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Careers in Medicine | AAMC

# CHOICES

The Careers in Medicine newsletter

Association of American Medical Colleges

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## In This Issue



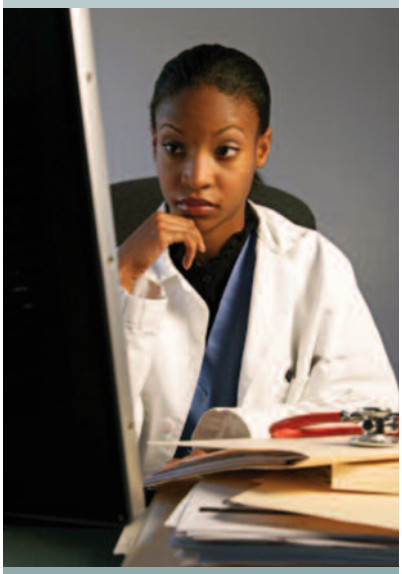
## From the Director

As the school year draws to a close, it is good to reflect on your successes from the year and to think about your plans for the next year. You may have already made plans for the summer or you may be realizing there is not much time between semesters to rest and relax. But it is important to think about your career in terms of what you've accomplished recently and what you hope to accomplish in the coming months or years.

Ask yourself the following questions: What experiences have you had (good or bad) that made you think about the specialty direction you are considering? What courses or topics resonated with you? Did you complete an activity or rotation that you really enjoyed or, alternatively, made you think a particular field is not for you? Are there some areas that you would like to explore in an upcoming class or clerkship that may help you crystallize your thoughts? How can your summer experience and the upcoming school year contribute to the development of your future career?

We all recognize that the focus of medical education is to train you to become a good doctor, but utilizing this educational microcosm to help you make your specialty choice is an additional benefit. Have a great summer!

**George V. Richard, Ph.D.**
*Director, Careers in Medicine*



Spotlight on Specialties

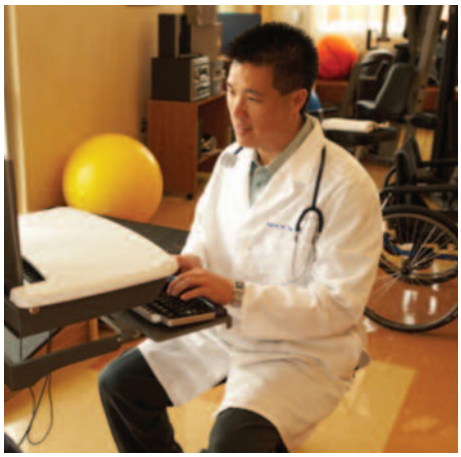
## Physical Medicine and Rehabilitation

Physiatry, or its official name physical medicine and rehabilitation (PM&R), is one of those specialty areas that often goes unrecognized. It's a small specialty but the physicians in the field do some very big work. They are the physicians mainly responsible for synthesizing the diagnosis and treatment of physical disabilities or catastrophic injuries. If there is an injury or physical disability stemming from any number of causes (i.e., trauma, sport injury, birth defect, disease, or musculoskeletal disorder), a physiatrist (pronounced fĭz′ ē-ăt′ rĭst) will diagnose, evaluate, and plan the comprehensive treatment and pain management for these patients. They get a patient's function and daily living back to normal, or as normal as possible, using a holistic approach. With the expertise of an interdisciplinary team of healthcare specialists, a physiatrist's main goal is helping patients work to achieve the highest level of physical, psychological, social, and vocational function possible by way of a carefully planned rehabilitation.[1] First recognized as a specialty by the American Medical Association and the American Board of Medical Specialties in the late 1940's, there were nearly 9,000 practicing physiatrists in the United States as of 2007.[2]

To get a current perspective on a day in the life of a physical medicine and rehabilitation physician, Careers in Medicine interviewed Darryl Kaelin, M.D., medical director of both the acquired brain injury program and brain injury research program at Shepherd Center in Atlanta, Georgia. Dr. Kaelin is also an associate

professor in the rehabilitation medicine department at Emory University School of Medicine.

