

White Paper on Medical Education and Students

Understanding and Shaping the Medical
Career Pathway in Switzerland



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DES
DOYENS**



SMIFK CIMS

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Joint Commission of the Swiss Medical Schools JCSMS

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swiimsa

Swiss Medical Students Association
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Introduction and Purpose

Medical training – from the first year of undergraduate study at the universities to the completion of graduate education under the guidance of the Swiss Institute for Postgraduate and Continuing Medical Education (SIWF/ISFM) and specific medical societies – has long been a source of pride in Swiss medicine, often cited as a model to emulate. Thanks to the reform of medical education in the 1970s, the Swiss model introduced students earlier to clinical practice and quickly placed them in positions of responsibility. The goal was to train young doctors with a high degree of decision-making autonomy, ensuring that by the end of their training, they would be capable of managing patients independently across all specialties.

Over the past few decades, demand for medical care has increased substantially; this was driven not only by demographic ageing, the growing prevalence of chronic disease, and the significant expansion of treatment options, but also by increasingly regulated working hours that reduce the overall clinical capacity per physician. However, training capacities have not expanded sufficiently to meet this growing need. This trend persists despite technological advancements such as artificial intelligence (AI) and a shift toward sustainable healthcare.

In parallel, the healthcare system has undergone profound structural changes. Hospitals and their service portfolios have expanded continuously along with the number of specialties and subspecialties, and the number of doctors employed in hospitals has risen accordingly. Similarly, the gradual shift from the hospital sector to outpatient care will require further adaptation of medical resources. However, this growth has not been matched by a proportional increase in graduates from Swiss universities, leading to a steadily expanding share of foreign-trained physicians. These developments are unfolding within a healthcare system that is becoming ever more complex and financially constrained.

Although the demand for outpatient and inpatient care continues to grow, medical education has not kept pace, and the resulting shortage of doctors is likely to intensify – both in hospital wards and in private practice. Recent statistics show a worrying trend: an increasing number of young residents are leaving the profession prematurely or interrupting their training for extended periods. The new collective agreement for resident and senior physicians, with its clearer regulation of working hours, represents an important step forward. However, it does not resolve the underlying structural problems and may even introduce new challenges, such as discontinuities in patient care and the attendant frustration among young physicians. Moreover, the clinical environment continues to burden residents with an increasing volume of administrative tasks that often do not require medical expertise.

Medical education remains a central pillar of the Swiss healthcare model. The critical question today is not whether this pillar still exists, but whether it is being actively shaped to meet the demands of a growing, increasingly complex, and resource-constrained healthcare system.

Are students being selected appropriately, and in sufficient numbers? Are we truly training them not only to be good students, but also to become skilled doctors with the resilience needed to face difficult and challenging scenarios? And are hospitals, outpatient health care centers and private practices still able to provide adequate and sufficient training to a new generation of physicians, now that the baby boomer generation is gradually leaving the workforce?

These and other fundamental questions concerning the future of Swiss medical training can no longer be deferred and require coordinated, evidence-based responses across all phases of medical education. Recognizing their urgency, the Collège des Doyens, the Joint Commission of the Swiss Medical Faculties

(SMIFK/CIMS), the Swiss Institute for Postgraduate and Continuing Medical Education (SIWF/ISFM), the Swiss Association of Resident and Senior Physicians (vsao/asmac) and the Swiss Medical Students' Association (swimsa) have resolved to address them in depth, to contribute to the ongoing debate and provide substantive insights and recommendations to the relevant technical and political working groups.

The medical training period considered in this white paper encompasses admission to medical studies, the structure of medical studies, and what is now referred to as the transition phase – namely, the preparation of students for their future professional practice. It is structured in three parts: the first presents a descriptive overview of the current situation; the second provides a critical assessment of the status quo; and the third sets out recommendations for future action.

This document is the full version, including all sources and references consulted. A summarized version exists for broader dissemination.

Note on the Use of Language and Editorial Tools:
Throughout the development of this white paper, the authors employed advanced digital tools, including artificial intelligence–based systems, to assist in articulating, organising, and refining the manuscript.

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List of Abbreviations	AI	Artificial Intelligence
	AMCAS	American Medical College Application Service
	BFS	Bundesamt für Statistik / Office fédéral de la statistique (Federal Statistical Office)
	BMAT	Biomedical Admission Test
	BMed	Bachelor of Medicine
	CanMEDS	Canadian Medical Education Directions for Specialists
	CBME	competency-based medical education
	CEO	Chief Executive Officer
	cf.	confer
	CMO	Chief Marketing Officer
	CR	Competencies & Roles
	e.g.	exempli gratia (for example)
	ECTS	European Credit Transfer System
	EDI	Eidgenössisches Departement des Innern / Département fédéral de l'intérieur (Federal Department of Home Affairs)
	EEA	European Economic Area
	EFTA	European Free Trade Association
	EMS	Eignungstest für das Medizinstudium / test d'aptitudes pour les études de médecine (Aptitude Test for Medical Studies)
	EPAs	Entrustable Professional Activities
	ERI	Education, Research and Innovation
	et al.	et alii / et aliae
	etc.	et cetera
	ETH	Eidgenössische Technische Hochschule Zürich / École polytechnique fédérale de Zurich (Federal Institute of Technology Zurich)
	EU	European Union
	f.	and the following page
	ff.	and the following pages
	FMH	Foederatio Medicorum Helveticorum (Swiss Medical Association)
	GPA	Grade Point Average
	HFKG	Hochschulförderungs- und -koordinationsgesetz / Loi sur l'encouragement et la coordination des hautes écoles (Higher Education Funding and Coordination Act)
	ibid.	ibidem (in the same place)
	IC – MD	Interactional Competencies – Medical Doctors
	IMAT	International Medical Admission Test
	L.AS	Licence Accès Santé
	MCAT	Medical College Admission Test
	MEBEKO	Medizinalberufekommission / Commission des professions médicales (Federal Commission for Medical Professions)
	MedAT-H	Medizinischer Aufnahmetest
	MedBG	Medizinalberufegesetz / loi sur les professions médicales (Medical Professions Act)
	MedReg	Medizinalberuferegister / Registre des professions médicales (Register of Medical Professions)
	mfe	Haus- und Kinderärzte Schweiz / Médecins de famille et de l'enfance Suisse (Swiss Association of Family and Paediatric Physicians)
	MMed	Master of Medicine
	MMIs	Multiple Mini Interviews
	n.d.	no date
	NC	Numerus Clausus
	OSCEs	Objective Structured Clinical Examinations
	PASS	Parcours d'Accès Spécifique Santé
	PBL	Problem-Based Learning
	PET	Psychometric Entrance Test
	PROFILES	Principal Relevant Objectives and Framework for Integrative Learning and Education in Switzerland
	SCLO	Swiss Catalogue of Learning Objectives
	SIWF/ISFM	Schweizerisches Institut für ärztliche Weiter- und Fortbildung / Institut Suisse pour la formation médicale postgraduée et continue (Swiss Institute for Postgraduate and Continuing Medical Education)
	SJTs	Situational Judgemental Tests
	SMIFK/CIMS	Joint Commission of the Swiss Medical Faculties
	SPHM	Special Programme for Human Medicine
	SSPs	Situations as Starting Points
	swimsa	Swiss Medical Students' Association
	SWIR	Schweizerischer Wissenschafts- und Innovationsrat / Conseil suisse de la science et de l'innovation (Swiss Science Council)

TMS	Test für Medizinische Studiengänge (Test for Medical Studies)
TOLC-MED	Test OnLine CISIA – Medicina
UCAT	University Clinical Aptitude Test
UK	United Kingdom
USI	Università della Svizzera italiana
VLSS	Verein der Leitenden Spitalärztinnen und -ärzte der Schweiz / Association des Médecins Dirigeants d'Hôpitaux de Suisse (Swiss Association of Senior Hospital Physicians)
vsao/asmac	Verband Schweizerischer Assistenz- und Oberärztinnen und -ärzte / Association suisse des médecins-assistant(e)s et chef(fe)s de clinique (Swiss Association of Assistant and Senior Physicians)
VWO	voorbereidend middelbaar beroepsonderwijs (pre-university education)
WBF	Eidgenössisches Departement für Wirtschaft, Bildung und Forschung / Département de l'économie, de la formation et de la recherche (Federal Department of Economic Affairs, Education and Research)
ZEQ	Zusätzliche Eignungsquote (Additional Aptitude Quota)
ZTD	Zentrum für Testentwicklung und Diagnostik / Centre pour le développement de tests et le diagnostic (Center for Test Development and Diagnostics)

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1.1
Admission to Medical Studies

Access to medical education in Switzerland is shaped by a complex interplay of legal frameworks, institutional capacity, and selection mechanisms. Amid growing demand for study places and persistent shortages in the healthcare workforce, the admission process has become a focal point of academic, social, and political debate. This chapter provides a comprehensive overview of the structural foundations, procedural tools, and equity-related challenges that define the current system of medical school entry.

1.1.1
Access Restrictions and Selection Criteria

Admission is regulated by both legal principles and practical limitations within the higher education system. As applicant numbers continue to exceed available places – often by a factor of four or more – universities and cantonal authorities rely on selection mechanisms to allocate scarce study places. These restrictions rest on a defined legal framework and are implemented in two different ways.

1.1.1.1
Admission Mechanism in Switzerland and Legal Bases

In Switzerland, the federal and cantonal authorities share responsibility for regulating medical education. However, the specific number of students admitted to medical studies is primarily determined by the available study places, which are agreed upon by the universities (through their faculties and rectorates) and the cantons. This information is then communicated to swissuniversities.

The Swiss *Numerus Clausus* (NC) system, which defines a specific number of students admitted to medical studies for each university, was formally introduced in 1998 in response to limited educational capacities at universities and clinical training institutions, particularly in the German-speaking region of Switzerland (Hängsen and Spicher 2001: 3; Hängsen and Spicher 2002a: 1653; SWIR 2016: 6).

According to the legal framework, cantonal universities are permitted to impose access restrictions only when all reasonable alternatives to expanding capacity have been exhausted, and the number of applicants exceeds a certain threshold (typically 20%) of the defined number of students to be admitted (Hängsen and Spicher 2001: 3).

From its inception, the admission procedure based on the NC was designed not as a labor market steering instrument, but as an educational policy mechanism to allocate limited study places fairly among applicants (Hängsen and Spicher 2001: 3). This legal interpretation was upheld by the Swiss Federal Court, which emphasized that any selection process must comply with the constitutional principles of equal treatment and protection from arbitrariness (ibid.).

The relevance of this framework remains high, as the number of applicants for medical studies has continuously exceeded the number of available places across Swiss universities (swissuniversities 2023: 3). Each university canton retains the autonomy to decide annually whether to implement such access restrictions, based on actual demand and infrastructural constraints (WBF/EDI 2016: 10). The universities of Basel, Bern, Fribourg, Zurich, and the ETH Zurich apply – based on the NC – the *Eignungstest für das Medizinstudium* (EMS) as selection instrument (swissuniversities 2023: 3)^[1].

By contrast, the French-speaking universities of Geneva, Lausanne, and Neuchâtel² allow open admission in the first year. However, capacity is ultimately regulated through a highly selective internal examination (*Concours*) at the end of the first year, where failure rates may reach up to 70% (SWIR 2016: 6; swissuniversities 2023: 3). While differing in timing and procedure, both models pursue the same objective: managing limited capacity through selection.

1.1.1.2
The EMS as a Cognitive Selection Tool

The EMS is a standardized test used to allocate medical study places based on cognitive performance alone (Spicher 2023: 5; SWIR 2016: 7). Developed as a Swiss adaptation of the German *Test für Medizinische Studiengänge* (TMS), it was further refined by the *Zentrum für Testentwicklung und Diagnostik* (ZTD) at the University of Fribourg (Spicher 2023: 4).

¹ This also applies to ap-
plicants for the St. Gallen
and Lucerne tracks, who
are formally enrolled at the
University of Zurich during the
Bachelor phase, as well as
to applicants enrolled at the
Università della Svizzera itali-
ana (USI) who complete their
Bachelor studies in Medicine
at the Universities of Basel
or Bern or at ETH Zurich;
these candidates are likewise
selected through the EMS.

² At the University of Neuchâ-
tel, only the first year of study
can be completed.

The EMS comprises nine task types assessing competencies such as text comprehension, diagram and table interpretation, memory performance, logical reasoning, pattern recognition, quantitative problem solving, and sustained con-
centration (Spicher 2023: 4; SWIR 2016: 7). These abilities were identified via task
analysis as critical for early academic success in medical school (Spicher 2023: 4).

Empirical studies confirm that the EMS has predictive validity for academic perfor-
mance during the first two years of study (Hängsen and Spicher 2001: 5; Hän-
sen and Spicher 2002a: 1654 f.). However, no data currently exist on its ability
to predict success in later clinical phases or in medical practice (SWIR 2016: 3).
Therefore, one may argue that the EMS can predict the capability to manage
multiple-choice test formats quite well, but not medicine itself. Critics argue that
the EMS captures primarily cognitive abilities and therefore reflects only part of
the competency spectrum required for the medical profession. At the same time,
non-cognitive qualities such as empathy, teamwork, communication, and ethical
judgment must be developed and assessed through complementary educational
and curricular mechanisms (ibid.: 15, 21).

