

Resident Selection Protocols in Plastic Surgery: A National Survey of Plastic Surgery Independent Program Directors

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Background: Plastic surgery training programs draw applicants directly from medical school (the “integrated path”), and they may also draw applicants who have completed other categorical training (the “independent path”). Much of the literature on applicant selection focuses on the integrated path. The authors sought to characterize the selection process of independent path programs and how they compare with the integrated path programs.

Methods: An anonymous, 42-question, multiple-choice, online survey was designed for program directors of the independent training path; it was mirrored to the previously designed survey of the integrated training path. Surveys were sent to all independent path program directors in the United States.

Results: Fifty of the 51 qualifying program directors (98 percent) completed the survey. Fewer exclusively independent programs (30 percent) used a United States Medical Licensing Examination step-1 cutoff for interviews than did programs using both training pathways (71 percent; $p = 0.015$). Letters of recommendation were deemed the most important academic criteria. The attrition rate for independent residents was 3 percent. The combined rate of the adverse outcomes of probation and attrition was statistically lower for independent programs (30 percent) than for integrated programs (43 percent; $p = 0.033$).

Conclusions: These results may answer some questions regarding what programs are looking for. The low rates of probation, dismissal, and attrition compared with those of the integrated path would support maintaining the independent path as a viable option for those who meet selection protocols, as these candidates may have already been preselected for success through their previous training programs. (*Plast. Reconstr. Surg.* 130: 459, 2012.)

The selection process of residents in any field is essential not only to the field itself but also to the legacy of the training program that assumes the responsibility of educating the next generation of physicians and surgeons. Plastic surgery training in the United States has the advantage of drawing applicants directly from medical school (the “integrated path”) in addition to applicants who have completed other categorical training, such as general surgery, otolaryngology, neurosurgery, urology, or orthopedics (the “independent path”). It would seem intuitive that even though these two groups include applicants with

the same trajectory to complete a plastic surgery residency, the applicants matriculate to plastic surgery residency with very different life experiences, backgrounds, and training. The crucial aspects of the selection process may also be different.

Much of the literature on applicant selection focuses on the integrated path rather than the independent path. For this reason, our primary goal was to characterize the resident selection process for the independent training path in plastic surgery. Our secondary goals were to compare the selection process between the two paths.

The senior author (J.E.J.) previously reported on selection protocols of the integrated plastic training programs.¹ Subsequently, we designed a

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survey to obtain and compare data at all stages in the resident selection process of plastic surgery training programs in the United States that use the independent path. We then compared the resident selection criteria of the two paths.

METHODS

An anonymous, 42-question, multiple-choice, online survey was designed specifically for the independent path, mirroring the previously designed survey of the integrated training path.¹ It addressed four general areas: selection process and candidate qualities, interview processes, rank list generation, and outcomes from the current selection process. (See Appendix, which shows the Independent Resident Selection Protocols Questionnaire used in this study). The data were collected through the American Council of Academic Plastic Surgeons SurveyMonkey (Palo Alto, Calif.) account.

Electronic letters were sent requesting participation in the survey to a list of all active independent plastic surgery program directors that was obtained from the San Francisco Matching Program (San Francisco, Calif.) and the American Council of Academic Plastic Surgeons. Programs that had converted to the integrated residency path, based on direct telephone calls or survey responses, were excluded from the data collection. A total of 51 active independent plastic surgery programs were identified during the data collection period. Several reminder e-mails were sent at periodic intervals to increase the response rate.

Survey responses were tabulated in a spreadsheet (Excel; Microsoft Corp., Redmond, Wash.). Internet protocol addresses were used to maintain anonymity and prevent duplicate submissions. Data from the previous survey of integrated programs was used for comparison.

Frequencies and proportions were used to summarize the binary and categorical data. Means and standard deviations were used to describe the rank. Fisher's exact tests were used to test differences in proportions between groups. Wilcoxon rank sum tests² were used to compare the continuous variables between two groups. A two-sided binomial test was used to compare rates to published standards. A value of $p < 0.05$ was considered significant. The analyses were performed using SAS 9.2 software (SAS Institute, Inc., Cary, N.C.).

