Applying for Residency: PHYSICAL Medicine and Rehabilitation (PM&R)

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Part I: Overview of Specialty

Description of Specialty, Common Conditions, Types of Patients
Physical Medicine and Rehabilitation (PM&R, also called physiatry) is a medical specialty focused on caring for individuals with physical illness or injury that impairs their ability to function at their pre-illness/injury baseline. A physiatrist’s overall goals are to restore function when possible, provide means to compensate for lost function when necessary, and assist the patient in achieving their goals and living the fullest life possible. Physiatrists also serve as advocates to promote more easily accessible and inclusive resources for individuals with disabilities within the healthcare system and beyond. Physiatrists get to know their patients well over time. They utilize exercise-based therapies, physical modalities, medications, bedside and office-based diagnostic and therapeutic procedures, adaptive equipment, mobility aids, lifestyle modifications, education, and prophylaxis for anticipated complications in the process of providing a comprehensive patient- and family-centered approach to care.

Common diagnoses encountered in the adult and pediatric inpatient rehabilitation settings include spinal cord injury, brain injury, stroke, severe burns, orthopedic trauma, joint replacements, amputations, cancer, and onset or exacerbations of neurologic diseases. After discharge, individuals with these diagnoses are commonly followed long-term in the outpatient rehabilitation setting. In addition, outpatient physiatrists see patients of all ages with sports and performing arts -related injuries, concussions, neuromuscular diseases (eg. amyotrophic lateral sclerosis, myasthenia gravis, muscular dystrophies), pain syndromes, back/spine pathologies, gait and balance impairment and falls, cerebral palsy, and spina bifida. Consulting physiatrists in the acute care hospital setting typically see inpatients with new catastrophic illness or injury and assist with early therapy and equipment recommendations, prevention and management of complications of immobility, and education and long-term planning with family members.
While PM&R is a non-surgical specialty, physiatrists perform some bedside and office-based diagnostic and therapeutic procedures. These include electrodiagnostic nerve and muscle studies, joint injections for pain management, intrathecal medication pump adjustments and refills for pain or spasticity management, and botulinum toxin injections for spasticity management. Physiatrists perform detailed neurologic and musculoskeletal assessments and provide prescriptions for physical and occupational rehabilitation programs, return to sports play schedules, orthotics, prosthetics, communication devices, and wheelchairs and other mobility equipment. Physiatrists can also assess and refer patients for research studies of all types, eg. for the study of genetics, therapeutic medications, and innovative technological devices. Physiatrists routinely work with a range of providers, including physical therapists, occupational therapists, speech language pathology specialists, orthotists, prosthetists, adaptive technology specialists, nurses, social workers, and community advocacy organizations. Physiatrists also work closely with neurologists, orthopedists, rheumatologists, oncologists, palliative care doctors, and others in coordinating care for their patients.

**Career Trajectories: Academics, Clinical, Research, Teaching, etc.**

Physiatrists practice across the full range of academic and private clinical and research settings. In addition to providing clinical care, physiatrists are sports team physicians, community and policy advocates for people with disabilities, and international aid staff working to bring rehabilitation services and equipment to underserved areas.

Robust departments of PM&R are often found in medical schools affiliated with large inpatient rehabilitation hospitals and outpatient services. The departments tend to include clinical faculty with subspecialties in many or all of the major PM&R disciplines (spinal cord injury, brain injury, stroke, sports medicine, spine medicine, pain medicine, neuromuscular disease/EMG, pediatrics, cancer rehabilitation, hospice and palliative medicine), and both clinician-researchers and full-time researchers working in fields from basic science to medical robotics. Department faculty regularly participate in bedside and didactic teaching of residents, fellows and medical students. In medical schools, the role of physiatrists can include providing education about the needs and care for individuals with disabilities, as well as teaching students musculoskeletal and nervous system anatomy and clinical exam skills. Physiatrists who work in the Veterans Affairs hospital system frequently encounter large populations of individuals with polytrauma, brain injury, spinal cord injury, and amputations. Physiatrists often co-moderate family support groups for patient populations such as stroke or brain injury, and especially in the acute care consultation or inpatient rehabilitation hospital settings, gather family and staff and lead interdisciplinary meetings to set meaningful long-term patient goals and coordinate care.

