Implementing AAIM Internal Medicine Structured Evaluative Letter Guidelines Frequently Asked Questions

The Residency Match is a pivotal and challenging transitional period with many stakeholders. Its process requires both transparency and a commitment to equity, ensuring the medical education community's commitment to society to train physicians who can competently care for a diverse population and advocate for improvement in health outcomes. Recently, the Coalition for Physician Accountability (CoPA) recommended sweeping changes to address the challenges in the UME-GME transition. These recommendations included utilizing Structured Evaluative Letters (SELs) as the "universal tool in the residency application process".[i]

What is the rationale for SEL implementation and use?

An SEL can balance the desire of medical schools and letter writers to advocate for clinical competencies and professional skills not assessed on standardized exams. It can further provide residencies with a more holistic view of an applicant's possible strengths and areas of growth, resulting in an appropriate learning and working environment as well as establishing a more reliable handoff tool.

Since a Department of Medicine (DOM) SEL (will be referred to hereafter as IM SEL) contains standardized national assessment data, local data, and information on the cognitive and non-cognitive skills that are important to professional development, the IM SEL could be the most useful tool to advocate for the skillsets of an applicant and prepare program directors (PDs) for resources a learner might need when they match to a program. Using the comments sections to contextualize numerical data with background information allows for a more complete story.

A 2019 survey of Internal Medicine program directors indicated a dissatisfaction with the current state of DOM Summary Letters.[ii] Furthermore, a recent review of Department of Medicine Letters identified areas for improvement, including clearly defined data on student performance, standardized and common descriptive language, and consistent information about the clerkship and sub-internship experiences.[iii] Emergency Medicine (EM) has utilized a standardized letter, termed Standardized Letter of Evaluation (SLOE), for over 20 years in their application process. Data from emergency medicine's experience with their SLOE shows that over 99% of EM PDs believe that the SLOE is an important evaluative tool, which is a substantial improvement over the current Internal Medicine DOM Summary Letters.[iv] As part of the AAIM recommendations for the 2020-2021 Main Residency Match in Internal Medicine, the DOM SLOE was introduced as a replacement for the IM Departmental or Chair letter and specifically addressed areas of improvement mentioned in the publications above.[v]

What are the major differences between the 2020 DOM SLOE and the new IM SEL?

Incorporating feedback from key stakeholders and in-line with CoPA recommendations, the revised IM SEL, to be used in the 2022 Main Residency Match, has been updated to include competency-based language reflective of the ACGME Milestones 2.0. Additionally, the revised SEL removed comparative ratings, including overall ranking through code word or numerical means. The use of criterion-references grading, rather than normative or comparative grading, provides transparency regarding the level of performance and can mitigate bias.[vi]

A residency advisor or a residency advising committee can further advocate for applicants by exploring career interests, learning styles, and directing applicants to programs that have compatible missions, career and mentorship opportunities, and learning environments conducive for their personal and professional growth.

Should all Letters of Recommendations (LoRs) be replaced by SELs?

The AAIM IM SEL is the recommended template for the Internal Medicine Chair/Department letter and can be adapted to accommodate candidates whose institutions do not provide these types of references. While AAIM and other disciplines work to augment their respective SELs, LoRs should not be eliminated as they can provide a balanced and in-depth perspective on a trainee that may not be represented in assessments or grading. Until other UME to GME transition materials allow for holistic review, AAIM recommends that LoRs remain in place.

Which IM applicants should receive an IM SEL as part of their application packet? Do preliminary medicine candidates require an IM SEL?

All applicants who are applying to categorical internal medicine or categorical internal medicine combined residency programs should have an IM SEL submitted as part of their application. Preliminary programs differ across programs in their requests for LoRs, some previously preferring a DOM Summary Letter and some with no listed preference. Further, medical schools vary widely on whether they provide DOM Summary Letters for preliminary applicants, given limitations in data available to supplement the MSPE. Last year, considering the pandemic's impact, AAIM recommended limiting letter requirements for preliminary medicine candidates to two letters: 1 clinical letter of recommendation from an internal medicine faculty member and 1 clinical letter of recommendation from any specialty faculty member.