RESULTS

Fifty of the 51 qualifying program directors completed the survey, for a response rate of 98

percent. The median number of independent residents per program was two.

Sixteen programs (32 percent) matched to both integrated and independent paths. Of these programs, seven (44 percent) agreed with the statement that independent resident quality is easier to predict than that of integrated residents, whereas three program directors (19 percent) were neutral and six (38 percent) disagreed. Programs using both training paths took significantly fewer independent residents per year than programs taking independent residents only ($p < 0.001$).

Selection Process

Twenty-two program directors (44 percent) reported using a minimum United States Medical Licensing Examination step-1 cutoff score for interview selection. This is in contrast to the 52 percent from the survey of integrated programs ($p = 0.409$). The mode for the United States Medical Licensing Examination step-1 cutoff score was 200 to 209 (33 percent), 20 points lower than the mode for the integrated survey ($p = 0.22$). The limited sample size, multiple categories of responses, and nonlinear data set restricted further comparison of these results, and the comparison is best represented by Figure 1. A post hoc power calculation would require 100 programs per group to achieve 78 percent power.

Although 30 percent of exclusively independent programs used a United States Medical Licensing Examination step-1 cutoff score for interview selection, a cutoff was reported in 70 percent of programs with both training paths, which was statistically significant ($p = 0.015$). Eighteen respondents (37 percent) also used a minimum American Board of Surgery In-Training Examination score cutoff. The mode was the 50th percentile (67 percent). Of respondents who reported using United States Medical Licensing Examination and/or American Board of Surgery In-Training Examination cutoff scores, 21 (64 percent) said that initial application cuts were made by the residency director.

Forty-five programs (90 percent) interviewed applicants who have had preliminary training outside of general surgery. Of these respondents, 100 percent considered applicants from otolaryngology, 78 percent considered applicants from orthopedic surgery, and 69 percent considered applicants from oral and maxillofacial surgery. Eight (17 percent) agreed, 15 (31 percent) were neutral, and 25 (52 percent) disagreed with the statement that, compared with general surgery, these

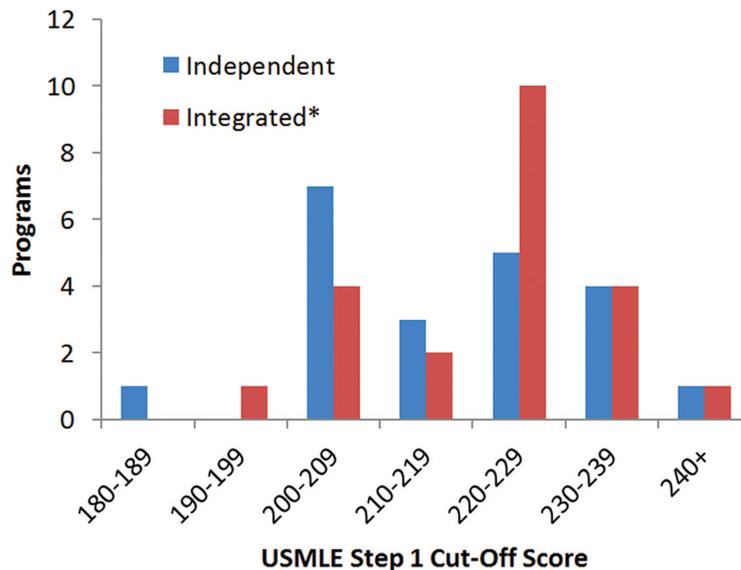


Fig. 1. Minimum acceptable United States Medical Licensing Examination step 1 score for residency interviews for independent and integrated plastic surgery programs. *Integrated data were previously reported by Janis JE, Hatef DA. Resident selection protocols in plastic surgery: A national survey of plastic surgery program directors. *Plast Reconstr Surg.* 2008;122:1929–1939; discussion 1940–1941.

other training paths better prepare applicants for plastic surgery.

