



American Academy of Neurology

AAN Resident Survey
Final Report
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AAN Resident Survey **Survey Methods**

Objective

The goal of the *AAN Resident Survey* was to obtain feedback from residents who had recently completed their neurology. The results from this survey will allow the Graduate Education Subcommittee (GES) and Consortium of Neurology Residents and Fellows (CNRF) to discover any deficiencies in the training of residents. In order to measure any follow-up actions conducted as a result of this survey, this survey will be conducted again in 3 years to ensure any issues are resolved.

Sample

All 633 neurology residents who had completed their residency training in the United States in 2007 were the target population for this survey. AAN members who had requested or reviewed the survey were ineligible for participation including members of the Graduate Education Subcommittee and Member Demographics Subcommittee (MDS) as well as officers from the Consortium of Neurology Residents and Fellows.

In addition, residents who had received 3 AAN surveys in the past 3 years were removed from the sample in accordance with AAN survey policy. Those who contacted the Academy to indicate they were still in residency and those who did not have accurate contact information were also removed from the list resulting in a final sample size of 523.

Instrument

An initial draft of the survey was created by members of the GES and CNRF in June of 2006 as a comprehensive, three part survey. After AAN staff reviewed the survey, the scope of the research was scaled down and a more condensed version of the survey was sent to the MDS in April of 2007. The MDS reviewed the instrument and provided suggestions for improvements. A final draft was agreed upon in September of 2007.

Data Collection

The survey was initially sent to the sample on October 30, 2007 via postal mail. A cover letter co-signed by the Chairs of the CNRF and GES accompanied each survey. An email was also sent that provided a link to the online version of the survey. The standard incentive of a \$25 gift certificate to the AAN Online Store was promised to all survey participants who were members of the AAN (non AAN members were excluded from the incentive per AAN policy). The second and third reminders were sent on November 20, 2007 and December 5, 2007, respectively. Both the second and third reminders were distributed via postal mail, which included a business reply envelope, and email. An addition reminder was sent on December 19, 2007 entirely via email. Data collection closed on January 7, 2008.

Response Rate

A final response rate of 54.5% (285/523) was achieved for the *AAN Resident Survey*. The margin of error for all respondents at a 95% confidence level is $\pm 4.4\%$.

AAN Resident Survey Survey Respondents' Demographic Characteristics

The following demographic information on survey respondents was analyzed from the AAN internal membership database. The descriptive demographic data indicate that the survey responders did not substantially differ from the survey non-respondents on major demographic variables.

The mean age of survey participants is 34 years and the majority is male. A detailed comparison of all demographic variables can be found in Table 1.

Table 1. Demographic characteristics of survey responders and non-responders

Demographic characteristics		Survey Respondents (N = 285)	Survey Non-respondents (N = 238)
Age¹ (mean)		33.6 years (SD = 4.1)	33.9 years (SD = 4.4)
Gender² (%)	Male	57.0	51.5
	Female	43.0	48.5

¹ Data missing for (30.2%) in the respondent population and (37.8%) in the non-respondent population

² Data missing for (22.5%) in the respondent population and (31.5%) in the non-respondent population

AAN Resident Survey Executive Summary

Positive Findings:

- Residents are well prepared in diagnostic formulations and patient management.
- Participants are overall pleased with their inpatient-ward, continuity clinic and subspecialty supervising/teaching physicians.
- Residents believe they received quality teaching from their neurology faculty.
- Nearly three-quarters agreed that the RITE helped in self-study.
- The vast majority (87%) were satisfied with the fellowship offers they received.

Potential Areas for Improvement:

- 37% agreed there were topics that were not taught but would have helped prepare them after residency.
- Residents as a whole do not feel their residency program prepared them for practice issues based on the percentage of those who marked poor for the following: billing (36%), contracts (50%), malpractice (40%), coding (38%) and office management (52%).

