Becoming a Pediatrician

Your Guide to Exploring Pediatrics, Matching for Residency, and Starting Intern Year
This publication is a collaborative effort. The leadership of the American Academy of Pediatrics (AAP) Section on Medical Students, Residents, and Fellowship Trainees (SOMSRFT), along with the SOMSRFT Medical Student Academy of Pediatrics (AAP) Section on Medical Students, Residents, and Fellowship Trainees (SOMSRFT), along with the SOMSRFT Medical Student Academy of Pediatrics (AAP) Section on Medical Students, Residents, and Fellowship Trainees (SOMSRFT), have joined efforts with the leadership of the Council on Medical Student Education in Pediatrics (CONESEP) to create this publication. The AAP SOMSRFT is composed of pediatric residents, pediatric fellows, and medical students. CONSEP is composed of pediatric clerkship directors.
It is no surprise that general pediatricians report greater satisfaction with patient relationships than any other specialists. Children make you smile; they create an ideal work environment when they walk in the door.

Pediatrics offers excellent job satisfaction, ample employment opportunities, and a great deal of flexibility. General pediatricians are less likely than any other specialist to have concerns about a lack of personal time and more likely than other physicians to recommend their specialty to a student seeking advice.

According to the 2006 American Academy of Pediatrics (AAP) Third-Year Graduating Resident Survey (unpublished data), 95% of graduating pediatric residents report that they would choose pediatrics again and 79% of those who sought a general practice position received an offer from their most desired position.

Pediatrics offers flexible work-hour arrangements. Of the 38 percent of graduating pediatric residents who apply for part-time work, more than half accept a part-time position.

Pediatricians Are THE Specialists for Children

Pediatricians complete 3 to 6 years of comprehensive training in the care of children after completing medical school. All pediatricians complete a 3-year pediatric residency, after which they are eligible to take the board examination for certification in general pediatrics. To become a pediatric subspecialist, pediatricians must complete an additional 1 to 3 years of fellowship training (3 years for most subspecialties), then pass a subspecialty board examination. This extensive and intensive training in the health needs of children and adolescents is unique to pediatrics. As a result, every other specialty, from family medicine to neurosurgery, looks to pediatrics for expertise in child health.

General Pediatrics Is More Than Just “Well-Child Checks”

Children are impressionable; early environments and experiences influence fundamental life choices. The patient education that pediatricians offer is potentially life-changing.

As specialists in child development, general pediatricians conduct complex assessments during well-child visits. A typical check-up features subtle assessments and significant benefits:

- The opportunity to form deep and lasting relationships with patients and families as the nucleus of a team-based approach to child health
- The joy in helping children grow healthy from birth through adolescence
- The responsibilities of health supervision, including those of the first physician to make diagnoses that signal a need for immediate attention and further investigation
- The privilege of counseling families in times of struggle or medical crisis
- The satisfaction of managing many pediatric illnesses without the assistance of subspecialists

Pediatrics Is More Than General Pediatrics

The 3-year general pediatric residency is the portal to further training in one of the pediatric subspecialties. Pediatricians must complete a 1- to 3-year fellowship to become pediatric subspecialists. The pediatric subspecialties include:

- Adolescent Medicine
- Allergy and Immunology
- Cardiology
- Child Abuse and Neglect
- Critical Care (Pediatric ICU)
- Dermatology
- Developmental and Behavioral Pediatrics
- Emergency Medicine
- Endocrinology
- Gastroenterology and Nutrition
- Genetics
Many pediatric subspecialties are currently experiencing workforce shortages or will likely experience such shortages in the near future, making the need for more pediatric subspecialists greater than ever.

**Unparalleled Ability to Advocate for Your Patients**

Opportunities in public health, international health, health policy, and administrative leadership continue to grow. In addition, administrators, educators, and policy makers need reliable advice about the needs of children, and pediatricians are the experts who can provide that guidance. From leading grassroots efforts to testifying before Congress and meeting with lawmakers, pediatricians identify the important problems facing children, and work to protect and promote the health of children in a meaningful way.

**Bottom Lines**

Pediatrics is a rewarding, engaging, and flexible specialty. Both general and subspecialty pediatrics accommodate a variety of practice settings and styles. Hospital-based medicine is increasingly popular among general pediatricians, although many continue to pursue rewarding careers as office-based physicians. Many pediatric subspecialties offer a mix of inpatient and outpatient practice models, while others allow a focus in one of these settings.

As more children are cared for by pediatricians rather than physicians from other specialties, opportunities for pediatric generalists and subspecialists continue to grow. Pediatricians are needed in direct patient care and also to serve as educators, mentors, and researchers. If these opportunities sound appealing, consider the extraordinary rewards and satisfactions of a career in pediatrics.

**References**

Abraham Jacobi, a physician who immigrated to the United States from Germany in 1853, is given credit for establishing departments of pediatric medicine in the nation’s hospitals. Jacobi believed that most clinical issues confronted in primary care had their roots in some aspect of community health that pediatricians had a duty to address.

Today, pediatricians and pediatric organizations are intentional and effective advocates for child health and well-being. Pediatricians advocate at many levels, including direct patient care, the community (local or national), and the legislative arena. Advocacy in the direct patient care context occurs every time a pediatrician provides information to, accesses services for, or educates children and families about health and safety. Public health education occurs every time a pediatrician collaborates in the greater community (local, state, or national) to promote health and safety. The American Academy of Pediatrics (AAP) Back to Sleep campaign to end sudden infant death syndrome, initiatives to discourage cigarette advertising targeting adolescents, and efforts to persuade local school boards to remove sodas from school cafeterias are examples of public health advocacy. Successful legislative efforts have included the 2010 Patient Protection and Affordable Care Act, the State Children’s Health Insurance Program (SCHIP), Project Head Start, the Flammable Fabrics Act Amendments, the Vaccines for Children Program, and the Poison Prevention Packaging Act, which decreased aspirin deaths by 65%. Pediatricians have a responsibility to participate in initiatives that promote healthy growth and development for children. Medical students with a commitment to effective health advocacy should strongly consider a career in pediatrics, because as pediatricians, they will have the credibility to make a difference.

Pediatricians have a responsibility to participate in initiatives that promote healthy growth and development for children. Advocacy work in pediatrics can begin during medical school. Medical students can testify at legislative hearings, help to run clinics for underserved children, and work with pediatric interest groups sponsored by their institutions’ residency programs.

**Bottom Lines**

A pediatrician understands that an individual’s health depends upon a wide array of influences. These include community-level factors that may be best addressed through education and policies that target entire populations. A pediatrician must look to the future with the perspective that today’s advocacy builds a better tomorrow for children. The AAP offers resources for medical students interested in advocacy because medical students have always been vital contributors to successful child advocacy.
During the first three and a half years of medical school, students experience a wide variety of interesting fields, study for innumerable exams, and help to treat hundreds of patients. For some students, these experiences help to narrow career choices; for others, they only exacerbate the dilemma. For those in the latter category, specialty interest groups may help.

**Pediatric Interest Groups (PIGs)** provide the opportunity to learn about and experience the field of pediatrics starting in the first year of medical school. PIGs sponsor talks and networking events, facilitate mentoring relationships with pediatric residents and faculty, and create opportunities to interact with pediatric patients and explore research interests. By introducing students to the pediatric community and enabling them to learn about the field from a variety of perspectives, PIGs can help students decide whether a career in pediatrics is a fit for them.

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The American Academy of Pediatrics (AAP) has developed a series of resources, available on our [medical student Web page](http://www.aap.org/sections/ypn/ms/getting_involved/) to help guide the development and funding of PIG events. Students, residents, and faculty around the country who would like to create new PIGs have found the [AAP Pediatric Interest Group Resource Guide](http://www.aap.org/sections/ypn/ms/getting_involved/PIGResource-Guide.pdf) to be particularly helpful. Materials in the guide are continuously updated with opportunities and ideas that anticipate questions, concerns, and interest of students exploring a career in pediatrics.

**Bottom Lines**

One of the most exciting (and daunting!) tasks facing medical students is choosing a specialty. PIGs provide a warm welcome to the pediatric community, where students will find a warm welcome and reliable advice.

**References**

Section 4 - The First 3 Years of Medical School: Dive Right In!

Paola Dees, MD; Kristina Betters, Med 4; and Katherine Snyder, MD

While your responsibilities and priorities will shift throughout medical school, certain themes persist. One of those is the importance of engagement in your profession, your specialty, and your training program.

The First 2 Years of Medical School

Time is at a premium in medical school, especially at the start. Finding the time to gain clinical experience and solidify specialty interests is among the biggest challenges. The key is to capitalize on existing opportunities and build on existing options within your school or community.

Pediatric Interest Groups (PIGs) can be an easy way to learn more about the field of pediatrics during medical school. Many PIGs offer lunchtime lectures and volunteer events in the evening or on weekends. Those whose schools do not yet have a PIG might approach their faculty or administration about forming one.

Pediatric faculty, residents, and fellows are ready resources. Most physicians at teaching institutions are delighted to talk with medical students and willing to be shadowed. Inquire about attending pediatrics grand rounds to learn more about the field and hear notable speakers from other institutions.

Summer research projects and community events are excellent ways to pursue an interest in pediatrics. Most schools offer research stipends for work in pediatrics during the summer after the first year of medical school. To explore opportunities, contact a pediatric faculty member who is active in research.

The pediatric chief resident often works closely with medical students; he or she can be a great liaison to the faculty. Chief residents can also advise about other opportunities, including volunteer options within the community, which can provide valuable experience. If a consistent commitment is not realistic, consider volunteering for a school health fair or educational event for local children. If none exist, recruit some students and hold your own event for local children!

Finally, upperclassmen can serve as great resources. Find third- and fourth-year students who have declared their interest in pediatrics and discuss the ways they explored pediatrics in their first 2 years of medical school.

