from faculty advisor or dean's office;
5. Poor interviewing/interpersonal skills;
6. Did not rank enough programs; and/or
7. Failed a USMLE exam

Plans of Students Who Do Not Match

As to the plans of students who are initially unmatched, the LCME Questionnaire of medical schools provides additional insight:

> 8d. For each student identified in Q8c who did not find a residency position, select the options that meet their future plans. (Select all that apply for each student.)
>
> Students who did not match:

#	%	Future Plans
245	39.2%	Will search for a residency position for entry in 2016
157	25.1%	Will continue searching for a residency position in 2015
133	21.3%	Will seek employment, such as a research position
47	7.5%	Plans unknown by school
33	5.3%	Will seek an additional degree
10	1.6%	Will seek a career outside of medicine

These data are reflected in the 2015 AAMC survey of student affairs deans, which describes the following strategies for unmatched 2015 seniors:

- Re-enter the Match next year
- Continue to seek a residency position for 2015
- Re-enter the Match next year applying to a different specialty
- Pursue a research year

The AAMC survey also analyzed the experiences of a second group of 2015 Match participants—the 203 U.S. MD seniors of 2014 who did not match in 2014 and delayed graduation until 2015. Of these, 12 (6%) were unmatched to first year positions by March 16, 2015, and eight remained without a position by March 27. Meanwhile, for a third group of 2015 Match participants—the 108 U.S. MDs who graduated between 2009 and 2014—a total of 67 (63%) were matched into a first-year position while 40 (37%) remained without a position. For this group, the leading strategies for those who successfully matched included research (25%), re-entering the Match and applying in a different specialty (14%), and clinical work experience (13%).

The Role of Medical Schools in Improving Match Rates

Medical schools should continue to explore institutional strategies to enhance students' ability to match, offer options for students who do not match, and seek to better advise and counsel students. At the University of Illinois College of Medicine, for example, students, faculty, and staff collaborated to develop the Residency Preparedness Initiative, consisting of a longitudinal career development course and loan interest assistance program.[15] The objectives of the course are that students: 1) demonstrate knowledge of various medical specialty/career options; 2) develop a strategic plan for the Match or an alternative career path; 3) complete the Electronic Residency Application System documents (ERAS) and submit them in a timely manner (if applicable), and 4) match into a residency training program or secure alternative career plans upon graduation.

Another institutional strategy can be implemented earlier in the pipeline—i.e., during the medical school admissions process. In her presentation to the APS, Betty Drees, MD, former APS liaison to the Council on Medical Education, described how holistic medical school admissions may ultimately help improve Match rates.[16] This perspective is mirrored in a presentation by William McDade, MD, former chair of the Council on Medical Education, to the AMA Commission to End Health Care Disparities at its fall 2015 meeting. Dr. McDade also described the merits of a holistic residency candidate interview process, to deemphasize scores on standardized tests and give greater attention to other important qualities, "such as clinical reasoning, patient care, professionalism, and ability to function as a member of a health care team."[17]

Concerns About Students Who Are Partially Matched

Even those individuals who are matched into a residency program may be on a short-term "road to nowhere" if the position is only a preliminary or first graduate year (GY1) slot. The majority of specialty programs encompass the first-year preliminary training as "categorical," in that the resident matches into the specialty program, not the preliminary position. However, some of these one-year positions remain as a prerequisite to enter another specialty program that requires one year of GME prior to entry (there also are some transitional year positions—although they do not guarantee further training in a specialty). In 2015, 2,573 U.S. seniors matched into preliminary or transitional year positions. At the end of SOAP, 605 additional preliminary or transitional year positions had been filled, although published data did not distinguish the type of applicant; i.e., we do not know how many of those positions were filled by U.S. seniors. U.S. seniors, however, comprised the majority of unmatched applicants who found positions in the SOAP (599, or 56.5%).