Additionally, concerns have been raised that the term “aptitude test” is misleading,
since applicants who may well have succeeded in their studies can be excluded
based on EMS scores (SWIR 2016: 11 f.). Earlier years showed higher admission
rates, whereas recent cohorts face growing competition despite no apparent
decline in candidate quality (ibid.).

1.1.1.3
The Concours as a Selection Tool

In the Concours model, progression in medical studies is determined by stu-
dents’ relative performance in comprehensive examinations at the end of the first
year. Admission to the second year is granted exclusively to those candidates
who achieve the highest rankings within their cohort, thereby regulating capacity
through competitive internal selection. The examinations cover the full scope of
the first-year curriculum and primarily assess the acquisition and reproduction of
taught content.

In contrast to the EMS, which is designed to measure general cognitive abilities
that are only limitedly amenable to targeted preparation, the Concours is curricu-
lum-based and therefore preparable. Success largely depends on students’ ability
to master, retain, and reproduce extensive bodies of factual knowledge acquired
during the first year of study. While this approach allows for a close alignment be-
tween assessment and curricular content, which also includes elements of health
and society, it has also been criticized for insufficiently capturing broader compe-
tencies required for later clinical practice, beyond cognitive performance alone.

Moreover, the early phase of medical training, during which students prepare for
selection at the end of the first academic year, has been identified as particularly
demanding: longitudinal data from medical students at the University of Lausanne
show that stress and several mental health indicators are most adversely affect-
ed during the early phase of medical training, before improving over subsequent
curriculum years (Carrard et al. 2024; cf. 1.2.3).

1.1.1.4
Distinguishing Capacity Control from Qualitative Selection

A fundamental distinction in the Swiss medical admissions system lies in the
separation of two goals: capacity control and qualitative selection. As a capacity
control tool, the NC defines the number of students who can be admitted – based
on infrastructure and available clinical resources. The selection process (typically
via the EMS or the Concours) determines who among the applicants receives
those places, given that the number of applicants exceeds the defined number
of study places (cf. Hängsen and Spicher 2001: 4 f.). This distinction is central to
the logic of both the EMS and the Concours model. Though procedurally different,
both aim to allocate scarce study places efficiently.

Importantly, while both systems rely on academic aptitude as their primary
criterion, critics warn that this narrow focus may not adequately serve societal
healthcare needs, underscoring the importance of competency development.
Particularly, the constant and increasing achievement of social and communicative
skills during medical training, as well as training of a sufficient number of general
practitioners or incentivizing care in underserved regions, are of utmost impor-
tance (SWIR 2016: 11–15).

1.1.2
Equity Issues and Social Biases

Merit-based testing is meant to provide a fair and uniform basis for allocating medical study places. Yet the Swiss debate around the EMS repeatedly returns to the question of whether performance differences reflect ability alone or are also shaped by structural and sociocultural factors.

1.1.2.1
Language-Based Disparities

One of the most consistently documented biases in the EMS is the language-based performance disparity. Studies have shown that French-speaking candidates systematically achieve lower average EMS scores than their German-speaking counterparts, despite efforts to provide the test in all three national languages (Spicher 2023: 12 f.; Klumb and Spicher 2024: 2–5).

These disparities stem from two main sources. On the one hand, they reflect intrinsic linguistic differences: Even when items are accurately translated, variations in sentence structure, complexity, or phrasing can unintentionally alter the difficulty of a task (Spicher 2023: 11). On the other hand, performance disparities are also fueled by unequal access to preparation opportunities. German-speaking regions benefit from a long-established coaching market and a wide range of preparation materials (Klumb and Spicher 2024: 3). This advantage is further amplified by their ability to access the well-developed preparatory ecosystem for the German TMS, which is structurally very similar to the EMS and offers a broad selection of compatible training resources and courses (SWIR 2016: 12; cf. MedGurus 2025). In contrast, such materials have historically not been available in French or Italian (Scheiwiller et al. 2023: 32; Klumb and Spicher 2024: 3).

In recent years, however, targeted interventions have significantly reduced these performance gaps. In 2022, the canton of Fribourg – which hosts the University of Fribourg where the EMS is administered in French – introduced free EMS practice trials in local upper-secondary schools, using official EMS tasks and coordinated through the cantonal school system. These were complemented by additional trial runs organized by a group of volunteering medical students (NCWiki), who develop and maintain their own practice tasks and make them available online free of charge in German, French, and Italian (Klumb and Spicher 2024: 4; cf. NCWiki n.d.). In 2023, newly released official open-access preparation materials were released in all three national languages (Klumb and Spicher 2024: 4). Klumb and Spicher (2024: 4 f.) show that these initiatives had measurable effects: the z-score gap between French-speaking candidates from Fribourg and their German-speaking peers nearly disappeared, with improvements also observed in other French-speaking cantons.

Since the study by Klumb and Spicher (2024) focuses exclusively on German- and French-speaking candidates, the effects of the NCWiki materials or the newly released official open-access preparation materials on the performance of Italian-speaking candidates remain unknown.

1.1.2.2
Socioeconomic Disparities and Coaching Market

In addition to language-based disparities, socioeconomic inequities represent a second major axis of bias within the EMS system. Although the EMS is officially described as a test that is “hardly coachable”, a substantial and growing market for commercial preparation services has developed, potentially introducing a social selection bias favoring wealthier applicants (SWIR 2016: 12). Surveys indicate that approximately half of all candidates invest in EMS-specific preparation, often through courses that cost between CHF 200 and 1,400, while more comprehensive offerings can amount to several thousand francs (ibid.).

Efforts to counteract this imbalance have been undertaken. In addition to regional interventions – such as the canton of Fribourg’s free EMS practice trials in 2022 – the test provider released standardized, publicly accessible preparation materials in all three national languages in 2023 (Klumb and Spicher 2024: 4). Complementing these top-down initiatives, NCWiki helps reduce financial entry barriers by providing preparation content at no cost, thus mitigating the influence of the commercial coaching market on EMS outcomes (NCWiki n.d.).

1.1.2.3
Gender Aspects

Gender-related performance differences constitute another frequently discussed equity issue in the Swiss EMS admission system. Across many test years, analyses show that male candidates applying for human medicine within the German-speaking group achieve slightly higher average percentile ranks, or – depending on the reporting format – test scores than female candidates, with these differences reaching statistical significance in a considerable number of years. In contrast, significant gender differences occur only sporadically among French- and Italian-speaking candidates, largely due to smaller cohort sizes and lower statistical power (cf. Hänsngen and Spicher 1998, 1999, 2000, 2001, 2002b, 2003, 2004, 2005, 2006, 2007, 2008a, 2008b, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016; Spicher and Hänsngen 2017; Spicher 2018, 2019, 2020, 2021, 2022, 2023).

According to the ZTD at the University of Fribourg, these findings do not indicate a violation of gender equity. This is because EMS participants are not representative of their age cohort, as selection already begins at upper-secondary school and is further amplified by the strongly gender-biased pool of applicants to medical studies. In human medicine, women have constituted a clear majority of applicants for many years, often exceeding 60%, making identical mean scores across genders neither statistically expected nor necessary for fairness (Hänsngen and Spicher 2003: 64 f.; Hänsngen and Spicher 2004: 78; Hänsngen and Spicher 2008b: 24; swissuniversities 2023: 5). Hänsngen and Spicher (2008b: 24 f.) of the ZTD instead define fairness in terms of equality before the law, meaning that candidates with equal suitability for medical studies must have equal chances of admission. The test developers further state that, since the primary purpose of the EMS is to predict academic success, the test must reflect objectively existing differences in the criterion of study success, irrespective of their underlying causes (ibid.).

Importantly, among students with comparable admission test scores, no substantive gender differences are observed in either examination performance or the pace of academic progress in medical training (Hänsngen and Spicher 2002a: 1659).

1.1.3
Alternative Selection Criteria

Given the structural limitations of existing selection tools and the social biases they may perpetuate, there has been growing attention to alternative or complementary admission criteria (SWIR 2016). Table 1 provides an overview of these selection tools and the model's potential strengths and limitations.

Table 1:
Comparative Overview of
Alternative Admission Criteria
Source: Authors' own compilation based on SWIR (2016), Schreurs et al. (2020), and Fleck et al. (2024).

Alternative Selection Criteria	Description	Potential Advantages	Potential Disadvantages, Risks	Recommendation of the Swiss Science and Innovation Council (SWIR 2016)
Baccalaureate Performance	Selection is based mainly on school performance in scientific subjects such as biology, chemistry, mathematics, and physics	Reflects long-term academic performance and cognitive diligence, which may serve as reliable indicator of success during the early years of medical education; cost-efficient	Heterogeneity of the Swiss upper-secondary schools, risk of grade inflation	Inadequate for implementation at Swiss level
Knowledge Tests	Discipline-specific knowledge tests, typically consisting of multiple-choice questions in natural sciences, aim to assess applicants' content-related preparedness and academic potential	May facilitate long-term learning benefits through structured test preparation by raising the scientific level among admitted students	Tend to favour candidates from science-heavy educational tracks, stimulate the private coaching industry, and lack meaningful predictive power for later clinical performance	Not recommend their use in the Swiss admissions context
Interviews, Motivation Letters, and Recommendation Letters	Allow for a more comprehensive view of applicants by capturing motivation, reflective capacity, and interpersonal skills	Promote a holistic and individualized approach	Low scientific validity, susceptibility to coaching, use of AI, potential legal disputes, and considerable implementation costs for the interviews	Justifiable in exceptional cases but otherwise unsuitable as a central selection mechanism
Situational Judgement Tests (SJTs)	SJTs are designed to evaluate how candidates are likely to behave in work-related situations. They are designed to assess attributes such as empathy, professionalism, and communication	The method holds promise, particularly in predicting professional behaviour and academic performance at the postgraduate level	Can sometimes lack predictive validity; risk of desirability bias; limited scenarios with consequent high renewal rate and elevated costs	Need for further empirical validation in the Swiss context, as well as careful attention to test quality and cultural fairness
Multiple Mini-Interviews (MMIs)	MMIs consist of a series of short, structured interview stations assessing a range of non-cognitive skills, including ethical reasoning, communication, and emotional intelligence	This approach is widely used internationally and is valued for its reliability, fairness, and predictive utility regarding clinical and academic success	Significant financial and logistical resources would be required for implementation in Switzerland, including estimated costs in the range of CHF 4–7 million	The potential of MMIs to contribute to a more diverse student body and to better assess applicants' suitability for the medical profession is acknowledged
Internships	Pre-admission internships in healthcare settings provide applicants with early insights into the realities of clinical work, supporting more informed career decisions and fostering interprofessional skills	May enhance intrinsic motivation and contribute to a more heterogeneous student population in terms of practical background and personality traits	Need for adequate supervision; risk of inequitable access, and potential delays in educational trajectories	The option is generally considered favourable. However, the system does not have the capacity to accommodate 4,000–5,000 candidates per year
Outcome-Based Selection (Schreurs et al. 2020)	Starting from the competences expected at the end of the curriculum (CanMEDS roles), the selection process reproduces an assessment of the same competences, at an upper-secondary school level, when possible (e.g. communication, collaboration, values and ethics, organization, reflection, consciousness, etc.). A combination of tools is used for this assessment (SJT, portfolio, aptitude tests)	Constructive alignment of medical school selection, curricula, and assessment with the ultimate outcomes (e.g., CanMEDS roles). Predictive value across the clinical years for several CanMEDS competencies	Complexity of combination of tests. Costs (to balance with effectiveness)	--
Interactional competencies in medical student selection (Fleck et al. 2024)	As a variation of the MMIs, a developed selection procedure "Interactional Competencies – Medical Doctors (IC-MD)" uses an MMIs circuit with five simulation patient scenarios and is rated based on the theoretically and empirically grounded construct of emotional availability	The validation study shows that the IC-MD is a promising selection procedure capable of assessing interactional competencies relevant to the medical setting. Moreover, it is fair regarding participants' age and gender. Measures of interactional competencies can complement the use of cognitive selection criteria in medical student admission	Significant financial and logistical resources if applied to the whole cohort of applicants. Moreover SPs have to be trained and available	--

1.1.4
International Perspectives

Switzerland is not alone in facing the challenge of regulating access to medical education through formalized selection procedures. Many other countries have developed their own admission models, shaped by similar concerns about capacity constraints, fairness, and the predictive validity of selection tools. In view of the challenges outlined in the Swiss context, it is instructive to explore how different systems have responded. Table 2 presents a comparative overview of selected international approaches, accompanied by brief comments that identify the potential advantages and shortcomings of each national system.

Table 2:
Selected International Admission Systems in Medical Education
Source: Authors' own compilation based on a wide range of sources. For reasons of clarity, the full list of references is not reproduced here. Instead, readers are referred to the separate bibliography compiled specifically for Table 2, which is appended to the white paper.

