



# CHOICES

The Careers in Medicine newsletter

Association of  
American Medical Colleges

## Volume 3, Issue 1

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## From the Director

Welcome to a new year in medical school! We know you'll soon face challenging career decisions. That's why we created the Careers in Medicine (CiM) program and based it on a well-established theoretical model called person-environment fit. This theory states that people will be more satisfied, productive, and successful if their interests, values, personality, and skills fit the work they do. Research conducted by experts in the field of vocational psychology shows this approach is highly successful in helping students of all ages choose their careers.

Using this theory, we've developed numerous resources to help you plan your career. In fact, some are highlighted here in the *Choices*

newsletter. This issue discusses the recent updates to the Physician Values in Practice Scale (PVIPS) assessment, which satisfies the "person" component of the theory. Our Spotlight on Specialties articles address the "environment" aspect, and in this issue, we paint a picture of general surgery. Then there's advice and guidance in our Ask the Advisor and Match Corner columns to help you find your fit.

If you need more information, visit [www.aamc.org/careersinmedicine](http://www.aamc.org/careersinmedicine) or talk to the CiM contact at your school or your student affairs staff. Good luck this year!

**George V. Richard, Ph.D.**  
*Director, Careers in Medicine*



## Spotlight on Specialties

### General Surgery

Can one person make a difference? You bet—if you become a general surgeon. "You can correct serious conditions, reduce or eliminate pain, and increase the chance to live a long, quality life," says Anthony A. Meyer, M.D., Ph.D., professor and chair of the department of surgery at the University of North Carolina at Chapel Hill School of Medicine in Chapel Hill, N.C.

While surgical subspecialties are increasingly popular, there's an aspect of practice that primarily distinguishes general surgery from surgical subspecialties: the diversity of cases. "I like the combination and breadth of activities: cancer, trauma, abdominal, vascular, and extremity cases as well as the immediacy and

acuteness of problems and the need for intervention," Dr. Meyer says.

General surgeons are involved in every aspect of surgical treatment: diagnosis and preoperative, operative, and postoperative care. And because of the breadth of their interests and capabilities, these physicians have a broader spectrum of responsibility, including frequent emergency call and initial evaluation of trauma.

While the scope of practice is broad, it most commonly involves the abdomen, breasts, peripheral vasculature, skin, and neck. And although general surgeons rarely perform neurologic, orthopaedic, thoracic, or urologic procedures, they should be familiar with other surgical specialties to know when to refer a patient.

#### Training

To prepare as general surgeons, these physi-

cians learn a central core of knowledge common to all surgical specialties: anatomy, physiology, metabolism, immunology, nutrition, pathology, wound healing, shock and resuscitation, intensive care, and neoplasia. They're trained to manage a broad spectrum of diseases and injuries affecting almost any area of the body that can require surgical intervention; as well as to provide comprehensive management of trauma and complete care of critically ill patients with underlying surgical conditions.<sup>1</sup>

"This training opens one's eyes to a multitude of surgical treatments that can radically help patients," says William P. Pannell, M.D., a general surgeon practicing with Surgical Associates, a private rural practice in Cordele, Ga., near Macon. And surgery is necessary because medication can only accomplish so much—but it should only be attempted when we lack other alternatives. "Any medical situation can worsen as the result of an operation," Dr. Pannell says. "So I respect every surgical procedure as being serious and potentially dangerous."

### Relationships

The seriousness of treatment as well as general surgeons' involvement from diagnosis to recovery encourages surgeons and patients to form strong, long-term bonds, says LaMar S. McGinnis Jr., M.D., F.A.C.S., president of the American College of Surgeons in Chicago, senior medical advisor for and past president of the American Cancer Society in Atlanta, and clinical professor of surgery at Emory University School of Medicine in Atlanta. Dr. McGinnis has largely treated cancer patients throughout his career, and the relationship he forms with patients is a rewarding part of his practice.