Currently, there is not enough data to recommend for or against an IM SEL or a departmental letter for preliminary medicine applicants and would leave this decision up to the preliminary medicine applicant's school. AAIM will consider future surveys to determine what could be useful information to preliminary IM PDs when reviewing applicants and will compare outcomes for preliminary applicants whose application included a standardized letter and those who did not.

How do we promote full disclosure among all institutions while ensuring that we do not harm our own institution's applicants?

Letters that provide more data will benefit applicants and will be viewed as trustworthy sources than

those letters which provide less data. Schools or letter writers that provide less data harm the competitiveness of their applicants compared to those that provide more data for residency programs to complete a more holistic review. Further, providing more data may benefit an applicant by allowing residency programs to incorporate clinical strengths and areas for improvement when building residency schedules and learning plans at the very beginning of the UME to GME transition. For example, if an applicant struggles with standardized test taking and schools are not transparent with standardized test grades, a resident may lose that growth opportunity as their need for test-taking coaching may not be revealed until halfway through the intern year, after the results from their first in-training exam.

How do program directors utilize Department of Medicine/Chair letters when reviewing applicants? What features of the letter (present or omitted) are worth noting?

Currently, every IM residency program has an individualized approach to reviewing departmental letters. This is out of necessity as there is significant variability in the content and structure of departmental letters across the country, leading to the inefficacy of comparing students from within the same institution and across institutions. This forces reliance on readily comparable measures, such as standardized test scores. The IM SEL offers a concise, holistic description of an applicant's abilities in IM-specific contexts, including an opportunity to comment on sub-internships which often are omitted from MSPEs or working environments if the learner has already graduated from an international medical school. Program Directors are looking for information to determine whether an applicant would thrive in their program's working environment and add needed diversity to fulfill the program's missions. By presenting specific data in a standardized and structured format, the proposed IM SEL would, in turn, enable a standardized and structured review of an applicant. Program Directors could then use this time to put their efforts into a focused review of a larger pool of applicants.

Many program director surveys have emphasized the desire for more quantifiable data on non-cognitive attributes, rather than purely cognitive qualities, to perform a more holistic review. At this time, current assessment systems in both allopathic and osteopathic schools may not be robust enough to divide students into discriminating categories for each of the non-cognitive attributes recommended in the IM SEL template. Furthermore, students on IM courses are in much more formative stages of their training, and education leaders have less time observing these competencies than their residency program counterparts, making a normative comparison possibly fraught with bias. Devising assessments for these non-cognitive attributes and focusing on ways to report these qualities in a meaningful way will be an area where AAIM can continue to create equitable evaluations through collaboration across schools, programs, and the educational spectrum. A shared mental model of competence was recommended by the CoPA UME-GME Review Committee (UGRC), as a lack of transparency in the MSPE is a persistent concern among program directors: "Shared outcomes language can convey information on learner competence with the patient/public trust in mind."[vii] The use of ACGME Internal Medicine Milestones 2.0 language to describe IM qualifications is a move toward a common language that is relevant to Internal Medicine, including patient care, teamwork, and communication skills. Milestones-based assessment can be used by letter writers for both international and US medical graduates and focuses on the learner's growth across the professional continuum.

How will program directors weigh SELs against other traditional DOM letters?

Ideally, a letter in any format would contain the same information, and applicants would be ranked

based on the program's clinical and academic missions. If letters in the IM SEL format contain more information than a traditional letter, program directors will be able to make better-informed decisions about an applicant. The components and structured nature of the IM SEL will allow PDs to perform holistic reviews of applicants more efficiently. More efficient reviews may have the benefit of curtailing program directors' current use of ERAS filters to narrow the number of files to a manageable review. Anecdotally, program directors found the DOM SLOE to be easier to navigate and interpret compared to the traditional Departmental/Chair letter, in large part due to the organized and streamlined format. Specific details about the learning environment along with details regarding a learner's roles, responsibilities, and patient loads were noted to be particularly helpful to program directors when reviewing. Written comments that specifically contextualize performance curtail inferences a program director may draw. The invitation to detail non-cognitive attributes, including altruism and intrinsic motivation, serves to highlight important characteristics of an internist that may not be explicitly stated in a traditional department letter.

For schools with pass/fail grading systems (with or without additional ranking data made available to those writing the SEL) what recommendations can you give to make the SEL most useful?

