The Orphaned Resident and Graduate Medical Education Program Closures

Ryan J. Keneally, MD
Harold A. Frazier, MD

Program directors (PDs) will sometimes receive a heartbreaking email from a well-qualified resident who is searching for a new position due to their program's closure. If a PD can add a trainee to their program, this scenario can become a feel-good story. However, this also reveals the unattractive graduate medical education (GME) problem of "orphan residents," trainees in good standing who must suddenly find another program, institution, specialty, or location for training. In 2019 the closure of Hahnemann University Hospital (HUH) raised awareness of the vulnerability of orphaned residents.[1] This event made transparent the conflict between institutional financial interests and a duty to trainees.[2] Leaders in the GME community met the HUH crisis with pragmatic solutions.[3] Each year since HUH's closure there continues to be a small but consistent number of US Accreditation Council for Graduate Medical Education (ACGME)-approved program closures[4] (TABLE). Today, despite the impetus for change as a result of the HUH closure, orphaned residents remain vulnerable to major disruptions to their training. In this article we discuss the duty of institutions to trainees.

Institutions have a responsibility to trainees affected by a program closure, but their responsibility is ill-defined. Per the ACGME's Institutional Requirements (IRs), when a program is closed: "the sponsoring institution must inform… affected residents/fellows as soon as possible" and "allow… to complete their education at the sponsoring institution, or assist them in enrolling in (an)other ACGME accredited program(s)…"[5] The requirement to "assist" is vague and does not address institutional financial responsibilities regarding assistance. When a program closes, the transfer of Center for Medicare & Medicaid Services (CMS) funding for trainees is governed by Public Law 111-148, the Patient Protection and Affordable Care Act, section 5506, Preservation of Resident Cap Positions from Closed Hospitals (PL111-148). The law states a priority for reallocation of institutional cap positions but does not address how affected residents will be treated.[6] Understandably, the law does not address institutional financial responsibility when the institution's total number of trainees is greater than their CMS cap. Trainees remain subject to the whims of their institution with current ACGME requirements and CMS law.

Imagine if trainee A, whose program is scheduled to be closed, is offered a spot in another specialty within the same institution. What if trainee A does not wish to change specialties? Through this offer of an alternate training spot, the institution may have met its responsibility under the IRs. The institution could be absolved of any responsibility if trainee A did not accept the offer. If there was a training spot in trainee A's chosen specialty available at another institution, the gaining institution would have to fund training. The likelihood of finding an available, funded training spot in some specialties is exceptionally low. What if trainee A also had a mortgage to pay and/or dependents to support? Further, the requirement to inform trainees of closure "as soon as possible," without further specification of a notification period, could leave trainees with insufficient time to find other positions. The pressure to accept a training spot in a different specialty at the same institution may become overwhelming. In this scenario, the institution met the requirement to "allow" this trainee "to complete their education," but was that really "their" education if it was not the training education initially promised by the institution? Who defines what "their education" means? In this situation resident A is vulnerable to coercion. The institution holds the power to define "their education." Financial regulations related to the cap do not apply in this situation.

Imagine a different scenario. What if trainee B quickly found a new training program in their desired specialty at another institution, but their prior institution refused to pay their salary and/or benefits to the institution gaining this resident? How is the lower limit of "assisting them in enrolling" defined? Could "assisting" be merely sending the requisite paperwork for a transfer without a funding transfer? If the original institution is over the CMS cap, issues related to The Patient Protection and Affordable Care Act will

DOI: http://dx.doi.org/10.4300/JGME-D-24-00809.1

TABLE
Program Closures 2019 to 2024

Academic Year	No. of Program Closures (% of Total Programs)	Total No. of Programs
2023-2024	50 (0.4)	13 393
2022-2023	52 (0.4)	13 066
2021-2022	34 (0.3)	12 740
2020-2021	40 (0.3)	12 420
2019-2020	63 (0.5)	12 092

Note: Data is from the Accreditation Council for Graduate Medical Education Data Resource Book for academic years 2019-2020 to 2023-2024.[4]

also be avoided here. The trainee could become stuck in the middle of an institutional standoff. What if the original institution then attempts to resolve the situation by arranging for a different, new program to accept the trainee, without the trainee's input? Trainee B could be given an ultimatum: accept the arranged training spot, or no support would be transferred to the new program. This scenario could involve moving away from the resident's current life and support system, as large multi-state health care systems continue to grow.