Some physicians who complete a preliminary year of residency training do not find a GY2 position. If these physicians are U.S. medical school graduates, one option is to obtain a license to practice medicine, without completing additional GME. In 35 of the 55 jurisdictions that issue licenses for medical practice (the 50 states, plus the District of Columbia, Guam, the Northern Mariana Islands, Puerto Rico and the U.S. Virgin Islands), U.S. medical school graduates may obtain a license to practice medicine with one year of GME (these requirements differ for international medical graduates).[18] Physicians who choose this option are not eligible for certification by a member board of the American Board of Medical Specialties, as they have not completed the required years of residency training. Obtaining hospital admitting privileges may also be challenging for this group, if not impossible, and receiving payments from insurers may be difficult as well. Finally, from a patient safety perspective, legitimate concerns may be raised about the quality of care provided by such physicians.

Bypassing the Match: The Assistant Physician Route

Three U.S. states (Arkansas, Kansas, and Missouri) have passed legislation to allow medical school graduates to practice as "assistant physicians" or "graduate registered physicians" under the supervision of a licensed physician in the state, without having completed any GME. Legislatures in Washington and Virginia considered but did not pass similar bills in 2016. While the laws in Arkansas and Missouri created new license categories for these individuals, Kansas' law established a process through which an individual can obtain a special permit to practice under physician supervision for a limited time.

The stated rationale for these legislative efforts is both the need for primary care services in underserved areas and concerns about difficulty in matching into GME programs. The AMA and other medical organizations are in opposition to such legislation, on the basis of patient safety and quality concerns about the inadequate preparation of new physicians who lack any exposure to GME but yet would be engaged in the practice of medicine.[19]

RELEVANT AMA POLICY

At the AMA's 2015 Interim Meeting, the House of Delegates approved new policy that calls for the AMA to pursue a national public advocacy campaign to "educate the public on the definition and importance of graduate medical education, student debt and the state of the medical profession today and in the future." Such work is aligned with other AMA efforts, such as the SaveGME.org website, which is focused on advocacy to Congress.

Currently, the AMA has a significant number of policies that address both Match policies and GME funding, as shown in the appendix to this report.

Of particular note is D-310.977, National Resident Matching Program Reform. This policy states that our AMA will:

- Work with the NRMP to better inform applicants about the NRMP matching process;
- Evaluate and comment on all proposals to modify the Match;
- Request that the NRMP explore the possibility of including the Osteopathic Match in the NRMP Match;
- Work with the NRMP and others to develop mechanisms that limit disparities within the residency application process and allow both flexibility and standard rules for applicants; and
- Encourage the NRMP to study the effects of the Supplemental Offer and Acceptance Program on the number of residency spots not filled through the Main Residency Match and include stratified analysis by specialty and other relevant areas.

The policy also calls on the AMA to work with other key stakeholders to:

- Evaluate current data or propose new research on how many students graduating from U.S. medical schools each year do not enter into a U.S. residency program; how many never enter into a U.S. 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;
- Study whether U.S. medical school graduates and IMGs who do not enter residency programs may be able to serve unmet national health care needs; and

- Evaluate the feasibility of a national tracking system for U.S. medical students who do not initially match into a categorical residency program.

SUMMARY AND RECOMMENDATIONS

A second Council on Medical Education report, planned for the 2017 AMA Annual Meeting, will address Policy D-310.977 (15): "Our AMA will discuss with the National Resident Matching Program, Association of American Medical Colleges, American Osteopathic Association, Liaison Committee on Medical Education, Accreditation Council for Graduate Medical Education, and other interested bodies potential pathways for reengagement in medicine following an unsuccessful match and report back on the results of those discussions." Aside from this work, one of the key areas to monitor will be the workforce distribution impact of the relatively static number of GME positions (barring any significant increase). Foreign national IMGs are more likely to practice in underserved urban and rural communities[20] despite state regulations that often serve to impede IMGs' licensure to practice medicine—e.g., through use of approved lists of foreign medical schools. If the increasing numbers of U.S. graduates displace IMGs from the Match over the next 10 or more years, then, fewer IMGs may be able to practice in underserved areas. Therefore, current health workforce shortages affecting underserved populations could be exacerbated if U.S. graduates do not fill that breach (although, from a global perspective, the "brain drain" would be reduced, which may result in improved access to care in less developed countries). The work of such organizations as ACGME-International is key in improving the standards of residency education and patient care in other countries.