General surgeons also often form strong bonds with their other surgical team members, who these physicians realize are critical to their success and their patients' welfare. In fact, over the last decade or so, while general surgeons have remained captain of the surgical team, they've more actively shared responsibility for patients' care, Dr. McGinnis says.

"There's little room for large egos and

prima donnas," Dr. Pannell says. "It takes many people to successfully run a surgical practice, which includes managing the increasingly complicated paperwork, scheduling, and most aspects of surgeons' life outside the home."

In the middle of the night, surgeons rely on operating room nurses, scrub technicians, anesthetists, and anesthesiologists to help them salvage the young people in car wrecks, Dr. Pannell says. Without a competent contingent of nursing personnel in the ICU and on the wards, surgeons could never leave patients' bedside. Dr. McGinnis adds, "When the team works together well, there's nothing more enjoyable than executing a successful operation and moving efficiently to the next case."

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— Dr. William Pannell

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### Schedule

Despite the help of the other surgical team members, general surgeons have historically maintained busy, erratic schedules. "General surgeons often have a 24/7 responsibility with less ability to compartmentalize, making finite scheduling more difficult," Dr. McGinnis says. Other factors including location (e.g., urban, suburban, rural), partners (e.g., multispecialty vs. single specialty group or solo), and academic affiliation are distinct variables that compound or simplify the schedule issue. And, Dr. Meyer notes, surgeons often conduct more clinical work than physicians in many other specialties.

"To tackle a surgeon's schedule, you must be an early riser and energetic person," says Dr. McGinnis. When he was in practice, he started his morning with rounds at 6:30 a.m., performed surgery until 2 p.m., then saw patients in

the office until 5:30 p.m., with call every other evening and every other weekend. He says, "It was a good surgical life!"

Dr. Meyer exercises at the wellness center at 4 a.m. so he can attend meetings or start clinical duties between 6:30 and 7 a.m. In addition to performing surgery, serving in the clinic, and managing administrative responsibilities, he also covers in the burn unit. Dr. Meyer generally works 68 hours dispersed through a 7-day workweek, with evening meetings, recruitment events, additional call, and other special activities adding more hours as required.

Dr. Pannell, who works with two younger partners, maintains a more consistent workweek. He spends two days each in two office locations and two days performing elective surgeries between two hospitals, leaving one day free and totaling 55–60 hours worked per week. Last-minute elective procedures, emergencies during on-call evenings and weekends, and hospital rounds can add more hours.

Can surgeons experience the balance of work and personal time increasingly preferred by younger physicians? Stephanie Pannell, daughter of Dr. William Pannell and a first-year general surgery resident at Atlanta Medical Center in Atlanta, reports favorable news: In her lifetime, she's witnessed the field of general surgery and her father's work schedule evolve.

Dr. Pannell, who plans to practice in a rural community like her father, says surgeons are no longer expected to sacrifice personal life and family for work. As a child, she was told she must choose between being a mother and being a surgeon. But more recently, she's "met great mothers who are also successful surgeons."

### The future

To address younger surgeons' demand for a more balanced life and provide more efficient, effective patient care, Dr. McGinnis anticipates multi-specialty private practices will replace single-practice surgeons. Also, "community hospitals

realize that without surgical services, their capability for treating patients is tremendously reduced,” Dr. William Pannell says. “Accordingly, they’ve realized to attract young surgeons, they must be more accommodating.” Dr. Meyer’s concern: As general surgeons are granted fewer, more predictable work hours, the general public will lack physicians who can provide urgent and emergent services.

Well, unfortunately, the public is already on track to suffer: The number of general surgeons has decreased by about 26 percent over the last 25 years, making general surgery one of the fastest-decreasing disciplines in medicine.<sup>2</sup> So the field of general surgery is poorly positioned as the overall physician shortage emerges. In addition to younger physicians’ demand for more reasonable workloads and schedules, several other factors are helping to create this perfect storm, with good and bad news accompanying each:

**The aging population.** The bad news: The growing segment of the population age 55 and older means more physicians retiring while more physicians are needed for this group who requires more care—especially care provided by general surgeons.