International perspective	Historical background	Description	Comments
Austria	Since 2013, Austria has implemented a standardized admission procedure for entry into human medicine studies known as the MedAT-H	This assessment comprises four central components: a subject-specific knowledge test in biology, chemistry, physics, and mathematics; a section on reading comprehension; a segment evaluating cognitive abilities and skills – such as numerical reasoning, memory performance, and verbal fluency –, and a module targeting social-emotional competences	Highly competitive; admission relies on the MedAT test and academic records. Focuses on cognitive ability, knowledge, and basic science skills; non-academic qualities are less formally assessed
France	A comprehensive reform of the medical studies has been implemented in 2020. The overarching goal of this reform is to enhance accessibility, reduce the excessively selective bottleneck effect of the first academic year, and establish a more holistic and aptitude-based admissions framework	Currently, access to medical education is offered through two alternative pathways: PASS (<i>Parcours d'Accès Spécifique Santé</i>), a health-focused preparatory year that includes a secondary subject, and L.AS (Licence avec Option Accès Santé), a standard bachelor's degree programme supplemented with health-related modules. Both tracks involve decentralized selection procedures administered by universities, including written and oral examinations, with continuous assessment forming a central element of the evaluation process	The French system prioritizes academic excellence and standardized evaluation, making it efficient and fair in theory. However, it largely neglects personal, ethical, and interpersonal qualities
Germany	Germany's medical school admissions process has undergone fundamental restructuring through the Masterplan Medizinstudium 2020 and is now centrally coordinated via the online platform <i>hochschulstart.de</i> . The overarching goal of the reform is to ensure a more equitable, transparent, and competency-oriented admissions procedure that better reflects the demands of the medical profession	Admission to programmes in Human Medicine is organized through three main quotas: 30% of study places are allocated based on outstanding Abitur results (<i>Abiturbestenquote</i>), 10% are awarded through a supplementary aptitude quota (<i>Zusätzliche Eignungsquote</i> , ZEQ), and the remaining 60% are distributed via individual university selection procedures. Each university retains the autonomy to define how these criteria are weighted within their selection processes	Admission combines upper-secondary school GPA (<i>Abitur</i>), test scores (TMS), and occasionally interviews. Competitive and structured, but largely academically focused
Italy	Until recently, access to Italian-taught medical programmes at public universities was determined through the TOLC-MED (Test OnLine CISIA for Medicine), a standardized aptitude test assessing scientific knowledge and cognitive abilities. However, for the academic year 2025/26, a significant structural change has been introduced. The TOLC-MED has been discontinued, and applicants may now enrol directly in the first semester without passing a selection exam	During the initial semester, students are required to complete a predefined set of academic credits in disciplines related to biology, chemistry, and health sciences. Admission to the second semester is then contingent on achieving a competitive position in a national ranking based on the acquired academic performance. This shift reflects a move away from a purely exam-based selection system toward one that rewards academic engagement and progression potential within the university context	Admission is via national entrance exams (IMAT for English programs). Highly competitive and primarily knowledge-based, with limited assessment of non-academic skills
Israel	Israeli medical schools switched from "extended unstructured interviews" to assessment centers about 15 years ago. The two-step selection process was introduced to address the limitations of the previous admission system, which relied heavily on unstructured interviews and academic scores	The admission process for medical studies is structured as a two-stage procedure, combining cognitive and non-cognitive assessments. This approach aims to select candidates who not only demonstrate academic excellence but also possess the personal attributes essential for the medical profession. The initial selection phase evaluates candidates based on their high school matriculation certificate (<i>Bagrut</i>) scores and their performance on the Psychometric Entrance Test (PET). Applicants who achieve high composite scores are invited to participate in the MOR or MIRKAM assessments. These evaluations are designed to assess non-cognitive skills through a series of structured interviews, situational judgment tests, and personality assessments	Combines psychometric testing, GPA, and non-cognitive assessment (MOR/MIRKAM, interviews); structured and holistic, with emphasis on academic and personal qualities

International perspective	Historical background	Description	Comments
The Netherlands	The Netherlands introduced a weighted lottery system for Numerus Fixus medical school admission around 1972. More structured, non-grade-based school-specific selection procedures began around 2000. Finally, from the 2017–2018 academic year, the national lottery system was abolished, meaning medical schools now must select all students via their own selection procedures	In the Netherlands, admission to medical studies is governed by the Numerus Fixus system, which limits the number of available places and delegates selection procedures to individual universities. These decentralized selection processes often involve multiple stages, including written tests, interviews, and portfolio assessments. International applicants must possess a secondary school diploma equivalent to the Dutch VWO, with sufficient proficiency in biology, chemistry, physics, and mathematics, along with adequate language skills in Dutch or English	Uses a combination of GPA, school-specific selection, and sometimes lottery. Holistic elements are included; academic performance is crucial, but some emphasis on motivation and non-cognitive skills
United Kingdom	The UK Clinical Aptitude Test (UCAT) was introduced in 2006	Access to medical education in the United Kingdom is governed by a multi-stage selection process that combines academic achievement, standardized testing, and non-academic criteria. A central feature of the UK admission system is the use of the UCAT. The UCAT is employed by the majority of medical schools and is designed to assess a range of cognitive abilities and professional behaviours through five subtests: verbal reasoning, decision making, quantitative reasoning, abstract reasoning, and situational judgement. Academic qualifications remain a key selection component. Applicants are typically expected to achieve top-level grades in secondary education (A-levels). In addition to test results and academic records, applicants must submit a personal statement articulating their motivation for studying medicine, relevant experiences, and personal qualities	Selection is holistic: high academic achievement, UCAT/BMAT aptitude tests, personal statements, and MMIs. Balances cognitive ability with communication, ethical reasoning, and teamwork
United States	The introduction of standardized testing (MCAT) and structured applications dates back to the 1960s. The modern version of the MCAT, with its current structure, was implemented in 2015	Access to medical education is structured as a post-baccalaureate program requiring completion of a four-year undergraduate degree. This model emphasizes both academic performance and non-academic competencies such as interpersonal skills and civic engagement. Admissions are coordinated via the centralized AMCAS platform, managed by the Association of American Medical Colleges. A core requirement is the MCAT, a standardized exam assessing scientific knowledge, critical thinking, and analytical reasoning. Applicants must also submit a comprehensive portfolio through AMCAS, including extracurricular activities, clinical and research experiences, a personal statement outlining their motivation, and several letters of recommendation	Highly structured and competitive; requires undergraduate GPA, MCAT, extracurriculars, essays, and interviews. Focuses on both academic and personal/professional attributes
Canada	The modern Canadian medical school selection system, combining MCAT + MMIs + holistic evaluation, has largely been in place since the mid-2000s, with key components (like MMIs) becoming widespread around 2008	Admission to Canadian medical schools is highly competitive and holistic, requiring a strong undergraduate academic record (typically 3–4 years of science courses with a high GPA), MCAT scores (for most schools), meaningful extracurricular activities, personal statements or essays, and performance in MMIs. Some schools also use SJTs to assess professionalism and ethical reasoning	Holistic selection combining undergraduate GPA, MCAT, extracurriculars, essays, and MMIs; some schools use SJTs. Emphasizes both cognitive skills and interpersonal/professional qualities

1.1.4.1
Comparative Reflections on the Swiss Admission System

Overall, it becomes evident that the Swiss admission procedure for medical studies shares several structural features with international models, while also exhibiting marked differences. Like many other countries, Switzerland relies on the EMS, a standardized aptitude assessment – comparable to the UCAT in the United Kingdom, the PET in Israel, or the TMS in Germany. Both – the EMS and the Concours – reflect a capacity-oriented admission logic, akin to the Numerus Fixus system employed in the Netherlands or the selective first-year model historically used in France. Their shared objective is to allocate a limited number of study places efficiently and equitably.

Despite these similarities, the Swiss model differs significantly in several key respects. Most notably, it does not take prior academic achievement – such as baccalaureate grades – into account when allocating study places. In contrast, academic records play a substantial role in countries like Germany (Abitur), Israel (Bagrut), and the United Kingdom (A-levels). In Switzerland, for students who have achieved a baccalaureate, selection is based solely on performance in the EMS or, at the French-speaking universities, on success in internal first-year examinations. However, in Switzerland, selection may be more severe earlier in school than in other countries due to the apprenticeship system, as only 23% of all students finish gymnasium (BFS 2023). Furthermore, the EMS is a purely cognitive assessment tool that measures abilities such as logical reasoning, memory, and quantitative problem-solving. It does not evaluate non-cognitive attributes such as empathy, communication skills, or vocational motivation – qualities increasingly emphasized in other countries through structured interviews, SJTs, or comprehensive applicant portfolios.

1.1.5
Debates in the Political Arena

The persistent friction between limited training capacities and demands for broader, more inclusive admission models has recurrently shaped political debate in Switzerland at both the national and cantonal levels.

1.1.5.1
National Level

At the national level, parliamentary submissions across the political spectrum have coalesced around two broad themes: first, proposals calling for an increase in the number of medical study places to ensure the long-term supply of healthcare professionals; second, initiatives seeking adjustments to admission and selection criteria, including discussions on the EMS and potential alternative models (see Table 4 in the appendix for an overview of the corresponding parliamentary items).

Despite broad agreement on the need for reform, legislative progress has often been hindered by Switzerland’s federal structure and the distribution of responsibilities among the Confederation, the cantons, and universities. While federal programmes have provided important impetus to expand training capacities, the Federal Council continues to emphasize subsidiarity and voluntary cooperation among stakeholders rather than binding obligations to expand capacities or alter selection procedures. This includes programmes such as the Special Programme for Human Medicine (SPHM) under the 2017–2020 ERI Dispatch, which sought to accelerate the expansion of medical education with the goal of reaching a total of around 1,350 medical graduates per year in Switzerland by 2025, as well as federal infrastructure contributions under the Higher Education Funding and Coordination Act (HFKG).

However, following the adoption of the motions by Roduit (23.3293) and Hurni (23.3854) – calling, respectively, for competence- and quality-based admission procedures (cf. Curia Vista 2023a) and for a substantial expansion of medical training and postgraduate positions, particularly in primary care (cf. Curia Vista 2023b) – an institutional exploratory process has been launched.

1.1.5.2
Cantonal Level

Falling within the cantonal sphere of responsibility, the organization of medical education has likewise triggered a range of political initiatives at the cantonal level.

The Canton of Zurich has already undertaken concrete measures to increase the number of medical study places. In November 2024, the Zurich Cantonal Council unanimously adopted an urgent parliamentary postulate instructing the Cantonal Government to create 500 additional study places in human medicine at the University of Zurich by 2028. This measure would more than double the current capacity of 430 (of which 360 are for human medicine, 50 for dental medicine,

and 20 for chiropractic). Following this mandate, the government presented its implementation report in May 2025, outlining the *Med500+* project, which proposes increasing the number of medical study places to a maximum of 700 to ensure the quality of medical teaching is not compromised. While this represents a substantial expansion, the report concludes that the originally envisioned target of 880 places is not feasible due to qualitative, infrastructural, and personnel-related limitations (Regierungsrat des Kantons Zürich 2025; Staatskanzlei Zürich 2025).

In the Canton of Geneva, the Grand Conseil adopted Motion 3015 in January 2025, which calls for a substantial expansion of training capacities across all health professions. Citing Geneva’s high dependence on foreign-trained staff and projected shortages of nurses and physicians by 2040, the motion urges the Cantonal Government to increase the number of study places, remove artificial admission limits, and strengthen the attractiveness of health careers. An additional amendment requests enhanced public–private collaboration, particularly to create more clinical training placements, positioning Geneva to contribute more robustly to Switzerland’s domestic health workforce supply.

The Canton of Fribourg is also looking into increasing the number (possibly doubling) of their Master students. In a mandate from October 2024, the Fribourg Grand Council asked the State Council to increase the number of places available on Fribourg’s Master programme. The deputies requested that inter-cantonal coordination be established to strengthen medical training, including practical placements. In its response, the State Council decided to conduct a feasibility study.

In the Canton of Bern, the Grand Council adopted a motion (107-2025) in September 2025 calling on the Cantonal Government to increase the number of study places in human medicine at the University of Bern. The initiative suggests expanding medical training capacity (without mentioning a specific number), prioritizing the completion of necessary infrastructure to accommodate more students and implementing measures that encourage newly admitted medical students to pursue specialties currently facing severe workforce shortages.

1.2
Medical Studies

As a central pillar of physician training in Switzerland, medical studies are shaped by a combination of structural regulation, institutional diversity, and individual student trajectories. The following sections examine key features of medical education in Switzerland, including its organizational framework, study progression and attrition, student well-being, and patterns of cross-border mobility.