**Practice Models**

Practice models for physiatrists include private solo or group practice, acute care hospital consultation, rehabilitation center inpatient hospitalist or outpatient work, and long term post-acute care/nursing home consultation. Physiatrists often work as consultants for sports teams, dance groups or other organizations. Some physiatrists join orthopedics groups to provide non-operative orthopedic and pain management – this includes provision of diagnostic and therapeutic injections, orthoses and other
equipment, education on activity modification, tailored exercise regimens, and medication management. Some physiatrists work with neurologists to provide rehabilitation interventions to improve quality of life over the course of neurodegenerative disease (e.g., mobility equipment for individuals with multiple sclerosis or amyotrophic lateral sclerosis). Physiatrists are trained in performing nerve conduction/electromyography studies for the diagnosis of peripheral nerve and muscle injury and disease. Some physiatrists perform testing in a consultative role; others perform testing and utilize results for management of their own patients.

Residency: Length, Typical Curriculum
PM&R residency is a total of 4 years (1 year of internship + 3 years of PM&R-specific training – categorical vs. advanced PM&R programs will be discussed below). The three years of PM&R residency training includes 12 months of inpatient clinical care, 12 months of outpatient clinical care, and the remaining 12 months typically divided among training in diagnostic nerve conduction and electromyography studies, acute care consults, research, and electives. Inpatient rotations include brain injury, spinal cord injury, stroke, polytrauma/orthopedics, burns, amputation, and pediatrics. Many programs also offer inpatient rotations in cardiac, pulmonary, cancer, and neurodegenerative disease rehabilitation. Outpatient rotations include pain management, sports medicine, spine management, pediatrics, neuromuscular disease, general rehabilitation (polytrauma, amputee), and neurorehabilitation (spinal cord injury, brain injury including concussions, stroke). Sports, spine, and pain clinics include training in diagnostic and therapeutic injections. Some programs also offer outpatient rotations in cancer rehabilitation, geriatrics, and orthotic and prosthetic design and management. Larger residency programs frequently include rotations in specialties with which PM&R often shares patients, eg. neurology, rheumatology, orthopedics, palliative care, and anesthesia/pain management.

Overnight call averages once per week, and more call is generally taken in the PGY-2 year than in the PGY-3 and PGY-4 years. Call typically includes responsibility for a large number of inpatient rehabilitation patients. Residents are responsible for following up medical management plans initiated during the day, occasional admissions (most rehabilitation hospital admissions are completed during daytime hours), and the management of acute condition-related complications or medical/respiratory decompensations. All PM&R residents participate in regular didactic sessions and complete a scholarly project.

Of note, there are 83 ACGME-accredited PM&R residency programs across 28 states. These programs vary in size, ranging from 2-14 residents per class. Thirty of these programs are categorical programs (internship and PM&R training are linked and occur in the same hospital system) and 53 are 3-year advanced PM&R training programs only (meaning a student must apply separately for internship and PM&R training, and complete one year of medicine, surgery, or transitional year internship prior to beginning the 3 years of PM&R training). (aapmr.org)

Fellowships Offered After Residency
PM&R residents are eligible to apply for both clinical and research-based fellowships. Clinical fellowships in PM&R are typically one year long, and most physiatrists who pursue fellowship training do so immediately following residency.
Clinical fellowships include spinal cord injury, brain injury, pediatric rehabilitation, pain medicine, neuromuscular medicine, hospice & palliative medicine, sports medicine, cancer rehabilitation, musculoskeletal/spine medicine, occupational and environmental medicine, neurorehabilitation (a combination of spinal cord injury, brain injury, and stroke), and disease- (eg. multiple sclerosis) or symptom- (eg. spasticity) specific training.

