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Medical Education Commentary

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Abstract: The Coalition for Physician Accountability's Undergraduate Medical Education-Graduate Medical Education (UME-GME) Review Committee (UGRC): Recommendations for Comprehensive Improvement of the UME-GME Transition final report includes a total of 34 recommendations and outlines opportunities to transform the current processes of learner transition from a US-based MD- or DO-granting medical school or international medical education pathway into residency training in the United States. This review provides a reflection on the recommendations from the authors, all members of the UGRC, describing the pros and cons and the opportunities and limitations, in the hopes that they might inspire readers to dig deeper into the report and contribute to meaningful improvements to the current transition. The UGRC Recommendations highlight the many opportunities for improvement in the UME-to-GME transition. They are built on the connection to the system of education and formation of physicians to a more just healthcare system, with attention to diversity, equity, and inclusion to improve health disparities and to the quality of care that patients receive. However, there are justifiable concerns about changes that are not fully understood or that could potentially lead to unintentional consequences. This analysis, reached through author consensus, considers the pros and cons in the potential application of the UGRC Recommendations to improve the UME-to-GME transition. Further debate and discussion are warranted, without undue delay, all with the intention to continue to improve the education of tomorrow's physicians and the care for the patients who we have the privilege to serve.

Keywords: COMLEX-USA; licensure assessment; medical education.

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The Coalition for Physician Accountability's Undergraduate Medical Education-Graduate Medical Education (UME-GME) Review Committee (UGRC): Recommendations for Comprehensive Improvement of the UME-GME Transition final report was released in August 2021 [1]. The 34 recommendations in the 26-page report (plus appendices) outline numerous opportunities to transform the current processes involved in learner transition from medical school at a US-based MD- or DO-granting medical school or international medical education pathway into residency training in the United States. Looking at the recommendations for pros and cons as well as opportunities and limitations, this description outlines several themes in the hope that they might inspire readers to dig deeper into the report and help to contribute to meaningful improvements to the current transition, ultimately impacting our healthcare system. Although all of the authors of this manuscript were members of the UGRC, engagement by other stakeholders could benefit everyone in the continuum as well as the patients we have the privilege to serve.

Pros/cons #1: consensus built, but lack of ownership/authority/accountability

The coalition itself represents individuals from 16 organizations entrusted with the responsibility for physician

accountability to the public and medical self-regulation in the United States, including in physician licensure; medical school, program, institution, and continuing education accreditation; board certification; undergraduate medical, graduate medical, and continuing education; and assessment. This includes all US physicians, DOs, and MDs (US and international graduates, with degree designations that include MD, MBBS, and others). Consensus gained through the coalition in the past has helped to foster change across the continuum. One example sometimes cited is the trust garnered across member organizations in the coalition in support of the single GME accreditation [2]. Another is the consensus recommendation from the coalition in 2020 leading to virtual residency interviews in the pandemic [3]. Consensus achieved on enhancements to the UME to GME transition could allow the transition to residency to evolve toward an ideal state if multiple organizations and stakeholders collaborate to bring them forth. The attention to continuous quality improvement shows the recognition of the complexity of the current system and some uncertainty regarding changes, with cautions against unintended consequences. However, the coalition itself lacks any unifying authority or staff resources to drive these changes, and organizations and other stakeholders may fear the changes proposed and their loss of autonomy, resulting in hamstringing of efforts to change the status quo. Although UGRC templates included the names of organizations that might collectively take responsibility for each recommendation, the final report did not task any group of organizations with moving forward. Without any accountability or central responsibility, and without clear outcomes of interest and mechanisms for tracking these outcomes, forward progress remains uncertain.

Pros/cons #2: diversity, equity, and inclusion (DEI) for learners, patients, and everyone

The UGRC attempted to pay attention to the ultimate good of improved access to quality healthcare for everyone at the forefront, specifically noting areas of systemic bias and inequities for learners and the resulting impact on patient care and the healthcare workforce. However, the balance of learner and institutional needs with the public good is complicated. Effectively improving DEI is a complex need given the deep-seated structural biases and lack of evidence-based models on how to move toward an antiracist medical education system.

From the standpoint of supporting a diverse educational milieu in residency programs, reducing structural bias with respect to race, ethnicity, and gender, as well as biases related to other characteristics such as the medical school educational pathway (e.g., US-MD vs. DO-granting medical school graduates vs. international medical graduates), the recommendations identify numerous imperatives for continued improvement. The key elements include more accurate, comprehensive, and trustworthy advising as well as evaluation resources and changes regarding application filters that unwittingly disadvantage applicants. From a just healthcare and workforce perspective, the critical need in primary care and other specialties with projected shortages are also important considerations. The need to improve care in medically underserved rural and urban settings requires prompt attention to those recommendations that remove systemic biases, reduce learner indebtedness, and further enhance wellness.