The Third Year of Medical School: Tips for Successful Clerkships

Before beginning your third year, find a few trusted senior students and discuss their thoughts on how to succeed at your medical school. It is likely that they will mention professionalism, medical knowledge, and communication.

Professionalism

❖ Professionalism is the central tenet to success in your third year. Arrive early, write legibly, dress appropriately, and act professionally at all times.
❖ Treat every member of the health care team with kindness and respect.
❖ Be compassionate. Empathize with your patients and their families. Try to think about things from their perspective. During your pediatrics clerkship, take care to talk to your patients in an age-appropriate way. One need not be a parent to imagine how scary it can be to have a sick child. Spending a few extra minutes actively listening can provide an enormous amount of comfort to an anxious family.

Pediatric faculty, residents, and fellows are active resources. Most physicians at teaching institutions are delighted to talk with medical students and willing to be shadowed.
Be enthusiastic: go above and beyond! Residents and attendings can identify disinterest and negativity as well as genuine enthusiasm. Their observations will be reflected in the final evaluations. Those who invest time and effort to learn more find that their residents and attendings invest more time to teach and mentor in return.

Be a team player. Offer to help others.

If others make inappropriate comments, jokes, or gestures, do not follow their example. Be a model of humanism and respect for others.

Medical Knowledge and Patient Care

Take ownership of your patients and show initiative. Go beyond reporting facts: become an investigator and an advocate. Make an active effort to anticipate and solve problems.

Read about your patients and their conditions, come up with a differential diagnosis, follow up on consults and labs, and check in on patients during your downtime. Use each patient encounter as a learning opportunity. What would be the next step if you were solely responsible for their care?

Speak up and show what you know! Don’t be afraid to answer questions confidently and contribute. At the same time, be careful not to think – or act – like a know-it-all.

Document precisely, thoroughly, and accurately. If you did not check it, don’t write it in the notes.

Study! Use resources recommended by your clerkship directors and be proactive about studying. Do not wait until the last week of the rotation to begin reading. Set aside time every day to cover core curriculum topics and review practice board questions.

Communication and Feedback

Know the expectations of your clerkship director, attendings, and residents. Ask for guidance at the beginning and midway through the rotation.

Communicate directly with patients and their families. Explain your role and offer to help them. Do not answer questions if you are not certain of the answer. If you do not know something, simply state that you will get an answer.

Communicate proactively. Check in with the supervising resident before rounds in the morning and again before you leave at the end of the day to exchange information and ensure that all outstanding issues are addressed.

Ask for feedback from your team. Take the opportunity midway through and at the end of your rotation. You are a third-year student; nobody expects perfection! Ask for tangible examples of your perceived strengths and areas for improvement. The best way to learn is to get constructive advice and to challenge yourself to integrate what you’ve learned into your repertoire. This is how you will become a better clinician.

Bottom Lines

The first 3 years of medical school reveal the extent to which medicine is a team endeavor. An effort to communicate, document, show respect, and seek out advice will both ease and enrich the learning process.
Research in Pediatrics During Medical School  
Linda Tewksbury, MD and Janice Hanson, PhD

Section 5 - Research in Pediatrics During Medical School

Pediatrics offers many exciting opportunities in research, including basic science research, epidemiology, translational research, clinical research and pediatric health services research. Pediatric clinician scientists are growing in numbers and funding, with the National Institutes of Health (NIH) funding for research in pediatrics totaling about $2.8 billion in 2008.1 If you are considering a career in academic pediatrics, you may have questions about doing research, such as the following:

**How Might Research During Medical School Help Me Excel in a Career in Pediatrics?**

While pediatric residencies do not require applicants to have research experience, such experience in medical school can be very valuable to the student considering a career as a clinician scientist or as an academic pediatrician.

You may have the opportunity or even be expected to do some research in residency, thus having the experience as a student can give you a head start on a clear idea for a pediatric research project, or at least provide insight toward a general research topic of interest, and may even position you well to compete for research funding. If you are interested in a career in subspecialty pediatrics, most fellowships require their trainees to complete a research requirement to become board certified in that subspecialty. For those interested in general academic pediatrics, there are fellowships available that will further assist you in refining research skills. Even for students who ultimately chose not to pursue a career in research, research experience provides an important perspective to the practicing clinician, such as expanding one’s knowledge about evidence based medicine and ability to critically evaluate current healthcare practices. While a meaningful research experience can certainly enhance a student’s application for residency in pediatrics, it is not essential and you should only pursue a research opportunity that sincerely interests you.

**When During Medical School Could I Participate in Research?**

Many medical schools have time in the curriculum for students to pursue research during the summer between the first and second year. While it can be challenging to start a new research project during the academic year, many students who start a project in the summer are able to continue into their second year and beyond. Opportunities for research electives are generally provided in the third or fourth years. Some medical schools require an additional fifth year, with opportunities and sometimes an expectation that students will get involved in research in some way. Some medical schools have support available for student-led community-based research or a research day for you to present your findings. Other schools have complete research tracks in which you can focus your study.

**How Can I Find Research Opportunities?**

The best way to begin your search for research opportunities is to think about questions that interest or intrigue you. Have you always been fascinated by new lab techniques and questions about biology, chemistry, or physiology? Then basic science research holds opportunities for you. Do you want to explore how health policy affects the provision of care for large numbers of children and families? Health services research may hold the key. Do you wonder about the connections between science and clinical practice? The growing field of translational research may help you build this bridge. Once you have an area of curiosity, or even when you’re trying to decide what intrigues you most, you may want to seek out a mentor or advisor in the department of pediatrics, network about research opportunities at a pediatric interest group at your school, visit your school’s department of research, or make an appointment with an advisor in the office of student affairs.

**What Sources of Funding Are Available to Support Medical Students Who Do Research?**

Some professional groups offer small grants or funding for students to present research at professional meetings. For example, the American Pediatric Society and the Society for
Pediatric Research offer a medical student research program that provides 8 to 12 weeks of funding for medical students who want to extend their education by working in research laboratories. Some medical schools offer small intramural grants for medical student research, available through a research office. The American Academy of Pediatrics provides grant support for community-based research for residents through the Community Access to Child Health (CATCH) grant program, and students may be able to collaborate with a resident on a project funded through this program, or obtain research experience that will position them well to apply for their own grant support when they are residents. The Society for Teachers of Family Medicine also provides some support for medical students to attend meetings to present their work, and students interested in pediatrics may find rewarding collaborations with students interested in family medicine. Finally, faculty who have research funding for their own work often seek students to assist, and the faculty grants sometimes provide some funding support for students' participation in the research.

What About Other Extramural Funded Programs?

Most offices of student affairs or research at schools provide lists of extramural grant funded initiatives that aim to increase student participation and careers in research. The Centers for Disease Control and Prevention and the National Institutes of Health have summer fellowships available, for example. These are competitive programs, so you should investigate early and give yourself plenty of time to complete the application and obtain letters of support from your faculty or offices of student affairs or research.

What If I Didn't Do Any Research and Now I Am a Third- or Fourth-Year Student?

Don't panic! Many candidates for residency training have not done significant research. Many other relevant extracurricular activities, such as participation in community service projects, student government or medical school committee service, will support and enhance your application to residency training in pediatrics.

Bottom Lines

Research during medical school is a highly valuable but often optional part of the overall education of a physician. Pediatricians that have experience with research gain skills that can help them critically analyze and apply the medical literature. Research skills offer one important way to express a commitment to medicine and to improving the health and health care of the children we serve. Finally, experience obtained through meaningful research in medical school may spark a passion for a career as a clinician scientist or academic pediatrician, laying an important foundation for residency and fellowship training and beyond.

References


The opinions expressed in this article are those of the authors and not necessarily of the Uniformed Services University of the Health Sciences or the United States government.
Everyone who is starting down the path to residency application and the Match needs a guide. By the end of the third year of medical school, it is important to identify a pediatric faculty member who will serve as your residency application advisor. It is the student’s responsibility to work effectively with this advisor to forge a successful working relationship. Essential elements of success as an advisee include preparing for each meeting, identifying tasks to be accomplished, asking the right questions, and listening carefully. Topics to be discussed include those listed below.

1. Grades and Board scores
2. Any “red flags” in your academic record (eg, unexplained gaps in education)
3. Anticipated problems with interviewing
4. Couples match, if appropriate
5. Geographic preference/restrictions
6. Deadlines – know them, you are responsible for them
7. Career decision (rationale for your choice or reasons for uncertainty)
8. Curriculum for your fourth year
9. Content of your personal statement
10. Your curriculum vitae (CV)
11. Letters of recommendation
12. Potential programs
13. Managing the interview schedule
14. Match list, including first choice and ranking
15. Practice interviews
16. Advisor available for general counseling/advice
17. How much information will be shared with the program director

Specific Questions for Advisors

Fourth-year Schedule

1. How many pediatrics electives should I do?
2. What kinds of pediatrics electives should I do? (ie, subspecialty consult service, subinternship (sub-I)/acting internship (AI), general pediatrics, ambulatory pediatrics, emergency room (ER), pediatric intensive care unit (PICU)/neonatal intensive care unit (NICU), or other?)
3. Should electives be 2 weeks or 4 weeks long?
4. When should I schedule away electives?
5. Should I schedule a sub-I? What part of the year?
6. When should I take United States Medical Licensing Examination (USMLE) Step 2 clinical knowledge (CK) and clinical skills (CS) tests?
7. Should I do research?
8. When is the best time to talk about international electives?
9. Should I do electives in areas of medicine which interest me but to which I may have limited exposure in the future?

Program Selection

1. What kind of program is a good match for me? At which programs will I be competitive? What is a reach (long-shot program)? What is a good back-up (safety program)?
   Consider the following:
   - Program size
   - Children’s hospital vs. general hospital
   - Community-based vs. academic medical center
   - Geography (restriction or preference)
   - Lifestyle and call schedule (ex: night float vs. no night float)
2. How many programs should I apply to?
3. How should I balance the number of competitive programs vs. backups? How many of each?