Non-clinical fellowship arenas open to physiatrists include research, public health, and informatics. Pain and spine fellowships are typically housed in departments of PM&R or anesthesia. Hospice & palliative medicine fellowships are typically based in departments medicine or anesthesia. Neuromuscular/EMG fellowships are housed in departments of neurology or PM&R. The HMS Department of PM&R offers ACGME-accredited fellowship training in spinal cord injury, brain injury, pediatric rehabilitation, and sports medicine. While many graduates of PM&R residency programs – especially programs affiliated with larger academic institutions – tend to pursue fellowship training after residency, many physiatrists go straight into practice after residency, commonly, but not uniformly, practicing in non-academic outpatient settings.

Part II: Life as a PM&R Doctor

Demographics
PM&R is a relatively young field, first recognized by the American Board of Medical Specialties in 1947. Since then, PM&R has grown steadily, and now includes over 9,000 practicing physiatrists in the United States alone. There was a 6.6% increase in the number of practicing physiatrists in the United States between 2012 and 2017. (AAMC Physician Specialty Data Report, 2018)

Women make up 35.3% of practicing physiatrists, which is roughly average when compared with all medical specialties. The fraction of practicing female physiatrists achieving full professorship in their departments seems to be increasing in recent years (~ 25% of PM&R full professors were women in 2014, increased to ~40% in 2017; Hwang et al, 2017; AAMC Medical School Faculty Report). DOs make up 14.2% of active PM&R physicians, which gives PM&R the 2nd highest concentration of DOs among specialties. International medical graduates make up ~24% of practicing physiatrists in the U.S., which matches the national average for all medical specialties combined. (AAMC Physician Specialty Data Report, 2018)

Non-Caucasian PM&R physicians made up 22.46% of PM&R professors in US medical school PM&R departments in 2017.

Earnings Potential
Annual compensation in PM&R is typically higher than in primary care, but lower than most surgical specialties. The median annual compensation ranges from $200,000-$276,510 according to the
American Academy of PM&R. According to the Sullivan Cotter 2018 Physician Compensation and Productivity Survey Report, the Northeast has the lowest median compensation at $205,000 and the Great Lakes sub-region has the highest annual compensation at $266,600. PM&R sub-specialists, who typically complete 1-2 years of fellowship training, tend to have higher annual salaries.

Lifestyle
Lifestyle in PM&R is as diverse as the range of subspecialties and settings in which physiatrists practice. Most full-time physiatrists work 40-60 hours per week, with physiatrists conducting research or sports team coverage putting in hours on the higher end (60+). In-house call is generally lighter than in other specialties, with physicians in major academic institutions taking call ranging from several times a month to several times a year. Overnight in-house call is rare. Many physiatrists report having routine, easily predictable hours.

Physiatrists who focus on inpatient care often see patients in a rehabilitation hospital or specialized rehabilitation floor in an acute care hospital, and may have occasional call or weekend rounding responsibilities. Some of these physiatrists also have an outpatient practice to care for patients after discharge. Physiatrists with outpatient specialties (e.g., sports medicine, pain, neuromuscular disease) in health care systems affiliated with inpatient units may have intermittent call or weekend rounding responsibilities. Exceptions to these generalizations are common however, allowing physiatrists to craft work schedules to fit their preferred lifestyles.

Academic Medicine
Physiatrists care for many patients with lifelong impairments and changing needs over time. A career in academics is an attractive choice for some physiatrists, as it allows them to stay closely connected to advances in the field, contribute to ongoing research, and collaborate with colleagues for patient care. In addition, frequent social interactions with colleagues during rounds, in the halls, and during regular didactic sessions allows for mutual emotional support while bearing witness to the suffering so many patients with catastrophic illness and injury endure.

According to the AAMC Faculty Roster of 2018, there were 1703 full-time PM&R faculty at U.S. medical schools (For comparison – internal medicine had 42,449). Combined with other data, this suggests approximately 18% of physiatrists are full time medical school faculty. Physiatrists who are not full time medical school faculty, however, often also have teaching roles in local medical schools and/or schools training allied healthcare professionals (i.e., physician assistants or physical therapists).