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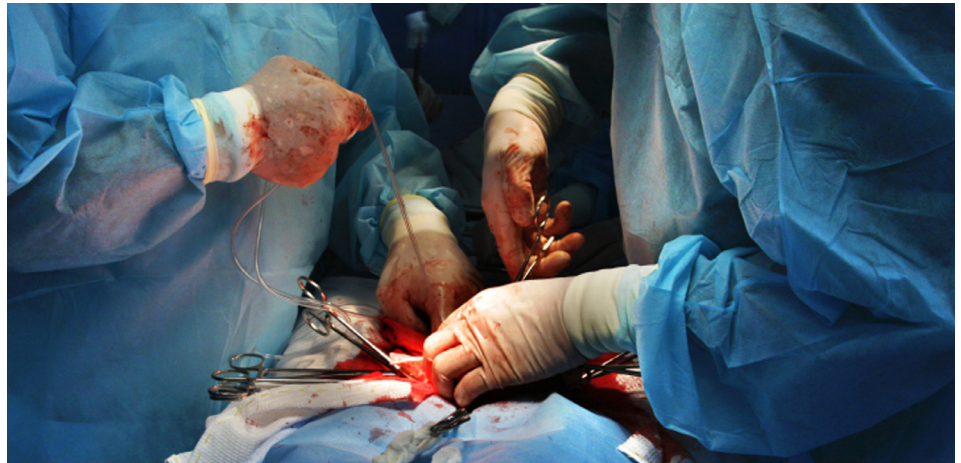
*Any medical situation can worsen as the result of an operation, so I respect every surgical procedure as being serious and potentially dangerous.*

— Dr. William Pannell

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The good news: Dr. Pannell says a swell of physician positions will open, which is great for those currently finishing their residencies.

**Limited candidates.** The bad news: Graduate medical education funding for residency slots provided by the federal government has plateaued at \$9.5 billion since the Balanced Budget Act of 1997 (P.L. 105-33), when Congress capped the number of Medicare-supported residency slots.



The good news: Congress has recognized our country’s need for more physicians and included two initiatives in the recent health care reform legislation aimed at addressing the physician shortage. One provision requires redistribution of 65 percent of unused residency slots (which, at most, amounts to fewer than 1,000 positions yearly) and 75 percent of those slots must be designated for general surgery or primary care residents.

“This provides teaching hospitals the resources to add general surgery residents to their program,” says Leonard Marquez, director of government relations at the AAMC. “It’s a drop in the bucket regarding the overall physician shortage, but it’ll help until the cap on the number of residency slots is increased.”

**A trend to subspecialize.** Over the last 10 or so years, many subspecialties have emerged, including minimally invasive, gastrointestinal, oncology, bariatric, and endocrine surgery. And in some locales, “general surgery” has narrowed to “acute and emergent surgery,” Dr. Meyer says.

The bad news: Simultaneously, general surgery residents have increasingly subspecialized. Dr. McGinnis says about 700 of 1,000 residents used to enter general surgery and 300 would enter fellowships—but now, it’s flipped.

The good news: The methodology of reimbursement has driven this trend, but the situation is changing: Congress’s other initiative in the recent health care reform legislation provides general surgeons increased CMS payments.

“Overall, I see excellent opportunities for physicians and surgeons to practice. Our citizens will not allow health care to deteriorate—they’ll insist it become more accessible,” Dr. Pannell says. “Potential shortages and rumors of government takeovers should not and cannot destroy the dream of becoming a medical doctor.”

#### Advice for students

If it seems general surgery might be the specialty for you, Dr. Pannell says you should maximize your years of basic medical education because they’re the foundation for your career. Also gain practical experience in the operating room, whether that’s serving as a technician or cleaning up, Dr. McGinnis says. “But enjoy your training—it’s likely the time you’ll have the least distractions.”

Additionally, Dr. Meyer says general surgeons must commit themselves to continually develop to become the best clinician possible, which will require adapting to the rapid technological and other changes common in the surgical field. Commitment to professional development should begin when students first consider general surgery for their specialty.

