# ADVICE FOR EMERGENCY MEDICINE APPLICANTS

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This article is not intended only for applicants to my own program, but to anyone anticipating the emergency medicine application process. It may prove especially useful to students from schools without their own emergency medicine program or those who wish a second opinion about a specific topic.

Over the years, I have given advice to hundreds of potential applicants to emergency medicine programs. Understandably, they have varied tremendously in background, training, prior experience in emergency medicine, and suitability for the specialty. What follows is a synopsis of the advice I have developed over this time period for such applicants. Pick and choose – some will be too basic for you, some may be too involved or detailed, and some may simply not apply.

A caveat: by its very nature, such advice is very much a matter of personal opinion. I suspect there are other, equally experienced emergency medicine faculty members out there who would disagree with one or more pieces of advice contained here. So, take advantage of other sources of information. One place to start is the Society for Academic Emergency Medicine, which has valuable advice on their home page at http://www.saem.org/inform/student.htm

**Is Emergency Medicine Right for Me?**
Good question. All specialties have advantages and disadvantages. I recall the long-ago comment of a favorite faculty member, a gastroenterologist. When I, an impressionable medical student, told him that his specialty seemed particularly attractive, he replied, "Nah. Ninety percent of what I see in the office is irritable bowel syndrome". Nothing, it seems, is perfect.

**So, What are the Pros and Cons of Emergency Medicine?**

**Pros:**

***Variety*** – Applicants always mention this, and it's true. You see a lot of different things in the ED, and you're always learning. I recall the story about a choking victim in a restaurant. The party at a nearby table included a physician. His tablemates turned to him to act, to which he applied "I'm a dermatologist – we don't do that kind of thing". Emergency physicians usually know what to do.

***Procedures*** – Certainly, emergency physicians lay claim to a variety of procedures, mostly minor, some major. This is probably overemphasized (trust me, nobody does thoracotomies and cricothyrotomies on a daily basis). The real world simply doesn't look like the TV show. Still, there are enough procedures to keep your hands busy and to contribute to the variety of the work.

***Acuity*** – This, too, is probably overemphasized. The real world it is not an adrenaline rush every minute. There's plenty of mundane, nuts and bolts primary care, more in some settings than others. Yet, emergency medicine still has more fun and exciting things going on than most other

specialties. And, there is the undeniable cachet of occasionally being an integral part of the 6 o'clock news.

***Lifestyle*** – Whether we like to admit it or not, a lot of people are attracted to certain aspects of our specialty which I lump together as "lifestyle". This includes limited hours, predictability of hours, and the concept that "when you're off, you're off". It is one of the few specialties where physicians can relatively easily cut back to part-time, if desired. There is mobility that few other specialties enjoy. However, there are distinct tradeoffs to the lifestyle issues (see under "Cons").

***Market Factors*** – I'll lump a couple of issues here. One is ***financial***. Although we're not cardiovascular surgeons, emergency physicians still do pretty well financially, and above average within the house of medicine. I don't point this out because I believe it should make much of a difference. It shouldn't – you should choose a specialty based on what you like and enjoy, not money (a medical career is a long time to do something you dislike just because it's lucrative). Still, to some medical students staring at a six-figure debt load, finances are a factor that some wish to at least consider.

The other factor is the ***job market***. It is my observation that the job market for residency-trained, board-prepared emergency physicians continues to be very good. Yes, there are certain perceived-to-be-desirable areas of the country in which the job market is tight. However, all jobs in these areas are tight, not just emergency medicine (great climate and ski slopes sell). The reality is that there are about 35,000 emergency physician jobs out there (this is my guess – other estimates exist). There are only a bit over 20,000 physicians boarded in emergency medicine. It seems to me that leaves a fair amount of opportunity.

**Con:**

***Lifestyle*** – As noted above, there is a flip side to the scheduling issue. Even though the hours are predictable, they are sometimes predictably lousy. Emergency physicians have to work their share of midnights, weekends, holidays, and other times when the rest of the world is home, with their families and friends or asleep. This can get old after awhile. Particularly challenging are the circadian rhythm changes, when one goes from days to midnights to days again. This gets palpably harder as physicians age, and is a quantifiable health threat.

***Respect*** – This is less a problem than it used to be, but there are still some medical schools and communities where emergency medicine lacks respect as a "legitimate" specialty and career. Faculty members from other disciplines (often older) still admonish students to become "real doctors", and not to "ruin" their careers. In some hospitals, emergency physicians still lack the respect of medical staff and administration, and are forced to put up with excessive amounts of flack on a daily basis. To an excellently trained, highly skilled emergency physician, this can be very demoralizing.

***Lack of Follow-up*** – This perceived disadvantage is often cited by non-emergency physicians, and almost never cited by emergency physicians. Certainly, a physician who deeply cherishes ongoing relationships with patients and their families may be a better fit for primary care. However, there

are plenty of rewarding opportunities in the ED to "connect" with patients and families, and make a real difference. Frankly, it's a non-issue.

***Burnout*** – Again, an oft-cited concern of non-emergency physicians. On one hand, surveys suggest that the rate of emergency physicians leaving the specialty is no higher than other specialties. On the other hand, I still get the sense of a vague, underlying dissatisfaction from some emergency physicians. Is it emergency medicine-specific burnout – or just the frustration many physicians are feeling with the pressures and turmoil roiling the health care industry? Don't know.

***Decision-Orientation*** – I'm not sure whether to list this as a pro or a con, but it needs to be pointed out, regardless. Emergency physicians must be comfortable making important decisions, sometimes with an incomplete database. Certainly, we all like to get all the necessary information before making clinical decisions. Yet there are times in emergency medicine when life and death decisions must be made immediately, critical pieces of information aren't available, and you simply have to decide. Whether you call it decision-orientation, or a propensity to shoot from the hip, it is largely a matter of personality make-up. If you're a data-gatherer by nature, you may not be comfortable in emergency medicine.

## What if I'm a Woman?

Although 50% or greater of medical school classes are now women, studies have suggested that a somewhat smaller proportion of those women enter emergency medicine (about 33% of entering classes). Is there something about the specialty that is unfriendly to women? Or is the applicant pool simply diluted out by those women that enter other specialties, such as OB/GYN, etc.?

Hard to say. Although it seems to me that emergency medical practice has some distinct advantages to female physicians, I'm probably not the one who would know (being male).