Candidate Qualities

Program directors were asked to rank 18 academic and 12 subjective qualities in order of importance for selection of potential resident candidates. These academic and subjective qualities were subdivided into three tiers of importance and compared with the previously reported integrated tiers (Table 1). Qualities relating to letters of recommendation were deemed the most important academic criteria, with “what it says” ranking higher than “who says it.” The traditional reputation of the applicant’s surgical training program was the third most important academic criterion. This finding was supported in the response to the follow-up question, in which 94 percent of respondents felt that it is important in the selection process. Although the applicant’s medical school reputation was in the lowest tier of academic qualities of importance, 78 percent of respondents still felt that it is important in the selection process. The strength of a medical school dean’s letter was considered the least important academic quality. These were findings similar to those reported in the previous integrated survey.¹

Faculty assessment of the applicant during the interview was considered the most important sub-

jective criterion, followed by “personality fit” with the program and maturity. Extracurricular activities and family obligations were considered the least important subjective criteria.

Dean’s letters were ranked higher by programs using both paths than by those using the independent path alone, with a mean \pm SD of 8.8 ± 6.5 versus 14.0 ± 4.6 , respectively ($p = 0.028$). Interest in an academic career also was ranked higher by programs using both paths than by those using the independent path, along with means (5.0 ± 3.2 versus 8.5 ± 2.0 , respectively; $p = 0.007$).

Interview Process

Thirty-four respondents (68 percent) did not use group interviews but rather used one-on-one interviewing. There was a trend ($p = 0.053$) toward group interviews in programs that take residents in both training paths.

Of the programs that did use group interviewing, 77 percent used a 2:1 interviewer-to-candidate ratio, and the remainder using a 3:1 ratio. None of the programs reported using surgical skills or art/sculpting testing during the interview process. In the integrated program survey results, only one program reported using skills testing.¹

Forty-eight respondents (96 percent) reported having their own residents take part in the interview process. This participation was usually in the

Table 1. Ranking Strength of Academic and Subjective Qualities by Program Directors of Plastic Surgery Training Programs Using Independent versus Integrated Training Paths

	Average Rank
Independent quality	
Academic quality rank	
Tier 1	
Letters, "what it says"	4.1
Letters, "who says it"	6.4
Residency program reputation	7.0
Tier 2	
USMLE step-3 score	8.0
Letter from plastic surgeon	8.1
ABSITE score	8.3
USMLE step-2 score	8.5
Publications	8.5
USMLE step-1 score	8.8
Residency honors	9.0
AOA membership	9.0
Tier 3	
Research experience	9.5
Medical school grades	9.7
Previous completion of fellowship	10.0
Medical school reputation	10.0
Plastic surgery research experience	10.0
Dedicated research year	12.0
Dean's letter	13.0
Subjective quality rank	
Tier 1	
Faculty interview performance	2.3
Personality "fit"	4.1
Maturity	4.4
Tier 2	
Resident interview performance	5.0
Initiative	5.3
Personality	5.6
Technical aptitude	6.5
Leadership experience	6.7
Tier 3	
Interest in academics	7.7
Appearance	8.2
Extracurricular activities	9.7
Family obligations	9.9
Integrated quality*	
Academic quality rank	
Tier 1	
Letters, "what it says"	3.8
Letters, "who says it"	4.3
AOA membership	4.6
USMLE step-1 score	4.6
Medical school grades	4.8
Tier 2	
Letter from plastic surgeon	5.7
Research experience	6.4
USMLE step-2 score	6.8
Medical school reputation	7.0
Tier 3	
Dean's letter	8.7
Subjective quality rank	
Tier 1	
Subinternship performance	2.3
Interview performance	3.3
Personality	4.0
Maturity	4.1
Leadership potential	4.2
Tier 2	
Research experience	6.0
Interest in academics	6.2
Publications	6.5
Tier 3	
Appearance	8.1

USMLE, United States Medical Licensing Examination; ABSITE, American Board of Surgery In-Training Examination; AOA, Alpha Omega Alpha. *Integrated data were previously reported by Janis JE, Hatfield DA. Resident selection protocols in plastic surgery: A national survey of plastic surgery program directors. *Plast Reconstr Surg*. 2008;122:1929-1939; discussion 1940-1941.

form of tours (90 percent) or attending social functions (81 percent). The majority of programs also included their residents in conducting interviews (65 percent) and giving significant input on the rank order list (66 percent).