Other Key Findings:

- The majority of residents entered into a fellowship training after residency.
- Approximately one-third have always worked under duty hour rules.
 - Those who haven't always worked under duty hour rules agree duty hours improve patient care, their education and quality of life.
- Two-thirds of respondents stated that their RITE scores are used only for self-study improvement.
- The vast majority (80%) of residents who entered into a fellowship selected a clinical fellowship.
- 42% of those in a fellowship chose the area of neurophysiology (EMG, EEG). 9% of survey respondents chose movement disorders and another 9% chose sleep as the area of their fellowships.
- After fellowship, 33% of residents expect to enter into academic practice and another 28% plan to go into private practice.
- The majority (61%) of residents selected their fellowship program based on a mentor in their institution.

Recommendations:

The survey results indicate that residents are overall well trained in their neurology programs and their instruction should continue as such. However, the survey also clearly indicates that residents feel they are overall poorly prepared for practice issues, especially when compared to the other topics addressed on this survey. It is the recommendation that these issues be studied and solutions for better preparation in these areas be implemented. As a means of examining the success of any new endeavors, it is further recommended that this survey be repeated in three years, to discover if the newly established programs better prepare residents in practice issues.

AAN Resident Survey Survey Frequencies

**1. How would you characterize your activities in neurology directly after your residency?
 (N=283)**

39.2%	Fellowship training at residency institution	0.0%	Went to PHARMA
38.5%	Fellowship training at another institution	0.7%	Left neurology
19.8%	Went into practice	0.0%	Left medicine
0.4%	Returned to home country	1.4%	Other

Duty Work Hours

2. How did ACGME duty work hours affect the following:

	Improved	Worsened	No change	Always worked under duty hour rules so cannot compare
a. Patient care (N=282)	41.1%	9.6%	15.2%	34.0%
b. Resident education (N=283)	39.6%	8.8%	17.7%	33.9%
c. Resident quality of life (N=283)	58.7%	0.7%	8.1%	32.5%

Residency Training Program

How well did your residency program do on the following:

	Very well	Well	Somewhat well	Not well	N/A
3. Preparing you to make adequate diagnostic formulations (N=282)	54.3%	39.4%	5.0%	1.4%	0.0%
4. Preparing you adequately for patient management (N=281)	58.0%	34.9%	6.8%	0.4%	0.0%
5. Providing didactic material for each category below:					
a. Basic science (N=284)	15.5%	37.7%	32.4%	14.4%	0.0%
b. Clinical skills (N=284)	47.5%	42.6%	8.8%	1.1%	0.0%
c. Conferences-Grand Rounds (N=284)	37.3%	46.5%	14.1%	2.1%	0.0%
d. Subspecialty training (N=284)	28.2%	39.8%	23.9%	7.4%	0.7%
e. Other neurology conferences (N=281)	24.6%	47.7%	19.2%	5.3%	3.2%

**6. Please rate the diversity of your residency training program for the following rotations
 (diversity includes the depth and breadth of patient cases and disease entities):**

	Very diverse	Somewhat diverse	Not diverse	N/A
a. Continuity clinic (N=284)	29.6%	56.0%	14.4%	0.0%
b. Inpatient rotations (N=284)	61.6%	35.2%	3.2%	0.0%
c. Pediatric neurology rotations (N=284)	45.8%	45.4%	7.4%	1.4%
d. Subspecialty clinic (N=284)	50.0%	40.8%	6.3%	2.8%
e. Subspecialty rotations (N=283)	43.5%	47.0%	6.7%	2.8%

7. Please rate your residency program on the following:

	Excellent	Good	Fair	Poor	N/A
a. Inpatient-ward supervising/teaching physicians (N=284)	56.7%	34.9%	6.7%	1.8%	0.0%
b. Continuity clinic supervising/teaching physicians (N=284)	42.6%	42.3%	10.9%	3.5%	0.7%
c. Subspecialty supervising/teaching physicians (N=284)	52.1%	38.4%	6.7%	2.1%	0.7%