Who would know is the American Association of Women Emergency Physicians. Find them at the ACEP web site (go to www.acep.org, and type AAWEP into the search bar). They have prepared a very nice 50-page document for women thinking of entering emergency medicine. The PDF file is at: http://www.acep.org/library/pdf/aawepYouCan.pdf

## Membership in Emergency Medicine Organizations

A good way to learn more about emergency medicine is to join professional emergency medicine organizations as a student. If you are definitely applying to emergency medicine, this is mandatory. You want to be able to list your membership in the various emergency medicine organizations on your ERAS application. It demonstrates your dedication to the specialty, and, as noted above, it a good way to find out more about the specialty.

- *American College of Emergency Physicians (ACEP)* – ACEP is the oldest and largest professional organization in EM. By virtue of your membership, you get a subscription to *Annals of Emergency Medicine*, various monthly newsletters, etc.

- *Emergency Medicine Residents Association (EMRA)* – This is an organization for emergency medicine residents, but they also have a medical student section. Highly recommended.

- *Society for Academic Emergency Medicine (SAEM)* – An academic organization that emphasizes research and education. Certainly the most prestigious place to present emergency medicine research. You also get a subscription to *Academic Emergency Medicine*.

- *American Academy of Emergency Medicine (AAEM)* – This is a younger professional organization, like ACEP.

Warning – It's simply human nature that every form of human interaction has politics, and emergency medicine is no different. Just be aware that there is sometimes bitter infighting and bad blood between AAEM and ACEP. Although lots of emergency physicians are members of both organizations, some physicians and entire programs are staunch supporters of one organization and rabid opponents of the other. The background to the squabble would take me hours to explain, and shouldn't prevent you from joining or listing your membership in either. I would just stay away from overly dogmatic and controversial stances if the subject comes up in an interview. You may not know how your interviewer feels about it.

## When do I Have to Make a Decision?

An unfortunate long-term trend in medical education is the push to force students to decide on their specialty earlier and earlier in the game. This is inevitably before students have a chance to experience the broad breadth of medical practice, and make a reasonably informed decision.

And, due to changes in graduate medical education financing, it has become considerably more difficult for people to change their mind later on. In many circumstances, programs and their institutions are at a financial disadvantage if they accept residents who have completed some or all of residency training in another specialty and then change their mind. Thus, it is getting harder to find an emergency medicine program to accept you if you have already completed, for instance, two years of internal medicine. Although one survey suggests that over 70% of EM programs still consider applicants with prior GME training, I believe the real numbers are much worse than that.

So, ideally, you should begin the planning process during your third year, at the time you start planning your fourth year schedule. Whether you've definitely decided upon emergency medicine, or still waffling between two possibilities, the course is pretty similar.

## How Should I Plan my Fourth Year Schedule?

### *You've Definitely Decided on Emergency Medicine*

If you've decided that emergency medicine is it, you should schedule one, and often two, emergency medicine electives as early in your fourth year as possible, like July through October. If your school's curriculum includes an emergency medicine rotation during the third year, you may

decide to do only one month during your fourth. If so, do it somewhere else – not much sense doing two rotations at the same place. If you don't have an emergency medicine rotation during third year, you will probably want to do two months during your fourth. I personally think that one month is plenty, but most applicants do two.

If your school has a required fourth year emergency medicine clerkship, that will obviously be one of the months. Where to take the other month depends:

- Is there a particular residency that you have an interest in? If so, do an elective month there. Such an "interview" elective early in the season gives you a month-long look at the program, and is a much more accurate picture than a several-hours whirlwind interview. Secondly, it gives the program a much better look at you, and (as long as you do a good job) probably gives you a leg up in the application and matching process.

    - Now, I have heard some advisors state that if you have a very strong medical school record (AOA, etc.), that you should NOT do an interview elective at the place where you think you want to go. Their logic is that you are already at the top of your class, so the only direction you can go is down. Thus, they feel that you have little to potentially gain from the rotation, and a lot to potentially lose.

    - Although this is certainly an interesting perspective, I still disagree. As noted above, there are two objectives here: for you to impress the program, and for you to evaluate the program. Sure, it's obvious that when doing an away elective you should do a great job: work hard, arrive early, stay late and be a generally enthusiastic, upbeat person. However, relatively few people really shoot themselves in the foot when on an away rotation, and it's even more unlikely that a top flight, AOA student will. More important is the chance for you to more thoroughly evaluate the program.

- What if there isn't a program that you have a preconceived interest in? I would then advise that your second month be in a different kind of setting than your first month. If your first month was at a university hospital emergency department, then choose a community or a city-county emergency department residency. Emergency medicine is a broad field, and it's possible that the first place you experienced had a skewed patient population and spectrum of pathology. Looking at the opposite end of the spectrum affords you some perspective (and may even change your mind!) However, whatever you choose, make sure that you choose a place with an emergency medicine residency.

What about if your school doesn't have an emergency medicine residency? Should you still do an emergency medicine rotation at home, even if you're not required to? Some students feel that such a rotation is "wasted". I've heard pros and cons to this, but my advice is that, most of the time, you should probably do the local rotation (unless the word on the street is that it's <u>really</u> bad), and then follow-up with a second, away rotation at a residency program.

The local rotation will still give you a view of emergency medicine, albeit one's that different from a residency program, and it will still get you a letter of recommendation. And, frankly, it always

looks a little funny when a student skips their home site - it sometimes raises the question whether there's a problem somewhere.

Beyond that, I wouldn't advise doing more than two months of emergency medicine during your fourth year. (Rare exceptions may include something unique: a month of emergency medicine research, a specialized EMS month, something international, etc.). Remember, you'll be doing emergency medicine the rest of your life, and fourth year is an opportunity to experience the rest of medicine. You should hone your basic medical knowledge with some core medicine, surgery and pediatrics (most schools require this, anyway). Beyond that, explore. Radiology, dermatology, ENT and opthalmology - these may be given little time in an emergency medicine residency curriculum. Have you always wanted to do some tropical or missionary medicine? This is a prime time to do it. But you have to plan ahead, or it won't happen.