Students should possess or develop the abilities to focus and make quick decisions, Dr. McGinnis says. And surgeons must have exceptional manual dexterity and hand-eye coordination, although some surgeons enter practice without it—either they didn’t know they needed it or didn’t realize they lacked it. But, Dr. Pannell says, “The truth is, most

of us can't sign our name legibly." Luckily, "most operative skills can be mastered with time and practice." And while procedural skills are important, Dr. Meyer says, "Ninety percent of surgery involves your head, not your hands."

Additionally, Dr. Pannell offers students this advice:

**Be willing to work.** "My colleagues and I have devoted our life to general surgery. And only when you demonstrate a similar degree of interest will we be willing to really teach you and, more importantly, recommend you for or accept you into a general surgery program," he says. Students who come early and interested, are always available and ready to help, and can relate easily to the other members of the health care team will be noticed, he says.

*Overall, I see excellent opportunities for physicians and surgeons to practice. Our citizens will not allow health care to deteriorate—they'll insist it become more accessible.*

— Dr. William Pannell

**Be empathetic.** Invariably, when difficult surgical decisions are required, a patient or a member of their family will ask you what decision you'd make. Answer honestly.

**Remain calm and in control** no matter how difficult the situation. "Be prepared. Know where things are. Know the people you work with and what they can do," Dr. Pannell says. "When you lose your composure, everything around you will crumble."

**Be aware you're fallible.** Accept that you can make a mistake and that something possibly went wrong with the procedure you just performed. "I've heard many stories about patients dying in recovery because the surgeon was convinced ongoing bleeding was impossible and later, realized the patient bled to death," he says. "When something goes awry, first ask 'What could I have done wrong?'"

"General surgery can be demanding and challenging. Multiple people need you simultaneously, and time pressures compound that," Dr. Meyer says. "At the same time, it's most rewarding because you can make a huge difference—not just to your patients, but in other ways too."

Dr. Stephanie Pannell offers her perspective. "Dismiss the stereotypes about lifestyle and any hesitancy about length of training," she says. "It'll definitely be worth it if you stick with it and love it."

Dr. McGinnis agrees. "I wish I could fully convey the joy of being a surgeon ... I have felt great satisfaction doing the actual work, developing relationships with patients and their family, as well as working with the full surgical team and other medical and professional staff. I cannot imagine a better, more satisfying life."

For more information on practicing general surgery, visit

- American College of Surgeons  
[www.facs.org/medicalstudents](http://www.facs.org/medicalstudents)
- Association of Women Surgeons (check out the free Pocket Mentor)  
[womensurgeons.org/Students/Students.asp](http://womensurgeons.org/Students/Students.asp)

#### Kelly K. Stazyk

*Communications Specialist, Careers in Medicine*

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## General Surgery by the Numbers

Number of practitioners in United States<sup>3</sup>  
31,634 in 2008

### Match Data/Competitiveness<sup>4</sup>

- Of 1,077 PGY-1 positions offered in the 2010 Match, approximately 895 or 83.1% of those are filled by U.S. seniors
- Number of total applicants for PGY-1 positions: 2,241
- Number of U.S. applicants for PGY-1 positions: 1,262

### Mean USMLE Step 1 Score<sup>5</sup>

U.S. seniors matched: 224  
U.S. seniors unmatched: 207

### Mean number of programs ranked<sup>5</sup>

U.S. seniors matched: 10.7  
U.S. seniors unmatched: 5.7

### Compensation

*For clinical practice positions<sup>6</sup>*

1-2 years in specialty  
Median: \$277,557

All physicians  
Low: \$260,056  
High: \$412,798

*For academic medicine position<sup>7</sup>*

Early career  
Low: \$201,000  
Median: \$243,000  
High: \$302,000

Mid to late career  
Low: \$248,000  
Median: \$313,000  
High: \$396,000

### Residency and Training Requirements<sup>8</sup>

Total residency length = five years

National Resident Matching Program/Association of American Medical Colleges; 2009.