Academic physiatrists participate in clinical care, research, teaching of medical students and residents, and the teaching of and learning from rehabilitation team members across disciplines. Some examples of research arenas in PM&R – listed here to demonstrate the broad scope of opportunities - include genetics, muscle physiology, hormonal/endocrine changes after neurologic injury, orthobiologic treatment techniques in sports medicine, neuroprostheses for amputees, brain injury outcomes in soldiers returning from war after polytrauma, exoskeletal orthoses for ambulation after spinal cord injury, identification of biologic markers for measuring treatment outcomes in amyotrophic lateral
sclerosis, medical education research around training doctors to care for patients with disabilities and their families.

Academic PM&R departments housing residency programs and/or medical student clinical electives have faculty who routinely integrate teaching into their practice. PM&R physicians not in academic medicine may continue to have a teaching role as clinical faculty with local or regional medical schools or schools for training allied healthcare professionals as described above. Another important teaching role for physiatrists – whether “academic” physiatrists or not -- is patient, family, and community education. A physiatrist plays a crucial role in helping patients and their families understand a patient’s illness/injury, its impact, and likely trajectory and complications. Helping patients and families anticipate future needs, training them to become effective advocates in their communities, connecting them with families who have had similar experiences, and directly educating schools and workplaces about a patient’s new needs or changing needs, can be the key factors in a patient’s successful return to their community and societal roles.

Part III: Applying in PM&R

How Competitive is PM&R?
Interest in PM&R has grown steadily in recent years, with all of the PGY-1 and PGY-2 spots filling through the Match in 2018. PM&R residency requires one year of internship, commonly done in internal medicine (surgery and transitional year internships are acceptable as well), followed by three years of PM&R specialty training. Some PM&R programs offer an integrated intern year, also called a “categorical” position which includes all four years of training. Most PM&R programs offer training from PGY-2 year onwards, known as an “advanced” position. In a recent Match year, graduates of US allopathic medical schools comprised 57.14% of the categorical PM&R spots, and 59.07% of the advanced positions.

While PM&R is generally not considered a competitive specialty, the top tier programs have become considerably more selective over the past several years. Medical students who match at the top tier programs generally have excellent board scores, demonstrated interest in PM&R, research productivity, and CVs which are all far stronger than the average numbers would suggest. In 2017, there were 399 first year PM&R residents and fellows in ACGME-accredited programs, out of a total of 45,530 total residents and fellows in ACGME-accredited programs in all fields combined. This number is similar to ophthalmology or otolaryngology, and just slightly lower than dermatology. Women made up about 40% of first year residents and fellows, similar to numbers in general surgery and internal medicine. (AAMC Physician Specialty Data Report, 2018 – data only list female and male for gender categories.)

Planning the Post-Clerkship and Senior Years
The HMS Department of PM&R is housed at Spaulding Rehabilitation Hospital. The department offers two clinical electives: Introduction to PM&R and Pediatric PM&R. If you are interested in learning more
about or pursuing PM&R, it is recommended you enroll in one or both of these electives. If you are unable to fit either into your schedule, please contact the course directors or the HMS PM&R Student Interest Group faculty advisors to arrange an alternate opportunity to explore rehabilitation and talk with residents and attendings in the field.

Once you have decided to apply for residency in PM&R, you should meet with your academic advisors, your PM&R course director, the residency program director at HMS, and the chair of the Department of PM&R to introduce yourself and discuss your interests. These advisors want to support and advocate for you to the best of their ability, and can help you plan your post-clerkship clinical experiences and extracurricular activities. Be open to discussing your interest in the field, your commitment to the patient population physiatrists serve, and to seeking opportunities to further demonstrate your dedication and enthusiasm.

Of note, even if you are not planning to stay in Boston for training, these advisors can talk to you about other programs, connect you with colleagues all over the country (PM&R is a small field), and help you prepare your applications.