### *What if I Haven't Decided Yet?*

If you are still on the fence between emergency medicine, and say, urology, request that your first two fourth year months include EM and urology. That way, you can (hopefully) choose after two months, and still have time to complete a traditional interview cycle. However, you will have to thoroughly investigate both specialties during the latter part of your third year, probably with two different advisors, so that you are prepared and ready to go either direction once your decision is final. You will probably need to have prepared two applications, two ERAS files, two Personal Statements, etc., so that you are ready to go either way.

### What if I'm Too Late?

It depends on how late, late is. Let's say you've already applied to fifteen pediatrics programs. Yet, you do an EM rotation in December, and fall in love with it. It is conceivable, with hard, fast work and a supportive advisor, you could quickly get an ERAS application together for emergency medicine, and get it out to EM programs. Admittedly, many programs have explicate or implicit deadlines for applications. Some may consider a late application if you are a particularly strong applicant or if you explain your predicament. Nonetheless, I would make sure that you apply to a lot of programs (thirty or more) to improve your odds.

Let's say you're even later, and there's no way you can interview this year. What to do? Intentionally go unmatched and try to scramble? Or intentionally match into a one-year position, and try again next year?

Very tough. There are few spots left over after the EM match each year (usually about twenty), and they go fast. Realistically, your chances of scrambling into an EM spot are slim. This would mean that you would then need to scramble for a one-year spot, perhaps transitional, preliminary medicine or preliminary surgery, and then try again next year.

Which is the best kind of program to spend one year in and try again? Changes in federal GME funding have complicated this somewhat. If you're reasonably sure that you'll be able to find an EM spot next year, you should try to maintain your eligibility for GME funding as much as

possible, to retain your financial desirability to the maximum number of programs. I would suggest a preliminary surgery spot or a transitional year.

On the other hand, let's say you're not at all sure that you're going to be successful next year, either. Maybe you made a full-court press application this year, and still went unmatched? You might then consider what your next choice of specialty might be. If, for instance, it would be internal medicine, you might consider doing a preliminary medicine year. Then, if you are unsuccessful in the EM match next year, you haven't thrown a year away.

One thing I wouldn't suggest: doing a different residency (say, three years of family practice) and then going out and practicing emergency medicine, anyway. You will likely find plenty of people (always from other specialties, I've noticed) who will suggest this route. After all, they remember a buddy from med school who did just that. And, they'll point out, you'll learn everything you need to know in family practice or internal medicine, anyway.

Wrong! Family practice or internal medicine residencies will teach you family practice or internal medicine, NOT emergency medicine. And, I promise you, in this day and age, that's the route to a dead end career. You'll never be able to become ABEM board-certified. Your job opportunities will be limited (and will continually shrink), and your income will lag that of residency-trained colleagues considerably. Trust me – don't do it.

**Finding an Advisor**

Early in this process, it is ***CRITICAL*** that you locate a good emergency medicine advisor! Every specialty is different, so advice that is great for the surgery-bound may be lousy for you. If your school has an emergency medicine residency program, or is affiliated with one, you have an advantage. Likely advisor candidates are the residency director, the associate residency director, the chair, or the director of undergraduate education. In some places the role is explicitly or implicitly assigned to one person. In others, several people function as advisors, and students choose. Ask the residents who's best. Ask the faculty. Ask the secretaries (they know everything). Then, introduce yourself, tell them you're interested in emergency medicine and ask if you can meet sometime to talk about residencies.

What if your school doesn't have a residency or a nearby affiliated one? The emergency medicine faculty within your medical school still may be very knowledgeable about the application and interview process and function as fine advisors. But, remember that not all emergency medicine faculty members are effective advisors. A good advisor usually is involved in the process of selecting and ranking residents on a yearly basis. Just because someone is residency-trained doesn't mean they know the latest about the application game.

But what if you're at a school or a campus with no emergency medicine presence at all? That's a tough spot to be in. You're going to have to be a self-starter, and do lots of bootstrapping, networking and self-education. However, it is still important that you have an effective emergency medicine advisor (and no, I don't mean the neurologist you were assigned to). After all, this is your career, and it's too important to leave to chance. If you're in this spot, you're likely going to be doing 1-2 away electives at emergency medicine residency programs, so you should quickly adopt surrogate advisors at one or both. Schedule time with the program director early in the

elective month to ask advice. You might even contact them a few months in advance (but after you've scheduled the elective) and get advance advice over the phone. Don't be shy about it – tell them your predicament, and ask if they can help you or refer you to another one of their faculty that can. And, if they are totally unhelpful, you should wonder how supportive a residency director they'll be.

Next, the Society for Academic Emergency Medicine has a "Virtual Advisor Program", which can be very helpful. Check out the web site for more details.

Finally, if you're still stuck, call me. I do this for away students all the time.

Once you've identified an advisor or advisors, you need to meet with them to discuss matters, (if they're remote, this may be by phone or e-mail). You need to consider what kind of program you want. What kind of eventual emergency medicine practice do you envision? Community? Teaching? University? City-county? Research? Do you have geographic preferences? What are things you've liked and didn't like about rotations you've had so far? Consider your feelings toward the pros and cons of emergency medicine. You will probably want to get your advisor's thoughts regarding away electives. They usually will know where some particularly good places are. You will likely get their advice on where to apply. You will probably go through the list of residencies on the SAEM web site and get their opinions on various programs. Although most program directors will understandably beat their own drum and paint their own program in the best light, the best advisors will keep this to a tolerable minimum and truly put on their "mentor" hat for you.

I would advise you to have your advisor review your Personal Statement and your ERAS information *before* you submit it. There are often inadvertent faux pas they can help you correct before it's too late.

If this all seems a bit much – trust me, it isn't. In the application game, the race is won by the people who are best prepared, arrive early, stay late, overdo the process and are frankly obsessive-compulsive.

**How do I Find out About Programs?**

***Green Book*** - The traditional way has always been to use the "Green Book". This lists each program, by state, along with its size, program director and contact information. However, this has been largely supplanted by more complete, digital data. Be aware that due to publication lag, the Green Book may not include the newest programs, and may have dated information regarding program directors, etc.