6 Medical Group Management Association. *Physician Compensation and Production Survey: 2009 Report Based on 2008 Data*. Englewood, CO: Medical Group Management Association. 2009.

7 Association of American Medical Colleges. *Faculty Salary Survey, 2007-2008*. Washington, D.C.: Association of American Medical Colleges.

8 Accreditation Council for Graduate Medical Education. *ACGME Program Requirements for Graduate Medical Education in Surgery*. ([http://www.acgme.org/acWebsite/downloads/RRC\\_progReq/440\\_general\\_surgery\\_01012008\\_u08102008.pdf](http://www.acgme.org/acWebsite/downloads/RRC_progReq/440_general_surgery_01012008_u08102008.pdf)). Revised August 2008. Accessed July 22, 2010.



## Match Corner

## Tips for Communication with Residency Programs

If you see fourth-year students incessantly checking their e-mail and phones, interview season has arrived. If you are one of those fourth-year students, you know how anxious you can feel waiting for an interview invitation from your top residency program.

### Responding to interview invites

Residency programs can begin downloading and reviewing applications from the Electronic Residency Application Service (ERAS) on Sept. 1. Some programs get a jump on the candidate pool and start offering interviews soon thereafter, while other programs wait.

Invitations to interview begin arriving in early September and continue through late November—the timing largely dependent on the program's process and number of applications received. How much a program values the Medical Student Performance Evaluation (MSPE, formerly known as “the Dean's letter”) also affects interview decisions. Since the MSPE isn't released until Nov. 1, some programs wait for its release to begin offering interviews.

If being fashionably late is part of your life strategy, you may need to change philosophies for this process. The earlier you complete your application, the earlier you can receive interview invitations.

When you receive an invite, respond promptly because only one or two interview dates may be available. Many programs invite more interviewees than there are slots, so don't wait to get in touch. In general, the earlier you respond, the more options you'll have. And your interview really starts with your first contact, so be professional and courteous in all communication.

### Scheduling interviews

Interview season usually lasts from October through January, and many students express concerns over how to order their interviews. There's lots of

advice out there, but common wisdom encourages scheduling programs you're less interested in first so you'll get some practice. Then schedule your most crucial interviews in the middle of the season before you're weary of the process. However, as competitive as the residency application process has become, there's no such thing as a “practice interview” once you get on the interview trail. Treat every interview as important.

The best advice is to do what works with your schedule and fret less about the timing, which is often out of your control. “Some believe the last person interviewed will be the person first remembered,” says Michael G. Kavan, Ph.D., associate dean for student affairs at the Creighton University School of Medicine in Omaha, Neb. “Although there's certainly some truth to this, if you're prepared and professional, people will remember you whether you interview in October or January.”

*If you're prepared and professional, people will remember you whether you interview in October or January.*

— Dr. Michael G. Kavan

Schedules change, conflicts arise, or you (hopefully!) get more interviews than you need. Canceling and rescheduling interviews is part of the process for programs. If you need to cancel or reschedule, do so as soon as possible—preferably two weeks in advance. A brief e-mail or phone call is fine. Canceling with less than a week's notice should be limited to cases of true emergency, such as a death in the family. And canceling at the last minute or being a “no show” is an absolute no-no. You're taking an interview slot from someone else and wasting the time program faculty and staff spent preparing for your visit. You also give your own institution a bad reputation with that residency program.

### Post-interview contact

Plenty of articles and guidance are available to help you in the interview itself, so we won't cover that here (see the “Getting into Residency” section on the CiM Web site or numerous articles in previous issues of *Choices*). Rather,



let's fast-forward to a brief discussion about post-interview communication. As Dr. Kavan notes, your communication skills can help you stand out—positively or negatively.

The first, often-debated issue is whether to send thank-you notes. Some program directors and faculty pay them no attention, while others expect to receive them. And some programs use thank-you notes to gauge applicants' interest.