In both scenarios, the institution with the closing program may have met its requirements, given the language in the current ACGME IRs. With variable interpretations of the IRs, institutions hold significant coercive power over orphaned residents. In either of the above cases, resident unions would be unlikely to provide much assistance. The available union tool is legal action, which may be protracted as well as potentially unsuccessful. In both scenarios, the institution has a significant financial interest in the outcome. The only course of action for the orphaned resident, other than to accept the dictate of the institution with the closing program, is to reapply through the Match process for a training spot beginning several months to over a year later. In our opinion, the ACGME needs to better define its IRs in order to protect orphaned residents.

The ACGME could amend the IRs in 2 ways. First, remove the language stating that institutions can offer a trainee a spot in another specialty at their institution to meet the requirement. Institutions can still offer this if a resident *wishes* to change specialty, but the IRs language should not include this as an unqualified option. For highly competitive or small specialties it is often challenging to find a training spot in the same specialty in which the resident initially matched. Thus, the requirement should not be specialty-specific. Rather, the requirement should read: "to complete their education *in the specialty of the resident's choice among ACGME-accredited available training spots*."

Second, the IRs needs to define the floor of "assist them in enrolling" in another program, by defining the minimum financial support that must accompany the orphaned resident. The ACGME does not need to dictate adjustment of the flow of CMS funds and cap readjustment but should address the ethical responsibilities of institutions offering ACMGE-approved training positions. If a resident's training program is closed, *the institution should be required to pay the full salary and benefits of any ACGME training program that accepts the orphaned resident* for the duration of the remaining training, determined by the length of their original training program. While this may involve substantial costs for large residency programs, the institution has an ethical responsibility to the residents it recruited for training. In comparison, trainee costs (eg, moving, partner/spousal loss of job, etc) may be proportionally higher.

In summary, the degree of sponsoring institution responsibility in the current ACGME's IRs is too low. Orphaned residents are especially vulnerable because they are in a highly structured labor market. The Patient Protection and Affordable Care Act does not protect individual trainees. No union can provide timely protection. The possibility of adverse action by the ACGME, such as withdrawal of institutional accreditation, may be the best way to enforce a requirement to protect orphaned residents.

References

1. Orlowski JM, Thompson T. Lessons to learn from Hahnemann University Hospital's closure. *Acad Med*. 2020;95(4):509-511. doi:10.1097/ACM.0000000000003170
2. Aizenberg DJ, Logio LS. The graduate medical education (GME) gold rush: GME slots and funding as a financial asset. *Acad Med*. 2020;95(4):503-505. doi:10.1097/ACM.0000000000003133
3. Berns JS, Coull S, Paskin D, Spevetz A, Boyer WC. Reflections on a crisis in graduate medical education: the closure of Hahnemann University Hospital. *Acad Med*. 2020;95(4):499-502. doi:10.1097/ACM.0000000000003156
4. Accreditation Council for Graduate Medical Education. ACGME Data Resource Book. Accessed January 29,

2025. https://www.acgme.org/about/publications-and-resources/graduate-medical-education-data-resource-book/
5. Accreditation Council for Graduate Medical Education. ACGME Institutional Requirements. Accessed February 3, 2025. https://www.acgme.org/globalassets/pfassets/programrequirements/800_institutionalrequirements2022.pdf
6. Patient Protection and Affordable Care Act (PPACA), Pub L No. 111-148, 124 Stat. 119 (2010).

Ryan J. Keneally, MD, is Vice Chair for Education, and an Associate Professor, Department of Anesthesiology and Critical Care Medicine, The George Washington University, Washington, DC, USA; and **Harold A. Frazier, MD,** is an Emeritus Professor of Urology, Department of Urology, The George Washington University, Washington, DC, USA.

Corresponding author: Ryan J. Keneally, MD, The George Washington University, Washington, DC, USA, ryankeneally@outlook.com