Away Electives

1. Should I do an away elective? Where?
   - Is this a reach program?
   - Is this a program that could be my first choice?
   - Will they learn more about me? Will I learn more about them?
   - Does this program offer an area of clinical expertise not available at my own institution?
2. When should I do the elective?
   - What is the last date to influence the Match?
   - Is it advantageous to do it earlier or later?
3. What kind of away elective should I do?
   - Consult service in subspecialty (which one?), Sub-I, general pediatrics or other ambulatory experience, ER, PICU/NICU, or other?
   - Where will I learn the most?
   - Where can I shine the most?
   - Where will my work be observed?
   - Will my performance be communicated to the residency program director?
4. Should I make an appointment to speak with the residency program director while doing an away elective?
5. Can I schedule other interviews while doing an away elective?
6. How long should an away elective be?
7. Can I drop away electives? How does that reflect on me?

Letters of recommendation
1. Who will write my letters?
2. Should they all be from pediatricians?
3. Should I get a letter from an away elective?

Personal statements
1. How long should it be?
2. What is the usual structure?
3. Are there any topics that should be included?
4. Are there any topics that should be avoided?
5. Should “red flag” areas be addressed in the personal statement?
6. Should I write about specific patient care encounters that were meaningful to me?
7. Should I discuss my rationale for choosing pediatrics?

Interviewing
1. What is the optimal timing? (October/November vs. January)
2. When should I expect to hear whether I have been granted an interview?
3. What kinds of questions are asked? Will I be asked medical knowledge questions?
4. If there are red flags in my record, how shall I prepare to address them?
5. What should I wear?
6. Should I attend the “optional” social event with the residents?
7. What is the best way to prepare for each interview? What do I need to know about the program?
8. Should I write thank-you letters to each interviewer? Is an e-mail acceptable?
9. Should I tell the program that they are my first choice?
10. What kind of questions should I have prepared?
11. Should I expect to hear back from the program if they liked me?
12. At what point is it too late to cancel an interview?
13. How many interviews should I schedule in a week?
14. Do informal conversations with residents during the course of the day influence the Match?
15. Should I go for a second look?

Preparing the Match List
1. How many programs should I rank?
2. How many back-up programs should I rank?
3. Am I at risk for not matching?
4. If I do not match, what happens?
5. Should I send a “first choice” letter or e-mail?
6. Should I send an “I am ranking you highly” letter or e-mail?
7. What should I do if the program director contacts me?

Bottom Lines
The early part of the fourth year of medical school will feature intense demands on your ability to organize and focus, not only in your clinical work but also in the residency application process. Building a successful advising relationship by preparing for meetings with your advisor, taking responsibility for keeping in touch with him or her, and carefully considering the advice you receive, will help to optimize Match results.
The number and variety of residency programs complicate the daunting business of deciding where to apply. It is important to give some thought to personal preferences and priorities before attempting to assess programs. Any accredited pediatric training program can lead to fellowship training in subspecialty pediatrics or a career in general pediatrics, which underscores the importance of choosing a program based on the best personal fit. This section will examine characteristics to be weighed and discussed with your clinical advisor to identify potential programs.

This section describes “regular” (or “categorical”) residency programs, which offer 3 years of training in pediatrics. “Combined” training programs, which will be discussed in the next section, provide training in pediatrics and another specialty, such as internal medicine. Characteristics to consider in evaluating a program are listed below.

Number of trainees

Programs may range from 4 to more than 50 residents per year. Smaller programs often offer more individualized attention and perhaps closer relationships with more faculty members. Larger programs often offer more options for clinical training venues, such as continuity and subspecialty clinics, electives, and hospitals. They also tend to have a larger and more diverse faculty.

University-affiliated vs. Stand-alone Programs

Most residency programs are affiliated with medical schools. In general, university-affiliated programs are considered more prestigious and may offer an advantage in applying for fellowship training, especially with more competitive fellowship programs. The few existing programs that are not directly associated with medical schools may be excellent choices for students due to location, desired features, innovative rotations, or even direct training in managed care (such as can be gained in the Kaiser-sponsored residency programs).

Children’s Hospital or General Hospital

Training in a stand-alone children’s hospital has advantages and disadvantages, as does training in a general hospital with pediatric areas or floors. Children’s hospitals tend to be more efficient for the care of children as they are completely equipped for pediatric medicine. Procedures and ancillary services are developed with pediatric care as the centerpiece (child and family friendly), which affects laboratory and radiology services as well as informatics and chart note templates. Children’s hospitals also tend to have a broader, systems-based understanding of the care of children and their families because they coordinate multiple medical services with a common focus and expertise in the care of pediatric patients.

General hospitals with pediatric areas or floors also offer unique advantages. In general hospitals, residents often have more contact with residents from other specialties. A multidisciplinary resident staff in a general hospital facilitates broader cross-specialty resident events, such as a general medicine review for all residents preparing for Step 3 of the USMLE, where internal medicine residents can learn from pediatric residents and vice-versa. Some pediatric areas within general hospitals are also quite robust and developed, thereby minimizing many of the differences between these care settings and those discussed above that are found in stand-alone children’s hospitals.
A Program With or Without Fellows?

Opportunities to work with fellows during residency are excellent ways to evaluate subspecialty options. Programs with many fellows are also programs that have more teachers for each specialty area because both the faculty and fellows serve as sources of your education. That said, programs without fellows often have more direct contact between residents and subspecialty attendings, which can translate to more autonomy for resident decision-making, compared to fellow decision-making, in the care of the patients.

Many residents develop ties to the communities where they do residency and would prefer to complete their fellowships in the same institution. If the training institution has a desirable fellowship program, graduating residents, who are well known to the faculty, may have an advantage in the selection process.

Residency “Tracks”

Certain residency programs have been approved to identify one or more “tracks” that allow the resident to explore more options relevant to what they wish to do after residency training. Common tracks focus on primary care, community pediatrics, research, international child health, and public health.

The Pediatric Residency Review Committee (RRC) of the Accreditation Council for Graduate Medical Education (ACGME) has requirements for most accredited programs. For example, all programs must offer a block of developmental pediatrics and a block of adolescent medicine rotations. While about two-thirds of resident rotations are stipulated by ACGME, a program’s choices for the remaining one-third tell much about its orientation. When considering programs, review the options for nonrequired rotations and those for being part of a track. Does the program use this time to maximize your learning opportunities?

A primary care track often offers extra clinical preceptorship months for residents to explore the various settings for general pediatrics—private practice, managed care, or community neighborhood clinics for the underserved. Others offer more specialized rotations to enhance communication skills; these might include opportunities in child psychiatry or working with parents who are in treatment for addiction. International tracks offer a gateway to an important and expanding field. Community tracks offer continuity clinics and preceptorships in community health centers. They also often require that students design, implement, and evaluate a community research project. Often, students with a combined interest in public health and pediatrics enter tracks such as this if a separate public health track is not offered. Pediatricians are often leaders in public health in the United States (in the last 20 years alone, 3 pediatricians—Joycelyn Elders, MD, Julius Richmond, MD, and Antonia Novella, MD—have served as US surgeons general).

Research tracks appeal to candidates with a combined MD-PhD, as well as those with an interest in bench, clinical, or other research. They also provide useful experience for those planning to pursue subspecialty fellowships, which have research requirements.

It is important to remember that this is a time of exploration. Choosing a program on the basis of certain tracks does not restrict exploration of other types of pediatric practice. An accredited residency program can lead to fellowship training. Many residents enter general pediatrics tracks and then discover an interest in a subspecialty. Also, every residency program allows elective months, when residents can explore subspecialty or other rotations.

Bottom Lines

The relative importance that an applicant gives to training program features and benefits will reflect his or her individual preferences and priorities. (For example, when an applicant must stay in a given location due to spouse/partner commitments, geography will be critical.) Many residency candidates are relatively unclear about what is most important to them until they actually visit programs during the interview process. This is normal. It is also one of many situations in which a clinical advisor can offer invaluable insight.

References

1. Accreditation Council for Graduate Medical Education: http://www.acgme.org/acWebsite/home/home.asp
Several combined programs are available to medical students interested in training to be board certified in both pediatrics and an adult specialty or pediatric subspecialty. Graduates of combined programs are able to sit for 2 (or in one case, 3) examinations.

The primary advantage to completing a combined residency program is fewer years of training; a combined program can be completed in 1 or 2 fewer years than individual residencies and fellowships taken in sequence. All combined programs truly combine the general pediatric training with training in another area, completing rotations in the respective components of the training program within each year of residency.

The primary advantage to completing a combined residency program is fewer years of training; a combined program can be completed in 1 or 2 fewer years than individual residencies and fellowships taken in sequence.

The most established of these programs combines a pediatric residency and an internal medicine residency for a 4-year medicine-pediatrics (med-peds) training program. Practicing med-peds physicians see patients in clinics and in hospitals. There are 80 such programs in the United States. Residents in this combined program will split their time between adults and children, completing 2 years of rotations in each specialty. Some programs have combined ward services and continuity clinics that allow residents to care for both adults and children on the same day, while other programs split the residents’ time between internal medicine rotations and pediatrics rotations. Graduates are able to take both the internal medicine and pediatrics certifying exams.

The pediatrics and medical genetics residency is a 5-year program that combines 2 years of general pediatrics and 3 years of genetics training. (The alternative for those interested in both disciplines is a 3-year fellowship in medical genetics following pediatric residency.) As of this writing, there are 16 such programs in the United States that qualify graduates to sit for both the pediatrics and medical genetics certifying examinations.

Graduates of a 5-year combined program in pediatrics/psychiatry/child psychiatry are eligible to test for board certification in all 3 disciplines. Ten programs currently offer this “triple board” residency.