So Dr. Kavan recommends sending thank-you notes to the program director, key faculty, and residents with whom you interviewed. Personalize your notes: use the interviewer's name and highlight important points that remind the interviewer of your time with him or her. “You don't have to say where you intend to rank their program, but make sure the recipient knows you're interested,” Dr. Kavan says.

Another confusing aspect of post-interview communication is the “love fest” phone calls and e-mails you may receive. Some programs will contact you following the interview and say ever-so-flattering things: how much they enjoyed speaking with you, what a great addition you'd be to their program, or even their intent to rank you to match. While certainly exciting to hear, these sentiments don't guarantee you a place on anyone's rank list. Applicants tell program directors what they want to hear. And, likewise, program directors tell applicants what they want to hear.

The best advice will always be to rank programs based on your true interests and chalk the rest up to human nature. And don't fret if you hear nothing from a program—“nothing” is exactly what it means. Many programs don't provide feedback, but rather let the rank list speak for itself.

**Jeanette L. Calli, M.S.**

*Program Manager, Careers in Medicine*



## Ask the Advisor

We know you have questions, so we went to the experts for answers. This column features experienced faculty advisors and student affairs professionals answering questions about choosing a specialty, applying for residency, and any other career-related concerns you may have. In this issue, we consider the importance of board scores in the residency application process and the perils of switching your specialty during residency.



**Dear Advisor,**  
**How important are board scores, and how are they used in the residency application and interview process?**

Board scores open doors. In all specialties, board scores matter to some degree. In most specialties, residency program directors use board scores as a screening tool for narrowing the pool of applicants. A strong Step 1 score will often compel the program director to review your application more thoroughly and consider you for an interview.

However, in many highly competitive specialties such as dermatology, radiology, otolaryngology, ophthalmology, orthopedic surgery, neurosurgery, and plastic surgery, a high Step 1 score is required to survive the initial cut and be considered for an interview. Since competitive programs rarely list absolute threshold

scores for considering your application, study hard to achieve the highest board scores possible. It should go without saying the higher your Step 1 and Step 2 scores, the higher your overall chance for passing the initial screening and eventually matching into your preferred specialty.

*A strong Step 1 score will often compel the program director to review your application more thoroughly and consider you for an interview.*

Regardless of a specialty's competitiveness, researching the competitive range of scores will help you grasp how you compare. The joint AAMC and NRMP report "Charting Outcomes in the Match: Characteristics of Applicants Who Matched to Their Preferred Specialty in the 2009 Main Residency Match (3rd Edition)" ([www.aamc.org/publications](http://www.aamc.org/publications)) is an outstanding resource. An excellent starting point is Chart 6: USMLE Step 1 Scores of Matched Applicants, which indicates the median score and range of scores for applicants who matched by specialty. Note Chart 6 shows the range of scores for applicants excluding the top and bottom quarters of the distribution, so some students did successfully match with higher or lower scores. Consider these ranges a "safe zone"—that you're a competitive applicant if your scores fall within the range.

Then, review the specific tables for the specialties you're considering. If your score is at or near the unmatched (or low) end of a particular specialty's range, it doesn't mean you should rule out that specialty. What it does mean is your chances for getting an interview and therefore matching into that specialty are lower. So you should apply to many and a range of programs to raise your chance of earning an adequate number of interviews within the specialty. And please create a robust Plan B (i.e., a back-up specialty choice) in the event you fail to match into your preferred specialty.

Once you're invited for an interview, board scores are less important. Another report, "Results of the NRMP 2008 Program Director Survey" ([www.nrmp.org](http://www.nrmp.org), also available on the CiM Specialty Pages), as well as other excellent resources identify factors program directors consider in the application and ranking process. Factors including grades in core clerkships, participation in visiting clerkships, research, and letters of recommendation as well as your interview largely determine your final ranking by program directors. Passing Step 2 CK and CS are also important as this accomplishment indicates to program directors the candidate is highly likely to also pass Step 3 and earn licensure during the first year of residency.