Dr. Kaelin was fortunate because he did not have much difficulty choosing a field—he knew he wanted to practice physical medicine and rehabilitation. Before deciding on a specialty, Dr. Kaelin had some experience with sports medicine and he considered it as a career. He liked the interdisciplinary and team approach common to both physiatry and sports medicine. Like other specialties, however, there are opportunities to focus on a more specific area within PM&R and Dr. Kaelin was initially unsure of how he would narrow his interest in the field. He found a mentor, Dr. David Cifu, who encouraged him to explore brain injury as an area within the specialty and he loved it. Dr. Kaelin practiced a wide variety of care for 10 years and was then recruited to his current position in 2005 to work specifically with brain injury patients where he found a perfect niche. He enjoys establishing long-lasting relationships with patients as he cares for them throughout what is quite possibly one of the most difficult



times of their lives—rehabilitation and recovery. Other areas in which physiatrists can subspecialize include spinal cord injury medicine, pain medicine, and neuromuscular medicine. It is this ability to build either a diverse, general practice or a very specialized practice that Dr. Kaelin finds to be a great advantage of physiatry.

Physiatrists can also focus on treating inpatients, outpatients, or both depending on their preference. Dr. Kaelin's practice has evolved over the years and he works with both inpatient and outpatient populations in brain injury rehabilitation. A typical day involves reviewing labs and x-rays from 7:30am to 8:00am, conducting rounds on up to 15 inpatients from 8am to 10am, participating in research meetings 3 days a week from 10am to 11am, and then seeing outpatients in the clinic from 11am to 3pm. From 4pm to about 6pm, he fulfills his duties as the medical director of the center, which typically involves attending administrative meetings or other related tasks. Given the typical day's work, Dr. Kaelin's average week is about 50 hours and sometimes more. Since there are few emergencies or unexpected events in a normal day, it is feasible for physiatrists to maintain a relatively normal, manageable work schedule. There will still be the occasional late-admitted patient, additional meetings, or the like, but for the most part, his schedule is predictable.

As a physiatrist, Dr. Kaelin works each day with a diverse interdisciplinary team in the effort to care for patients. He interacts with key nursing staff; physical, occupational, and speech therapists; neuropsychologists; and case managers involved with each patient to coordinate care. This extended team of experts gives Dr. Kaelin pertinent updates on how each patient is doing and any developments that may have occurred since he last saw him or her. He might also attend a patient's therapy session to observe or help trouble-shoot a problem as it is encountered. Playing a teacher- or coach-like role in the patient's recovery is very rewarding for Dr. Kaelin. He enjoys helping patients identify their personal goals for therapy or recovery and designing a plan to get the patients where they want to be. As patients work toward their goals, Dr. Kaelin is constantly evaluating and reassessing their progress and adapts the treatment plan in mid-stream, if need be. While working with an individual over the span of his or her recovery, it is common for the doctor-patient relationship to become more social and personal as the doctor gets to know the patient better. This friendship enables Dr. Kaelin to utilize his knowledge of the patient's personality, goals, and motivations in the hopes of expediting recovery.

As a routine part of their practice, physiatrists witness not only some of the highest highs but also the lowest lows of human experience. For Dr. Kaelin, aspects of his practice he likes the most are inextricably linked to those he likes least. On one hand, he loves seeing the amazing results patients achieve over the course of their treatment and the great satisfaction they get from regaining function and independence. Additionally, patients in rehabilitation tend to be very appreciative of the care their doctors are providing. On the other hand, physiatrists are caring for individuals during the most stressful and challenging time of their lives, which is perhaps the most difficult aspect of practicing PM&R. When communicating with patients and their families throughout the course of treatment, physiatrists often need to employ conflict resolution tactics. It takes excellent communication skills to navigate and manage the expectations that patients' families have for their recovery. Physiatrists need to feel comfortable dealing with interpersonal relationships in order to care for and manage patients who have experienced catastrophic injuries.

***Since there are few emergencies or unexpected events in a normal day, it is feasible for physiatrists to maintain a relatively normal, manageable work schedule.***

Doctors practicing physical medicine and rehabilitation quickly learn that people manage stress in very different ways. This fact requires a delicate understanding of how to get through to a patient effectively and establish trust while at the same time providing them the information they need to recover successfully. For a physiatrist, developing these communication and interpersonal skills is as imperative as having comprehensive clinical knowledge. Dr. Kaelin stressed that having good interper-

sonal qualities ranks among the most important components to being a quality rehabilitation physician. Students interested in the field typically place high importance on developing lasting relationships

with patients as well as approaching patient treatment in a holistic way as opposed to targeting only the physical problem or injury. A good physiatrist realizes he or she is not just treating an arm or a leg, but also the emotional and cognitive aspects of the problem occurring simultaneously during the rehabilitation process.