Seven programs offer a combined residency in pediatrics and physical medicine and rehabilitation (PM&R). Completion of this 5-year program allows graduates to sit for both the pediatrics and PM&R board examinations. Individuals wanting subspecialty certification in pediatrics PM&R will need to complete an extra year of fellowship (and take a third exam) in addition to the combined program. For those who do not elect a combined program, pediatric PM&R training is a 3-year fellowship following either a pediatric or a PM&R residency.

One program offers a combined residency in pediatrics and dermatology. After 5 or 6 years, graduates are eligible to sit for the pediatrics and dermatology board examinations. Subspecialty certification in pediatric dermatology requires an extra year of fellowship and another examination.

A combined residency in pediatrics and emergency medicine is available through 3 programs in the United States. Five years’ training qualifies graduates to sit for both the pediatrics and the emergency medicine boards. Individuals wishing further subspecialty certification in pediatric emergency medicine require further training. For those who do not choose a combined program, pediatric emergency medicine training involves a 3-year fellowship after pediatric residency or 2- to 3-year fellowship after emergency medicine residency.

Although medical graduates interested in child neurology and neurodevelopmental disorders have an option that condenses training by 1 year, this is not a “combined program” in the same sense as those discussed above. Pediatric neurology programs admit residents who have completed 2 years of a pediatrics residency; after 3 years in the neurology residency, graduates are able to sit for both the pediatrics and neurology boards. The 2 years of pediatrics residency must be designed to include all of the core rotations required by the American Board of Pediatrics; residents cannot simply start a pediatrics residency and leave after 2 years to join a neurology residency. Passing the neurology boards results in certification in neurology with “special qualifications in child neurology.” An alternative path is to take 2 years of a pediatric residency followed by 4 years in a program in neurodevelopmental disabilities. As they are not truly “combined” programs, application is a bit different. The neurology positions are not matched through the NRMP; rather, they are run through the
San Francisco Match™ and have different deadlines. Some residency programs will coordinate the first 2 years of pediatrics with the last 3 or 4 years of neurology at the same institution, but others do not.

Bottom Lines

Combined programs are longer than a 3-year general pediatrics residency but may be a good choice for students interested in a specific subspecialty pediatric practice or interested in both adult and pediatric medicine. New programs are added annually, it is important to look up the most current information before applying. The Accreditation Council for Graduate Medical Education™ has the most current listing of all programs and sites.

References

Letters of Recommendation
David Levine, MD

Medical students are often in a quandary about whom they should ask for letters of recommendation. Letters may not be the most critical part of the application, but they are important.

Medical students often ask how many letters they should have from pediatrics faculty and preceptors. Most pediatric residency training programs require 3 letters of recommendation. At least 1 letter should be from a pediatrics faculty member. Other letters should be from faculty members who have directly observed your clinical work and can favorably write about your clinical skills. These letters may come from other pediatrics faculty members or faculty from any other clinical department. For students who have done additional community work or research, a fourth letter documenting those activities enhances the application. The core 3 letters, however, should come from faculty who can relate personal experience with the candidate’s clinical work.

Most pediatric residency training programs require 3 letters of recommendation. At least 1 letter should be from a pediatrics faculty member. Other letters should be from faculty members who have directly observed your clinical work and can favorably write about your clinical skills.

Residency candidates should have an established relationship with an advisor who is a core member of his or her pediatrics faculty. It is important to choose someone who is very experienced in the application process. Advisors can guide the process of obtaining letters of recommendation; they are sometimes familiar with other students’ experiences and may have a sense of the quality of letters offered by their faculty colleagues. This can be a huge benefit.

Little has been published regarding letters of recommendation and the application for residency training in pediatrics. Seasoned educators Bruce Morgenstern, Edwin Zalneraitis, and Stuart Slavin wrote an interesting editorial on the subject for the Journal of Pediatrics in 2003.¹ Their letter was directed to writers of letters of recommendation; it analyzed how some comments might be misconstrued or even weaken a letter.

A second, more relevant study was presented by Monica Stoffer, MD, FAAP, who was then a medical student, at the 2003 Ambulatory (now known as Academic) Pediatric Association meeting.² Her research was assisted by faculty educators Stuart Slavin, Paul Chung, Leslie Fall, and Michael Lawless. The study was divided into two parts; the first, ranking the relevance of the different pieces of the residency application process. The second part ranked the strength of the letters from persons with different roles within clinical departments. (See Table 1)
Table 1

<table>
<thead>
<tr>
<th>Role of the Letter Writer</th>
<th>Relevance</th>
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<tbody>
<tr>
<td>Pediatric chair who has worked directly with student</td>
<td>4.40</td>
</tr>
<tr>
<td>Pediatric attending on inpatient 4th year Sub-I</td>
<td>4.38</td>
</tr>
<tr>
<td>Pediatric attending on clerkship</td>
<td>4.15</td>
</tr>
<tr>
<td>Pediatric clerkship director</td>
<td>3.93</td>
</tr>
<tr>
<td>Pediatric attending on outpatient 4th Year Sub-I</td>
<td>3.90</td>
</tr>
<tr>
<td>Pediatric community preceptor</td>
<td>3.20</td>
</tr>
<tr>
<td>Research mentor</td>
<td>2.91</td>
</tr>
<tr>
<td>Pediatric chair who has not worked directly with student</td>
<td>2.57</td>
</tr>
</tbody>
</table>

Reasons for ranking letters as less relevant included lack of honesty in describing weaker students, grade inflation, inadequate personal contact between the letter writer and the student, and a lack of detail about the student performance. Inconsistent use of performance descriptors was also observed; for example, the authors cited the example of the letter writer saying that a student possesses “outstanding clinical skills, at the level of an intern” when the student possesses clinical skills that are average when compared to peers. Given the absence of an agreed vocabulary for letters of recommendation, they found, the writer’s use of such terms as “average,” “outstanding,” or “solid” is subject to interpretation.

When students and letter writers were asked to rank the relevance of letters of recommendation, the researchers found, a direct working relationship between the letter writer and student was important, as was the nature of the letter writer’s role in the student’s training.

The quality of the letters as indicated by the source or letter writer; using a 5-point scale, with 1 being “not at all” relevant and 5 being “very highly” relevant was described as follows:

- Interview: 4.63
- Clinical Performance: 4.62
- USMLE Step 2 score: 3.75
- Class rank: 3.75
- Dean’s letter: 3.75
- Letters of Recommendation: 3.62
- USMLE Step 1 score: 3.59
- Leadership activities: 3.37
- Preclinical performance: 3.32
- Applicant’s medical school: 3.32
- Volunteer activities: 2.91
- Research experience: 2.57

The quality of letters is highly subjective and can vary widely. It is important to establish a clear understanding with the letter writer regarding the level of detail and objectivity desired in the letter.

Take-home messages

1. Request your pediatrics letters from core faculty members who have observed your direct clinical work with patients. (Some clerkship directors do see medical students’ clinical work directly, but that category was not analyzed.)

2. Pediatric department chairs may be very helpful in the application process; many have detailed understanding of other schools and their training programs. However, unless the residency program absolutely requires a chairperson’s letter, it is not wise to request a letter from the chair if he or she has not directly observed your clinical work.

3. Dean’s letter is generally not recommended. The Electronic Residency Application System (ERAS) “face sheet” has a selection marked “waived” or “did not waive” the right to read the letter before submission. Persons reading that letter who see that a candidate did not waive access may put less faith in the letter. Some faculty members may share a copy or discuss the details even if you have waived access. This is, of course, quite individualized.

Bottom Lines

Strong letters can distinguish an application that otherwise would not stand out. Letters from clinicians, preferably pediatricians who have seen you in action and can detail your clinical work, are best. And finally, discussing your potential future plans with your letter writers is a great strategy.

References

The personal statement needs to be personal. The content should reflect personal qualities, experiences, and special interests that enable the reader to assess, to some degree, the likelihood of a mutually successful Match outcome.

The residency programs have the applicant’s transcripts, along with a dean’s letter and letters of recommendation. The personal statement enables the applicant to add a new dimension to the application, to persuade those who read it that the applicant will be an asset to the program and will fit in, while reflecting special qualities and interests that separate the applicant from his/her peers.

To save time and improve the quality of the piece, consider starting with an outline. The statement should flow well. It should be organized – with a beginning, a middle, and an end. It should be grammatically correct and spell-checked. And it should reflect the character and personality of the writer. The following list suggests points to be considered in the personal statement:

- Interest in the field of pediatrics
- Personal credentials and strengths that the applicant brings to the field of pediatrics
- Experiences that demonstrate relevant personal qualities (eg, motivation, leadership, reliability, integrity)
- Distinguishing traits
- Volunteer experiences
- If there is a transgression on the medical school record, consider commenting on what was learned from the experience rather than offering excuses for it. How has the writer corrected any deficiencies? You will want to discuss the inclusion of this with your advisor prior to including it.
- Professional plans after residency
- Unique experience in medical school (or in pediatrics) that cemented the desire to pursue the field (ie, an experiential vignette that describes a patient interaction).
- Interests outside of medicine that lend insight into the applicant’s personality
- Content that is highly personal (ie, discussions of a divorce), may be “too much information.” Stories of family medical challenges, however, can be quite influential and instructive.
- Evidence of flexibility and openness to new ideas
- Narratives relating experiences or attitudinal shifts that reflect personal growth during medical school. How have you grown?
- Values

Bottom Lines

A personal statement should present a clear, honest, and concise summary of the applicant’s personal qualities. It should lend insight into your personality and your passions. A good statement will take time. Ask for honest feedback from friends, advisors, and at least one person who has strong editing skills.
Each year, as soon as soon as the graduating seniors complete their Match, the next class begins to prepare for fourth year, taking required examinations and applying to residency training programs. The deadline dates change from year to year, but the template for successful pursuit of residency training in pediatrics is relatively stable. Yearly deadlines from the Electronic Residency Application Service (ERAS), the National Resident Match Program (NRMP), and the San Francisco (or early) Match are available on their Web sites.

