The results from this year’s medical student match for orthopaedic surgery show a large number of unmatched applicants: 1470 applicants for the 875 available positions [1]. Given that about 40% of those who applied did not match this year, next year may have a record number of reapplications—but not all of those reapplications will be equal. Some of next year’s applicants will have numeric USMLE Step 1 scores [2], while others will not thanks to the COVID-19 era, initially curtailing clinical rotations, as well as restricting any away rotations for medical student education by nonessential activities. As a result, the Medical Examiners and the Federation of State Medical Boards to change these scores to pass/fail. Programs should prepare for how they might approach next year’s match given this key scoring change. Questions abound: How can programs distinguish between candidates with scores and those without? Given the limitations of the COVID-19 era, how can residency directors determine who might be a good match for their programs? What additional curveballs should we expect?

What Has Changed?

Before making predictions about next year’s match cycle, it’s important to review how medical student education and applications for residency have evolved in the past couple of years.

First, the COVID-19 pandemic restricted medical student education by initially curtailing clinical rotations, as well as restricting any away rotations for students [3]. One could argue that the separation of medical students from clinical rotations and declaring students “nonessential” has resulted in voids of both education and professional development [6]. Second, the interview process remains mostly virtual, resulting in many medical students not visiting the location where they might train. Both of these changes have made it difficult for program directors and medical students to get to know one another, particularly for medical students who are looking outside of their home institutions. Less interaction between the medical student and the residency program directors also impacts applicants who did not rotate because programs generally gravitate toward those who showed a genuine interest in the program by taking a visiting orthopaedic surgery rotation. Finally, the move from numeric USMLE Step 1 scores to pass/fail in early 2022 cannot be understated [2]. Most medical students take the USMLE Step 1 exam while they are finishing up their second year of medical school or starting their third year. For this next cycle, most applicants will have numeric scores, but the results of others will be reported only as pass/fail. In an attempt to offset the loss of scores, and to allow programs to get a more holistic view of the applicant, the Association of American Medical Colleges (AAMC) and the Electronic Residency Application Service (ERAS) have implemented new measures for the application process [4]. Unfortunately, I don’t think those new measures will help much.

New Changes, Same Problems

To offset the transition from numeric USMLE Step 1 scores to a pass/fail
system beginning the next selection cycle [2], AAMC/ERAS trialed a supplemental application during this last match cycle with three specialties: dermatology, general surgery, and internal medicine. The supplemental application consisted of: (1) geographic preference for training by the student; (2) rural versus urban training site preference; (3) description of up to five clinical, volunteer, or research experiences; and (4) signaling a desired program (up to five for general surgery and internal medicine) of interest in that program [4]. Supplemental questions, specific to each program, are a way to discern the level of interest a candidate may have for a specific program.

The AAMC/ERAS asked program directors within those specialties to complete a survey about the supplemental application [5]. Based on the survey responses, program directors found the supplemental application underwhelming. For instance, only 27% of the program directors in general surgery felt that the clinical, research, or life experiences portion of the application was useful for an initial holistic application review. Additionally, 22% of those surveyed felt that this section influenced their decision to invite an applicant for an interview. Furthermore, only 18% of program directors felt that the supplemental application added to the ERAS application; 24% felt it added to the personal statement.

Signaling is even more problematic. This year, students listed up to five preferential programs or declined to participate. Programs could not see whether an applicant participated in signaling, only whether an applicant signaled their program. Although 55% of the program directors in general surgery thought the signaling portion of the supplemental application was useful as a screening tool, only 17%, according to the survey, factored in applicant signaling when sending interview invitations [3].

Despite the apparent lack of utility, AAMC/ERAS are moving forward with plans to expand the number of programs using the supplemental application next year. And next year, students applying to orthopaedic programs will be able to signal up to 30 programs.

**Looking Ahead**

From a resident selection standpoint, the underwhelming supplemental applications and the increase in virtual interviews likely means that the resident selection committees will gravitate toward better-known applicants who indicate an interest in their program, either by an in-person rotation or some other means. Typical candidates (meaning candidates with an application perceived to be about average) may have a tougher time making their way to the upper reaches of rank-order lists because of the severe mismatch in terms of the number of candidates to the number of positions in orthopaedic surgery, assuming the numbers are similar to this year [1].

Because nearly 40% of this year’s applicants did not match, programs should review how they promote their specialty and how they counsel or mentor medical students. That said, the mismatch with applicants and available positions was not confined to orthopaedic surgery, and so the problem of mentoring and counseling medical students may be more widespread among medical education.

Whether this is an exceptional year because of pandemic-related restrictions or a gradual erosion of faculty interactions remains to be seen. Either way, we need to do better. Orthopaedics departments within a medical school have an obligation to provide quality education, become a beacon for the specialty within the school, and to review students who are interested in their specialty. This means spending time with the students, providing a clinical curriculum, and mentoring, including assisting students in preparing their residency applications.

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