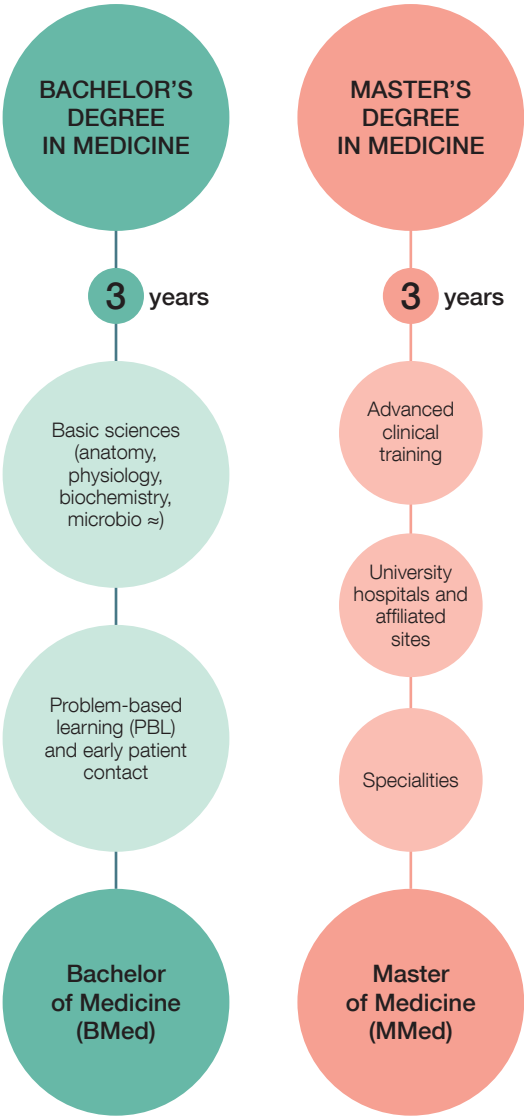
1.2.1
The Swiss Model: Structure and Peculiarities

The Swiss model of medical education is based on a set of shared national parameters, legally regulated by the Medical Profession Act (MedBG), with decentralized implementation across faculties. Within this framework, faculty autonomy coexists with mechanisms that ensure alignment across institutions, including standardized degree structures and the competency-oriented approach formalized in Principal Relevant Objectives and Framework for Integrative Learning and Education in Switzerland (PROFILES).

1.2.1.1
General Structure and the Medical Faculties

Medical studies in Switzerland are structured according to the Bologna model, which provides, for medical studies, 3 years of bachelor's and 3 years of master's, totalling 2x180 ECTS credits (Figure 1). Access to the national exams requires completing both cycles and earning the required credits.

Figure 1:
Structure of Medical Education in Switzerland



Overall, medical education – either in its entirety or in part – is provided at eleven universities in Switzerland. According to swissuniversities, the admission capacity for 2025/26 is 2,195 students. Table 3 presents the universities offering medical studies, their respective admission procedures, the program type offered, and the bachelor's admission capacity at each institution.

	Educational		Admission pro-cedure	Admission capaci-ty to the Bachelor
	Bachelor	Master		
University of Bern	YES	YES	EMS	320
University of Basel	YES	YES	EMS	190
University of Fribourg	YES	YES	EMS	125
University of Zu-rich (incl. Luzern & St. Gallen tracks)	YES	YES	EMS	380
ETH Zurich	YES	NO	EMS	100
Universita della Svizzera italiana	NO	YES	EMS	30 (15 via Basel, 15 via Bern)
University of Lausanne	YES	YES	CONCOURS	480
University of Geneva	YES	YES	CONCOURS	500
University of Neuchâtel	FIRST YEAR	NO	CONCOURS	70

Table 3:
Educational Offer – Medi-cal Studies in Switzerland (2025/2026)
Source: Authors' own compi-lation based on swissuniversi-ties (2025).

1.2.1.2 Study Structure

Universities are free to define their own study models, provided that the programme has been validated through a federal accreditation process, meets the 180-credit requirement per study cycle, and complies with the recommendations in the PROFILES document developed by SMIFK/CIMS, which defines general competencies. Alignment among the different models is largely ensured through the federal exam, which subjects all students from various faculties simultaneously to the same written tests and Objective Structured Clinical Examinations (OSCEs); however, this alignment focuses primarily on outcomes rather than on the learning processes and educational environments that shape competency development.

Variations among faculties in teaching methods and educational models are relatively broad, reflecting institutional autonomy. For the following aspects, no specific rules are defined, provided that adherence to the PROFILES model is maintained. These aspects can be summarized as follows:

- Overall structure of the Bachelor's and Master's programmes
- Student–teacher ratio during clinical training and group activities
- Assessment methods used throughout the studies
- Teaching tools and instructional support, including assessment instruments
- Structure and sequencing of internal Bachelor's and Master's examinations
- Duration of clinical exposure (clinical rotations and elective year)

1.2.1.3
PROFILES

In 2002, the first edition of the Swiss Catalogue of Learning Objectives (SCLO) was published; a second version of SCLO was released in 2008. As medicine and medical education evolve, SMIFK/CIMS launched a major revision of the SCLO, leading to the development of PROFILES. A working group composed of experts from all Swiss faculties, students and postgraduate representatives drafted PROFILES between 2013 and 2015. In 2016, a paper was published describing PROFILES’ structure and purpose: a shift toward competency-based medical education (CBME), with Entrustable Professional Activities (EPAs) and “clinical situations” as starting points. Since then, PROFILES has structured around three mutually linked parts:

- *Competencies & Roles (CR)*: Defines physician roles based on the CanMEDS model, such as Medical Expert, Communicator, Collaborator, Leader/Manager, Health Advocate, Scholar, and Professional.
- *Entrustable Professional Activities (EPAs)*: Specifies key professional tasks that graduates should be able to perform competently (with appropriate supervision) from day one of residency.
- *Situations as Starting Points (SSPs)*: About 265 realistic clinical (and non-clinical) scenarios that students should be exposed to during training.

In 2023, the document was revised, and a new version – PROFILES 2 – was introduced (Berendonk et al. 2025). In addition to updating the various chapters, it incorporates new themes such as planetary health, diversity, equity and inclusion, and digitalization.

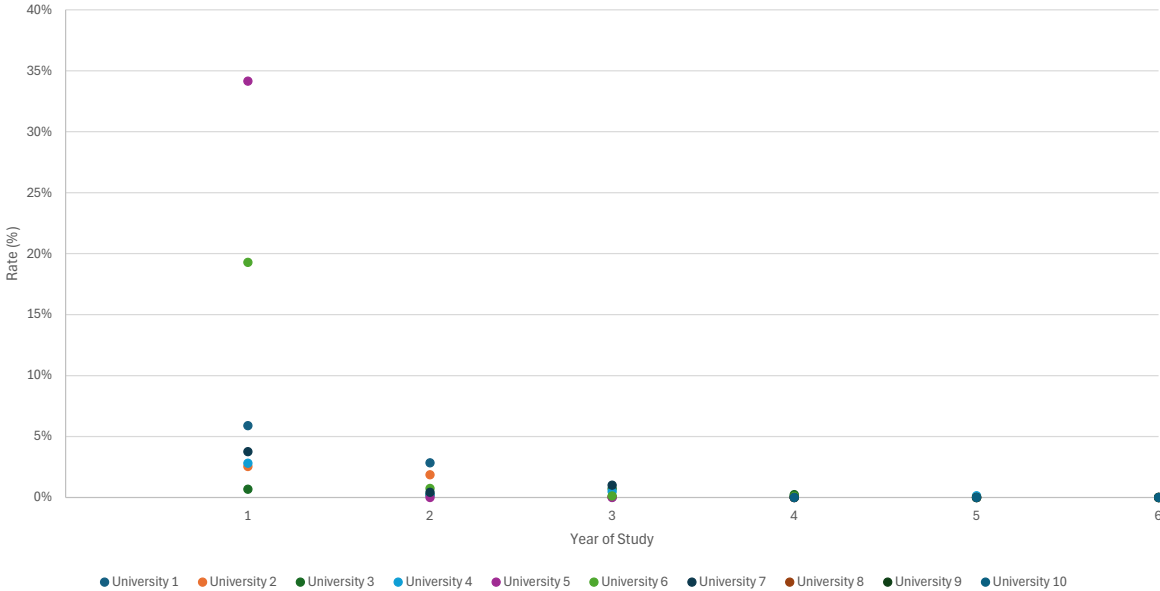
1.2.2
Dropout Rates and Study Progression

An important dimension of analyzing medical education concerns student attrition. It is essential to distinguish between involuntary attrition, resulting from exclusion after failing examinations, and voluntary attrition driven by personal reasons. Until recently, no systematic nationwide data collection on this issue had been conducted in Switzerland. This gap began to be addressed in autumn 2025, when the Collège des Doyens asked the individual faculties to compile and report their attrition data retrospectively from 2015 onwards.

1.2.2.1
Examination-based Exclusion Rate

Given the differing selection procedures – either via the EMS or the Concours – it is essential to distinguish between German-speaking and French-speaking Swiss universities when examining examination-related attrition. At universities employing the Concours system, the attrition rate due to examination failure in the first year is in the double digits, whereas at institutions selecting students via the EMS, this rate remains below 6%. From the second year onward, these differences disappear. Overall, the proportion of students excluded for academic reasons decreases as students progress and approaches zero by the time they reach the master's level (Figure 2).

Figure 2:
Examination-based Exclusion Rate
Note: Universities are presented in anonymized form, as the analysis is not intended to single out or evaluate individual institutions. Each point shown for a given university represents that institution's mean value for the respective year of study. Owing to data availability, the number of underlying academic years used to compute these averages varies across universities; all observations fall within the period 2015–2025. *Source:* Authors’ own illustration based on data provided by the universities.



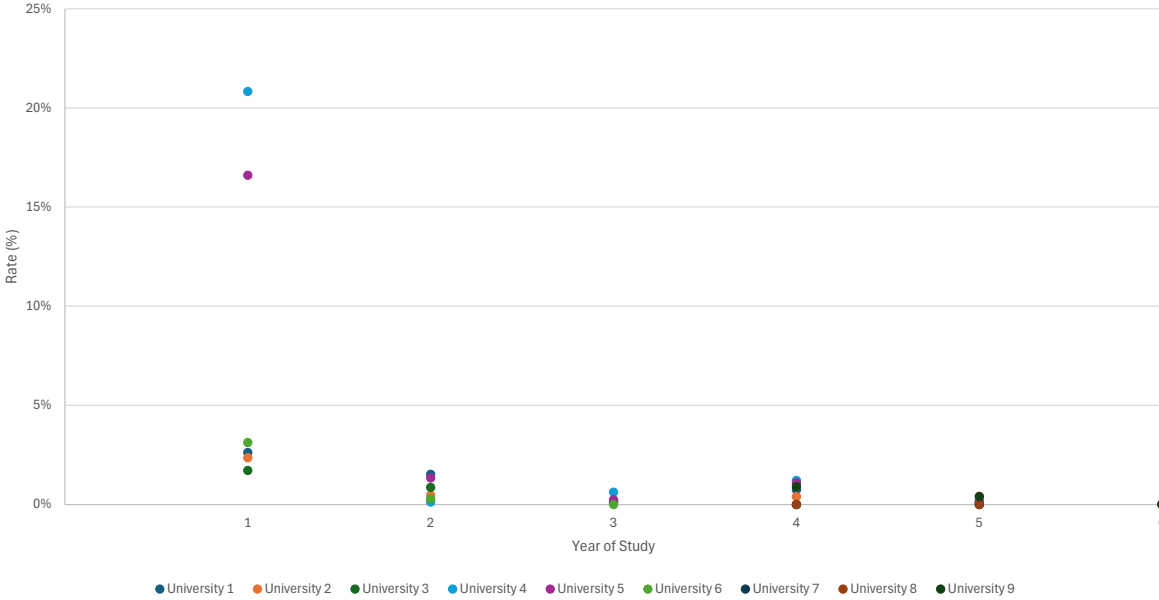
1.2.2.2
Voluntary Withdrawal Rate

Beyond examination-based exclusion rates, students may leave medical school for a range of reasons, including psychological or physical health issues, family obligations, or a shift in career goals (Loffing and Wunderlin 2025: 1). These motives are inherently individual and shaped by complex personal circumstances.

A survey by Scheiwiller et al. (2023: 33), which polled 2,292 medical students on study satisfaction and career expectations, found that 68% of respondents had never or rarely considered dropping out, while 30% had considered it often or sometimes. The most commonly cited sources of doubt included concerns about physicians’ work-life balance (46.7%), the heavy workload during medical studies (37.6%), and uncertainty about choosing a medical specialty (29%).

Data from various medical faculties nevertheless indicate that only a small proportion of students leave their studies for personal reasons, and that this group is smaller than those who discontinue due to examination failure. At universities that use the EMS, attrition rates for personal reasons already remain below 4% in the first year. At institutions that use the Concours, the intense pressure associated with this selection mechanism is reflected in higher first-year rates. From the second year onward, however, no further differences are observed between EMS and Concours universities, and, as with examination-related attrition, the rate of withdrawal for personal reasons likewise approaches zero as students progress in their studies (Figure 3).

Figure 3:
Voluntary Withdrawal Rate
Note: Universities are presented in anonymized form, as the analysis is not intended to single out or evaluate individual institutions. Each point shown for a given university represents that institution's mean value for the respective year of study. Owing to data availability, the number of underlying academic years used to compute these averages varies across universities; all observations fall within the period 2015–2025. *Source:* Authors’ own illustration based on data provided by the universities.



1.2.2.3
International Comparison and Efficiency Debates

A look beyond Switzerland reveals significant variation in medical school dropout rates internationally. According to Enabulele and Enabulele (2022: 3), aggregated national-level dropout rates, published after 2005, were 3.1% in Australia, 3.8% in Saudi Arabia, and 5.7% in the Netherlands. Much higher figures were reported for Germany and the United Kingdom, with 10% dropout rates. Particularly notable was Nigeria, where the dropout rate rose from 3.5% in 2015 to 20.8% in 2019. Reported causes include academic strikes, accreditation issues, financial burdens, and the impact of the COVID-19 pandemic (ibid.: 5). However, this study does not distinguish between voluntary withdrawals and academic exclusions.