Clinical Rotations

Sub-Internships
Many students going into PM&R decide to pursue a sub-internship in medicine. While you will not be disqualified for completing a pediatrics or surgical sub-I, sub-I’s in these specialties are less commonly pursued. You should complete a PM&R elective at Spaulding Rehabilitation Hospital, which will be treated as an acting internship. Sub-I’s in medicine and acting internships in PM&R should be completed by July of your senior year in order for both departments to have adequate time to submit your course grades and evaluations so they are included with your residency applications.

You should strongly consider seeking a letter from either the course director of your medicine sub-i or an attending with whom you worked closely. Similarly, for your elective in PM&R, a letter from someone in the field who knows you well goes a long way. Course directors and other faculty expect to be asked. Let potential letter-writers know as soon as possible you plan to ask for a letter so they have sufficient time to get to know you and to prepare your letter(s).

If you become interested in PM&R prior to your PCE ambulatory medicine month, consider asking your PCE medicine clerkship director if you can pursue one of your specialty clinics in PM&R. This option is already set up for MGH PCE students, and the HMS PM&R clerkship/PCE experience director at Spaulding can help arrange a clinical experience for students at other sites.

Away Electives
Away electives are often sought by students as “audition rotations.” Rather than going out of your way for the sole purpose of trying impress another program in person, consider away rotations in a few specific instances: to demonstrate your commitment to a specific location if you have a personal/family
need to relocate there; for you to evaluate a program you are truly interested in learning more about; and if the program offers opportunities for learning topics in PM&R you can not learn in other locations. Also consider away electives if you are confident you want to relocate and your clinical performance is likely to be markedly superior to your USMLE Step scores and/or academic record. It is important to put your best effort into these electives and get to know the residents and faculty you work with well. Feel free to reach out to the HMS PM&R student interest group advisors or HMS PM&R clerkship or residency directors for additional advice on selecting PM&R programs to meet your needs.

Other Recommended Electives
Clinical electives outside of PM&R can help sharpen your overall skillset as a physiatrist. Consider electives in neurology, orthopedics, and rheumatology. Also consider an elective in emergency medicine, as your overnight call in the rehabilitation hospital will require you to act quickly in determining which patients you can manage with limited resources and which patients might need to be emergently sent out to an acute care setting with more extensive imaging and management capability, as well as more overnight staff.

Many rehabilitation inpatients with stroke and amputation have baseline cardiac disease and/or diabetes. If you are interested in care for these populations, elective rotations in cardiology and/or endocrinology will be helpful.

A psychiatry elective, addictions medicine elective, or self-directed study in which you can learning effective motivational interviewing techniques will help equip you to help your patients make meaningful and lasting life changes.

Many patients in PM&R at some point experience existential distress in the context of major illness or injury. Some students and residents have found spending time with spiritual care teams either formally or informally very educational and of lasting benefit to equip you with communication tools when talking with your patients. Similarly, an elective in palliative care can equip you with crucial patient and family communication skills, conflict resolution skills, and skills and confidence in running team and family meetings.

You may want to schedule your electives during the fall of your senior year; just remember to discuss with your course directors the need for flexibility to interview during your electives. Winter and spring are also good times to schedule your electives. Summer electives may be challenging to obtain, since many students applying in these fields will also be looking for similar rotations.

Research
Almost all selective PM&R programs expect an applicant has research experience. Research experience does NOT need to be in PM&R. Far more important than the specific topic is your ability to learn about the research process, be able to pursue a research question in a meaningful way, and be an engaged learner and respectful colleague. Almost any kind of research will help your application, including lab science, public health, medical education, and clinical outcome studies. Most HMS students will have
some experience from their Scholars in Medicine project. If you do not have any research experience by
the time you decide on PM&R as a career path, plan to meet with the Department Chair, your course
directors for PM&R electives, or your specialty advisor. They can help direct you to an appropriate
project.
The sooner you start doing research the better, as you may be able to submit for a poster presentation
or publication prior to or during your application cycle and before graduation. Presenting a poster at a
conference is a great way to meet other students, trainees, and researchers in PM&R from around the
country and to learn about the various residency programs at program fairs and the like. The major
PM&R conferences accept poster submissions and other scholarly work from medical students, and the
Association of Academic Physiatrists sponsors a summer research program in PM&R (please see below).