For those interested in pursuing a residency in PM&R, Dr. Kaelin recommends students keep their minds open to interviewing at several different locations. With that strategy in mind, good candidates will be more likely to match among their top choice programs. It's also always a good idea to do a clinical rotation in rehabilitation medicine to better familiarize oneself with the field. Explore the possibility of working with an attending on a research project to reflect a growing knowledge and interest in PM&R. One further piece of advice for students interested in a career in physiatry is to seek out additional training opportunities for leadership skills. Dr. Kaelin found that as he began practicing, he was approached about stepping into various leadership roles within organizations where he worked. Often, by nature of their training and personalities, physiatrists are identified as good communicators and team players with a holistic view of patients and medicine, thereby making them attractive candidates for leadership positions.

There are several options for residency training in physical medicine and rehabilitation. Training is four years in length, usually beginning with one postgraduate year (PGY-1) after medical school. This PGY-1 year can be completed with an accredited transitional year or one year of an internal medicine, pediatrics, or surgery program. There are also categorical programs that provide all four years of training.[3] In the 2009 main residency Match, 92 physical medicine and rehabilitation training programs in the U.S. offered a total of 370 PGY-1 and PGY-2 positions and 170 (46%) of those were filled by U.S. seniors.[4] According to the *Charting Outcomes in the Match* report, the mean USMLE Step 1 score for U.S. seniors who matched into PM&R in 2007 was 209. Students who successfully matched ranked more than twice as many programs as students who did not match (9 versus 4, respectively).[5]

***Physiatrists help people who have lost function or independence secondary to injury or illness to reduce pain and regain their lives with hope and dignity.***

During almost 15 years of practice, Dr. Kaelin has observed big changes in the field. In the last decade, this has come in the form of movement toward more outpatient treatment for musculoskeletal care and pain management. Increased interest in both these areas is evident in the shift toward outpatient care for patients needing these treatments and the declining number of inpatient-only rehabilitation practices. More recently, with the number of veterans returning from war, there is an increased emphasis on training and retaining physiatrists within VA hospital settings. In the future, Dr. Kaelin believes that new and ever-advancing technologies will help increasing numbers of patients

## *Physical Medicine and Rehabilitation by the Numbers*

**Number of practitioners in U.S.**[2]:
8,815 in 2007

**Match data/competitiveness**[4]

- Of 82 PGY-1 positions offered in the 2009 Match, approximately 41 or 50% of those are filled by U.S. seniors
- Of 288 PGY-2 positions offered in the 2009 Match, approximately 129 or 45% of those are filled by U.S. seniors
- Number of total applicants for PGY-1 positions—347
- Number of U.S. applicants for PGY-1 positions—161

**USMLE Step 1 scores**[5]

| | 25th percentile | 75th percentile |
|---|---|---|
| U.S. Seniors Matched: | 195 | 222 |
| U.S. Seniors Unmatched: | 183 | 209 |

**Median number of programs ranked**[5]

- U.S. Seniors Matched: 9
- U.S. Seniors Unmatched: 4

**Compensation**

- *For clinical practice positions*[6]—
1-2 years in specialty Median: $213,701

All physicians Low: $199,538
High: $290,044

- *For academic medicine positions*[7]—
Early career Low: $128,000
Median: $152,000
High: $193,000

Mid to late career Low: $159,000
Median: $188,000
High: $216,000

**Residency and training requirements**[3]

- Four years, including a PGY-1 year of broad-based training.
- Prerequisites—A PGY-1 year to be completed through an accredited transitional year or a preliminary year of internal medicine, pediatrics, or surgery for programs that begin in PGY-2. There are also four-year categorical programs that include the first year of broad-based training.

regain or improve function, perform a lost function, or accommodate for a lost function. Notable advances in the fields of robotics, functional electrical stimulation, brain computer interface, and stem cell research (for brain, stroke, and spinal cord injuries) can be applied to some common rehabilitation treatments.