In contrast, a more nuanced picture emerges from an earlier study by Maher et al. (2013), which tracked attrition at University College Cork, Ireland, over 10 years. The total dropout rate was 5.7%, with only 15% (n=10) of the 70 recorded cases attributed to academic failure. The remaining 85% left voluntarily.

1.2.3
Mental Health and Stress

In addition to academic progression and attrition, medical education is characterized by substantial psychological demands that shape students’ well-being throughout training. Empirical research conducted at the University of Lausanne highlights marked differences in mental health outcomes among medical students, age-matched peers, and students in other disciplines, and points to specific stressors and resources embedded in the structure of medical education.

1.2.3.1
Mental Health Outcomes in Comparison with Age-Matched Peers and Other University Disciplines

Evidence from Carrard et al. (2024) indicates that medical students at the University of Lausanne experience substantial mental health challenges over the course of their training. Compared with age-matched peers from the general population, they exhibit significantly higher levels of depressive and anxiety symptoms (ibid.: 5 f.). Longitudinal analyses reveal non-linear trajectories: while depressive symptoms and perceived stress decline over time, anxiety remains persistently elevated, and suicidal ideation follows a U-shaped pattern, decreasing mid-curriculum before rising again in the final year (ibid.: 6). Burnout shows a distinct evolution, with increasing cynicism, declining academic efficacy, and peaks in emotional exhaustion early and late in training (ibid.: 6 ff.).

When these findings are situated within the broader context of university education, a more differentiated picture emerges. Comparisons with nonmedical students – who also study at the University of Lausanne – show that, in unadjusted analyses, medical students report fewer mental health symptoms and lower cynicism (Carrard et al. 2025: 5 f.). However, after adjustment for sociodemographic, psychological, lifestyle, and social factors, differences in depression and anxiety are attenuated. At the same time, lower suicidal ideation and cynicism persist, and higher emotional exhaustion among medical students emerges (ibid.: 5 ff.). Taken together, these findings indicate that psychological distress is not specific to medical education but is widespread across academic disciplines. At the same time, they suggest that where medical training is associated with greater vulnerability – most notably in terms of emotional exhaustion – this vulnerability is largely counterbalanced in unadjusted observations by a more favourable biopsychosocial profile among medical students, thereby limiting its manifestation in overall burnout levels (ibid.: 7 ff.).

1.2.3.2
Sources of Strain and Protective Resources in Medical Training

Further to the magnitude and trajectories of mental health outcomes among medical students, Carrard et al. (2024) and Monti et al. (2025), also drawing on data from the University of Lausanne, examine the sources of strain inherent in medical training as well as the resources that may buffer their effects.

Carrard et al. (2024: 9 f.) show that emotion-focused coping is the strongest and most consistent correlate of adverse outcomes, being associated with higher depressive symptoms, anxiety, suicidal ideation, perceived stress, emotional exhaustion, and cynicism, as well as lower academic efficacy. Strain varies further by gender, parental education, and prior consultation with a psychotherapist (ibid.). Conversely, perceived social support, satisfaction with health, help-seeking coping, problem-focused coping, and physical activity are associated with more favourable mental health and burnout profiles (ibid.). Complementing these findings, Monti et al. (2025: 1299–1303) show that professional identity is negatively associated with depressive symptoms, anxiety, stress, suicidal ideation, emotional exhaustion, and cynicism, and positively associated with academic efficacy, with particularly strong effects for cynicism and emotional exhaustion.

1.2.4
Swiss Students Studying Abroad

Swiss students aspiring to become physicians do not pursue medical education exclusively within Switzerland. Limited domestic training capacity and highly competitive admissions have contributed to a persistent pattern of Swiss students studying medicine abroad.

These students predominantly enroll in neighboring or nearby countries such as Germany, France, Italy, Austria, Romania, Hungary, the Czech Republic, and Slovakia, where many universities offer attractive medical programmes in English, German, or French. Popular destinations include Semmelweis University (Hungary), Charles University (Czech Republic), Comenius University (Slovakia), and the University of Cluj-Napoca (Romania) (praktischArzt 2024).

Most programs follow a six-year curriculum (three pre-clinical, three clinical years), similar to the Swiss model, and degrees from EU/EEA universities are generally recognized in Switzerland if the institution is listed in the MedReg database of the Federal Office of Public Health (praktischArzt 2024).

According to a report by the *Aargauer Zeitung* from September 20, 2024, 122 Swiss students were enrolled at the University of Cluj-Napoca in Romania during the autumn term (Bühler 2024). In addition, several dozen Swiss nationals were reported to be studying medicine in other Eastern EU countries, including 21

students enrolled in the German-language programme at Semmelweis University in Hungary.

Although these figures provide some insight, they remain fragmented and fail to reflect the full scope of Swiss medical student mobility across Europe. No comprehensive statistics exist on how many Swiss citizens are currently pursuing medical degrees abroad or where they are studying. Available data largely stems from degree recognition processes: in 2023, for instance, around 100 basic medical degrees earned by Swiss nationals in EU member states were recognised by the Federal Office of Public Health, with annual figures in prior years ranging between 56 and 90 (Bühler 2024). Over a longer timeframe, from 2002 to the end of 2024, a total of 2,200 such foreign medical degrees – obtained in EU or EFTA countries – were officially recognized by the Medical Professions Commission (MEBEKO), as recently confirmed by the Federal Council in response to a parliamentary inquiry by National Councillor Cédric Wermuth (Curia Vista 2025).

1.3
Transition Phase to Postgraduate Studies

The transition from medical studies to postgraduate training represents a critical phase in the professional development of physicians. In the Swiss context, this phase raises important questions about preparedness, role change, and the alignment between undergraduate education and the realities of clinical practice. These issues are addressed in the sections that follow.

1.3.1
Rationale for a Transition Phase

After passing their final exams, medical students enter the professional world directly. Ideally, in line with the objectives of the PROFILES document, they should have been adequately prepared for these changes – particularly equipped with the competencies (skills, knowledge, attitude, and critical thinking) necessary to face the first day of work in whatever professional context they may find themselves. (*...the aim of PROFILES is to outline what is expected of the holder of a federal license on the first day of their residency*). The question that arises is whether they have indeed been adequately prepared, and whether the Swiss model, as it is currently designed, allows entry into the professional world without risk of failure, in whatever form that may take.

In the Swiss model, the Federal Licensing Exam marks a clear formal boundary: it transforms individuals from students into residents. Yet this change is not only a legal or administrative step – it is, in practice, a profound shift in roles, responsibilities, and the working environment. Instead of functioning as a single “switch”, the move from undergraduate training to residency should be designed as a structured transition phase with clearly defined educational objectives, responsibilities, and support mechanisms focusing on the continuum of medical training – a period that requires deliberate support, targeted preparation, and structured learning opportunities.

By “transition phase”, we refer to the shift from the role of a student – characterized by a relatively protected learning environment and an increasing alignment of pedagogical tools and teaching content – to a professional setting that is exposed, highly heterogeneous, and sometimes suboptimally structured. This environment demands additional human and professional skills (such as resilience, administrative and managerial competencies) that are not covered during undergraduate training, and where learning no longer holds the same central role or priority.

Due to profound structural changes in the healthcare system and the rapid development of healthcare institutions’ service portfolios, universities must refocus on the transition phase, given its central importance. However, it has now become critically important in light of recent data showing alarmingly high levels of frustration and dropout among young residents. The insufficient focus on the transition phase is increasingly recognized as a potential contributor to the difficulties and vulnerabilities newly qualified doctors experience in the workplace.

1.3.2
The Final Phase of Medical Studies: How Current Training Prepares Students for Clinical Practice

In Swiss medical education, the final part of the curriculum is intended to consolidate clinical competence and ensure readiness for residency. Two elements are particularly influential in this phase: the elective year, which exposes students to everyday clinical practice, and the Federal Licensing Exam, which formally certifies readiness to begin professional practice.

1.3.2.1
Critical Role of the Elective Year

The elective clinical year constitutes the practice-oriented final year of medical education, during which students engage in supervised clinical work as junior trainees, explore various medical specialties, and prepare for their transition into postgraduate medical training.

Beyond its formal curricular function, the elective clinical year exposes students to the lived realities of medical practice. As such, it represents a pivotal stage in medical training, offering insights that profoundly affect career orientation. According to Scheiwiller et al. (2023: 33 f.), 14% of students consider dropping out of medical school after completing the elective year – compared to just 7% beforehand – and around one third contemplate not pursuing a career as a physician.

At the same time, the elective year also shows a stabilizing effect: 31% of respondents stated that the experience strengthened their career choice, while 33% reported no influence. This highlights how professional passion and dedication are shaped by real-world experiences and current working conditions (Scheiwiller et al. 2023: 33f.).

Further differentiation by admission pathway reveals notable differences. Among students who had already completed the elective year, Scheiwiller et al. (2023: 10, 33 f.) found that outcomes varied according to whether students had entered medical school through the NC or the Concours. While the overall distribution of responses showed that 34% of respondents did not want to work as a physician after the elective term, this negative shift was less pronounced among students admitted via the Concours. In this group, only 17% reported reconsidering a medical career, 29% indicated no change, and nearly half (48%) stated that the elective year confirmed their career choice.

In preparation for the elective year, most medical schools offer clinical rotations that immerse students in 20–30 weeks of clinical work across various hospital settings, expanding their clinical exposure.

1.3.2.2
Federal Licensing Exam: Structure and Conduct

At the end of their studies, students must take the Federal Licensing Exam, which aligns with the main point of the different faculties. While the elective year provides experiential insight into clinical work, the Federal Licensing Exam serves as the formal transition from student to resident. Its format and preparation practices, therefore, matter not only for assessment but also for what is prioritized in terms of learning and competence development.

The Federal Licensing Exam consists of a written part – two sessions of 150 multiple-choice questions each – and a practical part, involving a dozen clinical stations with simulated patients (OSCEs) over the course of three hours. Preparation for the Federal Licensing Exam occupies a significant portion of the last year of study.

To prepare, students use materials delivered by the lecturers but mainly rely on specific programs (such as AMBOSS), designed solely to help them pass the final exams. Preparation for the OSCEs is also highly structured. As a result, there is little focus in the final year on developing skills essential for entering the professional world. The only period during which students have meaningful contact with their future clinical environment is during hospital training.

1.3.3
Perceptions of Preparedness and Structural Shortcomings

Entry into residency exposes how medical training aligns with the realities of clinical work. Perceived shortcomings in preparedness highlight areas in which undergraduate education may not fully meet professional demands. As much of the available evidence predates PROFILES – including the studies below –, it contextualizes the rationale for competency-based reforms addressed in other sections (cf. 1.2.1.3 and 1.3.4.1).

1.3.3.1
Mismatch Between Training and Clinical Professional Practice

In a survey by Luchsinger et al. (2021), based on cohorts trained before PROFILES implementation, the transition from medical school to clinical practice was perceived by many early-career physicians as particularly challenging. Luchsinger et al. (2021: 946) report that only 23% of postgraduate trainees – showing notable differences among faculties – felt very well prepared for clinical work, while 53% felt somewhat prepared. The remaining 24% reported feeling barely or not at all

prepared. Although there is still considerable room for improvement, a longitudinal view across all universities reveals a positive trend: Compared to earlier surveys, the subjective perception of preparedness for professional practice has steadily improved (ibid.).

From the perspective of training supervisors, only 2% considered newly arrived physicians to be very independent, 33% as rather independent, and 46% as rather or very dependent during the first six months after graduation (ibid.: 945). These findings resonate with the results of Monti et al. (2020: 6) – which likewise reflect cohorts trained before PROFILES –, who showed that only a slight majority of residents (54%) felt adequately prepared for postgraduate practice, despite having completed a reformed, competency-based undergraduate curriculum. In this study, residents’ self-assessments largely aligned with senior physicians’ evaluations.

One of the concerns most frequently raised by respondents in Luchsinger et al. (2021: 946) was the insufficient linkage between theoretical knowledge and clinical application. Many trainees criticized the lack of perspectives on clinical care during medical studies: 46% agreed with this statement. Although this represents a slight improvement over earlier surveys (57% in 2003, 49% in 2008), its limited relevance to clinical practice remains a key shortcoming. This points out the need for stronger longitudinal integration of clinical reasoning, responsibility, and decision-making throughout undergraduate education.

1.3.3.2
Training in Transversal Skills

Beyond clinical competencies, transversal skills – such as communication, self-management, interprofessionalism and organizational competencies – are essential for physicians to function effectively in everyday professional practice. For physicians who completed their medical education before the implementation of PROFILES, the following evidence is available:

Luchsinger et al. (2021: 946) report that a majority of postgraduate physicians found their studies helpful in incorporating social factors into medical decision-making, with 38% indicating strong agreement and 45% partial agreement. For comparison, in 2003 these figures were just 21% and 39%, respectively, indicating a marked improvement.

