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Editorial

The Case for Reforming VSLO Eligibility and ERAS Screening to Address the Declining Representation of US Citizen International Medical Graduates in Orthopaedic Surgery

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In our work with medical students preparing for the orthopaedic surgery residency match, we have observed a specific structural pattern affecting US citizen international medical graduates (US-IMGs) that has drawn insufficient policy attention. The share of matched US-IMG orthopaedic surgery residents has declined from 0.94% in 2008 to 0.66% in 2024, even as the US osteopathic share expanded more than fortyfold following the 2020 accreditation merger. In this clinical opinion article, the authors argue that two targeted structural reforms would meaningfully advance orthopaedic surgery's stated commitment to workforce diversity: broadening AAMC Visiting Student Learning Opportunities (VSLO) US Network eligibility to accredited Caribbean medical schools, and disaggregating US citizen IMGs from non-US IMGs in the ERAS applicant-type field.

INTRODUCTION

In our work advising and mentoring medical students seeking orthopaedic surgery residency, we have repeatedly encountered a specific pattern. US citizen international medical graduates who complete their preclinical training at established Caribbean medical schools and their clinical clerkships at ACGME-accredited US teaching hospitals face a distinct set of structural barriers that differ meaningfully from those facing either non-US IMGs or US MD applicants. These barriers persist despite measurable equivalence on nearly every relevant metric of applicant quality.

Orthopaedic surgery is one of the least demographically diverse specialties in United States medicine (Day et al. 2019; Silvestre et al. 2024). Between 2008 and 2024, the share of matched US orthopaedic surgery residents who trained as US citizen international medical graduates (US-IMGs) fell from 0.94% to 0.66% (Tyagi et al. 2024). Over the same period, the matched US osteopathic (DO) share climbed from 0.31% to 13.97% after the 2020 single accreditation system merger (Tyagi et al. 2024). Both groups occupy the broader category of non-MD applicants to a highly competitive specialty, yet only one has expanded.

This divergence is not attributable to differences in applicant quality. Matched US-IMGs publish approximately

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Conflicts of Interest Statement for Robert Atkinson

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three times as many manuscripts as matched US MD seniors (Hoveidaei et al. 2024). What separates the two pathways is not measurable applicant performance but structural: the DO pathway underwent policy-level reform in 2020, while the US-IMG pathway has not.

In this opinion article, we argue that two targeted reforms would address the largest structural barriers documented for US citizen IMG applicants and produce measurable change in access to orthopaedic surgery residency: first, broadening VSLO US Network eligibility to include accredited Caribbean medical schools; and second, disaggregating US citizen IMGs from non-US IMGs in the ERAS applicant-type field.

THE 2020 DO MERGER AS PROOF OF CONCEPT

The 2020 single accreditation system merger (Accreditation Council for Graduate Medical Education, n.d.) dissolved the parallel match system that had previously separated DO graduates from the main ACGME residency competition. In the five years since, the matched DO share of orthopaedic surgery residents rose forty-fold (Tyagi et al. 2024). The merger functions as a natural experiment for the effects of policy-level structural reform on a non-MD pathway to a highly competitive specialty.

The merger did not lower any specialty's standards, nor did it obligate any program to accept a DO applicant. It removed a categorical structural barrier — the existence of a separate match — and allowed programs to evaluate DO applicants alongside MD applicants on individual merit. The subsequent expansion demonstrates that barriers to non-MD applicants in orthopaedic surgery can be substantially reduced when the barrier is addressed at the accreditation and match architecture level rather than at the level of individual applicant behavior.

To date, no reform of comparable scale has been directed at the specific structural barriers that shape the US-IMG pathway. This is despite the fact that US citizen IMGs share many of the characteristics that motivated engagement with the DO population: they are US citizens or permanent residents, they complete their clinical training at ACGME-accredited US teaching hospitals, they do not require visa sponsorship, and they enter the same match as US allopathic and osteopathic graduates. In our observation, the transformative effect of the merger on the DO pathway makes the absence of any comparable reform for the US-IMG pathway increasingly difficult to defend.

THE STRUCTURAL NATURE OF THE BARRIERS

Four structural barriers specifically disadvantage US-IMG applicants to orthopaedic surgery residency. In our conversations with applicants navigating this pathway, these barriers appear consistently, regardless of individual applicant qualifications or effort. They are institutional, not personal.