Rank List Generation

Twenty-nine program directors (58 percent) reported themselves as the primary rank list generators. The chairperson was the next most common, with 18 respondents (36 percent). Committees of various compositions were the next most common. Twenty-five respondents (50 percent) reported having rank order lists of more than 16 candidates; lists of nine to 12 and 13 to 16 candidates each were reported by 24 percent of respondents.

Resident Outcomes

Thirty-three respondents (66 percent) felt that performance during the interview process is indicative of the applicant's performance during residency. More importantly, 48 respondents (98 percent) felt that performance during surgical residency is indicative of the applicant's performance during plastic surgery residency. Twenty-nine respondents (58 percent) felt that the candidate's rank list position predicted the ultimate quality of the resident. This is significantly lower than the 72 percent of integrated program directors found in the previous survey results ($p < 0.001$).¹

Five respondents (10 percent) reported having at least one independent residency position go unfilled in the match in the past 10 years, for a total of seven positions; this was higher than the 4.8 percent ($p = 0.445$) previously reported in the integrated survey.¹ Nineteen program directors (38 percent) reported having placed an independent resident on probation for academic or ethical reasons in the past 10 years, which was less than the 62 percent reported in the integrated program survey ($p = 0.059$). Nine respondents (18 percent) reported having dismissed at least one independent resident for academic or ethical reasons within the past 10 years, for a total of 10 residents; this was significantly less than the 40 percent reported in the integrated survey ($p = 0.036$). Seventeen program directors (34 percent) reported having at least one independent resident quit their program in the past 10 years, for a total of 22 residents; this was similar to the 30 percent reported in the integrated program survey.

Knowing the number of residents accepted in the past 10 years,³ we determined that the attrition rate according to the program directors' surveys

was 3.1 percent, which is significantly lower than published attrition standards in the general surgical literature ($p < 0.001$).^{4,5} When the adverse outcomes of probation and attrition are combined, the independent programs had a statistically significant lower incidence rate (30 percent) than did integrated programs (43 percent; $p = 0.033$)¹ (Table 2).

Program Outcomes

Thirty-five respondents (71 percent) felt that their current selection process was adequate to determine any potential independent resident issues before matriculation into the program; this was statistically higher than the integrated program survey results (44 percent; $p = 0.018$).¹ Satisfaction with the current selection process was high; 11 program directors (22 percent) reported being “very satisfied” and 32 (64 percent) were “somewhat satisfied.” Only five (10 percent) reported being “neutral,” and two (4 percent) reported being “somewhat dissatisfied” with their current selection process, which is similar to the results of the integrated program survey. When “satisfied” responses were analyzed separately, there were no statistically significant differences in the responses to the other survey questions.

Eight respondents (17 percent) reported that over the next 5 years they intend to add integrated path residents, over and above that required to comply with the recent, new residency review committee mandate on program length. Of these eight respondents, six ($p = 0.015$) already take residents in both training paths. Thirteen program directors (26 percent) reported that their program intends to completely convert to integrated path residents within the next 5 years, and 10 of these

program directors ($p < 0.001$) currently take residents in both training paths.

DISCUSSION

This survey describes the independent path selection criteria and reveals improved outcomes compared the integrated path. This may make an argument to preserve this training path. The notably high response rate of 98 percent to an online survey suggests the importance of the topic of resident selection to directors of plastic surgery training programs that use the independent path across the United States. As the survey of programs using the integrated training path had a similar response rate of 88 percent,¹ we find that this magnitude of response supports the credibility and validity of the findings. The validity is further supported by statistically significant findings in several categories despite the limited sample size.

The future of the “traditional” path has been questioned.^{6,7} Even the name itself has been changed to “independent,” as this is no longer the standard path of plastic surgery training. Although few programs have returned to the independent path after experimenting with the integrated path, this survey reaffirms that more programs plan to change their training path to the integrated path completely. Most of these programs are currently training residents in both paths.