Regarding communication skills, a promising approach has been implemented at the University of Basel: the longitudinal curriculum “Social and Communication Skills” gradually prepares students for these challenges. It includes, among other components, training in communication techniques, breaking bad news, managing stress, and cultivating a professional feedback culture – integrated throughout all years of study. Accompanying evaluations indicate that students who complete this curriculum feel significantly more confident in handling difficult conversational situations (Kiessling and Langewitz 2014: 4–7).

At the same time, as demonstrated by Monti et al. (2020), advances in communication training alone do not automatically translate into preparedness for the broader non-clinical realities of clinical practice. In particular, gaps remain in self-organization, interprofessional collaboration, and coping with professional responsibility. Additionally, Kiessling and Langewitz (2014: 9) emphasize that although the progress in teaching social aspects and a shift toward more practice-oriented education is evident, the call for systematic integration of these transversal competencies into the curriculum remains.

With the digitalization of the healthcare sector and the development of widely accessible AI tools, likely to affect many aspects of medical practice as well as patient-provider and interprofessional relationships and skills, new training may have to be included in graduate medical education, such as more advanced digital literacy, fundamentals of modern AI, computational thinking, as well as research incentives.

With the introduction of PROFILES, a framework was established that explicitly addresses this challenge by embedding a range of non-cognitive and transversal competencies into undergraduate medical education (cf. 1.2.1.3 and 1.3.4.1).

1.3.4
Approaches to Supporting the Transition to Residency

In response to the structural shortcomings identified in the preparation for professional practice, different approaches have been proposed to support the transition from medical school to residency. These approaches operate at multiple levels, ranging from systemic reforms of curricula and assessment frameworks to individ-

ualized support through coaching and mentoring.

1.3.4.1

Structural Approaches: Rethinking the Curriculum as a Transition Phase

A full implementation of a CBME programme – based on PROFILES in the Swiss context – requires core components with programmatic assessment as one of these (van Melle et al. 2019). Programmatic assessment is a system in which many small pieces of information about a student's performance (tests, observations, clinical encounters, feedback) are collected over time, rather than relying on a few isolated high-stakes exams. Each piece is low-stakes on its own, but together they provide a much more reliable and objective picture of the student's competence across all seven CanMEDS roles.

An illustrative example is provided by the University of Fribourg, which launched its new master's programme in 2019. Fully grounded in PROFILES, the programme is competency-based, integrates programmatic assessment, and places strong emphasis on family medicine. It includes 30 weeks of clinical rotations, 15 days of a longitudinal family medicine clerkship, and an 11-month elective year (2 months dedicated to mandatory family medicine).

Grounded in humanistic pedagogy, it focuses on the development and assessment of all seven competency roles of PROFILES (not only Medical Expert and Communicator, as is often the case) as well as reflective practice (Bonvin et al. 2022). Students are trained to learn autonomously from clinical encounters, thereby assuming responsibility for their own learning process. They are also expected to develop their active contribution to care progressively. Thus, the master's is regarded as a transition to residency; it aims to prepare students for their first year of residency beyond the licensing examination. A comprehensive mentoring programme is central to this approach; every student is assigned a learning advisor to guide them throughout the three years of the master's.

With this distinctive approach, students from Fribourg perform exceptionally well on the licensing exam, and, more importantly, they feel better prepared for their start in residency, a fact recognized by their clinical supervisors.

1.3.4.2

Individual Approaches: Coaching and Mentoring to Support Career Decisions

While structurally redesigned curricula can substantially improve preparedness for residency, they cannot fully account for the diversity of individual career paths, personal aspirations, and contextual constraints faced by young physicians. Individual coaching and mentoring, therefore, are structural components of modern medical education, complementing curricular reforms and supporting informed career decisions at critical transition points. Both instruments can integrate expert and/or peer components.

Alongside the longitudinal mentoring model embedded in the Fribourg Master's programme (cf. 1.3.4.1), other universities, such as Geneva, propose individual projects to enhance the development of professional identity longitudinally, starting from the bachelor's level and including pair mentoring and faculty coaching.

Another initiative is *Coach my Career*, a cross-generational mentoring programme established to address this need (FMH: n.d.). Launched in 2018 by the FMH in collaboration with mfe, SIWF/ISFM, swimsa, VLSS and vsao/asmac, the programme addresses a well-recognized gap: young doctors are often required to make far-reaching choices – ranging from the selection of a medical specialty to decisions about academic trajectories, clinical leadership roles, or practice settings – without access to impartial, experienced guidance (VLSS: n.d.). Coach my Career therefore provides a structured framework in which mentees receive personalized, independent support at a crucial juncture of their professional development.

The programme pairs each participant with two volunteer mentors – one from the mentee's intended field and one from another discipline – drawn from a broad network of senior clinicians, including former or active chief physicians, hospital leaders and established general practitioners. Through a formalized matching process, mentees engage in a confidential two-hour advisory consultation, with the option of additional sessions as needed (Gubler 2024: 10).

2

Critical Assessment of the Current Model

2.1
Admission to Medical Studies

Admission to medical school represents the first decisive gateway in the physician’s educational pathway, potentially shaping the competency profile and personal attributes of students admitted to medical schools. The selection process not only reflects academic achievement but also conveys societal values and conceptions of professional suitability. At the same time, it exposes structural conflicts between objectivity, fairness, and predictive validity. A sound and equitable admission policy must therefore balance measurable academic indicators with the assessment of non-cognitive competencies, while ensuring national coherence and transparency in the selection process.

2.1.1
Selection Criteria: Identifying Core Competencies

One of the primary challenges in medical school admissions is determining the right set of criteria that best predicts a candidate’s potential for success in medical studies as well as for clinical professional practice. Core competencies such as academic ability, emotional skills, resilience, and (self-)compassion are important factors. While academic performance is relatively reliable to assess, competencies such as emotional competence or professional attitude are harder to evaluate. There is no universally accepted, unique tool, particularly when working with young people in their still-maturing phase, to reliably predict these traits and qualities.

Additionally, selecting based on predicted future career paths, such as specialization or geographic location, is fraught with difficulties. Many applicants may offer aspirational or socially desirable responses to questions about their intended career choices, making it difficult to accurately predict their future trajectory. Given the dynamic nature of medical careers and students’ evolving interests as they progress through their studies, selecting candidates based on such factors may be unrealistic and counterproductive.

The question of Nature or Nurture cannot be avoided (Schwartzstein 2015). The idea that once the right selection is made, the issue of those non-medical-expert competencies is resolved is a misconception. Those competencies may, at best, be buds at the selection stage that require nurturing and development throughout the entire medical training.

2.1.2
Use of Baccalaureate Grades and Academic Metrics

Baccalaureate grades are considered a reliable predictor of academic success in the initial years of university (Krings et al. 2020). In some countries, baccalaureate grades are used as an academic benchmark in the selection process. While this approach provides a measurable indicator of a candidate’s academic abilities, it is not without its drawbacks. There is a risk that upper-secondary schools may alter grading practices to optimize their students’ chances of being admitted to medical programmes, resulting in inflated or inconsistent grading standards across institutions. Theoretically, other levels of individual or institutional subjectivity may play an additional role. Furthermore, reliance on academic metrics, such as baccalaureate grades, risks narrowing the selection pool to individuals who excel early in traditional academic settings, potentially overlooking candidates who will cognitively mature later and/or those with valuable non-cognitive attributes critical to a medical career.

2.1.3
The Role of Multiple Mini Interviews (MMIs) and Other Selection Methods

MMIs have become a widely discussed tool for assessing non-cognitive skills such as interpersonal communication, ethical reasoning, and problem-solving. While MMIs can provide valuable insights into a candidate’s suitability for medical education, they are resource-intensive, requiring significant time and effort from both the candidates and the institutions involved. Given the logistical and financial demands, MMIs may not be a sustainable option for all medical schools, especially in systems with limited resources. As such, the balance between the insights gained from MMIs and the resource burden they impose needs careful consideration.

2.1.4
Clinical Immersion: A Valuable, Yet Resource-Intensive Approach

Clinical immersion, or the inclusion of real-world medical experience in the selection process, offers potential benefits by allowing candidates to experience the realities of medical practice firsthand. A well-planned and educationally structured clinical exposure can help individuals self-select based on their genuine interest and commitment to the field. However, using clinical immersion as part of the

selection process raises logistical and ethical questions. For one, assessing the value of clinical immersion experiences poses challenges, as it requires clear standards and evaluation criteria. Additionally, integrating such experiences places additional enormous strain on healthcare systems that may already be under-resourced, thereby limiting the practicality of this approach.

2.1.5
Equity and Fairness in the Admissions Process

Ensuring equity in the admissions process is paramount. Selection methods must not inadvertently favor candidates from privileged socio-economic backgrounds. For example, the use of letters of recommendation could skew the selection process in favor of candidates with access to influential mentors, exacerbating existing social inequalities. Thus, it is critical to design selection tools that are both fair and transparent, avoiding biases that could undermine the merit-based nature of the admissions process.

2.1.6
The Ideal Selection Approach

All the individual selection tools presented so far can predict one facet of future students. Some selection processes seek to combine multiple tools and integrate the advantages of each into a more holistic approach (Schreurs et al. 2018).

Costs also need to be considered. The ideal selection approach should be affordable. This favours paper-and-pencil tests like the EMS, or even upper-secondary school grades. The methodologies for selecting competencies, such as emotional competence or professional attitude, are usually costly, do not scale easily, and make cost-effectiveness difficult to establish. To make it more affordable and less resource-intensive, the selection process is conducted sequentially, with low-cost methods used for early, high-volume selection and more expensive approaches reserved for a smaller, pre-selected pool of candidates.

2.1.7
National Coordination and Consistency

Currently, the Swiss medical school admissions system is fragmented, with language regions and their institutions applying their own selection criteria and methods. This fragmentation can create inequities and potentially motivate candidates to apply to institutions where the admission process is perceived as more favorable to their chances of success. A more coordinated and shared national approach, while still respecting the federalist spirit, could ensure greater consistency across institutions, reducing disparities and promoting fairness in the selection process.

2.2
Medical Studies

The medical curriculum forms the core of physician education. It plays a central role in shaping the professional identity of future doctors, as well as indirectly influencing the entire health system. It stands at the intersection of traditional knowledge transmission and modern CBME, which increasingly emphasizes critical thinking, communication, and reflective practice. However, structural and resource-related constraints often hinder the realization of these aspirations. Consequently, medical studies must be understood as a dynamic process that integrates knowledge acquisition, personal development, and institutional responsibility into a coherent and sustainable educational framework.

2.2.1
Competency and What We Actually Assess

In medical studies, assessment largely centers around medical expertise, with approximately 90% of evaluations focused on cognitive knowledge. While frameworks like PROFILES highlight competencies across various domains – such as professionalism, collaboration, and communication – these skills are often underrepresented in assessments. The current approach predominantly evaluates students’ ability to give the right answers in exams, rather than fostering their capacity to ask the right questions and reflect on or assess their reasoning critically.

This focus on knowledge recall presents a challenge as technological advancements, such as large language models (e.g., ChatGPT), now outperform students on many traditional assessment tasks. This shift points to the growing need to reconsider how medical education and assessments are structured. The focus should evolve from testing knowledge to nurturing critical thinking, creativity, and reflective practices that allow students to engage with real-world medical scenarios.

2.2.2
Scalability and Resource Constraints

The scalability of CBME poses another major challenge for medical studies. The model emphasizes clinical placements and assessments tailored to competencies, requiring significant resources – both in terms of time and personnel. However, the available clinical resources do not match the demands of a growing student population. Clinical placements are limited, and structured exams, such as OSCEs, often disrupt hospital daily routines, further compounding the issue.

Given these resource constraints, there needs to be a rethinking of how clinical education is structured. Simulation-based learning and virtual patients offer an alternative to traditional clinical placements and may help alleviate some of the strain on healthcare systems. However, these tools must be integrated carefully to complement and prepare for real-world clinical experiences rather than replace them. Additionally, medical schools and healthcare institutions need to collaborate and coordinate more effectively to optimize the use of available clinical resources to avoid unhelpful tensions.

2.2.3
Dropout Rates and the Under-the-Radar Struggles

The official dropout rate in medical education does not fully capture the scope of the problem. Many students who do not officially drop out still face significant struggles. These students may continue through the programme, but are under extreme stress and have limited resources to cope. As a result, while they manage to complete the undergraduate training, they often face mental health issues that hinder their ability to succeed in their clinical careers.

These students may have passed initial assessments but lack the resilience or emotional resources to handle the demands of medical training. They may be struggling with mental health issues such as burnout, anxiety, or depression, which are not always visible in the early stages of their education. To address this, it is important to identify these students early on and offer them the support they need, such as mentoring, counseling, or disadvantage compensation, before their struggles affect their overall performance.

2.2.4
Special Learning Needs

The number of students requesting compensation and adaptations for their special learning needs is increasing. These requests are handled differently and not in a coordinated manner throughout the medical training journey. At all three key moments – the EMS, the universities, and the Federal Licensing Exam – different criteria may be applied, with varying degrees of consideration for the needs of the clinical profession. This results in a unequal treatment of those candidates. While acknowledging the inherent challenges, there is a need for a shared, coordinated approach among the admission testing bodies, all medical schools, the MEBEKO for the licensing examination, and the SIWF/ISFM for postgraduate training, to establish a unified catalogue of rules that would help candidates plan and prepare their studies.

