Myth-Busting Cards

Eight priority misconceptions — with the facts and why getting them right matters

MYTH 1 of 8

The ACGME runs the Match.

THE FACT

The National Resident Matching Program (NRMP) administers the Main Residency Match and the processes that pair applicants with residency and some fellowship positions. The Accreditation Council for Graduate Medical Education (ACGME) has no role in operating matching services. The ACGME sets the educational and clinical training standards that programs and institutions must meet to be accredited; it does not manage, control, or participate in the mechanics of placing applicants into those programs. In addition to the NRMP match, some specialty-specific matches are also administered by separate organizations. When the Match is scrutinized — for antitrust concerns, rule changes, or process questions — the relevant organization is the NRMP.

WHY IT MATTERS: *This is the most common misattribution in congressional and media discussions of the graduate medical education (residency and fellowship education) system. It has driven misdirected legislative proposals and led to the ACGME being questioned about decisions and processes it has no role in making.*

MYTH 2 of 8

The ACGME sets resident/fellow pay and controls working conditions.

THE FACT

Resident and fellow compensation, benefits, employment contracts, and working conditions are determined by teaching hospitals, health systems, the VA, and other employers that host graduate medical education (GME) programs. These are Human Resources and labor decisions made by institutions. The Accreditation Council for Graduate Medical Education (ACGME) sets educational standards and expectations for educational structure, such as work hour limits and supervision rules, but it does not set wages, dictate contract terms, or manage staffing models. Operational decisions belong entirely to Sponsoring Institutions as the employers of resident and fellow physicians.

WHY IT MATTERS: *Residents/fellows with employment concerns sometimes contact the ACGME; policymakers focused on resident/fellow labor conditions sometimes target accreditation rather than employment law or institutional policy. Employment accountability runs to institutions, not to the ACGME.*

MYTH 3 of 8

Because the ACGME is the only accreditor for residency/fellowship programs, it functions like a monopoly with market control over physicians.

THE FACT

The ACGME is a private, not-for-profit body that sets and enforces education and training standards, which are written by Review Committees comprised of practicing physicians, resident/fellow members, and public representatives. These standards are posted for public review and comment prior to implementation. One national standard means a physician trained anywhere can be trusted everywhere, which is the purpose of accreditation. The ACGME does not employ physicians, set wages, run the Match, control physician supply, or decide how many residency positions exist or are funded. Those functions are distributed across Congress, The Centers for Medicare and Medicaid Services (CMS), the National Resident Matching Program (NRMP), and teaching hospitals. One national standard supports consistency and portability: the same baseline training expectations apply whether a physician trains in a rural community hospital or a major academic medical center.

WHY IT MATTERS: *The 'monopoly' framing has appeared in congressional investigations and antitrust advocacy, often conflating the ACGME with other entities in the system and overstating its operational reach.*

MYTH 4 of 8

The ACGME licenses doctors.

THE FACT

The Accreditation Council for Graduate Medical Education (ACGME) does not license anyone. Medical licenses are issued by state medical boards – separate government bodies operating under state law. A physician must hold a valid state license to see patients, prescribe medications, or perform procedures. The ACGME accredits graduate medical education (GME) programs (residencies/fellowships) and the institutions that sponsor them; state medical boards license individual physicians. These are entirely separate functions with entirely separate authorities. Complaints about individual physician conduct belong with the relevant state medical board.

WHY IT MATTERS: *Patients and policymakers who believe the ACGME licenses physicians direct complaints and inquiries to the ACGME about individual physician conduct, matters that are entirely outside the ACGME's jurisdiction.*

MYTH 5 of 8

Graduating from residency means you are board certified.

THE FACT

Residency graduation and board certification are separate achievements governed by separate organizations. Completing an Accreditation Council for Graduate Medical Education (ACGME)-accredited residency program makes a physician eligible to sit for the relevant specialty board examination but does not confer certification. Board certification requires passing an exam administered by the relevant American Board of Medical Specialties member board, American Osteopathic Association, or other specialty certifying body, meeting other eligibility requirements, and maintaining continuing certification requirements, if applicable. Some physicians practice without board certification; many hospitals require it for credentialing and clinical privileges.

WHY IT MATTERS: *This distinction matters for patients evaluating physician qualifications and for policymakers writing insurance or hospital participation rules. Certification accountability runs to the applicable certification body, not to the ACGME.*

MYTH 6 of 8

The ACGME controls how many doctors the U.S. produces.

THE FACT

The Accreditation Council for Graduate Medical Education (ACGME) does not set caps on the number of residency or fellowship positions or determine physician supply. Accreditation standards address educational quality, not the quantity of trainees. The primary constraint on residency capacity is the federal graduate medical education (GME) funding cap established by the Balanced Budget Act of 1997, which limits the number of resident positions CMS will fund at each teaching hospital. That cap is set by Congress and administered by the Centers for Medicare & Medicaid Services (CMS). Individual programs determine how many positions to apply for accreditation for, and how many positions to offer through the relevant match program. The ACGME can accredit new and expanded programs if they meet standards; it cannot create the funded positions needed to make expansion financially viable.

WHY IT MATTERS: *Advocates addressing physician workforce shortages sometimes target ACGME accreditation as an obstacle. The actual policy lever is the federal GME funding cap — a Congress and CMS issue. Correctly understanding this distinction is essential for effective health workforce advocacy.*

MYTH 7 of 8

Accreditation is controlled by large, elite institutions.

THE FACT

Standards are set by Review Committees of practicing physicians drawn from a range of programs and settings, not only large research centers. Committees include resident members, every member discloses conflicts of interest, and proposed standards go through an open public comment period before the ACGME Board, which includes resident and public members, gives final approval. A rural community program and a major academic center are held to the same floor, or minimum standards .

MYTH 8 of 8

Accreditation is never really enforced, so the standards do not mean much.

THE FACT

Accreditation is continuous oversight, not a one-time stamp. Accredited institutions and programs submit data every year and are visited on a schedule. When an institution or program falls short, the ACGME may issue citations and require corrective action, and can place the institution or program on warning or probation, or withdraw its accreditation. Every accredited institution and program and its current accreditation status are listed in a public, searchable database.