If your school has a pass/fail grading system, the IM SEL will become an important evaluative tool. Reporting an applicant's competency in the IM *Qualifications* section will provide transparency for program directors to ascertain the sub-competencies that are most important to the program's learning environment. Including performance on the separate assessment components included in IM course grades and the overall distribution of scores for a specified cohort will be particularly helpful to provide needed context.

What is the best way to provide a template letter of recommendation when we have some students whose clerkships were impacted by COVID and some whose clerkships were not impacted?

Similar to the MSPE recommendations, the IM SEL provides a section to comment on how a student's IM experience may have been affected by COVID. AAIM recommends separating the cohorts and reporting on the competencies for which data exists. Describe any differences between the clinical experiences and assessment methods.

At my institution, we send students to 11 different campuses, and I have not worked personally with them. How can I choose a ranking for multiple different categories without direct observation?

Ensuring your evaluation forms contain questions directed to the specific IM qualifications, if not currently done, will be incredibly important. Qualitative information, perhaps even more than quantitative, could be helpful in selecting the appropriate anchors, as well as giving context to observed behaviors within each domain.

In addition, the creation of a Residency Advising Committee to discuss the process by which the rankings are selected and to craft the IM SELs would be an ideal foundational practice. Deliberate attention should be made to include site directors or other faculty who have worked with various students and IM clerkship directors (CDs). As interprofessional skills are essential for quality care

and teamwork, the committee will want to include an attending's direct observation of this. As such, ensure the committee is diverse and require bias training to mitigate explicit and implicit bias.

For allopathic and osteopathic programs that do not have a Residency Advising Committee process or for international medical graduate (IMG) letter writers, IM SEL authorship or responsibility will need to be adapted to fit the individual or institution's process. Details of authorship should be indicated in the IM SEL section, *Statement of Letter Preparation*. The IM SEL can be completed by an individual observer when a committee is not feasible or practical. Details of authorship should include relationship duration and the contact nature with the applicant (e.g., advisor, direct observer, indirect observer, etc.).

How are you rating your students' communication and teamwork skills?

Through narrative observations and quantitative data obtained from faculty/resident evaluations on all IM-specialty courses – including electives, performance within IM Clerkships, IM Electives, and other IM department activities that include the residency advising processes. SEL letter writers should also include observations of interprofessional and executive work, to provide the administrative team's perspective. Further, informing students prior to their rotations how observations and data will feed into the IM SEL is important in providing transparency.

Should shelf examination scores be part of the IM SEL? If we have shelf cut off scores for high satisfactory and honors, is that enough?

Including the shelf score is one piece of a student's story in taking standardized medical exams. It can be a way to illustrate improvement in test-taking skills, even if a student does not become an above-average test taker. It can also communicate to a program the learner's need to spend more time studying for the IM board exam during their residency training, an important handoff in the UME to GME transition.

The variability of each school's approach to and reporting of grading forces PDs to spend much more time interpreting the data and making assumptions when data is not presented clearly. When multiplied over thousands of applications, this reporting forces a system to become more reliant on objective data and filtering rather than holistic review.

Schools that provide shelf data could improve the UME to GME transition and can help advocate for the needs of a learner. Whenever cut-off scores are required to achieve a particular grade, this should be detailed.

How do we adapt our metrics (since models and processes differ widely) so that they can be integrated into the SEL and avoid disadvantaging our applicants?

As the standardized letter was introduced just this past year, many US allopathic and osteopathic schools are not yet currently structured to produce all the information sought in the IM SEL; you are not alone. It is acceptable and understandable if certain components of the SEL cannot currently be provided. This is a new document with room for enhancements, and widespread adoption will take time. In fact, for osteopathic and IMG applicants, the IM SEL can allow for more equitable and direct comparison in specific skills important in IM residencies.[viii]

Succinct descriptors of your assessment process, how your metrics are produced, and how you grade your students will assist in the holistic review process. It is acceptable, if not representative, to employ different metrics so long as the data illustrates the learner's performance. Also desired is information about non-cognitive skills specific to a career in Internal Medicine. Above all, IM SELs that provide more data will benefit applicants and will be viewed as a more trusted source.