Another thing the Green Book is useful for is that it contains a copy of the Program Requirements for Emergency Medicine residencies. You should read through it at least once. It lists the requirements that all approved programs in emergency medicine must adhere to. A related list of requirements, but more far afield, at the Institutional Requirements, also contained in the Green Book. These are the more generic requirements that the institution sponsoring the residency must adhere to. Both the Program Requirements and the Institutional Requirements can also be located at www.acgme.org

***SAEM Web Page*** – Probably the most valuable source of information is the on-line Residency Catalogue on the SAEM Web page. Point your browser to www.saem.org. There you will find the *Residency Catalogue*, an up-to-date two-page synopsis of each RRC-accredited emergency medicine residency program, including contact information, curriculum, volume, acuity, faculty members, and lots of valuable information. It also includes links to each program's individual web page. Usually, newly approved programs will get in this site earlier than others.

***EMRA MatchGuide*** – The Emergency Medicine Residents Association has started a similar, on-line source of information about programs. It's at www.emra.org. As an aside, EMRA has a medical student section with lots of useful information. You should probably join if you've decided that you're serious about emergency medicine.

***Residency Web Pages*** – The vast majority of emergency medicine residency programs list a web page with the SAEM Residency Catalogue. It's likely that the rest have web pages that simply aren't linked there yet. As you might guess, these pages range from the rudimentary to the highly professional and sophisticated. Some programs, mine included, contain their entire residency brochure on their web pages, and have done away with paper brochures entirely. Regardless, the web pages usually contain valuable information, and are mandatory reading.

***FREIDA*** – FREIDA is largely web-based now, as well. It allows you to search by a number of parameters, although I don't find it as useful for emergency medicine. The data listed is generic, and rather non-discipline specific. You should scan a few programs, to see if the specific information listed is helpful to you. For instance, it lists types of benefits, like childcare services, which may pertain to certain applicants. Otherwise, I would specifically review the FREIDA printouts only for those programs you decide to interview at.

***Residency Brochures*** – Many residencies have residency brochures specifically designed for prospective applicants. Like web pages, these brochures range from the cursory to the elaborate. However, as noted, programs are increasingly putting their brochures on their web pages, and doing away with paper-based brochures altogether.

I believe it is very helpful to spend time reading brochures (either web or paper-based) from as many programs as possible, even those about which you have little pre-conceived interest. There are two reasons for this. One, by keeping an open mind, you will likely discover programs which look and sound much more attractive than you imagined (i.e., if you don't look, you won't find). Second, even if you don't decide to apply, you will still learn a tremendous amount about the field of emergency medicine. It's a broad field, and residencies vary tremendously. It will make you a much better-informed and intelligent consumer on the residency trail.

In order to obtain residency brochures, first visit their web site, which may contain the brochure already. If not, some sites allow you to order a brochure on-line, or send an e-mail asking for a brochure. Finally, the Green Book, the SAEM and EMRA web pages, FREIDA and the program web pages all should have addresses, e-mails and contact people.

***Chat Rooms*** – As you may know, there are a number of student "chat rooms" and other similar sites on the net, where students on the interview trail trade tidbits, recommendations, gossip, etc. Frankly, I would view most of what you read there somewhat skeptically. You haven't any idea who's talking on the other end - for all you know, the information may be planted by a program director or their secretary (yes, I've seen it happen). I've read lots of stuff on these sites that I know for a fact was total rubbish. So, I advise you to either save your energy, or view such information warily, and worthy of independent verification.

**Getting your ERAS Application Ready:**

You should start getting your ERAS application together in August or so. Get a photograph taken. This doesn't have to be a formal sitting at a photographer (although most are), but shouldn't be a tacky snapshot taken at the beach, either. You should have a coat and tie on (or the gender-specific equivalent for women).

Of course, you need to write a Personal Statement, a task that strikes fear in the hearts of many applicants. It shouldn't. Maybe I'm different than other program directors, but I must say that the Personal Statement is usually one of the least valuable parts of the application. I can't remember an applicant that got moved up on the list because of a great Personal Statement, although I can think of a few (among thousands) that got moved down or off because of something strange, bizarre or terribly written.

My advice to you is to play it safe. Simply explain why you are interested in emergency medicine. What EM rotations have you had? Why did you like them? Do you have any subspecialty interests? What characteristics will you bring to a program? Importantly, the Personal Statement is the place to explain anything unusual or questionable about your applicable. If you bombed Step 1, but you had your appendix out the day before you took the exam, you should diplomatically point it out in your Personal Statement.

An all-too-common ploy is to start out with a "catchy", anecdotal event that supposedly deeply moved the applicant and got them interested in medicine/emergency medicine in the first place. However, most people really weren't performing CPR in a ditch on a dark and stormy night in high school. If you have to stretch it, don't try. Avoid being cute, creative or boastful (if you're a really good writer, you might pull it off, but I doubt it). And don't let your brother-in-law, the advertising major, get involved.

Finally, you must make sure that your entire ERAS application has been proofread multiple times by multiple people. Do not rely on your word processing program's spellchecker. Many faculty members believe, deep in their souls, that the care with which you treat your ERAS application (a pretty important document) corresponds with the care you will treat your residency and your patients. Misspellings, poor punctuation, lousy grammar, etc., will get circled on the application (in *RED* ink). Finally, have your advisor look it over. Family members can spot misspellings, but your advisor may pick up things that a layperson won't be aware of.

**Letters of Recommendation**

Most programs require three. I believe ERAS will allow four or five. Who to get them from? Well, you certainly need to get some from emergency medicine faculty. However, I personally don't think that all need to be from emergency medicine. You clearly need to cover all emergency medicine rotations that you have completed with a letter. So, if you did an EM month early in your fourth year at your own school, and then did an away elective, you need a letter from both.

Who to approach? This can be a paradox. The problem is choosing between the faculty member with whom you worked the most (often a more junior, relatively unknown, faculty member), and the most senior, well-known faculty, with whom you worked considerably less? Human nature being what it is, most people will regard a letter from someone they know or have heard of with higher regard than someone they don't. Some programs solve the issue by having one person write letters for the entire department, which them goes out under the boss's name, on behalf of the entire department. So, I'm not sure there is a right or wrong here, but most people seem to go with the more senior person.

Next, remember that all letters from emergency medicine faculty should ideally be written using the "Standardized Letter of Recommendation" ("SLOR") form developed by the Council of Residency Directors ("CORD"). Experienced EM faculty members should have this. If they don't know what you're talking about, you can find details on the SLOR at the CORD web site www.cordem.org. On the other hand, if they don't know what you're talking about, they obviously haven't been playing the game much over the past few years, and I question whether you want them to write a letter for you.