The benefits of the independent path are numerous, including surgical maturity and a “battle-tested” stamp of approval.⁸ The value of this experience is further evidenced by the responses of 98 percent of program directors using the independent path, who felt that previous performance during residency was indicative of performance in plastic surgery residency. The trend toward min-

Table 2. Independent versus Integrated Training Path Characteristics of Plastic Surgery Training Programs

Characteristic	Independent (%)	Integrated (%)*	<i>p</i>
No.	50	43	
USMLE step-1 cutoff	22 (44)	23 (53)	0.409
USMLE step-1 cutoff mode score	200–209	220–229	0.22
Interview performance reliability	33 (66)	24 (56)	0.27
Rank list reliability	29 (58)	31 (72)	<0.001
Unfilled position	5 (10)	2 (5)	0.45
Placed resident on probation	19 (38)	26 (60)	0.059
Dismissed a resident	9 (18)	17 (40)	0.036
Resident quit	17 (35)	13 (30)	0.664
Adverse outcomes (probation, dismissal, quit)	45 (31)	55 (43)	0.033
Current selection process, adequate	35 (70)	19 (44)	0.018
Current selection process, satisfied	43 (86)	32 (74)	0.36

USMLE, United States Medical Licensing Examination.

*Integrated data were previously reported by Janis JE, Hated DA. Resident selection protocols in plastic surgery: A national survey of plastic surgery program directors. *Plast Reconstr Surg.* 2008;122:1929–1939; discussion 1940–1941.

imally invasive technique training in general surgery has been argued as irrelevant but may provide fundamental training as such applications gain popularity in plastic surgery. Unfortunately, the core knowledge acquired by residents has diverged significantly, as general surgery has perhaps narrowed and plastic surgery has broadened in scope of practice.^{9,10}

Despite the arguably increased overlapping training of otolaryngology, orthopedics, and oral and maxillofacial surgery with plastic surgery, most respondents still felt general surgery-trained applicants were better prepared for plastic surgery training. We believe this to be representative of the hallmark of reputable general surgery training. The general surgery resident should be taught to critically think about surgery, not operations, and to treat patients as a whole and not by anatomy-based committee.¹¹

We find it intriguing that the use of the United States Medical Licensing Examination step-1 cutoff score for interview selection was more than twice as common among programs that also took residents in the integrated path ($p = 0.015$). This may be because these programs are using similar residency selection criteria for two very different groups of applicants. The independent applicant generally has proven clinical experience, which is a more concrete and trusted attribute than the conceptual “promise of future talent” of an applicant who has scored well on standardized tests in medical school. Because the tests were taken by the independent applicants years earlier, programs that use only the independent path may trust the known quantity and minimize the importance of the United States Medical Licensing Examination step 1. Although United States Medical Licensing Examination step-1 scores may correlate with general surgery board pass rates, they also are not highly ranked as factors for other surgical fellowships after general surgery.¹²⁻¹⁴

In contrast, the American Board of Surgery In-Training Examination cutoff score reported does concur with a report of its importance as a factor for residents applying to surgical fellowships, behind letters of reference and surgical training program reputation, whose importance was also supported in our findings.¹³ Qualities that have been previously shown to correlate with applicant success—such as medical school dean’s letters, family obligations, and additional years of research or training—were not found to be ranked highly in this survey.^{5,15,16}

The San Francisco Match report of plastic surgery residency may not appear promising to the

independent training path. Between 2005 and 2010, the applicant pool dropped by 52 percent, whereas the number of positions remained essentially the same, resulting in an increase in the match rate from 48 percent to 82 percent. The number of unfilled positions increased from one to 13.³ This may be a consequence of the increase in training length requirements¹⁷ or a reflection of the coming of age into the residency pool of the current generation’s varying values, expectations, and trend toward the need for instant gratification.¹⁸ Regardless of the reason, this trend in applicants, whether they are more or less competitive than those in previous classes, provides a smaller pool from which to choose.