Important Note About the Military Match

The timelines in this section are for the nonmilitary Match. Students planning to participate in the Military Match should check in early with their student affairs offices to ensure that all requirements are met on time. The Military Match ends sooner; results are released in mid-December.

Spring Forward!

The spring of your third year is the time to plan away rotations for fourth year. If these are desirable or applicable (especially if you need to be in a particular institution or geographic location), consider a month-long “audition” away rotation; a daily 110% effort allows a program to get to know you and your abilities.

The summer before your fourth year will be a busy time. A short list for the early weeks includes:

- Resolve any outstanding third-year clinical grade disputes.
- Prepare your CV/resume and ask advisor to review it.
- Prepare your personal statement and ask someone with great writing or editing skills (perhaps a former English major) to critique your first draft for grammar and content.
- Ask a friend to review the statement. Does it truly reflect your personality and character?
- Ask your advisor to review it from the residency perspective.
- Consider whom to ask for letters of recommendation and make those requests early. Most programs will want a least 3 letters.
- Meet often with your advisor at this time.
- Request a meeting with the pediatrics chairperson. If a chair’s letter is required (not typically the case) or if you worked with the chair directly, ask him or her for a letter of recommendation.

Month-to-Month Timeline

June
Electronic Residency Application Service (ERAS) “token” ID provided via student affairs office

July 1
ERAS goes live and is available to students. Begin completing your application online and determine the number of programs to which you will apply

August 15
National Resident Match Program (NRMP) applicant registration opens

September 1
Some programs begin to offer interviews, although some programs will not offer interviews until Medical School Performance Evaluation (MSPE) forms have been received (in November). Do not be alarmed if you are not offered interviews in September.

Medical schools begin to issue medical school transcripts to residency programs and residency programs begin to download candidate applications. Apply early—Interviews can be scheduled before all materials are uploaded. Don’t delay scheduling interviews. Consider a mock interview at your home institution.

November 1
MSPE letters are released by all US medical schools

November – January
The bulk of residency program interviews commence. Meet with advisor during interview season as needed.

December
Military Match for students participating in the Armed Forces Health Professions Scholarship Program

January
Early Match - San Francisco Match
For pediatric neurology and pediatric neurodevelopmental disorders
January 15 – February
Enter the NRMP Rank Order List (ROL). Your list should reflect a mix of more and less competitive programs. Ask your advisor to review your ROL. Rank Order List closes on the third Wednesday in February. Do not plan to rely upon the Scramble (see p. 40).

Match Week (third week of March)

- **Monday**, an e-mail from the National Residency Match Program (NRMP) to students is sent at noon EASTERN time zone to tell students if they have matched.
- **Tuesday**, programs learn if they filled, and the Scramble begins. Unmatched applicants begin calling program directors with unfilled positions at noon Eastern time.
- **Thursday** is MATCH DAY. Celebrate!

May 1
List of unfilled programs closes on the NRMP Web Site.

Bottom Lines

Each year, third-year students feel quite overwhelmed on the senior class Match Day. Many juniors wonder how they will meet all of the requirements on deadline while maintaining excellence in their third-year rotations. While the process may seem daunting, each graduate by and large finds a position that is acceptable through the Match, and many match into one of their top choices.

Enjoy the fourth year, exploring new hospitals and communities and meeting new faculty members, residents, and students from across the city, region, or nation. This is one of the most exciting years of your medical education! It need not be the most daunting.

Those who start early, stay on track with deadlines, work closely and consistently with their advisors, seek out constructive criticism about their applications and personal statements, and prepare for interviews do well in the Match.

Before you know it, it will be the class behind you that is saying, “How am I going to get this done in a year?”
Interviewing is a 2-way street that calls for thoughtful preparation. Residents preparing for interviews should think about what interests them about each program on their list. This helps to prepare for the interview — and to ensure that it is reasonable to invest time and expense to visit. The important variables will be different for each student, but may include the size of the program, the size of the city, geography, competitiveness of matching into the program, characteristics that make the program unique, areas where it excels, and proximity to family.

Before the interview, residents should discuss the program with advisors and mentors, making an effort to examine its strengths and weaknesses. This facilitates another important step: preparing well thought-out and relevant questions. The more thorough the applicant’s research on the program, the better his or her questions will be. Develop a list of questions and review that list the night before the interview; it will make the interview go more smoothly.

Questions to ask and to avoid are not always intuitive. A systematic approach will begin with categories for inquiry. Suggested questions posed below are a place to start.

**Program/Department Environment**
- What makes the program special? Why did you come here (or train here) — and why do you stay? What do you like best about the program? What are its strengths and weaknesses? How well do the residents get along with each other and with the faculty?
- Do you foresee any significant changes in the department or residency program over the next 4 years? What attracted you to this program/department? If given the choice, would you choose this program/department again? If there were any one thing you would change about the program or department, what would it be?

**Education/Learning Atmosphere**
- Are there any current problems and concerns that may affect resident education? How does the program plan to address them?
- What are the academic successes of the pediatric residents, as compared to other programs within the institution? Is there support for meetings or other educational opportunities?
- What is your board pass rate? Do I get to teach students? Do I have a required research project? How are the residents involved with reviewing and improving the program? Is there an opportunity to do an international elective? What qualities do you value most in your residents? How do your residents interact with community physicians?
Future Academics and Employment

What is the general theme or mission of the program (primary care, subspecialty or research-focused)? What do your graduates do after they finish training? Where have your residents matched for fellowship? How would former residents rank this training program? How are your chief residents selected?

Lifestyle

What is the community like? What is there to do when not at work? How expensive is it to live here? What opportunities are there to do community service?

Topics to Avoid in the Interview

Stay away from issues of money, number of call nights, and perks, including book funds (these can easily be found out from the residents or the Web Site). Avoid questions about any conflicts, problems and politics at any level (unless it directly affects education). Also, steer clear of comparing or criticizing any program or institution – the pediatric graduate education world is smaller than it seems.

Bottom Lines

- Unlike interviews for medical school or employment, the interview for admission to a residency training program is a dynamic exercise. Candidates are interviewing program representatives to see if they warrant their ranking. Program representatives interview candidates to assess qualifications and to determine whether or not they are a fit for the program.

- As most graduating seniors wishing to match in pediatrics will match into pediatrics, the interview is an opportunity to select the program that fits their needs. This is unlike the typical interview for employment, where 20 applicants compete for one position.

- This is a 3-year decision; keep this in mind while working through the options. Lifestyle and work/life balance are important to pediatricians and should be important in training.
The Residency Match
Angela Mihalic, MD; Robert Drucker, MD; and Michael Barone, MD, MPH

Medical students apply to residency programs by participating in the Match, which is coordinated through the National Residency Matching Program (NRMP). In the 2010 Main Residency Match, the NRMP provided services to 37,556 applicants, and a record number (22,809) of PGY-1 positions were offered.

Within that total were 2,428 categorical pediatrics positions offered by 209 programs. Of those, 2,383 positions were filled in the Match -- 70.5% by graduating US seniors. Overall, 10.6% of applicants matched to categorical pediatrics first-year positions. These and other very useful data on the most recent Match can be found in the NRMP Data Book.

It is important to understand the difference between the NRMP and the Electronic Residency Application Service (ERAS). ERAS is a method for applying to residency programs. The NRMP is a system for matching applicants with available positions in those programs. In order to participate in the Match, applicants must separately register with ERAS and with the NRMP.

The Match employs a mathematical algorithm using the preferences expressed in rank order lists (ROLs) provided by the applicants and the programs. It is important to understand that the process is student-centered, not program-centered, and begins with an attempt to place each applicant into his or her most-preferred program. If applicants cannot be matched to their first-choice program, an attempt is made to place them in their second-ranked program, and so on.

An applicant is tentatively matched to a program if he or she appears on the preferred program’s ROL and the program has an unfilled position -- or the program does not have an unfilled position but the applicant is more preferred by the program than another applicant who had been tentatively matched. The process continues until all applicants have been considered, at which point the Match results become final.

More information on the match process and algorithm in complex situations is available on the NRMP Web Site, as well as in the AAMC publication, Roadmap to Residency: From Application to the Match and Beyond.

Couples Matching

The NRMP also offers the opportunity for a pair of students graduating or applying in the same year to link their ROLs so that both residency applicants can match to their preferred programs. This process is called couples matching.

Partners register with the NRMP separately and submit a fee for each to participate in the Couples Match. Each person in the couple ranks his or her interviewed programs in priority order, indicating the partner’s (Student Y) preference if the student (Student X) successfully matches at that program. Each partner must have the same number of ranked preferences. This may be a difficult process to understand, so talking with your advisor or student affairs dean is strongly recommended. (Also, note that couples matching does not apply when one partner in a couple is participating in an early Match.) A hypothetical couples match is illustrated below.

<table>
<thead>
<tr>
<th>Partner X</th>
<th>Partner Y</th>
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</thead>
<tbody>
<tr>
<td>Choice 1</td>
<td>Choice 1A</td>
</tr>
<tr>
<td>Choice 1</td>
<td>Choice 1B</td>
</tr>
<tr>
<td>Choice 1</td>
<td>Choice 1C</td>
</tr>
<tr>
<td>Choice 2A</td>
<td>Choice 2</td>
</tr>
<tr>
<td>Choice 2B</td>
<td>Choice 2</td>
</tr>
</tbody>
</table>
Section 13 - The Residency Match

Tips for Making Your Rank Order List

When all interviews are complete and the applicant has determined what features are most important to him or her, it is time to construct a ROL of most preferred down to least preferred residency programs. In creating their lists, candidates should consider the following:

1. Base rankings on your personal assessments of the programs. Program directors very often send complimentary notes and messages after interviews. This can create false impressions and misinterpretations about where programs plan to place applicants on their rank list. Complimentary comments and correspondence should not affect the ranking for a training program. It is very important that applicants construct their ROLs solely on the basis of their own opinions of programs. Your top choice should be the program that you believe would provide the best training experience.