Additional research may also be warranted into the impact of applicants' race/ethnicity on Match outcomes. Indeed, the research by Sondheimer et al., cited earlier in this report, was developed in response to concerns in this regard. That study found that "Unplaced black, Hispanic, and non–US citizen graduates increased over time. Racial/ethnic minority graduates were consistently less likely to begin GME the year they graduated than whites. . . ." The authors also noted that, although nearly all graduates entered GME or began medical practice in the United States within six years after graduation, "The racial/ethnic differences seen at graduation diminished with time but remained statistically significant." Wider adoption of a holistic approach to both medical school admissions and the residency candidate interview process could help ameliorate this trend.

Additional studies could examine in further detail the impact of IMGs and their Match behaviors. One previous study, in the *Journal of Graduate Medical Education*, "looked at differences in interview and ranking behaviors between matched and unmatched IMGs participating in the 2013 Match and explored strategic errors made by unmatched IMGs when creating rank order lists."[21] The authors found that "Unmatched IMGs were more likely than matched IMGs to rank programs at which they did not interview and to rank programs based on their perceived likelihood of matching." They conclude, "The interview and ranking behaviors of IMGs can have far-reaching consequences on their Match experience and outcomes." This study reinforces the experiences of U.S. medical school seniors, as outlined in this report.

Other research may focus on Match rates and helpful application (and reapplication) strategies for successful matching in a given field. For example, a recent study looked at the experiences of unmatched residency applicants in orthopedic surgery, one of the most competitive specialties to enter. The authors found that pursuing a preliminary internship or research fellowship in the year prior to reapplication to orthopedic surgery did not increase the success rate among such applicants. They conclude, "Success of reapplication into orthopaedic surgery may be less dependent on research or internship and more dependent on developing relationships with faculty at a local or regional institution."[22]

For prospective and newly matriculated medical students, up-front disclosures on Match potential and a realistic assessment of career possibilities are needed. Students should be provided accurate data about graduation and Match rates, as well as projected Match rates for the institution. In the legal field, for example, entering students are informed that graduation is no guarantee of a career in law. A more informed perspective on future career prospects can also affect student borrowing as well as lender practices. Although this is not currently an issue, the Department of Education is beginning to look closely at this metric as a medical school outcome. In short, what does a medical school degree prepare one to do? Further, can one do anything else (that is, a non-clinical career) that would make going to medical school worth the investment?

Finally, the potential impact on Match rates of the unification of the GME accreditation systems for allopathic and osteopathic medicine is another area for possible study.

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

1. That our AMA reaffirm D-305.967 (4) and (22), The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education: "4. Our AMA will strenuously advocate for increasing the number of GME positions to address the future physician workforce needs of the nation" and "22. Our AMA will advocate for the appropriation of Congressional funding in support of the National Healthcare Workforce Commission, established under section 5101 of the Affordable Care Act, to provide data and healthcare workforce policy and advice to the nation and provide data that support the value of GME to the nation." (Reaffirm HOD Policy)

2. That our AMA reaffirm Policy H-200.954 (4) (5) (6) (7), US Physician Shortage: "Our AMA: . . . (4) encourages medical schools and residency programs to consider developing admissions policies and practices and targeted educational efforts aimed at attracting physicians to practice in underserved areas and to provide care to underserved populations; (5) encourages medical schools and residency programs to continue to provide courses, clerkships, and longitudinal experiences in rural and other underserved areas as a means to support educational program objectives and to influence choice of graduates' practice locations; (6) encourages medical schools to include criteria and processes in admission of medical students that are predictive of graduates' eventual practice in underserved areas and with underserved populations; (7) will continue to advocate for funding from public and private payers for educational programs that provide experiences for medical students in rural and other underserved areas." (Reaffirm HOD Policy).