So scores open doors. Understanding how you compare to previous applicants allows you to plan your future realistically. Do your research, and know what other experiences and accomplishments lead to success in your preferred specialty and strengthen your candidacy in these areas. Plan carefully, consider all possible alternatives, and always have a back-up plan.

**Patricia A. Barrier, M.D., M.P.H.**  
*Associate Dean for Student Affairs  
 Mayo Medical School*

**Dear Advisor,**  
**I am trying to decide on a specialty and hope to make the right decision. But in case I don't, how difficult is it to switch specialties during residency?**

Current data on how often residents switch specialties is hard to find. Historically, 10-15 percent of medical school graduates switched specialties.<sup>1-3</sup> Now, about 70 percent of residents complete the program they initially enter, says Gwen Garrison, Ph.D., director of student and applicant services at the AAMC. The remaining 30 percent either switch from their intended specialty after a transitional or preliminary year or switch outright during their specialty residency. While residents in transitional or preliminary year programs are often unsure about their future specialty,

making the true number of residents who switch murky, this data still suggests switching specialties is more common than I initially suspected.

Among other reasons, residents primarily switch because they a) realize their initial choice is not as interesting as another specialty, or b) desire a different lifestyle, level of flexibility, or income. Residents have discussed with me the difficulties they faced when considering switching specialties. One resident who switched from a surgical specialty to radiology put it nicely when he said, “During medical school, you pick a residency and the assumption is that it will be your life. But you make a decision based on your ideal of a specialty, and sometimes the reality is quite different. Since you’re already on this predetermined path, you feel trapped. But you aren’t.”

And while you’re not trapped, the decision to switch is a serious one. So pursuing a different specialty can be stressful for several reasons.

One reason: others’ reactions. In particular, residents worry their current program director (PD) will view them as a traitor or be unsupportive during their transition to a different program. They worry the PD in their new specialty will view them as indecisive or immature. And they feel guilty that they may be letting their fellow residents and faculty teachers down.

Another reason: self-doubt. Residents worry whether the new specialty will live up to expectations and whether they’re making the right decision to switch.

Last, there are the logistical difficulties of switching programs. Residents worry whether switching programs will add time to their training.

However, reactions from fellow residents and faculty teachers are often better than imagined. In speaking to PDs, their main concern is the resident’s well-being and whether he or she has put enough time and energy into their new decision.



“I challenge them to think through their reasoning and motives for wanting to change based on a long-term life plan,” says Kelly Leite, M.D., program director of the pediatrics residency at the Penn State Hershey Children’s Hospital in Hershey, Pa. “I don’t view it as a betrayal or failure—more a near miss in that the learner realized which specialty they truly want to pursue a little later than others. Ultimately, I see it as a success for them.”

And while it’s important to try to get it right the first time, it’s not the end of the world—or your medical career—to switch specialties. However, if you do plan to switch, consider these points:

- Research your new specialty.
- While you don’t have to defend your decision, be prepared to explain it.
- Try to get credit for time served. Some programs will give you credit for your internship year, thereby minimizing the additional training time in your new specialty.
- View your fellow residents and PD as allies, not enemies. Most PDs are supportive, and you may need their letter of recommendation.
- Honor your commitment. Even if you’re leaving a residency, remember

you signed a contract and are obligated to work hard in that program.

- Review the NRMP Match Agreement at [www.nrmp.org](http://www.nrmp.org) and the AAMC publication “Medicare Payments for Graduate Medical Education: What Every Medical Student, Resident and Advisor Needs to Know,” available at [www.aamc.org](http://www.aamc.org) under Publications.

#### **George F. Blackall, Psy.D., M.B.A.**

*Professor of Pediatrics and Humanities, Director of Student Development, Penn State College of Medicine; Lead author of “Breaking the Cycle: How to Turn Conflict into Collaboration When You and Your Patients Disagree.”*

**Have a question you want our panel of experts to address? Send your queries to [careersinmedicine@aamc.org](mailto:careersinmedicine@aamc.org) and put “Ask the Advisor” in the subject line.**

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## CiM Toolbox

### PVIPS Update

You want to help underserved communities or find the next big cure. You want to be a great doctor and have a life too. You want to be paid well. These statements are just a few examples of how values can be reflected in your career as a physician. And while all of these ideals may sound appealing, you'll likely focus your efforts to achieve those most important to you.