2. Mix More and Less Competitive Programs. The pool of competitors widens dramatically with the Match because applicants compete with equally qualified graduating seniors from medical schools around the country and with international medical graduates. For this reason, it is essential that each applicant’s ROL includes programs on a wide competitive spectrum.

3. Rank Programs Without Regard to Your Choices. The mathematical algorithm always begins with the student’s lists; the programs’ lists are secondary. There is no advantage in ranking a highly competitive “dream” program first on your list rather than a program that feels safer but that has offered assurances. The ROL should always begin with those sites where the candidate would most like to train.

4. Avoid the Scramble at all Costs. Unless you would rather take a year off and reapply, it is critically important to apply to an adequate number of programs, to interview at an adequate number of programs, and to rank all of those programs at which you would be willing to train — not just where you would prefer to train. It is increasingly difficult to place in a residency program (especially in your preferred specialty) in the Match, and it is no longer realistic to count on the Scramble as a back-up method. Plan for the worst case by ranking several less competitive schools and/or consider applying to programs in a backup specialty (which would be placed at the end of your ROL).

5. Continue to Seek Guidance. It is a good idea to consult your specialty advisor when making your rank order list. He or she can advise on the number of programs to include on the list, whether your list has enough depth and competitive range, and if a back-up program or specialty is required to assure a match.

Applicants enter ROLs directly into a computer at the secure NRMP Web site in 1 or more sessions between mid-January and mid-February. After entering their ROLs, applicants are asked to certify their lists. It is important to remember that applicants must recently their ROLs each time changes are made. Only the applicant can see his or her list, a copy of which can be printed out at any step during the process.

Match Week

On Monday of Match week, the NRMP notifies applicants by e-mail and posting on the secure Web Site whether they have been matched to a residency program. Students who have not matched are strongly encouraged to meet immediately with their student affairs deans and advisors to talk about why they did not achieve a successful match and come up with good strategies for “scrambling” into an open position. The Scramble, a process by which applicants who have not matched in the main Match apply to unfilled positions, takes place between noon on Tuesday and noon on Thursday of Match week.

On Tuesday, the NRMP notifies programs that have unfilled positions and applicants who have not matched to a program are notified of a list of unfilled programs. ERAS has provided a mechanism by which applicants can apply to programs in the Scramble and attach their materials (eg, letters of recommendation, CV, scores). Typically, the student begins by contacting the unfilled program (by telephone, email or facsimile) and expressing interest. If the program is interested, the applicant formally applies in ERAS or directly to the program (at the discretion of the program), which enables the program to view all supporting documents in the application. When programs accept an applicant, a contract is sent to him or her for signature. For more details, please refer to the AAMC Roadmap to Residency document.2

Results for Pediatrics Residency Applications

In 2010, there were 43 unmatched U.S. seniors and 388 unmatched independent applicants in the categorical pediatrics match. The NRMP categorizes all applicants other than seniors graduating from US allopathic medical schools as independent applicants. This category includes previous graduates of US allopathic medical schools, students/graduates of Canadian and osteopathic medical schools, students/graduates of Fifth Pathway programs, and US citizens and noncitizens who are students/graduates of international medical schools.

There were 87 unfilled pediatric residency positions in 2008 and 45 in 2010. This trend, while good for the specialty of pediatrics, should send a clear message to anyone who plans to match in the specialty: Never count on matching to a pediatric residency program in the Scramble! In 2009, for every pediatrics residency position available there were 1.1 independent applicants who listed pediatrics as their first specialty choice.

Some advisors may recommend that a candidate select an additional specialty as a back-up plan especially if there are any deficiencies in the medical school record. For example, family medicine programs have the largest number of unfilled 3-year positions after the Match and family physicians also care for children as part of their practices. Only preliminary surgery, a 1-year program that would necessitate reaplication for the following year for another program, had more unfilled positions than family medicine.

Supplemental Offer and Acceptance Program (SOAP) to Replace the Scramble in 2012

The Scramble has become very difficult for all concerned -- applicants, advisors, and student affairs deans. Recent problems stem from several trends reflected in NRMP data including a dramatic increase in the overall number of applicants to all specialties (37,557) and only a modest increase in PGY-1 residency positions (22,809). A subsequent decline in the number of unfilled positions in all specialties (from 2288 in 2001 to 1,060 in 2010) as compared to a modest increase in U.S. unmatched seniors (from 913 in 2002 to 1,078 in 2010) has been the result. Finally, there has been a dramatic increase in the total number of unmatched applicants (from 5,627 in 2001 to 8,794 in 2010) as compared to unfilled PGY-1 positions (from 2,288 in 2001 to 1,060 in 2010).

The following are selected tables from the NRMP Web site that highlight this information for the 2010 Match:

Results for Pediatrics Residency Applications
Always have a back-up plan – Once again: avoid the Scramble!

Your back-up plan might be to include a sufficient number of less competitive programs. It might be to apply to a less desired specialty for either a preliminary or categorical position. Include these programs at the bottom of your rank order list with your pediatrics programs at the top.

References

3. ERAS: http://www.aamc.org/audienceeras.htm

Bottom Lines

1. Apply to, and interview with, an “adequate” number of programs - According to ERAS data on the average number of applications per applicant by specialty, pediatrics training program candidates apply to a mean number of 18 programs. When interpreting this, individual applicants should bear in mind that the number is a mean and does not account for variation in applicant credentials. It is imperative that applicants discuss the number of programs and the choice of programs on their ROLs with their specialty advisor, program director, or chair.
2. Don’t cancel interviews until you have a sufficient number completed – Graduating seniors may be tempted to cancel interviews toward the end of the season. If you are leaning this way, see point #1!
3. Make sure that at each stage (application, interview, and ranking) you have an appropriate range of competitiveness - Even students at the top of the class are at risk if they only rank the top ranked programs in the country.
4. Avoid “short listing” - Unless you are willing to risk taking a year off, include each and every program where you interviewed on your ROL. In other words, include less-preferred programs where you would be willing to train rather than not match. Short-listing often results from too-few interviews offered or completed, overconfidence based on communications from programs, and geographical constraints on the applicant’s Match preference.

The NRMP has announced plans to do away with the Scramble in its current form. Because of the trends noted above and the Scramble’s short time frame, Tuesday through Thursday of Match Week has often featured a chaotic series of communications between students, programs, and student affairs offices. A more organized method to accommodate the needs of unmatched students accepting program offers is in development. The Supplemental Offer and Acceptance Program (SOAP), or “managed” Scramble, is scheduled to launch with the 2012 Match. Please visit the NRMP Web site for details.


Congratulations! You are about to embark on one of the most memorable years of your life. The next 12 months will undoubtedly be challenging, exhausting, and stressful, but fear not! Those who take the information in this section to heart will have the knowledge they need to rise to the top.

Survival Tips

- **Attend to the fundamental courtesies**: Arrive early, write legibly, dress professionally, and be polite. Treat all members of the health care team, including the support staff, with respect. Do not underestimate the power of kindness.

- **Stay organized**: Methods vary; find a system that works for you. Keeping an active “To Do” list will help you stay sane and maximize efficiency. Write everything down when it is suggested or ordered. You will inevitably get busy and distracted, and hoping you remember to review a lab or reassess a patient is an impractical strategy. Write down test results so that you can quickly recall the specifics when your senior resident or attending asks for them. Find a way to highlight priorities in your notes; some people find a check-box system helpful; others use colored highlighters or pens. When there are multiple items to follow up on during your shift, consider writing out a chronological timeline showing what is due when. This strategy may be particularly helpful during months when you have labs to check throughout the night, such as in the NICU.

- **Give (and demand) a thorough signout**: “Everyone is stable, there’s nothing to follow up” is not responsible signout. Give your cross-covering residents a concise snapshot of your patients’ histories and current status. Know your patients’ status when transitioning care to the next team. If concerned about a patient’s condition, emphasize that to both your fellow intern and the senior resident. Tell the incoming team about any worrisome developments that you have been watching for and talk about how to manage them. Similarly, when receiving signout, ask questions to ensure that you understand the patients’ status, active issues, and preferred course of action for decisions you may need to make. Memory is less reliable when one is tired, such as at the end of a shift. For that reason, write down every issue that comes up when on call. Document what was done right away so it is clear who spiked a fever and whose medications were changed. Good notes contribute to a better signout when the primary residents return. More important, good records facilitate better patient care.

- **Communicate**: Sit down with your senior and attending at the beginning of each block to establish expectations and get off to a good start. Continue to touch base throughout the month and request interval assessments of your performance. Ask for specific examples of your strengths and the areas where you need improvement. We learn much more from honest and constructive feedback than a hollow pat on the back.

- **Read about your patients**: Finding time to sit down and study for hours like you did in medical school will be difficult: take every possible opportunity to learn as you go. Even the most straightforward patient can be a learning opportunity. Challenge yourself to learn from each experience: your 20th patient with asthma has something to teach you.

- **Utilize your resources**: The fact that you are now officially a doctor does not mean that you are supposed to know all the answers. Ask for help! If you are not comfortable making a decision or assessing a patient, lean on your senior resident, nurses, respiratory therapists, and other qualified staff. The biggest mistake you can make as an intern is to misjudge a situation that then results in an avoidable unfavorable outcome.

Find a Good Mentor

Many residency programs have a structured mentorship program built into their curriculum, but don’t let that limit you. Like patients, mentors come in many different shapes and sizes, and you can learn from all of them.