If Dr. Kaelin could dispel one myth about rehabilitation physicians, it would be to clarify that physiatrists do not do the same work as physical therapists. Often people confuse the two types of practitioners but, instead of actually performing physical therapy, physiatrists prescribe treatments (which commonly include physical therapy) to accomplish very specific treatment outcomes. Many people do not know what the term physiatrist means. Dr. Kaelin's favorite definition is that physiatrists help people who have lost function or independence secondary to injury or illness to reduce pain and regain their lives with hope and dignity. While it may seem like a tall goal, it is precisely the goal that all physiatrists aim to achieve with their patients.

To decide whether composing and managing comprehensive treatment plans for patients with their sights set on recovery is something you'd like in your medical career, consult the online resources below.

- Association of Academic Physiatrists **http://www.physiatry.org/**
- American Academy of Physical Medicine and Rehabilitation **http://www.aapmr.org/**
- American Board of Physical Medicine and Rehabilitation **http://www.abpmr.org/**
- American Congress of Rehabilitation Medicine **http://www.acrm.org/**

*By* **Carissa A. Englert, M.S.**
*Research Analyst, Careers in Medicine*

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2 Careers in Medicine. Physical Medicine and Rehabilitation Specialty Page: Workforce Statistics. (http://services.aamc.org/careersinmedicine). Revised 2007. Accessed April 15, 2009.

3 Accreditation Council for Graduate Medical Education. ACGME Program Requirements for Graduate Medical Education in Physical Medicine and Rehabilitation. July, 2007

4 National Resident Matching Program (2009). Advance Data Tables: 2009 Main Residency Match. Washington, DC: National Resident Matching Program.

5 Association of American Medical Colleges & National Resident Matching Program. Charting outcomes in the match: Characteristics of applicants who matched to their preferred specialty in the 2007 NRMP main residency match. Washington, D.C.: National Resident Matching Program/Association of American Medical Colleges; 2007.

6 MGMA Physician Compensation and Production Survey: 2008 Report Based on 2007 Data. Reprinted with permission from the Medical Group Management Association, www.mgma.com. 2008.

7 Faculty Salary Survey, 2007. Association of American Medical Colleges.

## Ask the Advisor

**We know you have questions, so we went to the experts for answers. This column features experienced faculty advisors and student affairs professionals answering questions about choosing a specialty, applying for residency, and any other career-related concerns you may have. In this issue, we consider how to evaluate your specialty prospects after a negative clinical rotation and how to obtain glowing letters of recommendation.**

**Dear Advisor,**
**I always thought I wanted to go into pediatrics, but I hated my peds rotation. Where do I go from here, and should I still look at pediatrics considering my experience?**

Don't panic! You are experiencing a common dilemma. This is a good time to stop and engage in some self-reflection. A good starting point is to ask yourself some key questions. First, what drew you to the specialty when you entered medical school? Students sometimes come to medical school with a career interest based primarily on theory. Their model for a pediatrician may be one they saw as a child or the persona of one on TV. Once you do a clinical rotation, you see the specialty as it is really practiced. You may find that, while you like interacting with children, you really don't want to take care of sick kids or interact with anxious parents. In a different scenario, you may have enjoyed anatomy during your preclinical years but you don't like to be in the operating room. It is important to separate the *reality* of the specialty from the *theory* of the specialty.

Second, did you dislike the *specialty* or the *rotation*? It is absolutely possible that you participated in a rotation that provided you with a skewed view of the specialty. A good way to determine whether this was the case is to ask clinically active faculty or alumni what their day-to-day practice of the specialty is like. Frequently, it is very different from the third-year clinical experience.

Third, was your experience representative of the specialty? Try to tease out whether it was the personalities of the team and/or the work environment that contributed to an experience you enjoyed less than you expected.

> ***The clinical years can help you find those areas in which you are good and in which you are interested.***

And finally, does the specialty match your skills and interests? It is common for medical students to be good at many things. The clinical years can help you find those areas in which you are good *and* in which you are interested. Consider whether there were times when you felt the hours went by quickly or others when the day dragged on and take note of which specialties those were.
In addition to these topics for self-reflection, concrete questions to ask yourself include:

- Do I prefer a specialty in which I will

provide direct care to patients (e.g., medical oncology) or one in which I will play primarily a supportive role to colleagues (e.g., radiology)?
- Do I prefer to be in a specialty where I provide predominantly interventional modalities (e.g., surgery) or non-interventional modalities (e.g., infectious disease)?
- Do I prefer longitudinal patient contact (e.g., primary care internal medicine) or episodic patient contact (e.g., emergency medicine)?
- Do I prefer to work with a broad patient population (e.g., family medicine) or a specific patient population (e.g., pediatrics)?
- Do I work best in relatively high-pressure situations (e.g., trauma surgery) or would I prefer to practice in a more controlled environment (e.g., pathology)?