While you're at the CORD web page, look at the Bibliographic Citation Guidelines. If you have any publications, you would do well to follow these directions regarding listing them in your application.

Finally is the question of faculty photos. It's helpful to glance at the program's individual web page, and check out the photos of the faculty (if they have them). You never know who you'll run into in the bathroom.

### ***Should I Waive my Right to Read my Letters?***

As you may know, there is something called the *Family Education Rights and Privacy Act (FERPA).* Under it, students have the right to review their academic records, including their letters of recommendations. However, students have the option to explicitly waive this right, if they wish.

Traditionally, medical school letters of recommendation were confidential, and were not been shared with applicants. Therefore, most medical schools and/or letter-writers specifically ask applicants whether they do or do not waive their rights under FERPA. To this end, most letters specifically contain a phrase like "This student has waived their right to review this letter", or the inverse. Indeed, the CORD SLOR contains a check-off box for it.

So, you will be asked whether do you or do not want to waive your right (ie, do you want to read the letters or not?). Programs will then be notified which one you choose. What should you do?

Well, on one hand, it would be nice to know what's in your letters. Forewarned is forearmed if there are red flags. Some schools even allow students to cherry-pick the best letters. And, why should you give up your legal rights?

On the other hand, programs will know if you have demanded the right to read your letters. Some programs believe, rightly or wrongly, that letters students can review will be less honest and candid than private ones. This might hurt your chances with that program. Compounding this is the fact that, at least in my anecdotal experience, the VAST majority of applicants (90% +) do not ask to see their letters. That makes the occasional student who does stick out. And finally, the reality is that very few letters are truly negative. Most medical school faculty members are intrinsically student advocates. As such, they become masters of vague adjectives, obfuscation and the art of writing acceptable letters for weak candidates.

So, although I hesitate to recommend that anyone relinquish his or her legal rights, in this circumstance it is probably advisable to do so. Although these decisions do not impact how I write my letters, or how I personally view applications, they may well affect other programs.

### *Dean's Letters*

As you know, all Dean's letters are held until November 1, and then posted to ERAS simultaneously. This means that November 1 is a huge day for residencies, with downloads taking hours. Your school will draft Dean's letters in the weeks leading up to November 1. If you can, make it a point to read over the letter as soon as possible to correct any mistakes. Many schools will allow you to do this. Additionally, this will give you an idea of what programs are going to read about you. If any red flags are found, at least you are forewarned so you can formulate answers to the inevitable questions during your interviews.

### *Should I do Research?*

Many applicants want to do know if they should do some research to bolster their application. Programs vary in how much weight they place upon research in their ranking decisions. Some give lots of extra brownie points, others don't.

Remember, that not all research experience is created equal. It's very common for applicants to have spent some time in a lab somewhere as a research assistant, and maybe even got their name on an abstract or publication. If it isn't related to emergency medicine, it usually doesn't count for much. Of course, be sure to list it on your application; just don't count on getting many brownie points.

On the other hand, emergency medicine research counts more, particularly if it is clear that the applicant played a major role in the project. For example, I've had students who themselves came up with an emergency medicine research question, themselves developed the protocol, themselves sought and obtained external grant funding (as the principle investigator, no less), themselves completed the study, and themselves presented it at SAEM as first author. Now, THAT'S impressive!

However impressive, it takes an unbelievable amount of time. It is critically important that activities such as research (or any outside activities, for that matter) do not in any way impact how well you do in your class work and clinical rotations. Research isn't going to make up for flunking your surgery exam. This is important, because the very applicants who are most anxious to buff their applications are those who perceive that they have weak applications in the first place – just the ones who should be concentrating on acing their clerkships.

Thus, I advise you to pursue research ONLY if you actually want to do it in the first place (and not simply to buff your application), AND you have sufficient extra capacity to do it, in addition to the rest of your academic load. An exception might be those medical schools that require some sort of research project as part of their required curriculum. In that case, you might as well double-dip if you can, and do something emergency medicine-oriented, while satisfying a graduation requirement at the same time.

**Should I do a Three Year or a Four Year Program?**

As you probably know by now, emergency medicine residencies come in three flavors, 1-2-3, 2-3-4 and 1-2-3-4. About 75% are 1-3, about 11% are 2-4 and about 13% are 1-4. These competing formats have been the topic of rancorous, heated and sometimes bitter debate for decades among educators and leaders within the specialty. By now, most everyone has heard the debate, considered the pros and cons, and made up their minds. For most it has become a rather religious matter, either they're "believers", or they're "non-believers".

Before I go any further in this discussion, I should reveal my own potential biases, so that you can judge my comments with however many grains of salt you deem worthy. I personally completed five years of residency: three in internal medicine followed by two in emergency medicine (back in the days when 24 months of emergency medicine passed muster). My emergency medicine residency was a 1-3 program, which changed to a 1-4 program the year of my graduation. I since have been involved in the start up of two new programs, both 1-3, including my present program. Thus, the following comments are my own personal opinion, and you can be very sure that everyone else has equally strong, probably contrary opinions. Just ask them.

As always these days, financial issues play a role. As you recall, the federal government, via Medicare, financially supports teaching hospitals for graduate medical education. Several years ago, the Feds decided that they would fully fund only three years of emergency medicine residency training. Thus, 2-3 and 1-4 programs now only get partial funding for the 4$^{th}$ year of residency. This has pressured some programs to convert to a 1-3 format. Programs that maintain a 2-3 or 1-4 format either eat the difference or fund it from other sources.

Proponents of 48 months of training make the argument that emergency medicine is an extraordinarily broad specialty that simply can't be learned in 36 short months. They point out that 48 months of training afford residents the opportunity to explore more areas in greater breadth and depth. Their curricula may offer additional experience in research, academics or administration. Some applicants aren't sure they will be sufficiently confident in their clinical abilities without 48 months of training. Four year proponents also point out that for those interested in an academic career, it is difficult for a fresh, 36 month graduate to acquire a faculty position in a 48 month

residency program (as this would lead to the seeming paradox of a new faculty member with three years of residency supervising residents with exactly the same amount of training). Thus, such programs often require that 3-year grads acquire additional EM experience or fellowship training prior to considering them for a faculty position.