3. That our AMA reaffirm D-310.977 (11), 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." (Reaffirm HOD Policy).

4. That our AMA encourage 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. (Directive to Take Action).

Fiscal note: $500 for staff time.

APPENDIX: RELEVANT AMA POLICIES

D-310.977 National Resident Matching Program Reform
Our AMA:
(1) will work with the National Resident Matching Program to develop and distribute educational programs to better inform applicants about the NRMP matching process;
(2) will actively participate in the evaluation of, and provide timely comments about, all proposals to modify the NRMP Match;
(3) will request that the NRMP explore the possibility of including the Osteopathic Match in the NRMP Match;
(4) will continue to review the NRMP's policies and procedures and make recommendations for improvements as the need arises;
(6) does not support the current the "All-In" policy for the Main Residency Match to the extent that it eliminates flexibility within the match process;
(7) will work with the NRMP, and other residency match programs, in revising Match policy, including the secondary match or scramble process to create more standardized rules for all candidates including application timelines and requirements;
(8) will work with the NRMP and other external bodies to develop mechanisms that limit disparities within the residency application process and allow both flexibility and standard rules for applicant;
(9) encourages the National Resident Matching Program to study and publish the effects of implementation of the Supplemental Offer and Acceptance Program on the number of residency spots not filled through the Main Residency Match and include stratified analysis by specialty and other relevant areas;
(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;
(12) will work with the AAMC, AOA, AACOM and appropriate licensing boards to study whether US medical school graduates and international medical graduates who do not enter residency programs may be able to serve unmet national health care needs;
(13) will work with the AAMC, AOA, AACOM and the NRMP to evaluate the feasibility of a national tracking system for US medical students who do not initially match into a categorical residency program;
(14) will study, in collaboration with the Association of American Medical Colleges, the National Resident Matching Program, and the American Osteopathic Association, the common reasons for failures to match; and
(15) will discuss with the National Resident Matching Program, Association of American Medical Colleges, American Osteopathic Association, Liaison Committee on Medical Education, Accreditation Council for Graduate Medical Education, and other interested bodies potential pathways for reengagement in medicine following an unsuccessful match and report back on the results of those discussions.

H-200.955 Revisions to AMA Policy on the Physician Workforce
It is AMA policy that: (1) any workforce planning efforts, done by the AMA or others, should utilize data on all aspects of the health care system, including projected demographics of both providers and patients, the number and roles of other health professionals in providing care, and

practice environment changes. Planning should have as a goal appropriate physician numbers, specialty mix, and geographic distribution. (2) Our AMA encourages and collaborates in the collection of the data needed for workforce planning and in the conduct of national and regional research on physician supply and distribution. The AMA will independently and in collaboration with state and specialty societies, national medical organizations, and other public and private sector groups, compile and disseminate the results of the research. (3) The medical profession must be integrally involved in any workforce planning efforts sponsored by federal or state governments, or by the private sector. (4) In order to enhance access to care, our AMA collaborates with the public and private sectors to ensure an adequate supply of physicians in all specialties and to develop strategies to mitigate the current geographic maldistribution of physicians. (5) There is a need to enhance underrepresented minority representation in medical schools and in the physician workforce, as a means to ultimately improve access to care for minority and underserved groups. (6) There should be no decrease in the number of funded graduate medical education (GME) positions. Any increase in the number of funded GME positions, overall or in a given specialty, and in the number of US medical students should be based on a demonstrated regional or national need. (7) Our AMA will collect and disseminate information on market demands and workforce needs, so as to assist medical students and resident physicians in selecting a specialty and choosing a career.