Your values influence your decisions and, consequently, your experiences. We choose to include specific people, places, and things in—or exclude them from—our life. Have you noticed what attracts you to a group, environment, or activity? Whether you chose them consciously or subconsciously, they likely reflect your values.

*Your PVIPS scores will best help you determine how you want to practice in your chosen specialty, rather than decide what specialty to choose.*

The Physician Values in Practice Scale (PVIPS) is how we help you understand your core values as they relate to your career in medicine. The PVIPS measures six values found to be important among medical students: Autonomy, Management, Prestige, Service, Lifestyle, and Scholarly Pursuits (see Value Definitions). The assessment uses your responses to 60 statements to identify how you prioritize these values. A report is generated that you can use to compare various environments and activities in medical practice, so you can explore those that most reflect your values and may lead to greater satisfaction in your career.

The PVIPS's recent updates help you do this even better. First, our research

yielded new subscales: Schedule, Work/Life Balance, Research, and Teaching, which describe more specific activities within the Lifestyle and Scholarly Pursuits scales. If these values are important to you in your career, you may prefer the environments and activities of a particular subscale.

#### Bonus Feature

We've made it easier to share your assessment information by enabling you to e-mail, save, and print recent versions of your PVIPS and MSPI-R reports as PDFs. Read these assessments' FAQs for more information.

Our research showed little differentiation among individual specialties by value; meaning physicians across specialties have a varying mix of values. But, with this update, we're able to identify trends in values among specialty groups (e.g., primary care, surgical, and support specialties). For instance, and not surprisingly, students who entered residency in primary care specialties generally scored Service highest. And students who later started residency in surgical specialties generally scored Prestige highest. But it's important to understand that while certain values may be slightly more prominent in one specialty group over another, you can find environments and activities that reflect your values in any specialty.

In your PVIPS results, you'll see your scores for each of the six values, indicating your priorities and offering examples of work settings and activities that reflect those values. Your scores will best help you determine how you want to practice in your chosen specialty, rather than decide what specialty to choose. Specifically, use your scale and subscale scores to determine the work environments (e.g., a research-intensive or community-based hospital) and activities and tasks (e.g., providing medical care to the underserved, serving on community boards) you prefer. The

information provided in the report can guide you as you explore your options.

The best approach to choosing your specialty and planning your career is to consider your PVIPS results with information from other tools in the CiM program. The Medical Specialty Preference Inventory, Revised Edition (MSPI-R) helps you identify your interests in medicine and indicates the likelihood you'll enter each of 16 major medical specialties. And the Specialty Pages offer quantitative and qualitative data about more than 120 specialties. Many students use the Specialty Pages to start researching specialties and exploring their fit.

When used together, these tools can paint a detailed, comprehensive picture of you and the medical career you envision. Bring your PVIPS results and any other information you gather to an advisor or mentor to get their feedback. If you do, you're on your way to making sound, well-informed career decisions.

**George V. Richard, Ph.D.**

*Director, Careers in Medicine*

#### Value Definitions

- **Autonomy:** Freedom, independence, and control over clinical decision-making; opportunities to work creatively
- **Management:** Supervision, leadership, and administrative responsibility
- **Prestige:** Recognition, social status, and financial compensation
- **Service:** Caring for and contributing to the welfare of others; working with community services
- **Lifestyle:** Hours worked; call schedules; work demands; and time for leisure, family, and friends
  - **Schedule:** Work demands, regular work hours, and call schedule
  - **Work/Life Balance:** Time for personal, leisure, and social activities
- **Scholarly Pursuits:** Research, teaching, and scholarship
  - **Research:** Conducting research, writing or editing for scholarly journals
  - **Teaching:** Teaching and working in a medical school as faculty or staff