National Meetings
The two main national PM&R organizations are the American Academy of Physical Medicine and
Rehabilitation (AAPM&R) and the Association of Academic Physiatrists (AAP).
The AAPM&R is the larger of the two organizations, representing over 9,000 physiatrists. The annual
AAPM&R assembly is held in October. It is a large conference, and includes didactic and hands-on
programming for physiatrists across practice settings and clinical subspecialties. The AAPM&R offers
free membership for medical students, a host of online career-related resources and podcasts for
medical students, and medical student-specific programming at conferences including a residency fair
where students can meet representatives from multiple residency programs. The AAPM&R conference
is a great place to meet other students interested in PM&R, to learn about the range of subspecialties of
PM&R, and to network and learn about PM&R programs and practice patterns across the country.
The AAP, as its name suggests, focuses on academic physiatry, and the annual conference in February is
typically attended by physiatrists, trainees, and students with interests in research and medical
education. During the conference, there is a medical student roundtable, an award given for best
medical student paper, and hands-on workshops for medical students, eg. a recent workshop was given
on wheelchair componentry and prescription. The AAP offers the Rehabilitation Research Experience for
Medical Students (RREMS) program, which supports an 8-week summer research experience in PM&R.
Students who participate in the RREMS program also have an opportunity to present at the subsequent
AAP meeting. Also of note, the AAP provides mentorship resources and is home to the National PM&R
Medical Student Council, which helps connect students from across schools and creates resources and
programming for students. There is a small fee for medical students to join the AAP.

Other degrees
Additional degrees (such as a PhD, MGH, EdM) are not required to be competitive for PM&R.
Competitive academic programs will display a slight preference for candidates who have a strong record
of publishing meaningful research. Individuals with additional degrees beyond the medical degree will
find ample opportunities to utilize their interests and skill sets within residency programs and beyond.
Research, teaching, and community advocacy are all encouraged and embraced as integral to the
success of PM&R as a field.
Part IV: Assessing your Competitiveness

What Criteria do Programs Consider?
PM&R programs are looking for genuine commitment to PM&R, demonstration of compassionate and collegial patient care, a strong academic record, and reasonable USMLE scores. Community service, disability/health care advocacy, and research absolutely strengthen your application, as do excellent evaluations during a PM&R clerkship and the successful completion of electives to strengthen key skills needed as a physiatrist. Strong letters from physiatrists who can comment on your specific strengths and how they translate into anticipated strengths as a physiatry resident and attending are also helpful.

An important first step as you choose which programs to apply to is to realistically assess your competitiveness with your faculty advisor and PM&R advisor. If you and your advisors feel your application is not as strong as you would like in order to be competitive at the programs you are seeking, you might consider applying for an away elective at one or more of the programs you have your eye on. Being engaged, enthusiastic, and devoted to learning and patient care, and obtaining a letter of recommendation from a faculty member describing these qualities, can strengthen your application.

1. Grades and your DSA
The DSA is intended to capture a student’s professional growth over time and includes all clinical coursework in a specialty from the clerkship through July of the application year. All students receive a DSA in Medicine; you may want to request the second DSA in surgery, neurology, or another field. PM&R programs generally use a holistic approach to evaluating students, and generally will evaluate your grades and DSA in the context of your entire application.

2. USMLE Step Scores
While the national average USMLE scores for entering PM&R residents is 225 – somewhat lower than, for example, internal medicine or neurology, the more selective PM&R programs (those with larger rehabilitation hospitals, more highly trained academic faculty with a diverse set of interests and skills, more rigorous and diverse research opportunities for residents, etc.) are seeking higher USMLE scores than the national average. As you might imagine, lower USMLE scores might mean you need to apply to a broader range and larger number of programs. Your advisors can be helpful in assessing your other characteristics and strengths as an applicant in balancing the import of your USMLE scores and determining a list of possible programs.