H-305.929 Proposed Revisions to AMA Policy on the Financing of Medical Education Programs
It is AMA policy that: (1) Since quality medical education directly benefits the American people, there should be public support for medical schools and graduate medical education programs and for the teaching institutions in which medical education occurs. Such support is required to ensure that there is a continuing supply of well-educated, competent physicians to care for the American public. (2) Planning to modify health system organization or financing should include consideration of the effects on medical education, with the goal of preserving and enhancing the quality of medical education and the quality of and access to care in teaching institutions are preserved. (3) Adequate and stable funding should be available to support quality undergraduate and graduate medical education programs. Our AMA and the federation should advocate for medical education funding. (4) Diversified sources of funding should be available to support medical schools' multiple missions, including education, research, and clinical service. Reliance on any particular revenue source should not jeopardize the balance among a medical school's missions. (5) All payers for health care, including the federal government, the states, and private payers, benefit from graduate medical education and should directly contribute to its funding. (6) Full Medicare direct medical education funding should be available for the number of years required for initial board certification. For combined residency programs, funding should be available for the longest of the individual programs plus one additional year. There should be opportunities to extend the period of full funding for specialties or subspecialties where there is a documented need, including a physician shortage. (7) Medical schools should develop systems to explicitly document and reimburse faculty teaching activity, so as to facilitate faculty participation in medical student and resident physician education and training. (8) Funding for graduate medical education should support the training of resident physicians in both hospital and non-hospital (ambulatory) settings. Federal and state funding formulas must take into account the resources, including volunteer faculty time and practice expenses, needed for training residents in all specialties in non-hospital, ambulatory settings. Funding for GME should be allocated to the sites where teaching occurs. (9) New funding should be available to support increases in the number of medical school and residency training positions, preferably in or adjacent to physician shortage/underserved areas and in undersupplied specialties.

D-305.967 The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education
… 3. Our AMA will 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). ... 11. Our AMA: (A) recognizes that funding for and distribution of positions for GME are in crisis in the United States and that meaningful and comprehensive reform is urgently needed; (B) will immediately work with Congress to expand medical residencies in a balanced fashion based on expected specialty needs throughout our nation to produce a geographically distributed and appropriately sized physician workforce; and to make increasing support and funding for GME programs and residencies a top priority of the AMA in its national political agenda; and (C) will continue to work closely with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, American Osteopathic Association, and other key stakeholders to raise awareness among policymakers and the public about the importance of expanded GME funding to meet the nation's current and anticipated medical workforce needs. ... 13. Our AMA will continue to strongly advocate that Congress fund additional graduate medical education (GME) positions for the most critical workforce needs, especially considering the current and worsening maldistribution of physicians. ... 19. Our AMA will continue to work with stakeholders such as Association of American Medical Colleges (AAMC), ACGME, AOA, American Academy of Family Physicians, American College of Physicians, and other specialty organizations to analyze the changing landscape of future physician workforce needs as well as the number and variety of GME positions necessary to provide that workforce. … 22. Our AMA will advocate for the appropriation of Congressional funding in support of the National Healthcare Workforce Commission, established under section 5101 of the Affordable Care Act, to provide data and healthcare workforce policy and advice to the nation and provide data that support the value of GME to the nation.

D-305.992 Accounting for GME Funding
Our AMA will encourage: (1) department chairs and residency program directors to learn effective use of the information that is currently available on Medicare funding accounting of GME at the level of individual hospitals to assure appropriate support for their training programs, and publicize sources for this information, including placing links on our AMA web site; and (2) hospital administrators to share with residency program directors and department chairs, accounting and budgeting information on the disbursement of Medicare education funding within the hospital to ensure the appropriate use of those funds for Graduate Medical Education.

D-305.958 Increasing Graduate Medical Education Positions as a Component to any Federal Health Care Reform Policy
2. Our AMA will 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.

H-310.917 Securing Funding for Graduate Medical Education
Our American Medical Association will: (1) continue to be vigilant while monitoring pending legislation that may change the financing of medical services (health system reform) and advocate for expanded and broad-based funding for graduate medical education (from federal, state, and commercial entities); and (2) continue to advocate for graduate medical education funding that reflects the physician workforce needs of the nation.

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