8. Overall, what was the quality of the teaching from the neurology faculty in the institution you completed your residency? (N=274)

52.2% Excellent 40.1% Good 6.2% Fair 1.5% Poor

9. Please rate your non-neurology residency supervising faculty:

	Excellent	Good	Fair	Poor	N/A
a. Pathology (N=283)	41.3%	39.9%	11.0%	3.5%	4.2%
b. Radiology (N=284)	41.5%	35.2%	15.8%	4.9%	2.5%
c. Neurosurgery (N=283)	17.3%	40.3%	17.3%	4.9%	20.1%
d. Rehabilitation (N=283)	10.6%	34.6%	18.4%	5.7%	30.7%
e. Psychiatry (N=284)	15.8%	42.3%	26.4%	6.7%	8.8%

10. Are there any areas or topics that would have helped to prepare you for fellowship or practice that were not taught? (N=278)

36.7% Yes (go to question 10a) 63.3% No (go to question 11)

10a. If yes, what areas (please specify):

See survey comments on page 9

Residency In-service Training Examination (RITE)

11. The RITE helped define areas for my self-study to strengthen my neurologic knowledge. (N=283)

18.4% Strongly agree 7.8% Disagree
 54.8% Agree 2.8% Strongly disagree
 16.3% Neutral

12. Was your RITE score used for any other purpose other than self-study improvement (e.g., comparison to other residents, fellowship acceptance, honors)? (N=283)

14.5% Yes (go to question 12a) 66.1% No (go to question 13) 19.4% Unsure (go to question 13)

12a. If yes, explain:

See survey comments on page 9

13. I was satisfied with the mentoring available in my residency program in guiding me to find a fellowship and/or career after residency. (N=282)

28.4%	Strongly agree	6.7%	Disagree
39.7%	Agree	2.5%	Strongly disagree
22.7%	Neutral		

Fellowship (If you did not enter a fellowship please skip to QUESTION 20)

14. What type of fellowship are you in? (N=220)

1.4%	Basic science research	14.5%	Clinical research fellowship
79.5%	Clinical fellowship	4.5%	Mixture of basic science research and clinical research

15. What is your area of fellowship training? (N=222)

2.7%	Behavioral	1.8%	Neuro-ophthalmology
7.7%	Cerebrovascular	3.6%	Neurocritical care
0.5%	General	42.3%	Neurophysiology (EMG, EEG)
9.0%	Movement Disorder	0.9%	Research
5.4%	Multiple Sclerosis	26.1%	Other (please specify): ¹

¹See survey comments on page 9

16. How long is your fellowship? (Please mark only one) (N=222)

65.8%	One year	5.4%	Three years or longer
26.6%	Two years	2.3%	Other (please specify): ²

²See survey comments on page 9

17. At the end of your fellowship, what type of practice do you expect to enter? (Please mark only one) (N=223)

32.7%	Academic practice
0.0%	Basic science research
4.5%	Basic science research with part-time clinical practice
10.3%	Clinical/clinical research
4.0%	Clinical research with part-time clinical practice
15.2%	Not sure yet
0.4%	Pharmaceutical industry
28.3%	Private practice
4.5%	Other (please specify): ³

³See survey comments on page 9

18. How did you select a fellowship program? (N=218)

17.0%	AAN online fellowship directory	1.4%	Networking at the Annual Meeting
3.7%	Mentor in another institution	5.0%	Program Director
60.6%	Mentor in my institution	12.4%	Other (please specify): ⁴

⁴See survey comments on page 9

19. How satisfied were you with the fellowship offers you received? (N=218)

61.0%	Very satisfied	3.2%	Somewhat dissatisfied
26.1%	Somewhat satisfied	0.5%	Very dissatisfied
9.2%	Neutral		