2.2.5
Mental Health: A Growing Concern in Medical Education

Mental health concerns among medical students have become increasingly prevalent. There has been a noticeable shift in the mental health profiles of medical students over the past decade, with more students reporting high levels of stress, anxiety, and burnout. These issues are not only prevalent during the educational phase but continue into residency, where the pressures of the job often exacerbate existing mental health problems.

It is essential for medical schools to address mental health concerns proactively. On one hand, they need to ensure that their curricula do not unnecessarily harm students' mental health (content overload, excessive competitiveness, exam pressures, etc.). On the other hand, they must provide support systems such as counselling services, mental health resources, and mentoring programmes to help students manage the pressures of medical training. Additionally, addressing the stigma around mental health is crucial to ensuring students feel comfortable seeking help when they need it.

2.2.6
Studying Abroad: Untapped Potential

Medical students who choose to study abroad often encounter negative perceptions upon their return to Switzerland. Their peers, who studied within Switzerland, as well as supervisors, may view them as individuals who were unable to pass the Swiss exams. This perception can lead to discrimination and a sense of failure

among these returning doctors. Such negative attitudes devalue the valuable knowledge and experience these students acquire while studying abroad. Despite the challenges they face, students who study outside of Switzerland tend to possess a strong drive to succeed in the medical profession. Their decision to pursue education abroad demonstrates a deep commitment to becoming a doctor.

There is agreement that significant efforts are needed to integrate these students into the Swiss medical education system in a more structured and supportive manner. Switzerland could explore partnerships with foreign universities, as Norway does, in which students trained abroad are more openly accepted and even organized into associations. Such an approach would not only recognize the value of foreign education but also help address the national shortage of medical professionals.

2.3
Transition Phase to Postgraduate Studies

The transition from medical studies to postgraduate training is one of the most sensitive and structurally complex stages of medical education in Switzerland. It is characterized by fragmented governance, uneven accountability, and a lack of integration between the university and hospital systems. This phase – the bridge from student to physician – is essential for the formation of professional identity and the consolidation of clinical competence. Yet, it currently suffers from systemic disconnection and cultural inconsistencies that limit its effectiveness. Medical schools and hospitals must recognize that they are co-responsible for success in this transition phase and need to adjust their training accordingly.

2.3.1
Governance and Structural Discontinuity

A central challenge during the transition phase lies in the institutional risk of discontinuity and fragmentation between undergraduate and postgraduate education.

From a historical perspective, despite the different methods of financing educational and clinical activities, as well as the distinct regulatory processes (universities and cantons for undergraduate education, government and SIWF/ISFM for clinical, graduate education), the overarching goal has been to maintain a close relationship between the two spheres – in a system of communicating vessels. However, in some areas, this goal has been only partially or even completely unsuccessful, leaving the system vulnerable to fragmentation. While the clinical environment serves both students and residents, it often lacks the necessary structures, protected time, trained supervisors, and incentives to ensure high-quality teaching at both levels. Without aligned governance and responsibility, the transition phase risks becoming an institutional gap rather than a seamless educational continuum.

Indeed, the concept that any clinical setting that benefits both students and residents must have a training mission – whether at the undergraduate or graduate level – is a central aspect of modern medical education. This mission should, therefore, be promoted at every institutional level.

The principles of competency-based medical education can support this continuum and help bridge the gap between undergraduate and postgraduate training, as well as across different stages of postgraduate education. This approach is akin to the “Competency by Design” model introduced by the Royal College of Physicians and Surgeons of Canada in 2017. Achieving such integration requires sustained and dedicated effort. It becomes essential to identify or create additional piloting structures extending beyond the current interactions between undergraduate education and SIWF/ISFM at SMIFK/CIMS.

2.3.2
Educational Space and Institutional Accountability

The transition from student to resident depends heavily on the presence of a sustainable educational space. This encompasses not only physical resources such as offices, equipment, and access to patient data, but also the cultural and organizational climate that supports learning. Currently, hospitals and clinics often lack protected teaching time and do not formally recognize teaching as a core institutional mission. Educational duties remain dependent on individual goodwill rather than structural accountability.

Leadership engagement – particularly from hospital CEOs, CMOs, and department heads – is critical but often insufficient. Without explicit mandates and incentives for teaching quality, education remains subordinate to service and research

priorities. This lack of institutional accountability undermines both the consistency and the perceived value of clinical education. The transition phase, therefore, requires a redefinition of teaching as an institutional responsibility embedded in the governance and resource allocation structures of healthcare institutions.

2.3.3

The Need for Coordination and a Closed Feedback Loop

The current lack of coordination between undergraduate and postgraduate education systems hinders the creation of a closed feedback loop. This mechanism would enable information about student preparedness and residency performance to inform curriculum development. While postgraduate education currently benefits from quality assurance tools such as site visits and national surveys, these methods are not systematically applied to undergraduate clinical placements. As a result, there is limited data flow, leading to missed opportunities for continuous improvement.

Without such a loop, universities remain uncertain about how effectively their graduates transition into residency, and hospitals have limited opportunities to influence the preparation of incoming residents systematically. Establishing this bidirectional exchange of feedback would enhance responsiveness in medical education, enabling dynamic curriculum adjustment and alignment of expectations across training phases.

2.3.4

Clinical Learning Environments and Teaching Quality

High-quality clinical education during the transition phase depends on well-functioning clinical learning environments and well-trained educators. However, these environments are increasingly under strain due to pressure in clinical routine, limited resources, and growing student numbers. Supervisors often lack the time and institutional support to engage meaningfully in teaching or even to be adequately trained. Moreover, educational activities are rarely linked to performance evaluations or institutional accreditation, leading to variable quality across training sites.

While postgraduate programmes have introduced structured quality assurance processes, such as surveys and site visits, undergraduate placements often lack similar oversight. As a result, the quality of clinical teaching during the master’s years can vary significantly between hospitals and regions. Implementing structured, national-level quality assurance mechanisms for both undergraduate and postgraduate placements would promote consistency, transparency, and accountability. An important part of quality assurance also lies in the professional educational training of trainers, which is currently offered at universities and by the SIWF/ISFM. Mutual recognition of these training programs would help ensure that clinicians’ professional education qualifications are recognized and simplified, as teaching clinicians are often responsible for teaching students and residents. Moreover, universities could improve the valuation of clinical teachers by establishing academic pathways in which existing titles, such as clinical teacher (*Klinischer Dozent, Maître d’enseignement Clinique*), serve as the entry point for further advancement possibilities.

2.3.5

Outpatient and Ambulatory Teaching: Untapped Potential

Outpatient settings – including general practice, pediatrics, and psychiatry – represent valuable yet underutilized during medical studies learning environments. They offer authentic exposure to patient-centered, longitudinal care and provide insight into specialties often overlooked in hospital-based education. These placements can serve as an important “reality check,” giving students a clearer understanding of professional life beyond tertiary hospitals and potentially enhancing the appeal of general practice careers.

However, integrating outpatient teaching requires addressing logistical barriers such as supervision capacity, infrastructure, and financial incentives. Without dedicated funding or recognition for teaching in private practices, the potential of these environments remains underexploited.

2.3.6

Responsibility, Self-Regulation, and Professional Maturity

One of the defining characteristics of the transition phase is the progressive assumption of responsibility. Students in their final years must evolve from passive learners to active contributors capable of autonomous work within clinical teams. Yet, current structures often fail to support this transition effectively. Supervisors, constrained by time and service demands, may find it easier to give direct instructions rather than fostering independent reasoning. This inhibits residents’ development of self-regulation and confidence.

On the other hand, trainees must also internalize their professional obligations. The transition phase is not only about learning but also about contributing meaningfully to patient care and the health care system, even on a micro level. Balancing autonomy and supervision requires a culture of shared responsibility in which both learners and educators understand and respect their roles. The gradual assumption of responsibility must be guided and structured – neither imposed prematurely nor withheld excessively.

2.3.7

Culture of Change and Educational Continuity

Beyond structural reforms, the transition phase requires a cultural transformation. Teaching must be recognized as a shared institutional duty rather than a voluntary act of goodwill. Educators, students, and institutions must engage in mutual accountability, with feedback, evaluation, and improvement integral to the educational culture. Without this cultural shift, even well-designed reforms will struggle to achieve long-term sustainability.

Finally, fostering educational continuity depends on concrete instruments – such as digital portfolios, EPAs, and cross-phase educator roles – that enable longitudinal tracking of competencies. These tools can bridge institutional divides and ensure that students’ progression from university to clinical practice is guided, monitored, and supported at every stage of the medical training continuum.

General Conclusions

The analysis of the different phases of medical studies in Switzerland makes it possible to draw a sufficiently accurate picture of the current context and provides clear indications regarding the mechanisms and dynamics that govern its functioning. At the same time, it allows us to draw conclusions about the measures needed to address the various challenges, by fostering active learning, critical thinking, patient-centered action, and personal resilience, while ensuring that educational quality is maintained as training capacity expands.

The first general conclusion that can be drawn is that the Swiss model remains attractive and competitive and is still capable of meeting the educational objectives required for high-quality medicine.

There is no doubt that the decisive element that has enabled the definition of shared curricula and educational objectives among the different faculties has been the introduction of PROFILES, recently updated with the implementation of PROFILES 2. The PROFILES framework, together with the significant work carried out by SMIFK/CIMS, represents the *fil rouge* on which a new unified educational culture can be built – while fully respecting the teaching autonomy of each faculty, which should be seen as an important added value. This unified culture should address current weaknesses and gaps within the system and better prepare students for upcoming professional challenges, an aspect explored in this document through reflections on the transition phase.

However, the document clearly highlights certain limitations of the current model, which will likely require, even in view of present healthcare and educational policy activities, a thorough revision of mechanisms that have become outdated and no longer meet the modern requirements of a training system that remains too focused on passing exams and not sufficiently on preparing for the subsequent professional phase.

The main critical points of the current model of Swiss medical studies, which will be discussed below, can be summarized as follows: the admission criteria for studies, both qualitative and quantitative, no longer meet current educational needs and professional expectations; during the course of studies, in addition to the unresolved issue of students who, out of necessity, complete their studies at foreign universities, a portion of students exhibit concerning symptoms of mental stress, even though the attrition rate remains low; and finally, as discussed under the transition phase, preparation for future professional life does not appear adequate to meet the challenges of the working world.

Admission to Medical Studies

The current model, with the introduction of the NC, implemented in two different modalities, effectively allows for managing the number of students in a sufficiently objective manner based on cognitive criteria, but does not allow for the assessment of core competencies, which include, in addition to academic ability, transversal skills such as emotional skills, resilience, and (self-)compassion.

While the model ensures adequate selection in terms of successful completion of studies and exams, it no longer meets modern standards. Also, it introduces a component of stress, particularly evident in the Francophone Concours system.

Comparison with other contexts shows that alternative mixed models already exist and are being implemented: models that take into account both cognitive competencies – through aptitude tests and school grading – and broader competencies that better define future professional attitudes (MMIs, motivational letters, etc.), without requiring hospital internships, which would inevitably place additional strain on the healthcare system. The introduction of additional competency tests would inevitably entail a new, rigorous standardization, given the inherent risk of interpretative bias. This document provides an extensive analysis of the various assessment methods, together with a comparison with major international systems.

The second major issue in the student admission process concerns the number of students to be admitted. While it is acknowledged that the number of physicians currently trained is insufficient and that demand exceeds the existing threshold of 1,350 students, there remains a lack of national, coordinated, and strategic planning to determine the number of physicians required by the community and, consequently, the appropriate number of medical students to be trained.

The definition of the student contingent has national strategic relevance, as it will determine the future contingents for hospitals and medical services nationwide. As such, it requires a broadly shared solution within a strategic vision coordinated among the government, the cantons, and the universities.

Medical Studies

As mentioned, the Swiss model – with a document that clearly and practically defines educational outcomes while leaving each faculty the freedom to develop its own teaching model, and with final alignment ensured at the time of federal exams – is undoubtedly successful. As such, it should be maintained, protected, and promoted. Similarly, the mobility currently guaranteed to students within the Swiss educational pathway should be defended and encouraged.

The dropout rate after selection is marginal and is mainly linked to failures in faculty-level exams. However, the number of students who annually choose to attend foreign universities to pursue their aspirations – estimated, albeit with unreliable data, at 50–100 per year – is a cause for reflection. In this regard, more reliable monitoring is certainly advisable, along with consideration of how the start of their clinical career could be facilitated through appropriate onboarding to prepare them for the demanding Swiss labor market.

Regardless of dropout data, one issue that deserves attention – and possibly solutions – is the level of mental distress and stress perceived by students throughout their studies.

Certainly, it is important to engage students more closely by offering a high level of interaction and communication, promoting role models, and, at the same time, supporting them with structured and continuous coaching.

A matter to consider, though perhaps over a longer-term horizon, is improved coordination of the teaching pathways between universities, primarily to facilitate student mobility across the different medical schools.

Transition Phase to Postgraduate Studies

The transition phase, commonly defined as the period between student life and professional practice, has emerged as one of the “critical” points in the document. It has not yet been sufficiently explored or studied in Swiss medical education. Still, it appears to be a key factor that heavily influences graduates’ transition into professional life. Numerous indicators, from both young doctors and medical students, point to significant distress and inadequate preparation for hospital work and postgraduate training. The problem likely begins already at the level of medical school admission and persists throughout the course of studies, with a model still too focused on academic success and too little on professional preparation.