- **Formal mentoring is usually best provided by a seasoned faculty member**. In general, the goal is to be paired with a mentor who shares your professional interests and has a wealth of knowledge in your desired field. However, many incoming residents have not yet finalized their future career plans. Experiences during intern year will largely influence the decisions to specialize, and if so, in what field. An experienced mentor in any specialty can be an invaluable resource, providing not only information but less tangible support through the challenges of residency. From academic to personal to career-oriented issues, a mentor can provide impartial and confidential advice. If your program does not offer an official mentoring program, be your own advocate and seek one yourself! Don’t be afraid to approach...
an attending you enjoy working with and ask him or her for advice and support. Also, senior residents, chief residents, and program directors are excellent sources of informal mentoring. Remember, knowledge is power! Being proactive and asking questions can help reduce a lot of the anxiety that accompanies all the “firsts” throughout the intern year. Practical knowledge from a veteran is sometimes worth more than anything you read in a book!

**Tips for That First Night On Call**

- **Remember, you are not alone!** Nurses can share a wealth of information and can help you prioritize what you need to do. Whether by phone or in person, you always have backup from a senior resident or attending as well.
- **Get a good signout.** Ask if there are any patients anyone is worried about. Your signout should be complete and thorough. Write down any symptoms or changes in the patient’s condition. Make sure the patient’s current medications and allergies are up to date. Any concerns like pain or anxiety should be noted. Be sure to communicate any additional information you feel is relevant.
- **Organize.** You will have a lot to do, so create a system. Tips for that first night on call can help you prioritize what you need to do. When nurses call, don’t forget to ask about medical conditions, vital signs, weight, or allergies. If you are unclear about these, ask if they could impact your decision-making. Nurses often have a wealth of information and experienced nurses can often help you to evaluate how best to proceed. Knowing the nursing assessment and plan can be quite valuable.
- **Prioritize.** When nurses call with a concern, ask them to clarify the urgency and whether the matter requires an immediate in-person assessment. If it is less urgent and you are in the middle of an admission or attending to something with higher acuity, be honest about when you will be able to attend to their concern. Have them page you back as things change or with further updates. Getting a set of vital signs on a patient over the phone can be reassuring when you are busy and unable to see the patient right away.
- **Assess all patients whom you are called about!** If a nurse or parent is concerned, you should be, too. Don’t just patch up a symptom. Really think about what could be going on and what steps you should take. For example, perform a full physical assessment when a child develops a new fever instead of just ordering acetaminophen over the telephone. Because the patient is in the middle of the night, don’t rely on hearsay or a report that is not complete. Make sure you see the patient for yourself.
- **Document.** Because those on the next shift may wonder why specific interventions were ordered, include your reasons for interventions in the patient’s chart. Also document assessments made during the night. These can be much abbreviated incident notes or SOAP (subjective/objective/assessment/plan) notes. For example: 5 - called to assess itchy rash in pt without facial swelling or difficulty breathing; 0 - VSS, HEENT exam reveals no rash or swelling, heart RRs, lungs CTAB, unlabored respirations, no wheezing, skin reveals diffuse 1 - 2 cm pruritic erythematous patches that blanch; Assessment: Urticaria; Plan: Benadryl®, will follow as needed.) Careful documentation promotes patient safety is appreciated by your colleagues, and may prevent a post-call page to you.
- **Avoid mistakes.** For example, when writing an order, especially a prescription, always double-check it. Focus on the task at hand.
- **Know when to ask for help.** It is normal for this to happen a lot at first. Seek help from the nurses, from your senior resident, and from your attending. Remember, they are there to help you and help the patient. If a patient is getting worse, notify your team and others who are also responsible for the patient.
- **Be ready for a nonstop night!** Consider having the following items in your white coat pocket or readily available: a general pediatrics reference, a pediatric drug reference, a stethoscope, and anything else you may need that may apply to both inpatient and outpatient settings. Consider having a snack, gum, and a toothbrush as well. A snack break or quick freshening up might really help you reenergize. Finally, have your pediatric advance life support (PALS) algorithms readily available at all times.
- **Attend to the basics.** Two hours of sleep and a quick shower make a world of difference when you have to stay sharp the next day, but you won’t always get them. If you end up with free time, sleep! Also, don’t forget to eat!
- **Keep an open mind.** It can be difficult to gracefully accept feedback in your sleepy post-call stupor. Listen, repeat the concern, ask how things can be better approached next time, and thank the person giving your feedback for the advice. When provided the advice at a later time to ask if they have seen improvement.
- **Keep your charts daily.** Make sure you are aware of all changes, go to assess the patient – even if it is the middle of the night. If a family is not sure of a medication dose, ask them to check it for you. Scrutinize everything. Take nothing at face value; investigate everything you were told. When called because a patient’s status changes, go to the bedside, assess the patient, and gather data that is relevant to the problem, research potential answers, and present a proposed course of action to your supervising resident. For example, don’t simply say, “The nurse called me because the patient’s blood pressure is low, what should I do?” Go to the bedside, assess the patient, review the flow sheets, gather the blood pressure readings, anticipate possible questions from your senior resident (such as checking that an appropriately sized cuff is used, rechecking the blood pressure personally, assessing ins/outs, and determining what medications the patient is on), and make a suggestion (such as giving a fluid bolus).
Lead the way. Actively interact with your consultants and ancillary providers such as respiratory, speech, physical, and occupational therapists. Use all available resources to ensure that your patients are receiving the best possible care. Your job is to be the captain of your patient’s team, the person who assimilates and integrates information from all relevant sources. Keep everyone informed of the patient’s condition and promptly employ suggested recommendations. These steps can help decrease the length of hospital stay and improve outcomes. When caring for hospitalized patients, communicate with their primary care pediatricians.

Communicate with the patient and family. There is no rule that says you are limited to 1 interaction per day. Actually, you should see your hospitalized patients multiple times each day. Keep in contact with the family, update them often, assess their needs, answer their questions, reassure them when appropriate, and provide them with education. Families will appreciate the extra time you spend to help guide them through what is probably a frightening experience. Try to place yourself in their position and let the insight from that perspective guide your interactions.

Patient Ownership
When you think about responsibly taking ownership of your patient, think about the relationship you expect to have with your doctors.

Remember to relate. Try to remember the experiences you or your loved ones have had in the past. Patients are anxious, feel crummy, and want to know what is wrong with them and what their medical team is going to do about it. They want to know the plan before it is executed. No one enjoys learning that labs are going to be drawn when the nurse arrives to draw them! They want cost effective care with minimal, or at least disclosed, side effects. They also want to be listened to and treated with compassion and dignity.

Take ownership of your patients. An attitude of ownership reflects a philosophy and an attitude about your role and responsibility to your patients. It takes practice and commitment. The reward for this commitment is the satisfaction found in caring for your patients, seeing their gratitude, and earning the respect of your senior residents and attendings, which will translate to more autonomy.

Know all there is to know about your patients. You should know more than all of the consultants and even the primary attending. It is difficult for interns to balance patient ownership with work demands and duty hour restrictions, but this is what your fellow interns, senior residents, attendings, patients, and families will expect! Have the facts readily on hand (if not memorized). Details can save patients from redundant, invasive, and expensive workups. When the clinical picture is not making sense, these details may be the clues that reveal the diagnosis.

Remember that you are the patient’s primary doctor, not a messenger or secretary to their attending. You are the one who coordinates the patient’s care! In fact, the more consulting attendings involved, the more the patient needs you to sort out the potentially conflicting messages. Take pride in caring for your patients and knowing them better than anyone else. Consult other physicians wisely. Even when you consult another service, challenge yourself to figure out what is going on before the consultant simply gives you the answer.

Keep the family updated. Explain evaluations and treatment in advance! Ask the family what questions they have and let them know you are available if they need you. Tell them about results promptly. After a lumbar puncture, let them know how it went. Share and explain the CSF findings right away. If you don’t know something, be honest with them. They will appreciate it. Most patients and families understand that you are learning. Let them know you will help them find the answers to their questions so you can learn together. Teaching directed at families and patients is at least as important as teaching medical students. If you bring the medical student with you to talk with families, you can even teach everyone at once!

Expedite patient care. Don’t keep that patient in the hospital for an extra day and $1,500 more because a test is not yet complete. Although difficult to achieve at first, this is a worthy goal. Anticipate needs, manage, and coordinate care aggressively. Be the advocate for your patients and their families. Don’t stop short because information is missing. Pull the old chart from medical records or have the patient’s family sign a release from the other institution. Advocating for your patients, mobilizing resources for them, and expediting their care may require a few telephone calls. Be creative and make things happen!

Be accountable and responsible for patient care. You are supervised and will have to report most of the things you do with senior residents and attendings. Discuss your diagnosis, plan, differential, and plan for evaluating and treating the patient. It is fine to be unsure and ask for help, but start by disclosing what you are thinking. This will allow your senior residents and attendings to see your thoughtful investment and give you feedback. If you are concerned that a patient’s treatment may not meet the standard of care, respectfully discuss your concerns and reference evidence-based medicine guidelines, if they apply. Sharing your concerns openly will either achieve better care for your patient or be a great learning opportunity for you (or both!). Welcome feedback and let yourself be molded into an amazing pediatrician!

Be ready with a systematic approach when you call on your senior or attending in the middle of the night. Prior to calling, have the patient chart and flowchart of vital signs readily available, assess the patient, and think critically about what you think is going on, why, and what you would like to do. Present the concern or question in the SBARR format (describing the situation, the background information, your assessment, and your recommended action). Then process and document their response.