Although several authors have focused on applicant selection directly after medical school in plastic surgery, in addition to other fields, there is a paucity of recent information on the applicant selection process through the independent path.^{1,5,12,15,19-22} This may be correlated to applicants applying to other fellowships after completing general surgery, such as the evolution of vascular surgery training and selection.^{23,24} The finding that 78 percent of medical students entering general surgery internships change their minds about future fellowships is a strong argument to keep this path to plastic surgery training a viable option to the “late bloomers” to plastic surgery.²⁵ With limited applicants for program directors to choose from, a successful selection process becomes even more important to the survival of this training route.

In 2010, Evans²² reported looking for residents who “will not create too much ‘trouble.’” Compared with our previous study of integrated programs¹ we found that independent programs trended toward fewer probations and significantly fewer dismissals. Even though probations did not reach statistical significance, we believe that this finding is noteworthy and would likely have reached significance if there had been a larger cohort. This is supported by the fact that when all adverse outcomes of probation, dismissal, or quitting were evaluated collectively, the independent path had a significantly lower rate of “causing trouble.” This is further supported by the extremely high satisfaction rate with the current selection processes of independent programs.

We calculated a 3.1 percent independent path attrition rate over the past 10 years. This may be underestimated because of errors in recall but is still lower than other published reports of similar fields. In addition, this applicant pool has proven

durability, as most residents are at risk for attrition early in training.²⁶

Limitations to this survey lie primarily in the question of what predicts a successful resident, as priorities vary with each individual, program director or otherwise. This study attempted to further describe the attributes valued by independent program directors. Future studies could follow the factors elicited in this survey and correlate successful outcomes. This survey did not stratify programs according to hospital setting (community or university), geography, or faculty size, primarily because of the limited number of programs.

To improve the applicant selection protocol for independent training programs, we suggest coordinating interviews by dates and regions. The Louisiana State University and Tulane residency programs exemplified this by combining their interviews. With the applicant pool changes, this coordination may increase programs' exposure to additional qualified applicants. This would also have the potential to decrease applicant expenses but also save limited interview time during the demanding senior years of their current training programs.

Several program directors commented that the accuracy of letters of recommendation is an area for improvement. Truthfulness in letters of recommendation and even telephone calls were characterized as less than forthcoming. This may explain why traditional resident rank list position was also found to be less predictive of the ultimate quality of the resident than the integrated path resident. One program director suggested adding a structured questionnaire for letter writers to rank applicant qualities for more objective data.

We hope that independent applicants can use the results of this study as a reference as to what program directors value in the selection process. This additional knowledge may help alleviate some of the apprehension of the application process and potentially save on interview expenditures and time.

CONCLUSIONS

This survey obtained a baseline of independent plastic surgery residency selection protocols, a subset that has not been recently characterized in the literature, as most of the attention is focused on the integrated path. This article attempts to answer the most important question of all applicants, which is, "What are programs looking for?" Our findings may be a resource to aid candidates when applying. The exceptional response rates in

this study and in our previous study verified the value of these results and allowed for credible comparisons between the two groups. The low rates of resident probation, dismissal, and attrition reported in this study would support maintaining the independent path as a viable option for those applicants who meet a program's selection protocols. Further studies using these selection protocol characteristics can be designed and tracked to predict applicant success, although this specific demographic of independent residency candidates, if their letters of recommendation are an accurate reflection, may have already been preselected through their previous training programs. As the future of the independent training path may be in flux and as the applicant pool may change for multiple reasons, applicant reliability and predictability should be kept in mind. Only time will tell.

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APPENDIX: INDEPENDENT RESIDENT SELECTION PROTOCOLS QUESTIONNAIRE

1. How many TRADITIONAL [INDEPENDENT] residents do you take per year?
 - a. 0.5 (every other year)
 - b. 1
 - c. 2
 - d. 3
 - e. 4
2. Does your program also take residents in the Integrated/Coordinated pathway?
 - a. Yes
 - b. No
3. If "Yes" to the above, is it:
 - a. Integrated
 - b. Coordinated
4. If "Yes" to question 2, how many Integrated/Coordinated residents do you take per year?
 - a. 0.5 (every other year)
 - b. 1
 - c. 2
 - d. 3
 - e. 4
5. If "Yes" to question 2, the ultimate quality of our TRADITIONAL [INDEPENDENT] residents is