What changes are anticipated for the future of SEL?

Regarding the *Qualifications for IM* section, a large portion of students typically receive very high scores on Clinical Performance Assessments (CPAs) for questions that would reflect Teamwork/Accountability. Incorporation of Milestones 2.0 with reporting of frequency achieved in IM-specific contexts is a step in the direction of a shared language between UME and GME.

AAIM anticipates the greatest amount of process change will occur in the IM *Qualifications* section. As each letter writer works to adopt the SEL and as PDs review incoming SELs, sharing what they have found helpful when completing and/or utilizing the *Qualifications* section, what they have found to be meaningful and reliable ways to handoff the information, and suggestions on collaborative and improved ways to communicate these important skills of an internal medicine physician would be extremely helpful.

For the benefit of IM SEL authors, what would be the most critical elements of the IM SEL to adopt if modifications cannot be implemented at this time?

- Data on grade/assessment component distributions and where the applicant fell within the distribution, if available.
- Settings and responsibilities of the IM rotations that the applicant did complete and any COVID-specific changes.
- IM *Qualifications* Section if you have current reliable data.

How can a residency program encourage the adoption of the IM SEL?

Updating the IM program residency website with your program's specific preferences for types of DOM letters and providing details on the minimum and maximum number of LoRs that will be reviewed would facilitate the utilization and uptake of the IM SEL and provide clarity to applicants and residency advisors.

Our chair has not interacted with the students. Is a co-signature necessary for the IM SEL?

All schools approach this differently. Some allopathic and osteopathic schools may not have a Department of Medicine. Currently, most departmental letters are written by the clerkship director or a residency advisor, and chairs review and sign the letters without necessarily meeting the student. Some chairs like to play more active roles. Chair meetings are not required for the completion of an IM SEL.

Whom can I contact if I have other questions?

Please contact the AAIM IM SEL Guideline Writing Group Co-Chairs Reeni Abraham, MD (reeni.abraham@utsouthwestern.edu) or Susan Lane, MD (susan.lane@stonybrookmedicine.edu).

References

[i] https://physicianaccountability.org/wp-content/uploads/2021/04/UGRC-Initial-Summary-Report-and-Preliminary-Recommendations-1.pdf. Downloaded June 16, 2021 from https://physicianaccountability.org/.

[ii] Levine D, LaRochelle JS, Kisielewski, M, et al. *Current Department of Medicine Summary Letters Are Falling Short. J GEN INTERN MED* (2021). DOI: https://doi.org/10.1007/s11606-021-06693-w.

[iii] Ferris AH, Pereira AG, Angus SV, et al. *Compliance with CDIM-APDIM Guidelines for Department of Medicine Letters: An Opportunity to Improve Communication Across the Continuum*. J GEN INTERN MED (2021). DOI: https://doi.org/10.1007/s11606-021-06744-2.

[iv] Love JN, Smith J, Weizberg M, et.al. *Council of Emergency Medicine Residency Directors' Standardized Letter of Recommendation: The Program Director's Perspective*. Acad Emerg Med. 2014 Jun; 21(6): 680-7. DOI: https://doi.org/10.1111/acem.12384.

[v] Chretien KC, Raj JM, Abraham RA, et al. *AAIM Recommendations for the 2020-2021 Internal Medicine Residency Application Cycle in Response to the COVID-19 Pandemic*. AM J Med 2020; 133 (10): 1223-1226.e6. ISSN 0002-9343. doi/10.1016/j.amjmed.2020.06.002.

[vi] AAIM Recommendations to Promote Equity in Internal Medicine Clerkship Assessment and Grading. https://www.im.org/resources/ume-gme-program-resources/resources-clerkship-equity

[vii] https://physicianaccountability.org/wp-content/uploads/2021/04/UGRC-Initial-Summary-Report-and-Preliminary-Recommendations-1.pdf. Downloaded June 16, 2021 from https://physicianaccountability.org/.

[viii] Daniel M, Gordon M, Patricio M, et. al. *An Update on Developments in Medical Education in Response to the COVID-19 Pandemic: A BEME Scoping Review: BEME Guide No. 64*. Med Teach. 2021 Mar; 43(3): 253-271. DOI: 10.1080/0142159X.2020.1864310.