Signout: Be the Key to Your Patients’ Safety
It is okay to be human at the end of a shift. Before you leave, let patients and families know it’s the end of your shift, and you just have a few minutes but wanted to check on them to see if there are concerns the oncoming team needs to address. The residents coming in to replace you will likely be able to tell that you have been up all night and will have some mercy on you. This doesn’t excuse you from having foresight. Don’t leave that extensive discharge on your chronic patient for the cross-cover team to complete. Get it ready in advance for the benefit of your patient and your colleagues. When you leave, ensure a good signout on your patients -- one that includes troubleshooting (“if this happens, do this”) for the on-call team. On the flipside, when you are cross-covering and on call, ensure that you are receiving enough information to provide exemplary patient care in the primary residents’ absence, because when you are on call or cross-covering, patient ownership continues. Remember, all of the patients are your patients! Caring for your patient requires a team effort and good communication. When you write an order, make sure the appropriate people know about it (nurse, pharmacist, etc.) and follow up to be sure it was completed. When it comes to your patient, lead the team!
Discharges go smoothly, patients understand what happened during their hospital stay, and they can effectively follow their discharge instructions and relay them to their primary physician at their follow-up visit. Although patient understanding is important, call your patients’ primary outpatient doctors to be sure they know what happened with their patients under your care and what the plan was at the time of discharge.

Studying During Intern Year

- Read about your patients’ conditions!
- Read journal articles relevant to your rotation and your patients.
- Attend conferences and lectures that are designed for you! These conferences are intended to enhance your learning, so don’t let the work of the day prevent you from attending. The work will still be there after the conference, so make sure to attend unless you have acute patient care needs.
- Pediatrics in Review is a great publication! As a resident member of the AAP, you will receive this monthly. The review articles in this publication are high-yield, concise, easy to read, and written by content experts. Try to read every month’s edition. This is great general learning as well as board review because the topics of the Pediatrics in Review articles are based on the American Board of Pediatrics general pediatric boards content specifications. In fact, 5 years of Pediatrics in Review covers the content specifications of the exam.
- The AAP publishes PREP® questions each year. These questions are written in pediatrics boards style and cover the content specifications of the general pediatrics boards. You will have access to these questions online at Pedialink (the AAP online learning site). These questions are a great way to review pediatric topics. Cover just a few questions at a time each week or several questions at a time, and you will become one of the many residents who use these questions to help prepare for the in-training exam to be taken each July during residency.
- Talk to your program leadership or mentor near the start of residency to map out a plan for boards preparation. Much like the other learning that occurs during residency, preparing for boards is a marathon, not a sprint! There is no need to stress about boards during the first week, but it is smart to develop a plan early on to review routinely throughout your years as a resident.

Bottom Lines

The intern year is meant to be challenging. Taking ownership of patients will be difficult at first. However, with organization, focus, consistent documentation, and a willingness to ask for help, the intern year can be intensely rewarding as well.
Work/life balance is a moving target, fluid and dynamic, requiring both attention and intention. Career choice is personal and requires that you know yourself first to best assess how a medical specialty aligns with your lifelong goals.

Work/life balance is a matter of understanding that the choices we make impact the paths we take. Each of us has unique needs, goals and values; no single career or specialty can meet everyone’s priorities in the same ways. The key is to recognize that career demands interplay with other life priorities, and to ensure that your choices sustain those things that support personal well being. The content of this section is designed to trigger a personal and creative pursuit of success in medicine and to help students determine whether or not a career in pediatrics is a good fit for them.

Medicine is a high-stakes job with complex responsibilities that presents challenge, enjoyment, satisfaction, and stress. High risk begets high stress and high satisfaction. Those who choose medicine understand this. They are eager to take on the role of a physician, to develop the skills required to serve and heal.

When contemplating a career specialty, it is useful to consider what brings you stress and what brings you satisfaction. With that in mind, consider, too, that there are many ways to practice pediatrics: as a hospital-based, office-based, or community-based generalist or subspecialist; in academia as an educator, researcher, and/or clinician; and any of these full-time or part-time. Each physician’s practice evolves throughout his or her career. As in any field, physicians may change jobs in order to advance or to develop further skills or to pursue new interests.

Personal needs ebb and flow. Sometimes work needs you more; sometimes you need more work; sometimes you need more space. It is rare for an individual to have a sense that life is in perfect balance, but knowing what you need and making deliberate choices that are consistent with self knowledge will help to achieve it. Know when you need help; this is not a failure. Try to identify leaders, champions, mentors, or colleagues who can help you to articulate goals, track your objectives and celebrate successes. When you are able to stay on track, you will nurture happiness and further success.

The entries below are goalposts against which to measure your work/life balance.

Be honest about your priorities and values

❖ How do you feel day to day? During a clinical rotation, what is your prevailing state of energy? Some experiences are purely exhausting. Others will require the same hours but will be remarkably doable. At still other times, the most strenuous work is actually energizing. It is important to be motivated to get up and go each day. Your career choice should accommodate your personal values and lifestyle and not conflict with your priorities.

Define Your Boundaries

❖ It could be that the hardest personal piece to achieve is defining and living within your own boundaries. We all have values that should guide and drive our decisions. Those who value family above all else will need to prioritize their responsibilities accordingly. Those who value exercise and personal fitness will need to structure a systematic routine. We are all subject to pressures that push away from personal values to meet the needs of others. The conflicts that develop can be very challenging but those who know what is important to them can maintain focus on both career and life outside of work. Those who set limits to prevent over doing and establish achievable goals make choices that align with their personal goals and priorities. If it is among your values to provide the highest quality of care that you can, you may choose to study further, spend another hour in the hospital, or devote more time to an individual patient. Recognizing that your choices are consistent with your values will move you closer to your goals.
Never Lose Sight of Your Dreams

Have you defined your goals and values? Can you articulate a 1-year, 5-year or 10-year dream? It can be easier to describe dreams than define plans. Dreaming allows us to aim high and consider what makes us happy without being encumbered by the means to achieve it. Knowing yourself well enough to define your goals is critical to personal success because progress cannot be measured without recognizing the objectives and accomplishments along the way. Defining priorities as stepping-stones to our goals brings us closer and closer to our dreams.

Reflect and Revisit

Reflection may be the most powerful step in moving forward. It is very useful to take note of what gives us pause and inspiration. Whether it’s an ever-growing document on your laptop or a bound journal in your backpack, create a system to make note of compelling or intriguing experiences and insights. It may be weeks before you have time to analyze it, but that record will resurrect the moment. Upon reflection, we generally look a bit deeper and decide whether the action, activity, or event warrants further thought.

Bottom Lines

Pediatricians tend to value work/life balance, perhaps because we work with families every day. Maintaining balance is difficult when new challenges and responsibilities are added to the mix, but we strive to enjoy the journey. While coping with stress is a personal endeavor, the freedom to focus and prioritize time spent as spouses, parents, friends, sports fans, artists, advocates, coaches, and church leaders is a key to work/life balance.
Since 2001, medical students have been welcomed as affiliate members of the American Academy of Pediatrics (AAP) Section on Medical Students, Residents, and Fellowship Trainees (SOMSRFT).

- Medical students must be enrolled in a medical school accredited by the Association of American Medical Colleges (AAMC) or the American Association of Colleges of Osteopathic Medicine (AACOM).
- A 12-month membership is only $16!
- A link to the membership application can be found on the AAP Web site.

**AAP Membership Benefits for Medical Students**

- Inclusion on the medical student listserv, which provides regular updates on what the AAP is doing for medical students and opportunities available to medical students.
- The opportunity to network with residents, fellows, and young attendings via YPConnection, the AAP’s online social networking site.
- Medical student e-newsletters.
- A subscription to Resident Report, the AAP SOMSRFT national publication.
- Opportunities to network with pediatric residents, learn about pediatrics and pediatric residency, and work with local residents on advocacy efforts.
- FREE admission to the annual AAP National Conference & Exhibition (NCE), which includes medical student programming!
- Opportunities for funding and to present clinical posters at the AAP NCE.
- Opportunities to pursue leadership and publication opportunities within SOMSRFT.
- Opportunities to work on the SOMSRFT annual national advocacy project.

**AAP National Conference & Exhibition (NCE)**

- FREE admission for medical students!
- Annual meeting of the AAP.
- Multiday programs with seminars, plenary sessions, and workshops designed for all levels of learners.
- Specific high-yield and engaging programming just for medical students!

**How to Get Involved**

Become a member today! Medical student members get involved at many levels. We currently have 2 key focus areas aimed to improve communication and infrastructure at a local and a national level:

- Pediatric Interest Groups: The Local Level -- The AAP is working to partner with pediatric interest groups (PIGs) at every medical school in the United States, and has developed a Pediatric Interest Group Listserv to enhance networking between groups and also with the AAP. The AAP has also developed a Pediatric Interest Group Resource Guide designed to help medical students at medical schools without an interest group start PIGs and also help students already leading a PIG at their school make their group even more successful.

- Medical Student Subcommittee: The National Level -- SOMSRFT started a medical student subcommittee in 2007. This group currently has 6 medical student members, each of whom serves 2 years. The terms overlap, so that 3 positions open to new members at the end of each year. For more information about this group or to learn more about how to apply to become a member, visit our Web site.
Other opportunities to get involved include:

- Writing an article for the Medical Student Newsletter*
- Partnering with residents in their annual AAP advocacy project* (http://www.aap.org/sections/ypn/ms/advocacy/)
- Connecting with leaders within your AAP chapter**
- Maintaining membership as a resident, with even more benefits and opportunities!

Bottom Lines

Getting involved with the AAP is one of the best ways that medical students, residents, fellows and attending pediatricians take care of their patients... and themselves! Professional involvement adds a rich dimension; take advantage of it!

References

1. Section on Medical Students, Residents, and Fellowship Trainees: http://www.aap.org/sections/ypn/resident/
2. AAP membership application for medical students: http://www.aap.org/member/medstudentApp.pdf
3. YP Connection: http://www.aap.org/sections/ypn/yp/ypconnectionhome.html
10. AAP chapters: http://www.aap.org/member/chapters/chap-list.cfm

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If you are interested in becoming a medical student member of the American Academy of Pediatrics (AAP), please call the AAP Membership Department at 800/483/9016 or obtain a medical student membership application online at http://www.aap.org/member/memcat.htm.

This publication appears both in print and on the American Academy of Pediatrics Web site (http://www.aap.org/). If you have the print version, please consult the Web version for quick links to many useful resources.