This is a good time to log on to the Careers in Medicine Web site (www.aamc.org/careersinmedicine) to utilize resources that may be particularly helpful at this point, such as the Specialty Indecision Scale (SIS) and other self-assessment tools. These exercises will guide you through a series of questions to help you hone your interests, values, and skills. We also suggest that you meet with a faculty member whom you trust and with whom you have good rapport. It can help to talk through these issues as you consider whether or not to pursue your interest in pediatrics.

**Shalini Reddy, M.D. (and the Pritzker Career Advising Team)**
*Assistant Dean of Student Programs and Associate Professor of Internal Medicine*
*University of Chicago Pritzker School of Medicine*

**Dear Advisor,**
**What are residency programs looking for in a letter of recommendation? Does it matter who writes my letter of recommendation as far as the writer's title or rank?**

Residency programs hope to learn several things from a letter of recommendation. They want to understand the context in which the letter was written, i.e., how well the letter writer knows you, and in what capacity. The more knowledgeable the writer is and the closer his or her interaction with you, the more useful the letter will be to the program. Equally important though is what type of student you are and your potential as a resident. Programs are interested in your fund of knowledge, clinical judgment, interpersonal skills, and other personal qualities. Essentially, will you be a "good fit" in their program?

When deciding whom to ask, the most important condsideration is to ask someone who knows you and is able to accurately describe your clinical abilities, strengths, and personal characteristics. Beyond that, a letter from a "famous" or more senior faculty member can be extremely helpful ***only*** if they know you well. If not, this will be obvious and the letter will carry little weight. In general, do not request letters from preclinical faculty, non-physicians, relatives, or family friends. A letter from a faculty member with whom you did research is an exception. A letter from a research advisor would be helpful if you are seeking a specialty and/or program with heavy emphasis in research.

When applying for residency you will need three to four letters of recommendation. The exact number is program specific. Most of your letters will come from your third and fourth year work in the specialty you are pursuing. This is not always possible due to scheduling, timing of specialty choice, etc. However, you will need at least one letter, preferably two, from within the specialty. Some programs will also request a letter from your department chair. ***The bottom line is your letters should come from faculty who know you well and can write a strong letter of recommendation.***

When making the request, it is extremely important to ask your letter writer if he or she can write you a strong letter of recommendation. If there is any hesitation in the response, you should look elsewhere. To ensure receiving a glowing letter, meet with your letter writer in person to discuss your career goals, strengths, accomplishments, and interests. Provide your CV, personal statement, and transcript so that he or she has all necessary information about you at their fingertips. This will help them compose a stronger and more personal letter. Also remember that quality takes time, so allow your letter writer four to six weeks to complete their task.

***When making the request, it is extremely important to ask your letter writer if he or she can write you a strong letter of recommendation.***

As always, if you have any questions about your specific situation or need guidance on who would be best to ask for a strong letter, seek advice from your advisor or student affairs staff. Letters of recommendation are a crucial part of the residency application process. Knowing the process and planning properly will result in positive, valuable letters in support of your residency application.

**Marie Hartman**
*Director, Career Development Center*
*Drexel University College of Medicine*

**Have a question you want our panel of experts to address? Send your queries to careersinmedicine@aamc.org and put "Ask the Advisor" in the subject line. We won't be able to answer every question in the newsletter, but we'll answer as many as possible.**

CiM Toolbox

# Using Your Clinical Rotations to Explore Specialties

As you gather knowledge and skills during medical school, your clinical rotations are going to be a valuable experience, not just for learning how to be a good physician, but also to help you figure out which specialty might be the right fit for you. To make the most of these opportunities, it is important that you keep track of the thoughts, feelings, and experiences you encounter along the way.

While completing your rotations, consider how your values, interests, skills, and practice needs might be met by the specialties you're exploring. For example, how do you feel about:

- Providing inpatient vs. outpatient care?
- Working with different age ranges?
- Working with one or both genders?
- Providing diagnostic-oriented care vs. performing procedures?
- Dealing with a breadth vs. depth of patient problems?
- Providing short-term vs. long-term or continuous care?
- Having direct vs. indirect communication with patients?