Pros/cons #3: comprehensiveness and transparency, but at the cost of being overwhelming

The UGRC took on a detailed review of a complicated, multifaceted problem and outlined and documented its process in the comprehensive report and the supplemental materials provided. From the preliminary work documenting the inclusive nature of the nominations process, to the sharing of the Ishikawa diagrams documenting the potential causes of the challenges to the current transition system, and the extensive appendices provided, interested stakeholders can gain a sense of the rigor of the debate and the UGRC's work as well as the complexities before us. At the same time, stakeholders external to the UGRC work who have been standing up admirably to the enormous challenges and uncertainty in supporting learners, faculty, and patients brought on by the COVID-19 pandemic may be overwhelmed by the comprehensiveness of the report. The opportunities to demonstrate "early wins" with progress in several of the recommendations already (e.g., virtual residency interviews in 2020 and 2021 due to pandemic risks and potential improvements in equity) since the release of the report are positive. In addition, there were efforts by the UGRC to provide some bundling, sequencing, and prioritization across the 34 recommendations to assist stakeholders

as they seek to implement the UGRC recommendations. However, the report did not rank the impact of the recommendations, which could lead to lead to low-impact, low-effort changes happening and high-impact, high-effort changes being set aside.

Pros/cons #4: continuous learning/ growth mindset but how can we reduce application inflation?

The emphasis on competency-based education across the continuum, including the need to instill in learners a growth mindset and the habits necessary for continuous lifelong learning, allows for individual trainee growth and the development of a culture supporting an adaptable physician workforce. Holistic review of applicants and a learner handoff during the UME-to-GME transition are related aspirational goals supported by many people. However, a key tension in the transition to residency is difficulty differentiating among different applicants or programs given the overwhelming application burden. If unaddressed, application burden may instead incentivize the development and use of assessments in an inappropriately normative framework, contrary to the ideal state vision presented by the UGRC recommendations. One positive note is the call to explore ways to limit the numbers of interviews an applicant needs to complete and the innovations implemented to reduce the overall number of applications for most applicants.

Pros/cons #5: reduce educational indebtedness, improving wellness

Several recommendations, if implemented, will likely save learners and others money. Needless duplication of expenses related to applications and interviews, test prep, and redundant assessments for certain learners, add to the financial stress, indebtedness, and further anxieties in the transition. Helping learners financially and instituting standards for dedicated time for relocation/transition should help wellness. However, it is not completely clear who would fund some of the initiatives, and many stakeholders may be concerned with budgetary implications ultimately becoming counterproductive if they lead to increased tuition and educational indebtedness. In addition, the financial challenges remain more significant for some than for others, which is a contributing source of inequity in the current system.

Pros/cons #6: the almighty power (and perils) of pilots

Innovations via pilots were recommended to address the problem of application inflation, which is one of the most acute problems driving the need for the UGRC. Pilots are a reasonable approach to the lack of outcome data in the context of the application process, which remains high-stakes for each graduating class of students. Pilots would allow individual specialties and organizations to collect data during a single application process and potentially correct course before substantial numbers of applicants or programs are affected. Additionally, successful processes will be able to collect data prior to broad implementation. However, pilots are by design only exploratory and will not improve the process for most applicants right away. Given the financial expense and emotional cost of the current system, applicants could suffer by waiting for the perfect solution when a good solution would suffice. Also, pilots naturally worsen the fragmentation that has been identified as a root cause of significant dysfunction in the UME-GME transition. If different solutions are identified for different specialties, the fragmentation could worsen and create problems for applicants in special categories, e.g., dual-specialty applicants or couples-match applicants.

Pros/cons #7: individualism vs. collectivism in specialty-specific vs. common framework of competencies and competency expectations

Related to the pros and cons of pilots described above, the focus on specialty-specific language allows individual specialties to adjust according to the unique aspects of their field. Shared competency frameworks that allow additional domains or skills important to certain specialties or educational pathways (e.g., osteopathic medical schools) can live together in this space, and they are consistent with the coalition's Consensus Statement for a Framework on Physician Competence [4]. Although this is

widely valued as a pro, there could be unintended consequences.

Ensuring that there is a specialty-specific component to faculty development, developmental milestones, and other materials is essential to making them usable and actionable. However, the specialty specificity must be balanced. The goal of UME is to create an undifferentiated DO or MD graduate, respectively. A focus on specialty-specific language fragments the implementation of change and threatens to further existing inequities across subspecialties. Some cultural aspects of specialties may need to change in response to community needs, such as equity and wellness. Additionally, learners and faculty do not function in a vacuum. Given that they spend time together, it will be best if there is some amount of alignment of the language and process while valuing parallel processes. However, our nation's 200 different DO- and MD-granting medical schools, for example, highly value the autonomy they are currently provided with their educational and assessment programs, and they are generally not enthusiastic about increased standardization or regulatory frameworks that they perceive will limit that autonomy and/or increase costs. In contrast, the over-10,000 GME programs in the United States have come to embrace the shared mental models of competency provided by the ACGME Milestones project and the coalition's competency consensus statement. Challenges inherent in the uses of summative assessments in a formative manner and the ideal of fostering a growth mindset contributing to true competency-based medical education present true tensions in this work.

Conclusions

Throughout the UGRC's work, it became clear that there are many opportunities for improvement and that there are considerable concerns about changes that are not fully understood or potentially lead to unintentional consequences. The connection to the system of education and formation of physicians to a more just healthcare system, with attention to diversity, equity, and inclusion to improve health disparities, and to the quality of care that patients receive, became increasing clear as the UGRC delved deeper into their work. Further debate and discussion are warranted, without undue delay, all with the intention to continue to improve and care for the patients who we have the privilege to serve.

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Competing interests: None reported.

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