Many PM&R residency programs will consider granting interviews to applicants without Step 2 scores. Step 2 scores must be available to programs by January of your senior year. For candidates who are less
competitive, taking the Step 2 exam (and earning a high score) early enough for consideration in your initial application review may boost your chances for an interview. Programs will not rank an applicant for the Match without a passing Step 2 score.

3. Research Experience
According to NRMP data from 2018, applicants in PM&R participated in a mean of 2.9 research experiences, with no differences seen between the matched and unmatched groups.

4. Publications
According to NRMP data from 2018, successful applicants into PM&R had an average of 4.2 abstracts, presentations and publications, while unmatched applications had an average of 3.4. You should be prepared to discuss any publications or abstracts listed on your CV during your interviews.

5. Extracurricular Activities
The NRMP data from 2018 show successful applicants in PM&R had an average of 7.8 volunteer experiences, compared with unsuccessful applicants, who had an average of 6.6 experiences. Successful applicants have a variety of volunteer experiences, and these are a common point of discussion during interviews. Many applicants choose experiences related to advocacy for and the care of people with disabilities, which is generally looked upon favorably as a demonstration of your commitment to, familiarity with, and comfort with the PM&R patient population.

Getting an Interview: Attributes Residency PDs Consider in Granting Interviews
USMLE Step 1 scores are used by many competitive programs as a rough screening tool to determine who is granted an interview. According to the 2018 NRMP Program Directors survey, the average Step 1 score below which interviews were generally not granted was 210. Other factors used in the decision to grant interviews include letters of recommendation from faculty in PM&R, your personal statement, and your perceived commitment to the specialty.

The most important factors in ranking applicants according to the same Program Directors survey were interactions with faculty during interview, interpersonal skills, integrations with house-staff, and feedback from current residents. Another important factor was perceived commitment to the specialty. In general, PM&R program directors are seeking academically successful applicants with a strong track record of compassionate patient care and excellent interpersonal skills, who have a clear understanding of PM&R and dedication to the patients’ physiatrists treat.

Letters of Recommendation
You will need at least 3 letters of recommendation (LoR). Ideally, you want to choose faculty who will be strong advocates for you as an individual and can comment on your personal and clinical or research strengths, using examples from personal experience. A strong letter from a physiatrist is extremely helpful. Especially if you choose a physiatrist from outside of HMS as a letter writer, please ask that they comment on your abilities to perform as a PM&R resident.
Ask for letters of recommendation as soon as possible during or after working with an attending, and try to meet in person with each letter-writer to discuss your request. Share your interests, your CV, a personal statement, and the ERAS letter request form. Also share your ideal timeline, including the need for letters to be in to ERAS by August 31st. If a letter has not been submitted by September 1st, send a gentle reminder and ask if there is any additional information your letter writer might need. Consider writing a thank you note to your letter writer after they have filed your letter, and keeping them abreast of your progress and ultimate match results. Ask for assurance your letter writer can provide a strong letter. If they hesitate, consider alternative letter-writers. ERAS gives you the option to waive your right to review your letters of recommendation. It is expected PM&R applicants will waive their right to review their letters.

How many programs should you apply to?

There is no uniform number of programs recommended for any given applicant to apply to. According to National Resident Matching Program (NRMP) data from 2018, ranking 10-11 programs gave US medical school seniors overall a 90% chance of matching. As in all specialties, in determining how many programs to apply to and which to rank, you need to consider personal preferences, whether you are couples matching, and your overall strengths and weaknesses.

Based on NRMP data, no PM&R applicants with STEP 1 scores > 240 failed to match. Of the 29 applicants who did not match in 2018, only 7 had STEP 1 scores above 220. Looking at your USMLE scores in the context of these numbers, you might consider creating a list of programs to apply to including some “reach” and some “safety” programs.