Throughout your various required and elective rotations, it will be helpful to take notes about your experiences. Reflect on the rotation and perhaps even commit your thoughts to computer or paper while they're most fresh. As time goes on, your memories of the experience will inevitably fade and, as you approach decision time, it's best to have something to remind you of how you felt and what you learned about each specialty. The Careers in Medicine (CiM) Web site has a tool that can assist you in gathering these reflections. The Clinical Rotation Evaluation is a convenient way to methodically record your thoughts and opinions on each rotation you experience. The evaluation is a simple list of questions that will help you record what you learned, liked, and disliked about each specialty. Complete the evaluation after your first rotation to become more cognizant of what you need to pay attention to in each subsequent rotation. As you compile information about all of your rotations, the evaluations will help you to see how you fit—or don't fit—with each specialty, identify what additional information you may need to gather, and ultimately make a good decision about which specialty suits you best. Go to the CiM Web site at www.aamc.org/careersinmedicine and login. The Clinical Rotation Evaluation can be found under the "Exploring Options" menu.

Of course, not all of your clinical rotations will be what you expected. You can take copious notes or fill out evaluations all day long, but a bad rotation experience is still a bad rotation experience. Nonetheless, don't make your specialty choice based on ***one*** clinical rotation. Always keep in mind that, whether the rotation is a good one or a bad one, it is just one experience. If you are really interested in a particular specialty but had a bad experience (or, for that matter, a phenomenal experience), make sure that you analyze it realistically. Were there personality conflicts that may have influenced your opinion? Did you get to experience many aspects of the specialty, or was your exposure to patients/procedures limited? If you had a bad rotation in a specialty you always thought would be for you, consider seeking out more opportunities in that area to clarify your thinking.

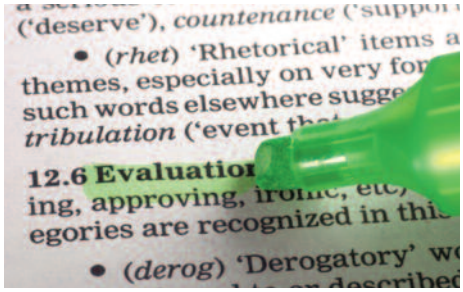
Another important characteristic to keep in mind about rotations is they are frequently experienced within an academic medicine setting. This can affect the type and number of patients you see as well as the amount of interaction you have with other specialties and subspecialties. If you think that you'll likely want to practice in a setting other than an academic medical center, look for opportunities to learn in ambulatory settings, community hospitals, rural areas, or other environments. Seeking these experiences will give you a broader perspective on what it might be like to practice that specialty.

Finally, on a practical note, make contacts and capitalize on interactions with physicians and residents in the specialties you are considering. These individuals can give you valuable "inside" information and will likely play a key role when you are going through the residency application and selection process. The contacts you make now will help you evaluate residency programs or identify key individuals to contact prior to applying. They may even be willing to submit a recommendation on your behalf to someone at one of your prospective residencies. The more you cultivate professional relationships during your rotations, the more you will gain on your journey toward choosing a specialty and earning a residency spot.

*By* **Carissa A. Englert, M.S.**
*Research Analyst, Careers in Medicine*
*and* **Jeanette L. Calli, M.S.**
*Program Manager, Careers in Medicine*

Match Corner

# An MSPE Primer




There are many pieces of information a residency program uses to evaluate a candidate. The ERAS® application, the CV, letters of recommendation, grades, board scores, and information gleaned from the interview all play a big role in the process. Another important piece is the Medical Student Performance Evaluation (MSPE). The MSPE, or it's previous incarnation the Dean's Letter, has been a part of medical school for decades. Not to be confused with a letter of recommendation, the MSPE is a synthesized evaluation of a medical student's academic performance and professional attributes. The document is written in the fall of your fourth year and is used by residency programs to objectively compare your performance with that of your peers.