Proponents of 36 months of residency acknowledge that emergency medicine can't all be learned in 36 months of residency. However, they point out that it can't be totally learned in 48 months, either. Regardless, emergency physicians (like all physicians) will have to be life-long learners. These individuals also point out that there is no evidence that 48 months of training produce better, more capable clinicians. To the contrary, ABEM In-Training Exam scores consistently show that 3$^{rd}$ year residents in 1-3 programs score as high or higher than 4$^{th}$ year residents from 2-4 and 1-4 programs (I've never seen actual ABEM pass rates). Many applicants with real or perceived financial pressures (families and debt come to mind) are often attracted to the prospect of a "real" paycheck 12 months sooner. Some would simply like to get residency over with as soon as possible. Finally, some critics of four-year programs charge that the fourth year principally affords the program cheap junior faculty, and thus, the main advantages are to the program, not the residents.

So, given these pros and cons, what is my very personal and biased advice? I think applicants should (to the extent that their personal circumstances, families and finances allow) openly and fully look at <u>all</u> kinds of residencies, regardless of length, and select based on other residency features, which I think are more important than length. Most people can live through four years, if the residency is otherwise attractive and a good fit (of course, this is easy for me to say, after doing five years). Thus, I would ignore the program length and choose based on other features.

**Which Programs are the Best?**

Many applicants, particularly very competitive ones, want to know what the "best" programs are, so they can apply and hopefully be accepted there. However, I've got bad news. I've long held the perhaps heretical view that there is no such thing as a "best" program. And most of the really good emergency medicine advisors I know think the same way.

The problem is that programs vary tremendously. Yes, virtually all RRC-accredited programs have all the tools necessary to allow you to become an excellent emergency clinician. Nonetheless, beyond those baseline characteristics, programs still differ tremendously with regard to location, size, attitude, flavor, gestalt and feel. Depending on your individual needs and wants, you may find that you "fit" better with one program much more than another. However, the opposite may be true for the next candidate. One may be "best" for you and "worst" for them. For example, I once knew an outstanding applicant (one of the most competitive I've ever seen, out of thousands) whose most important priority was how "warm and fuzzy" the program was!

Regardless, many people still recant lists of "best" programs. Their information is often dated to when they interviewed (perhaps decades prior). Often, their opinion is really a measure of how well known programs are. "Well-known" is usually a factor of how much research they do, how much they publish, how many grants they get, whether a famous person works there (or used to work there), or simply how sexy the location is. The trouble is, these factors may not correlate with how

good the educational program is or how happy the residents are. Although I've known many "well-known" programs with great educational programs and happy residents, I've also seen lots where the residents were miserable and the education stunk. Conversely, I'm aware of little-known places where they stick to the knitting, run a great residency, train great emergency physicians and have very happy residents. So, you really have to look for yourself and trust your instincts.

**Scheduling Interviews**

So, you've done everything right, you've applied to thirty programs, and you're hoping to be contacted by lots of people wanting to interview you.

First, be sure that your e-mail is working properly. Most programs use exclusively e-mail-based communication. That means that invitations to interview, etc., are all by e-mail. You need to make sure it is working properly, and that your school doesn't have any sort of strange firewalls. During October and November, you need to check your e-mail frequently (like four times a day).

One recent change in the environment is that programs are issuing interview invitations and scheduling interviews earlier than they used to. Given that Dean's letters don't arrive until November 1, most programs used to wait until after November 1 to issue invitations, so they could check the Dean's letter first. However, the past year or so, I've had advisees receiving invitations in October or even September, and interviewing in October.

Regardless, whenever programs invite you for interviews, I suggest you respond immediately (same day). Many programs invite more people that they have interview slots for. This is because most applicants apply to more places than they can realistically visit. Consider a program that schedules 100 interview slots - if they invite a hundred, they may get 80 takers while 20 slots go empty. Thus, they invite 120 or 130 to be on the safe side. If 110 respond, the late responders get put on a waiting list. So, respond quickly to ensure that you aren't left out.

When you put together your fourth year schedule, I encourage you to schedule a month off in either December or January to interview. Programs' interview seasons vary, but in general, they start about mid to late November, and finish up in late January or early February. Things cool off the last ten days of December for the holidays.

So, which month to take off? January is probably best, although it really isn't a big deal. December tends to have fewer interview days available, although it is nice to have the time off around the holidays to visit family, which might not occur if you did MICU in December. Regardless of which month you pick, I would schedule something pretty lightweight the other month. For instance, if you decide to take December off to interview, schedule a rotation with flexible hours during January, just in case you need to escape for a few days to get in an interview or two. Most schools have some senior rotations that are either sufficiently understanding or sufficiently unchallenging for this to occur. Ask around.

Putting your interview schedule together is like an expensive three-dimensional chess game. There is a fair amount of schedule changing and juggling to make things work out. However, I would admonish you to keep your commitments, and not be a "no-show". In fact, a late cancellation (2-3

days notice) is almost as bad as a no-show. Emergency medicine is a small universe, and word gets around quickly. Being a no-show is a good way to get black-balled. Yes, I've seen it happen.

Understandably, lots of applicants tire as the interview season drags on (I can assure you that we get tired, too!) Some applicants become convinced that they have found their ideal program and don't want to look any further. Some may be run out of money, time or energy. Maybe true, but if you can, stick it out. You never know what you might find at that last interview. If you can't, give the program as much advance notice as possible, so some other applicant might be able to take your interview slot.

**How to Prepare for the Interview**

One thing I haven't plugged yet is Ken Iserson's excellent book, "Getting into a Residency – A Guide for Medical Students". Although the book is not specific to emergency medicine, the author is an emergency physician and former program director. I would advise you to read it cover to cover (I have, and I'm not even applying). Another source is a book entitled "AAEM's Rules of the Road for Medical Students". You can locate this at www.aaem.org.

**What to Do After the Interview?**

First, send a thank you note to every program within a few days (this may be understandably delayed if you are on a road trip). Regardless of whether you liked the program or not, a gracious note is still the polite thing to do. After all, the program has expended a fair amount of time and energy on you, and probably at least bought you lunch. Your mother will be proud of you.

The actual form the note takes probably doesn't matter. Some are typed letters, some are hand written, some are thank you cards, and lots are e-mail. Sometimes I see applicants writing separate letters to each person they interviewed with, and more for the secretaries. This is probably overkill.