20. Please rate your residency on preparing you for the following practice issues:

	Excellent	Good	Fair	Poor	N/A
a. Billing (N=283)	6.7%	20.1%	33.9%	35.7%	3.5%
b. Contracts (N=283)	2.5%	10.6%	31.1%	49.5%	6.4%
c. Malpractice (N=282)	2.5%	16.3%	35.5%	39.7%	6.0%
d. Coding (N=283)	5.7%	18.7%	32.9%	37.8%	4.9%
e. Office management (N=283)	1.8%	10.2%	28.3%	51.9%	7.8%

21. If you completed medical school outside of the US, and are not a US resident and do not have a green card, after all your training is completed, your intention is to: (N=56)

16.1%	Return to my country of origin for practice
78.6%	Stay in the US for practice
5.4%	Go to a third country for practice

22. Please provide any comments you may have on the topic of this survey.

See survey comments on page 9

**AAN Resident Survey
Survey Comments**

10. Are there any areas or topics that would have helped to prepare you for fellowship or practice that were not taught?

10a. If yes, what areas (please specify):

- Behavioral neurology and movement disorders (2)
- At that time, there was no movement disorder specialist and this was a big hole (it is now being remedied)
- Basic science education
- Behavioral and neuropsychology; neuroanatomy
- Behavioral neurology
- Better neuromuscular disease exposure
- Better organized curricula in basic sciences, neuroanatomy, pathology, radiology
- Better radiology training
- Better understanding of billing
- Billing
- Billing and coding
- Billing, coding, business
- Billing/coding, how to get a job (private practice) and contracts with jobs, etc. A formal teaching handbook for the residency program (similar to Baylor). Formal boards training.
- Billing/coding, setting up practice, etc.
- Billing/legalities/compliance
- Business aspect – setting up a practice, billing
- Business aspects of practice
- Business management, coding for billing, educators should be more knowledgeable on the signs of resident fatigue
- Business of medicine / research topics
- Business skills. Reading EEGs, Evoked Potentials and PSGs; performing EMG/NCV studies with ease/confidence.
- Clinics
- Cognitive/behavioral neurology
- Cognitive neurology, more supervised patient interactions
- Critical care neurology (but the program has that now), neuromuscular disease (we don't have as much exposure)
- EMG/EEG
- EMG/NCS
- EMG, neuromuscular, dementia, peripheral
- Epilepsy surgery monitoring, better follow-up in continuity clinic
- Evoked potentials, dementia
- Headache
- How to negotiate your first contract, what to look for in an academic job
- I could have used more psych
- I feel that our training in the area of movement disorders was lacking the didactics but there are not enough patients to subsequently learn from.
- ICU training

- Immunopharmacology
- In general, too much in-patient, not enough out-patient
- Increased exposure and education regarding movement disorders, as well as cognitive disorders/dementia.
- Issues regarding reimbursement and billing.
- Just not enough due to over-extended program. Our program is now increasing the number of residents to offset the heavy work demands, and the result will be much improved. Unfortunately, my class was unable to benefit, and our educational and career advancement opportunities suffered because of it. All areas were deficient due to poor attendance at lectures. Would have appreciated better teaching of neuroanatomy, neuropathy, neuroradiology, neuropharmacology (all had limited teaching).
- Localization in neurology
- More basic science
- More exposure is required in sleep medicine and EEG
- More exposure to basic science and neuromuscular aspects of neurology
- More hands-on ICU experience, more experience reading inpatient EEG.
- More movement disorders exposure, more geriatrics/dementia neurology, more exposure to neurosurgery patients
- More neuromuscular/EMG training - it was VERY difficult to get this during my training.
- More opportunity for research and subspecialty exposure. I received little to no elective time.
- More organized neurophysiology teaching (EEG reading, EMG interpretation), and clinical dementia teaching.
- More outpatient exposure to sleep, neuromuscular
- More outpatient general neurology continuity.
- More peds rehab physicians. We have only 1.
- More specialty outpatient rotations
- More subspecialties: neuro-oncology, neuro-radiology, headache
- Movement disorder, behavioral neurology
- Much of the clinical practice of neurology
- Need more exposure in Multiple Sclerosis and Dementia Clinics
- Neurocritical Care
- Neuro-critical care training
- Neuroendocrine, neurogenetics
- Neurology practice issues (dealing with insurance, employees, etc.), career selection. Would have liked more neurophysiology, especially EEG
- Neuromuscular
- Neuromuscular, evidenced based patient management
- Neuromuscular, neuro-oncology, movement disorder
- Neuromuscular training and EMG – Teaching is not optimal and the program is not well structured.
- Neuropsychiatry
- Neuropsychology
- Neurorehabilitation
- Neurosurgery, rehab, psychiatry
- No open discussion about management
- Not enough EEG or EMG unless you learn on your own
- Not nearly enough neuro-oncology
- Oncology