- easier to predict than that of our Integrated/Coordinated residents.
- a. Strongly agree
 - b. Somewhat agree
 - c. No opinion
 - d. Somewhat disagree
 - e. Strongly disagree
6. Program location:
- a. Northeast (Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, Connecticut, New York, New Jersey, Pennsylvania, Delaware, Maryland)
 - b. Midwest (Ohio, Indiana, Michigan, Illinois, Wisconsin, Minnesota)
 - c. Southeast (Virginia, West Virginia, North Carolina, South Carolina, Kentucky, Tennessee, Georgia, Florida, Alabama, Mississippi, Louisiana, Arkansas)
 - d. Central/West (North Dakota, South Dakota, Iowa, Nebraska, Kansas, Missouri, Oklahoma, Texas, New Mexico, Arizona, Colorado, Utah, Wyoming, Montana, Idaho, Nevada)
 - e. West Coast (California, Oregon, Washington, Hawaii, Alaska)
7. Do you have a minimum acceptable score cut-off for interviewees based on USMLE I scores?
- a. Yes
 - b. No
8. If "Yes" to the above, which score range do you set the minimum acceptable score at?
- a. 180–189
 - b. 190–199
 - c. 200–209
 - d. 210–219
 - e. 220–229
 - f. 230–239
 - g. Greater than 240
9. Do you have a minimum acceptable score cut-off for interviewees based on ABSITE (American Board of Surgery In-Training Examination) scores?
- a. Yes
 - b. No
10. If "Yes" to the above, which score range do you set the minimum acceptable percentile at?
- a. 30–39
 - b. 40–49
 - c. 50–59
 - d. 60–69
 - e. 70–79
 - f. 80–90
 - g. Greater than 90
11. If "Yes" to question 6 and/or question 8, who makes the first cut?
- a. Residency coordinator
 - b. Residency director
 - c. Administrative Assistant
 - d. Other
12. Do you interview applicants who have done preliminary training outside of general surgery?
- a. Yes
 - b. No
13. If "Yes" to the above, which ones (check all that apply)?
- a. Otolaryngology
 - b. Orthopedic surgery
 - c. Oral maxillofacial surgery
 - d. Dermatology
14. Compared with general surgery, preliminary training in ear, nose, and throat, orthopedics, OMFS, or dermatology better prepares the applicants for plastic surgery.
- a. Strongly agree
 - b. Somewhat agree
 - c. No opinion
 - d. Somewhat disagree
 - e. Strongly disagree
15. Please rank the following academic criteria in order of importance when selecting potential resident candidates, with "1" being the most important, and no ties:
- a. Medical school grades
 - b. AOA membership
 - c. USMLE step 1
 - d. USMLE step 2
 - e. USMLE step 3
 - f. ABSITE scores
 - g. Traditional reputation of applicant's medical school
 - h. Traditional reputation of applicant's surgical training program
 - i. Other honors awarded during surgical residency
 - j. Research experience
 - k. Research related to plastic surgery
 - l. Has published complete peer-reviewed articles
 - m. Dedicated 1 or more years to research
 - n. Completion of another fellowship (i.e., hand, craniofacial, burns, microsurgery)
 - o. Strength of medical school's dean's letter