No matter how many programs you apply to, you should interview at as many programs as you need in order to match and where you are interested in visiting/learning more about. In recent years, HMS students applying in PM&R matched into their top 1-2 programs, but you should rank enough programs to ensure a successful match. Just be sure every program you rank is a program you would attend. When you rank a program, you are agreeing to employment at that program. The best anyone can do is to choose rank order carefully in the order you prefer, and trust in the NRMP and Match process.

In addition to a PM&R residency, you will need to apply to an internship. As discussed above, some programs will offer an integrated intern year and residency together, called a “categorical” position. In contrast, some students opt to pursue a separate intern year, and then matriculate into their PM&R residency during their PGY-2 year for what is known as an “advanced” position. You may rank both advanced and categorical positions. One is not necessarily thought to provide better training than the other.

Your choice of internship is an important one. Most physiatry residents choose to pursue an internship in internal medicine. This is regarded as a reasonable option, since the basics of internal medicine will be applicable to your care of patients on the inpatient rehabilitation floors. A small percentage chooses to pursue a surgical intern year, hoping to gain skills in wound care and comfort with complex surgical patients. An even smaller fraction considers a pediatric intern year. These tend to be students hoping to
pursue a career in pediatric PM&R in the future. Some programs will discourage students from a pediatric internship. PM&R residents spend the majority of their training caring for adult patients with complex medical and rehabilitation needs, and therefore a pediatric intern year may not provide adequate preparation. A transitional intern year is commonly chosen, and provides a mix of internal medicine, pediatrics, and other specialties during the internship year. A strong internship will serve as a base for your physiatry knowledge, so be sure to choose one that provides excellent training!

**Common Questions You May Be Asked – Specialty Specific:**
Be prepared to discuss anything and everything listed in your ERAS application. It is common to be asked about your personal statement and any unique extracurricular activities. Be prepared also to talk about your accomplishments and any current research or other projects, publications, or presentations.

Interview questions fall into several categories:
- Why PM&R?
  - How did you decide on physiatry as a field?
  - What about PM&R attracted your attention?
- If not PM&R, what else would you do? Why here?
  - What makes you want to come to this program in particular?
  - What are you looking for in a program?
- Why you?
  - What makes you an attractive candidate?
  - Why should we take you? What stands out about your application?
- Career plans
  - What does your practice look like in 5, 10, 15, 20 years?
  - Geographically, where do you see yourself long-term?
- Assessment of your ability to be a team player
  - Tell me about a complex or difficult case you saw as a student. How did you deal with it?
  - How do you handle challenges?
  - Tell me about a time when a situation went poorly; what would you do differently?
- Unique questions
  - Tell me a story not related to medicine.
  - What else should we know about you that is not on your application?

Stay calm, think about your answers, and THEN speak. Be confident. Don’t ramble.

**Common interview errors** include:
- Poor preparation- not being familiar with the program or PM&R
- Inconsistent or inappropriate answers to questions
- Condescending or evasive behavior
- Lack of interest in the interviewer, the question, or the program itself
- Inappropriate humor
- Inappropriate language when discussing individuals with disabilities or families
- Negative comments on other programs, candidates, or the program itself

Communication with Programs: NRMP Code of Conduct for Applicants and Programs
It is important to adhere to the NRMP Code of Conduct. This is a contract you agree to when you participate in the Match. This Code exists to protect applicants’ privacy, to prevent inappropriate communication from programs (such as asking coercive questions about your rank list) and to create a fair environment for programs and applicants to evaluate one another.

If you have one clear first choice program, discuss with your student advisor whether you should communicate that to the program director. Some programs want to know this information, while others may not use such information in their rankings. **Do not** tell a program you are ranking them first if in fact you are not planning to do so. PM&R is a small field and word does spread among program directors.

**Advocating for Interviews**
If you do not get an interview offer with a desired program, you should discuss this with your course director or specialty advisor. It may be beneficial to reach out to the program director or coordinator depending on your competitiveness. Other options include asking your course director, student advisor, or others to advocate for you.