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Residency Program Alert

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14 markers of a problematic residency application

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September 15 marks the start of the main residency Match season. For the most part, each residency program's highly tailored—and often subjective—residency application screening process yields a high enough number of interviewees to provide an adequate statistical probability for the National Resident Matching Program's (NRMP) Match algorithm to consistently fill about 95% of residency slots. However, the process and outcome for the unfilled 5% of slots that are reintroduced to residency candidates during the annual Match week's Supplemental Offer and Acceptance Program are the subject of incredible debate and anxiety. Many residency programs struggle with the regret of having to rank candidates with whom they were not 100% comfortable, on top of "missed opportunities" from not having invited—or having the interview slots to invite—more suitable applicants, especially when precious interview spots were misallocated.

In the 2018 Match, the challenge of inviting the most suitable candidates to interviews will be further complicated by three factors:

1. Over-application straining residency resources: Over the past 10 years, increasing competition and the fear of remaining unmatched has forced medical residency applicants to over-apply across every specialty, increasing pressures on residency programs that already lack the resources to effectively screen and distinguish applicants (Overton et al., 2017).
2. A growing number of seemingly qualified foreign applicants: Selection committee gatekeepers (i.e., residency program coordinators, secretaries, and residents) have to make rapid judgment calls on applicants who demonstrate signs of strength on some, but not all of the six ACGME core competencies. This trend has become more noticeable among international medical graduate (IMG) candidates who have learned about the significance of the ACGME core competencies but have mentors and non-U.S. medical schools that are slow to adapt.
3. Newly ACGME-accredited (former American Osteopathic Association–accredited) residency programs evaluating IMG applicants for the first time: When all is said and done, the single GME accreditation system will make about 6,000 additional residency slots available to allopathic medical graduate applicants in the 2021 Match, with a considerable number of these slots already listed and made available in the 2018 Match. Although many former DO programs are led by MD program directors, the majority remain osteopathic in nature, a style of medical education that is only taught in 33 accredited colleges of osteopathic medicine in the United States.

Such mounting pressures may force selection committee gatekeepers to over-rely on rapid filtering techniques that have proven ineffective for identifying residents who will find themselves in trouble in the future. These filters are:

- Years since graduating from medical school
- Need for visa sponsorship

- United States Medical Licensing Examination (USMLE) scores
- USMLE attempts

In my experience, having mentored and selected both U.S. and IMG residency applicants for interviews at two family medicine residency programs and one private institution, our gatekeepers are asking for tools to help them rapidly assess each applicant more efficiently, fairly, and holistically prior to implementing these four filters. Although the Association of American Medical Colleges has responded by moving in the direction of mandatory standardized video interviews, this promising tool is only available to emergency medicine candidates and programs in the 2018 Match. For all other residency programs, selection committee gatekeepers will have to continue to rely on existing application screening processes and hopefully make them standard practice for anyone who is authorized to recommend, reject, or hold an application for interviews.

Figure 1 lists 14 residency application clues that could serve as markers for future resident difficulties, independent of years since medical school graduation, need for visa sponsorship, or USMLE scores or attempts. These markers are:

1. Poor grammar; usage of unfamiliar terms.
2. Insufficient quality (or non-existence) of recent post-graduate year 1 relevant U.S. patient experience.
3. Poor or lacking signs of commitment to U.S. healthcare or specialty.
4. A non-U.S. address or phone number.
5. Blank fields in Electronic Residency Application Service (ERAS) application (e.g., no response to the "Reason for leaving" field).
6. Lack of true U.S. GME exposure.
7. Lack of exposure to electronic medical records/electronic health records.
8. No U.S. research experience, or multiple research experiences with no PubMed-listed publications.
9. Overly subjective letters of recommendation (LOR) that lack ACGME reference by way of personal clinical examples.
10. LOR writers with no evidence of personal U.S. GME experience.
11. Unexplained gaps during medical school.
12. Prolonged and repetitive gaps since graduating from medical school.
13. Self-reported personal challenges without adequate explanation.
14. Minimal to no support system in the U.S. This could include a foreign mailing or permanent address, international phone numbers, repetitive "trips back home," suspicious (uninsured or possibly unlicensed) practice of medicine, and short-term (less than four weeks or 25 hours/week) U.S. shadowing experiences in non-relevant medical specialties.