- p. Strength of recommendation in letters of recommendation (“What it says”)
 - q. Strength of letters of recommendation writers’ reputation (“Who says it”)
 - r. Letters of recommendation being from plastic surgery faculty (as opposed to general surgery or other faculty)
16. Please rank the following subjective criteria in order of importance when selecting potential resident candidates, with “1” being the most important, and no ties:
 - a. Faculty assessment of applicant on interview
 - b. Resident assessment of applicant on interview
 - c. Leadership experience
 - d. Maturity
 - e. Initiative
 - f. Family obligations
 - g. Technical aptitude
 - h. Interest in academics
 - i. Appearance
 - j. Personality
 - k. Personality “fit” with your program
 - l. Extracurricular activities
 17. The reputation of the medical school that an applicant attended is important for our selection process.
 - a. Strongly agree
 - b. Somewhat agree
 - c. No opinion
 - d. Somewhat disagree
 - e. Strongly disagree
 18. The reputation of the surgical program that an applicant attends is important for our selection process.
 - a. Strongly agree
 - b. Somewhat agree
 - c. No opinion
 - d. Somewhat disagree
 - e. Strongly disagree
 19. A candidate’s performance during our interview process is indicative of their performance during residency.
 - a. Strongly agree
 - b. Somewhat agree
 - c. No opinion
 - d. Somewhat disagree
 - e. Strongly disagree
 20. A candidate’s performance during surgical residency is indicative of their performance during plastic surgery residency.
 - a. Strongly agree
 - b. Somewhat agree
 - c. No opinion
 - d. Somewhat disagree
 - e. Strongly disagree
 21. The ultimate quality of our residents has consistently been predicted by their position on the rank order list submitted for the match.
 - a. Strongly agree
 - b. Somewhat agree
 - c. No opinion
 - d. Somewhat disagree
 - e. Strongly disagree
 22. We utilize group interviews in screening candidates.
 - a. Yes
 - b. No
 23. If “Yes” to the above, what is the ratio of interviewers to interviewees?
 - a. 2:1
 - b. 3:1
 - c. 4:1
 - d. >4:1
 24. We utilize surgical skills testing during our interview process to screen candidates.
 - a. Yes
 - b. No
 25. We utilize art/sculpting tests during our interview process to screen candidates.
 - a. Yes
 - b. No
 26. Do your residents take part in your interview process?
 - a. Yes
 - b. No
 27. If “Yes” to the above, in what capacity do they participate? Please mark all that apply.
 - a. Conducting interviews
 - b. Attending social functions
 - c. Giving tours
 - d. Giving presentations
 - e. Giving significant input for rank order list generation
 28. Our rank order list is generated by (please mark all that apply):
 - a. Chairman
 - b. Program director
 - c. Committee composed of core faculty
 - d. Committee composed of all faculty (full-time and clinical)

- e. Committee composed of faculty and residents
- f. A standardized attempt to objectively stratify candidates with no one person deciding on the final rank order list
- g. Other: _____
29. In general, how long is your rank order list?
- 1–4 candidates
 - 5–8 candidates
 - 9–12 candidates
 - 13–16 candidates
 - Greater than 16 candidates
30. Have you had a spot go unfilled in the match in the past 10 years?
- Yes
 - No
31. If “Yes” to the above, how many spots in the past 10 years?
- 1
 - 2
 - 3
 - 4
 - Other (please fill in number): _____
32. Have you placed a resident on probation for academic or ethical reasons within the past 10 years?
- Yes
 - No
33. If “Yes” to the above, how many residents in the past 10 years?
- 1
 - 2
 - 3
 - 4
 - Other (please fill in number): _____
34. Have you dismissed a resident for academic or ethical reasons within the past 10 years?
- Yes
 - No
35. If “Yes” to the above, how many residents in the past 10 years?
- 1
 - 2
 - 3
 - 4
 - Other (please fill in number): _____
36. Have you had a resident quit your program in the past 10 years?
- Yes
 - No
37. If “Yes” to the above, how many residents in the past 10 years?
- 1
 - 2
 - 3
 - 4
 - Other (please fill in number): _____
38. Do you feel that the current selection process is adequate to have determined potential resident issues before matriculation into your program?
- Yes
 - No
39. Please comment on your satisfaction with the current selection process.
- Very satisfied
 - Somewhat satisfied
 - Neutral
 - Somewhat dissatisfied
 - Very dissatisfied
40. Does your program intend to add (or add more) Integrated/Coordinated pathway residents within the next 5 years, over and above that required to comply with the new RRC mandate on program length?
- Yes
 - No
41. Does your program intend to completely convert to Integrated/Coordinated pathway residents within the next 5 years?
- Yes
 - No
42. What do you do that is different from other programs that is helpful in selecting residents for your program? Where do you see room for improvement? Any other comments?

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