Although the PROFILES framework emphasizes that the declared objective is to prepare students for their first day of work, the essential competencies and skills needed to make this transition as smooth as possible – and to prevent many students from perceiving it as traumatic – are currently insufficiently addressed. These missing elements can deter some students. There is no immediate solution for developing resilience, but the issue must be studied and taken very seriously. Already during medical school, through targeted training and by rethinking the clinical pathway model (the *cand. med.* period), it is possible to design a system that enables students to succeed academically and achieve professional readiness.

It is also clear that a thorough reflection is needed to foster a more coherent educational alignment between undergraduate and postgraduate education, which is currently only partially addressed and still in its early stages.

The healthcare environment also needs to adapt to the new situation and rethink how residents are employed for administrative tasks and the work environment.

3.5

Conclusion

In conclusion, we are convinced that the white paper prepared by the Collège des Doyens in collaboration with SMIFK/CIMS, and supported by SIWF/ISFM, as well as the medical and student associations vsao/asmac and swimsa, provides a reliable overview of the current Swiss medical education model and, at the same time, offers guidance on how to explore specific aspects further. We are confident that future academic and political actions can draw useful insights from it to develop practical solutions, some of which are relatively urgent.

4

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4.1

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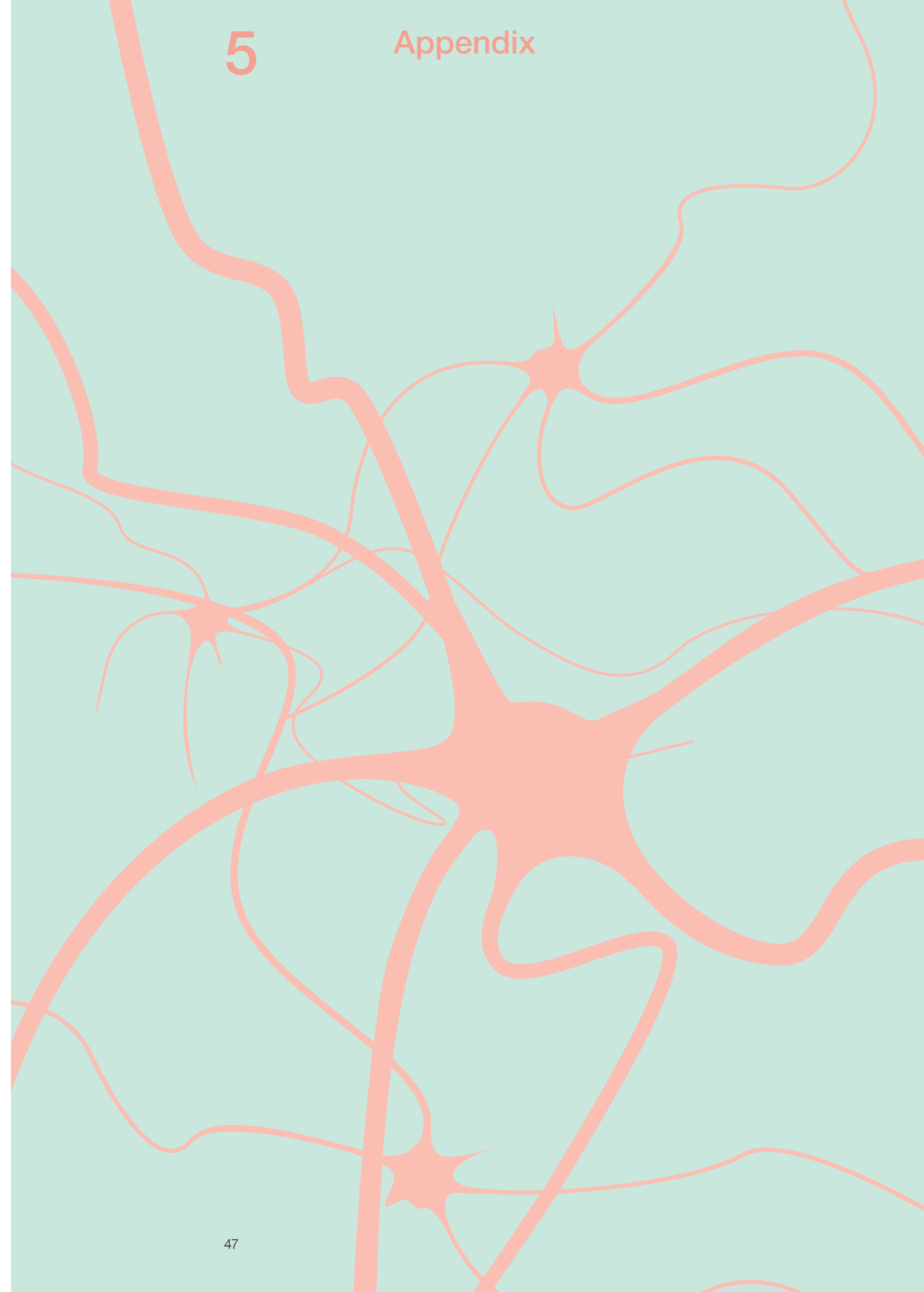
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Item Number	Type of Parliamentary Instrument	Submitting Person / Group	Political Affiliation	Canton	Title
92.1146	Question	Wick Hugo	CVP	BS	Ungebremszte Zunahme der Ärztedichte in der Schweiz
93.3414	Motion	Plattner Gian-Reto	SP	BS	Sozialjahr statt Numerus clausus Pour une période de travail social en lieu et place du numerus clausus
93.3503	Postulate	Wick Hugo	CVP	BS	Pflegepraktikum als Voraussetzung zum Medizin-studium Stage d'infirmier comme condition aux études de médecine
94.3487	Postulate	Schmid-Sutter Carlo	CVP	AI	Pflegepraktikum als Voraussetzung zum Medizin-studium Stage d'infirmier comme condition aux études de médecine
94.5168	Question	Hollenstein Pia	GP	SG	Medizinstudium
95.3169	Motion	Comby Bernard	FDP	VS	Hochschulen. Propädeutisches Jahr anstelle des Numerus clausus Hautes écoles. Année propédeutique au lieu d'un numerus clausus
97.3102	Interpellation	Iten Andreas	FDP	ZG	Koordination der Reform des Medizinstudiums Coordination des projets de réforme des études de médecine
98.3176	Interpellation	Guisan Yves	FDP	VD	Zugang zum Arztberuf und Medizinstudium Accès à la profession médicale et aux études de médecine
98.415	Parliamentary initiative	Guisan Yves	FDP	VD	Zugang zum Arztberuf und Medizinstudium Accès à la profession médicale et aux études de médecine
01.3171	Interpellation	Rossini Stéphane	SP	VS	Ärztedichte. Steuerungselemente Densité médicale. Instruments de pilotage et options
09.321	Interpellation	Gutzwiller Felix	FDP	ZH	Attraktivität des Medizinstudiums Attractivité des études de médecine
10.454	Parliamentary initiative	Neiryck Jacques	CVP	VD	Bundesweite Koordinierung der Zulassung zu den medizinischen Fakultäten Coordination fédérale de l'admission aux facultés de médecine
11.3526	Motion	Häberli-Koller Brigitte / Amherd Viola	CVP	TG / VS	Mehr Schweizer Nachwuchs dank Aufhebung des Numerus clausus Accroître la relève suisse en supprimant le numerus clausus
11.3885	Interpellation	Mitte-Fraktion	CVP		Mehr Studienplätze und Alternativen zum Numerus clausus Places d'études supplémentaires et solutions de remplacement pour le numerus clausus
11.3933	Interpellation	Schwaller Urs	CVP	FR	Mehr Studienplätze und Alternativen zum Numerus clausus Places d'études supplémentaires et solutions de remplacement pour le numerus clausus
12.4028	Motion	Neiryck Jacques	CVP	VD	Garantie des Bundes für genügend Ärzten-achwuchs Garantie de la relève médicale par la Confédération
13.2047	Petition	Wäfler Urs			Abschaffung des Numerus clausus für das Medizinstudium Suppression du numerus clausus pour les études de médecine
14.407	Parliamentary initiative	Kessler Margrit	GLP	SG	Mehr Ausbildungsplätze in der Humanmedizin. Stopp dem drohenden Ärztemangel Plus de places de formation dans la médecine humaine. Halte à la pénurie de médecins qui se dessine
14.3112	Interpellation	Stahl Jürg	SVP	ZH	Hausgemachter Fachkräftemangel im Gesundheitswesen Secteur de la santé. Pénurie de personnel spécialisé due à des raisons internes
15.3687	Motion	Humbel Ruth	CVP	AG	Praktikum als Eignungstest für das Medizinstudium Un test d'aptitudes sous forme de stage pour entrer en faculté de médecine
15.3967	Postulate	Cassis Ignazio	FDP	TI	Numerus clausus. Israelisches Modell für die Selektion der Medizinstudenten in der Schweiz? Numerus clausus en médecine. Introduire le modèle israélien en Suisse?

Item Number	Type of Parliamentary Instrument	Submitting Person / Group	Political Affiliation	Canton	Title
15.5015	Question	Friedl Claudia	SP	SG	Anzahl der Studienplätze 2015 in der Medizin Etudes de médecine. Nombre de places disponibles en 2015
15.5033	Question	Neiryck Jacques	CVP	VD	Medizinstudium und Numerus clausus Numerus clausus. Formation des médecins
15.5166	Question	Neiryck Jacques	CVP	VD	Irreführende Informationen zum Numerus clausus für das Medizinstudium Données fallacieuses sur le numerus clausus en médecine
16.4118	Motion	Bulliard-Marbach Christine	CVP	FR	Das Medizinstudium mit Medical Schools reformieren Réformer les études de médecine avec les "medical schools"
19.3308	Postulate	Addor Jean-Luc	SVP	VS	Tendenz zu immer mehr ausländischen Ärztinnen und Ärzten umkehren Inverser la tendance à l'augmentation du nombre des médecins étrangers
20.3394	Motion	Barrile Angelo	SP	ZH	Stärkung der Ausbildung von Ärztinnen und Ärzten in der Schweiz Pour la formation de davantage de médecins en Suisse
20.3425	Motion	Carobbio Guscetti Marina	SP	TI	Die Schweiz muss mehr Ärztinnen und Ärzte ausbilden Il faut former plus de médecins en Suisse!
20.3587	Interpellation	Chiesa Marco	SVP	TI	Numerus clausus und Aussichten in der Ausbildung von Ärztinnen und Ärzten Numerus clausus et perspectives de la formation des médecins
21.3843	Postulate	Riniker Maja	FDP	AG	Auswirkung des Numerus clausus auf die medizinische Versorgungssicherheit Conséquences du numerus clausus sur la sécurité de la couverture des besoins en soins médicaux
21.7553	Question	Riniker Maja	FDP	AG	Anzahl Frauen und Männer mit erfolgreicher Numerus clausus Prüfung sowie erfolgreichem Abschluss des Medizinstudiums Nombre d'hommes et de femmes ayant réussi l'examen d'admission aux études de médecine et l'examen de fin d'études
23.3293	Motion	Roduit Benjamin	Mitte	VS	Numerus clausus. Schluss mit dem Ausschluss von Medizinstudierenden aufgrund anderer Kriterien als Kompetenzen und Qualität. Numerus clausus. En finir avec une sélection des étudiants en médecine sur des critères autres que de compétences et de qualité
23.3678	Postulate	Juillard Charles	Mitte	JU	Wie kann dem Mangel an Hausärztinnen und Hausärzten sowie Ärztinnen und Ärzten in bestimmten Fachgebieten sofort begegnet werden, insbesondere in bestimmten Regionen der Schweiz? Comment faire face dès aujourd'hui à la pénurie de médecins généralistes et de certains spécialistes, en particulier dans certaines régions du pays?
23.3854	Motion	Hurni Baptiste	SP	NE	Mangel an Ärztinnen und Ärzten in der Schweiz. Vorbeugen ist besser als Heilen! Pénurie de médecins en Suisse. Mieux vaut prévenir que guérir!
23.3864	Postulate	Hurni Baptiste	SP	NE	Mangel an Ärztinnen und Ärzten. Vermeiden wir einen Mangel an Lösungen! Pénurie de médecins en Suisse. Evitons la pénurie de solutions!
23.3889	Postulate	Wyss Sarah	SP	BS	Ärztemangel bekämpfen. Prüfung der Einführung einer medizinischen Hochschule Schweiz Lutter contre la pénurie de médecins. Quid de la création d'une haute école de médecine en Suisse?
24.3170	Motion	Bulliard-Marbach Christine	Mitte	FR	Gegen Ärztemangel: Erleichterter Zugang zum Medizinstudium für höhere qualifizierte Pflegefachpersonen Faciliter l'accès aux études de médecine des infirmiers hautement qualifiés pour lutter contre la pénurie de médecins

Table 4:
Overview of Parliamentary Submissions
Note: The entries included in this table were retrieved through systematic searches of Curia Vista, the official parliamentary database of the Swiss Parliament (Swiss Parliament, n.d.). The corresponding numbers enable direct consultation of the original records.