Proper implementation of Figure 1 can help you screen each applicant quickly. Naturally, each program will have different thresholds and tolerance levels when dealing with resident difficulties, especially depending on the magnitude and complexity of the situation. As such, residency selection committees and their gatekeepers should standardize their screening process by taking the following three steps:

1. Categorize each example of future resident difficulties according to their program's internal levels of tolerance, without overlooking any single ACGME core competency.
2. Look for at least one marker in the "Possible markers in residency application packages" column that correlates with the most serious examples of future resident difficulties.
3. Attempt to identify a repeating pattern for the marker(s) found in step 2. Finding at least two repeats results in rejecting the applicant. If one or no repeats are found, redo steps 2 and 3, looking for another marker. If at least two repeats are found for this additional marker, reject the applicant. However, if only one or no repeats are found for the second marker, put the applicant on your shortlist for an in-person interview invitation with a prescreening video interview via Skype, Google Hangouts, FaceTime, WhatsApp, or Viber. Every indicator is pointing to a continued uptick of candidates over-applying to residencies in the 2018 Match, meaning some pro-

Figure 1: Application screening protocol

Example of future resident difficulties	ACGME core competency	Possible markers in residency application packages
• Interpersonal problems with patients and their families	Patient care	• Poor grammar; usage of unfamiliar terms • Insufficient quality (or non-existence) of recent PGY1 relevant U.S. patient experience • Poor or lacking signs of commitment to U.S. healthcare or specialty
• USMLE Step 3 failure • Low scores on in-service exams	Medical knowledge	• Insufficient quality (or non-existence of) recent PGY1 relevant U.S. patient experience • Overly subjective LORs that lack ACGME reference by way of personal clinical examples
• Failure to consider recent evidence • Incomplete recordkeeping and poor documentation • Non-attendance at seminars or journal clubs • Noncompliance with notes and treatment plans	Practice-based learning and improvement	• Poor grammar; usage of unfamiliar terms • Blank fields in ERAS application (e.g., no response to "Reason for leaving") • Insufficient quality (or non-existence) of recent PGY1 relevant U.S. patient experience • Lack of true U.S. GME exposure • Lack of exposure to EMR/EHR • No U.S. research experience, or multiple research experiences with no PubMed listed publications
• Interpersonal conflict with colleagues, patients, and families • Complaints or lawsuits due to interpersonal conflict in clinical situations	Interpersonal and communication skills	• Insufficient quality (or non-existence) of recent PGY1 relevant U.S. patient experience • Lack of true U.S. GME exposure • Overly subjective LORs that lack ACGME reference by way of personal clinical examples • LOR writers with no evidence of personal U.S. GME experience • Minimal to no support system in the U.S.
• Tardiness or absenteeism from call duties • Intoxication during work hours • Complaints about insensitive comments regarding patient's ethnic or religious background • Poor work ethic	Professionalism	• Unexplained gaps during medical school • Prolonged and repetitive gaps since graduating from medical school • Insufficient quality (or non-existence) of recent PGY1 relevant U.S. patient experience • Self-reported personal challenges • Minimal to no support system in the U.S.
• Inability to make appropriate referrals inside hospital system or to outside agencies • Taking on too much patient care (i.e., procedures on psychiatric patients) due to lack of understanding of their role within the system • Failure to seek attending or consultant's opinion on difficult cases	Systems-based practice	• A non-U.S. address or phone number • Overly subjective LORs that lack ACGME reference by way of personal clinical examples • Insufficient quality (or non-existence) of recent PGY1 relevant U.S. patient experience • Lack of true U.S. GME exposure • LOR writers with no evidence of personal U.S. GME experience • Minimal to no support system in the U.S.

grams can expect to receive up to 200 applicants per residency position. Not only would implementing and standardizing an ACGME competency-based screening protocol (like the 14-marker system introduced in Figure 1) prior to filtering help your program maintain order, but doing so may also help mitigate legal liabilities against claims of an unfair or unequal application review process.

Keep in mind that in order for your screening protocol to work, your residency selection gatekeepers must avoid over- or under-relying on any one competency (e.g., inviting a candidate who has copied and pasted the descriptions in every section of his or her ERAS application's experiences for an interview due to a Step 2 CK score of 240); all six competencies must be satisfactorily met by each medical resident.

In my experience, the sooner a program implements a standardized screening protocol, the higher the chances of inviting candidates with matching interests and accomplishments. This improves all aspects of the residency Match process, including attending satisfaction and improved resident morale.

Please feel free to share any clues or markers not listed in this article that your residency program has identified.

All the best in this year's Match!

REFERENCES

Overton, R., & Dunleavy, D. (2017). The AAMC standardized video interview. [Webinar]. Retrieved from http://www.ecfmg.org/echo/webinars-may-2017.html.