Finally, toward the end of the season, is additional contact warranted? Well, on one hand, the ethics and strategy of the Match suggest that it shouldn't matter to programs what you think of them (or how they perceive you think of them), and vice versa. However, the reality is that both applicants and programs often contact each other at the end of the season to communicate their interest in one another. I suppose that they both think that such behavior is expected, and that their expressions of interest in each other MAY influence some lists. Some write, some e-mail, some call.

So, what is the best way to handle the Match Ethics of these communications? The following quotation is from the NRMP's web page:

*"There is one cardinal rule for both programs and applicants: neither must ask the other prior to the Match to make a commitment as to how each will be ranked. It is okay for each party to express a high level of interest in the other. However, references to how each party will rank the other should be avoided and should definitely not be solicited. Neither programs nor applicants should consider these comments about interest as commitments."*

So, it sounds like it is acceptable for either party to voluntarily express interest in the other, but unacceptable to be overly specific about that interest (i.e., "you're number one"), and it is forbidden to ask the other party to reveal his/her cards. Finally, don't believe anything anyone tells you, and certainly don't base your Match list decisions on it.

What this means is that communication between programs and applicants consists of a lot of creative and largely subjective euphemisms for "expressing interest in one another". It is very hard for anyone to know what "highly competitive", "strong", "good", "excellent", or "great" really mean. You don't know, and I don't either. A "highly competitive candidate" might be number one on one person's list and 75 on somebody else's. So, don't pin your hopes (or your Match list) on such adjectives. They can easily be misinterpreted.

Some programs explicitly tell applicants what they prefer in terms of contact. For instance, some reportedly tell applicants that they're so busy at the end of the season that they DON'T want phone calls from applicants. In fact, some reportedly say they'll kick applicants off the list if they call! On the other extreme, I've heard of some that explicitly tell applicants that if they are truly interested in the porgram, they MUST contact the program toward the end of the season and say so. This reportedly influences their Match List. Both stories seem extreme, but if someone tells you that, I would certainly follow their advice.

## Mistakes Applicants Make

***Not ranking enough programs.*** The #1 mistake I see people make is applying to, interviewing at and ranking too few programs. Usually it is naivete, or what I call the "Podunk syndrome". It goes something like this:

> "Well, you know I was born and raised in Podunk. I went to college and med school here. My family's here. My spouse's family's here. The kids like the schools here, and all their friends are here. We like Podunk, and this is where we want to stay. Of course, there's only one emergency medicine program here in Podunk, but there are two others within possible commuting distance. So, we're going to apply to those three programs".

Wait a minute. Unless you're a real all-star, applying to only three programs is pretty risky. You're going to have to decide which is more important to you: living in Podunk for the next 3-4 years, or being an emergency physician the rest of your life? There may not be a right or wrong answer, but you need to decide.

Of course, not ranking enough programs is related to not applying to or interviewing at enough programs. Here, literal interpretation of conventional wisdom can get you into trouble. The standard conventional wisdom is "don't rank any place that you don't want to go". Although true, this piece of advice is relative, and a matter of interpretation. I've seen applicants who say "I love Program X, and therefore, I don't want to go anywhere else". Some take this literally to mean that they won't rank any place other than Program X. Pretty dumb - some call it the "suicide match".

Here's my advice: when you get to the bottom of your list, and you're trying to decide whether to even list a few places or not, the real question is*: Would I rather be at this (undesirable) program,*

*or not be an emergency physician?* If the place is really so bad that you'd rather be a pediatrician than go there, by all means, leave it off the list. However, if you'd rather be in emergency medicine for your career, I advise you to leave it on. Why? Your chances of successfully scrambling are slim. And, the traditional advice of "do transitional and try again next year" is getting harder to pull off (see above). So, this year is your best shot.

This then begs the question of how long your match list should be. Match statistics show that successful applicants to emergency medicine programs average between nine and ten places on their lists. Remember – that's the number of places on the list. You may have to interview at more to winnow it down to ten. And then, how many do you apply to in order to interview at 12-15? Finally, if it was *my* career on the line, I don't think I'd want to settle for just "average".

So, what this means leads to one overall piece of advice that I have for you is to: *"Apply, interview and rank as widely and broadly as your time, energy and money possibly allow. There's always a bigger and better fish in the sea, but you won't find it if you don't look for it."* You have relatively little to lose, and everything to gain. I advise most applicants to apply to 30 programs.

*Screwing up your match list:* I know you've heard this one before, but you should list the programs on your Match list exactly in your order of preference, without consideration for your perceived competitiveness for the program. The reason I repeat this admonition is that there are lots of rumors that float around on the interview trail, and it's easy to get confused. People will darkly whisper about vague algorithms and other such tripe. Trust me – list them exactly how you want them. That is, go for broke, and shoot for the stars.

***Shooting yourself in the foot during the interview**:* Assume that nothing is off the record. That includes facility tours, lunch with the residents, phone calls to the secretaries, bathroom breaks, and the night before at the bar. Most programs include resident and secretary input to the decision process.

An occasional applicant will be on his/her best behavior during the interview, only to relax too much when alone with the residents, get obnoxious, shoot off their mouth, or otherwise get offensive and irritating. Others will be rude to the secretaries, either at the interview or on the phone. I've never known a program that didn't listen to the secretaries.

### How do I Decide How to Rank Programs?

As pointed out above, there are no universally "best" programs. So, your ideal Match list will probably look very different from that of your colleagues.

***Location*** – Studies have repeatedly shown that geography is by far the most important factor in applicants' decisions. This might involve how close a program is to home, mom & dad, significant other, spouse, significant other's university or job, baby sitter, etc., etc. Alternatively, it may be how warm or cold it is, how close it is to ski slopes or beaches, how large or small the city is, or "how much there is to do".

However, I've got news for you: The temperature inside every hospital in this country is 72 degrees. And more news is you're going to spend so little time outside the hospital over the next three years, it's not going to matter what the temperature is, or whether there's a beach or a mountain.

In reality, the overwhelming majority of your time and interaction will be within the program and with its people. So, my advice is to pick the program and the people you will be working with, NOT the location. Even if you're in a gorgeous location with beautiful weather and stunning vistas, if you're miserable 79.9 hours a week, the weather and vistas will grow old real fast. It's unlikely that your very "best" program will be necessarily be within a one hour radius of mom and dad, home, alma mater, boyfriend, or whatever. Thus, you'll be unnecessarily limiting yourself and the quality of your choice.