The *absence of a home orthopaedic department* at Caribbean medical schools cuts US-IMG applicants off from the mentorship, research infrastructure, and departmental introductions that US MD students access by default. Students at institutions with a home surgical residency program have been shown to be 1.76 times more likely to match into a surgical specialty than students without one (Manhas et al. 2024), and mentorship from orthopaedic faculty ranks as the most important selection factor in the 2024 NRMP Program Director Survey (National Resident Matching Program 2024).

Exclusion from the AAMC Visiting Student Learning Opportunities (VSLO) platform restricts US-IMG access to the away rotations that program directors use to evaluate applicants directly. The US Network is limited to LCME- and COCA-accredited schools; the Global Network is intended for foreign nationals (Association of American Medical Colleges 2025b). Caribbean medical schools do not function as VSLO Home institutions in practice, leaving US-IMG applicants to arrange rotations through fragmented direct-application pathways at substantially higher per-rotation fees than US MD students.

Categorical ineligibility for Alpha Omega Alpha (AOA) honor society membership flows from the AOA constitution, which permits chapters only at LCME-accredited medical schools (Alpha Omega Alpha Honor Medical Society 2025). The ERAS application asks about AOA membership; for US-IMG applicants the field is empty by definition. At programs that use the AOA field as a screening filter, US-IMG applications can fail to reach holistic review regardless of their content.

Reputational bias attached to Caribbean medical school origin operates through perception rather than through formal policy. The clearest evidence is indirect and appears in asymmetries of research productivity: matched US-IMGs publish approximately three times as many manuscripts as matched US MD seniors (Hoveidaei et al. 2024), evidence of a higher effective threshold for demonstrating competitiveness (MacLeod et al. 2025). Applicants we have advised describe a persistent sense that their credentials are being read through the lens of school origin rather than individual merit — a perception reinforced by ERAS classification fields that treat US citizen IMGs and non-US IMGs as a single category.

TWO REFORMS WITH IMMEDIATE PRECEDENT

The barriers described above operate through mechanisms modifiable at the policy or institutional level. Two reforms in particular would directly address the largest of them. In our view, both reforms are notable for what they would not require: they would not lower any standards, alter any program's admissions criteria, or obligate any program to accept any individual applicant.

First, VSLO US Network eligibility should be extended to US citizens and permanent residents attending WFME-accredited and NCFMEA-recognized international medical schools (World Federation for Medical Education, n.d.; US Department of Education, n.d.). This reform would allow US-IMG applicants to access orthopaedic away rotations on terms comparable to those available to US MD and DO students. Importantly, this reform would not obligate any program to accept an individual US-IMG applicant; it would

simply allow programs to evaluate candidates through in-person clinical performance rather than through a binary signal of accreditation type.

Second, the ERAS applicant-type field should separate US citizen IMGs from non-US IMGs (Association of American Medical Colleges 2025a). The current grouping causes programs that use this field to filter on visa-related concerns to inadvertently exclude US citizens whose visa status is not actually at issue. This is a data-architecture change, not a program-level policy change, and it would allow existing screening practices to function more precisely.

Both reforms have identifiable institutional owners: the AAMC for VSLO eligibility, and the ERAS platform for the applicant-type field. Both operate at the architectural level that the 2020 DO merger has demonstrated can produce rapid change in access to competitive specialties.

CONCLUSION

The barriers facing US-IMG applicants to orthopaedic surgery reside in the architecture of the application process rather than in applicant merit. The 2020 MD-DO accreditation merger stands as proof of concept that comparable structural reform in this specialty is capable of producing rapid change. Two targeted reforms of the same character — one to VSLO eligibility, and one to the ERAS applicant-type field — would directly address the largest structural barriers documented for the US-IMG pathway and would meaningfully advance the specialty's stated commitment to workforce diversity.

In our observation, the specialty has repeatedly expressed a commitment to workforce diversity through position statements, task forces, and diversity initiatives. Yet no comparable investment has been made in the structural reform of the pathway that produces one of the most measurable and least-examined disparities in the current match. The specialty and its supporting institutions have both the tools and the precedent to act.

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