Schools have differing curricular models and grading systems which make it difficult for residency programs to decipher how well a student has performed during both their basic science years and core clinical rotations. There have been efforts in the medical education community since the late 1980's to standardize the evaluative information provided to residency programs about students. Prior to these efforts, most Dean's Letters, as they were called, made all students sound as if they were poised to win a Nobel Prize and would make nothing but the finest physicians. The letters more often served as a tool to advocate for a student rather than a pure evaluation of performance. Since those days, the MSPE replaced the Dean's Letter and evolved into its current format, which seeks to provide a well-rounded view of a medical student's attributes. Released in 2002, comprehensive guidelines for the preparation of the MSPE are provided by the AAMC that encourage schools to include the same type and level of information about all students.[1] The goal of this standard evaluation model is to level the playing field and allow program directors to make better informed decisions.

The MSPE generally consists of six sections:

1. *Identifying Information* – This section contains your legal name and the name and location of your medical school.
2. *Unique Characteristics* – This is usually a narrative statement about any distinctive qualities you may have including demonstrated leadership, research activities, and community service involvement during medical school. It's also the place where your MSPE-writer can provide information about any hardships you may have encountered.
3. *Academic History* – This section provides your dates of matriculation and expected graduation; participation in joint degree programs; and extensions, gaps, or any remediation or adverse actions that may have occurred during your education program.

***As you gear up for the residency application process, make sure you understand your school's process for preparing the MSPE.***

4. *Academic Progress* – This section is typically the meatiest portion of the document and includes information about your academic performance and your professional attributes throughout medical school. There are narrative portions about overall performance in the preclinical curriculum and in each of the core clinical clerkships and elective rotations completed to date. There is also narrative information about softer skills and qualities such as enthusiasm, initiative, and compatibility with faculty, peers, health care team members, and patients.
5. *Summary* – The summary section includes a summative assessment that compares your performance to those of your medical school peers. This comparison should be based on your school's evaluation system and includes information about any school-specific categories used to differentiate among students.
6. *Appendices* – There are five appendices; the first four of which provide graphic representations of your performance relative to your classmates in each basic science course, each core clerkship, your professional attributes, and your overall performance in medical school. The final appendix is a medical school information page which provides the specific or unusual characteristics of your medical school which will help program directors understand the information about you within the context of how your school functions. It is the "key" to understanding the evaluation system at each school.

A Professionalism Assessment Form is also available for adoption or adaptation by medical schools desiring to assess and report further on the professionalism attributes of their students.

The Student Affairs Dean is responsible for every MSPE that goes out from the school but he or she may well share the writing responsibilities with several faculty members. Most schools follow the AAMC guidelines about what information to provide but each school has its own process for preparing the document. Initiating your MSPE usually entails meeting with your student affairs dean or your school's designated writer. The goal of the meeting is to ensure your evaluation reflects personal insight into your performance. This meeting is also a good opportunity for your dean to check in with you about your career goals and make sure you are on track as you move toward applying for residency. You will usually need to provide a copy of your CV and possibly your personal statement. Some schools may also recommend that you bring the list of

programs you are considering since the MSPE meeting often turns into a career advising session. Once your MSPE has been written, you usually have a chance to review it and correct any factual errors. You will not be able to edit any of the evaluative statements.

Once completed and reviewed, the MSPE is delivered to programs through the Electronic Residency Application Service (ERAS®) and has a standard release date of November 1. Even if you are not applying to all of your programs through ERAS, schools will not release the document until November 1. Concerns have been raised over this date being too late in the residency application process and there is discussion under way in the student affairs community to make the release date earlier. Residency programs have complained for years that the document comes too late in the process to be of much use to them. In fact, a recent study of residency programs' selection criteria found that the MSPE was ranked lowest of all criteria by the program directors surveyed.[2] The authors suggest that this is possibly due to the late release and/or the variability in quality of the MSPE across institutions. It also may be less useful in the early stages of the resident selection process since some of the information included can be acquired from other sources, such as ERAS, letters of recommendation, and the medical school transcript. However, it remains useful as a summary document while programs interview and begin ranking applicants.

As you gear up for the residency application process, make sure you understand your school's process for preparing the MSPE. Ask when you can start making an appointment with your dean to begin the process, what resources you need for the meeting or to assist in the preparation (CV, personal statement, etc.), how you should get your MSPE to programs not participating in ERAS, and about the general timeline for preparation. Start early—the more information you have about the MSPE and steps to take at your school, the better prepared you will be!

*By* **Jeanette L. Calli, M.S.**
*Program Manager, Careers in Medicine*

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