So, if you possibly can, pick the program that you truly like the best, not the location. Yes, I realize that sometimes you're stuck – like if your husband is half-way through a non-transferable PhD program at State U back home. If, on the other hand, you're basing your Match list on your conviction that your mother is the ONLY person on the face of the earth remotely qualified to baby sit your two year old, I respectfully suggest that you may need to reevaluate your assumptions.

***Fellowships*** – Some applicants worry that they have to choose the correct residency in order to get accepted into a fellowship. Wrong. While that may be a factor in internal medicine or some other specialties, it isn't an issue in emergency medicine. Many, many fellowship spots in emergency medicine go unfilled every year, and even the "best" have surprisingly few applications. This is probably because the market for newly minted emergency medicine grads is so good. Regardless, virtually any emergency medicine grad can get accepted into fellowship after residency, if desired, and the specific residency they trained at has little impact on their chances.

It's true that if your heart is already set on a certain fellowship in a certain institution (pretty rare), doing a residency in that same institution may give you an inside track for getting into the fellowship (assuming the fellowship is hard to get into in the first place - unlikely). And, the presence of, say, a toxicology fellowship in an institution likely means that the toxicology experience in that institution's residency is good. However, these factors are of little impact to the vast majority of residency applicants, and are a non-issue.

***Volume*** – Candidates struggle to find objective, quantitative ways compare and contrast programs. A readily available statistic is patient volume. A common applicant conclusion is that more is better. Wrong again. Remember, whether an ED has 50,000 visits or 250,000 visits, you can only see one patient at a time.

The RRC mandates that, in most circumstances, ED volumes have to be at least 30,000 per year. On the low end, I personally would look carefully at a place with ED volumes (combined of all the ED's in the program) of less than 40,000. I would worry about whether they'll have enough volume to provide a sufficient variety of pathology. They may, but you need to look closely to make sure. But on the high end, more does not equal better. Once an ED's volume passes 70-80 thousand, chaos and service pressures sometimes start overwhelming clinical education. Not always, but look carefully.

The vast majority of programs fall between these two extremes. So, the bottom line is that patient volume is usually NOT something to base your Match list on. Anything from maybe 45k-90k is fine.

***Ultrasound*** – Some applicants use the presence of an emergency ultrasound program as a big factor in their decision. It's relatively tangible, like patient volume. This perception, of course, is encouraged by those residencies with strong U/S programs, and criticized by those with weak ones.

I'm pretty ambivalent on this one. Yes, emergency U/S is finally becoming established in the real world and residents with strong U/S skills occasionally have an advantage in those job markets. And, U/S use in the ED really can substantially change and improve day to day practice. On the other hand, the RRC now mandates U/S training in all emergency medicine programs, so the differences between programs has diminished. And, unfortunately, many (probably most) real world ED's still do not do emergency U/S, so the skills learned in residency may atrophy in those settings.

Finally, to clarify some confusing terminology: "certification" and "credentialing". Some applicants report that they can get "board-certified in ultrasound" at certain residency programs. Sorry, but there's really no such thing as board certification in U/S for emergency physicians - it's not like the American Board of Emergency Medicine. What does exist is "credentialing", which is the decision of an individual hospital to allow a doctor to perform a certain procedure, be it emergency U/S or laparoscopic cholecystectomy. Whether or not to allow emergency physicians to perform U/S in the ED (and the criteria for granting that privilege), is a decision of each individual hospital you go to work at, not the residency program you trained at. You might be the most skilled ultrasonographer in the land, but if the hospital you're working at doesn't grant you privileges to do it, you're up a creek.

It's true that both ACEP and SAEM have developed "model" credentialing criteria for U/S, which they propose that individual hospitals adopt. Some residencies may make sure that residents fulfill those criteria during residency. However, unless the hospital that the resident subsequently goes to accepts those criteria, it won't mean much.

Finally, to confuse matters more, there actually is a "certification" in U/S of sorts, that a few emergency physicians have pursued. Certification as a "Registered Diagnostic Medical Sonographer" (or RDMS) is a process that ultrasound techs use. A few emergency physicians around the country have gone out and gotten "certified" by this route (essentially as an ultrasound tech). Originally, this was largely a political end run around the various road blocks that radiology put up in some hospitals to prevent emergency physicians from performing U/S. However, as emergency U/S becomes more and more accepted into the mainstream, the political need for this ploy is diminishing. Nonetheless, some programs may offer residents the opportunity to achieve RDMS designation, leading to the perception that they are getting "certified". Well, kind of, but not quite.

***The Residents*** – Finally to the things that actually matter. What about the residents you met? What do they think of program? Are they happy? Did you like them? Would you enjoy working with them?

Pay very careful attention to the residents. Of course, it's kind of unusual for residents to really badmouth their own program, because frankly, it makes them look bad ("Wow, if this place is that bad, I guess you must have been a really crummy student to have gotten stuck here, huh?"). But, take any isolated comments, positive or negative, with a grain of salt. They might have finished a lousy midnight shift just before meeting you, or the program may have marched out their one Pollyanna for the occasion. So confirm your impressions with multiple residents.

Finally, be very careful about a program where you don't have a chance to meet residents (actually, many residents). Are they so overworked that they don't have the time or energy? Are they so burned out that they don't care? Or is the program hiding them?

***Gestalt*** – Some applicants admit that a big part of their decision-making stems from the emotional "feel" or "gestalt" that they get when they interview at a place. Others, however, reject such subjective impressions in favor of more objective "evidence-based" scoring systems, with spreadsheets and the like.

While spreadsheets and scoring systems are great, I advise you not to ignore gestalt. It isn't as subjective as many think. An applicant often leaves a place with a "good feeling" or a "bad feeling", but can't put their finger on exactly why. However, it's probably simply because they are new to the interview game. If an experienced program director was a fly on the wall during the interview, they could probably identify explicit, objective factors that made the candidate feel good or not. So, trust your instincts. If you actually like the people the program, it will make your residency much more pleasant. Trust me, on a busy midnight shift when you've just restrained your fourth drunk and a fifth just vomited on your shoes, it helps a lot to be with people that you actually like.

Good luck!