- Oncology, movement disorders, neuro-critical care
- Our neurology program is deficient in sleep. Also could benefit from more time in EEG/EMG and having more clinics where residents take care of patients with various problems as opposed to only have resident's clinic where it is mostly headache patients.
- Outpatient management of epilepsy, outpatient management of Parkinson's disease, ophthalmological examination.
- Pain management/symptom management
- Pathology
- Practical parts of billing
- Practice management
- Practice management, billing
- Practice management/politics
- Pre-surgical epilepsy evaluations
- Psychiatry – currently is now integrated into curriculum at my training institution.
- Research methodology
- Research methods, academic pursuits
- Rotations in psychiatry/neuropsychology. And effective/meaningful radiology and pathology rotation
- Sleep
- Sleep medicine
- Sleep medicine, neuropsychology
- Sleep, neurorehabilitation, botox,
- Some more basic science
- Subspecialties like headache, movement disorder
- Teach more on current medical practice, have didactic activities with a purpose not to “fill out the spot.” Include neuro-ophthalmology rotation and muscle biopsy review.
- There could have been more exposure to subspecialty care, and more exposure to the elements of business and private practice neurology.
- Variety in the continuity clinic would have greatly improved my outpatient skills
- Vascular neurology
- Yes, more emphasis on studies such as EMG/NCS, EEG, etc.

12. Was your RITE score used for any other purpose other than self-study improvement (e.g., comparison to other residents, fellowship acceptance, honors)?

12a. If yes, explain:

- Comparison to other residents (8)
- A lot of pressure is put on the residents to do well on the exam. Promotion is based on achieving a minimum score.
- Awards to the best score in the program
- Compared to other residents, and also to remind us to improve ourselves. Mayo clinic also asked me for [??] scores for epilepsy fellowship application.
- Comparison to other residents at institution
- Comparison to other residents by some faculty in the program.
- Comparison to other residents, played a role in selection of Chief Resident
- Comparison to prior year's personal scores by residency director.
- During evaluation time they would compare us to other residents

- For fellowship applications one institution (Mayo) requested the scores
- Funding to attend meeting
- I think that fellowship directors use this to compare residents.
- I was asked for my first year RITE score on a fellowship application at another institution (not where I did my residency).
- I was compared to other students (verbally and very unprofessionally) who had a better score by my program director. I think this is not good.
- It was a major component of our yearly evaluation letters.
- Most of the faculty discovered resident scores and did affect how we were viewed. Also was used as a factor for who would be chief.
- One fellowship program (not my current one) asked for copies in the interview process
- One program asked all my scores (fellowship interviews)
- Organization of opportunities within the residency.
- Our program takes the RITE exam seriously; top scores are rewarded.
- Program director compared our scores to each other in order to give us feedback regarding where we stand in our class and general knowledge.
- Resident attaining highest score is recognized and honored; scores are compared to other residency programs
- Scores were compared against all others in my year, and all others in my program.
- The score was used in our bi-yearly evaluation, and was in the eval letter.
- The RITE exam was taken very seriously by our program and was frequently used as a measure of our knowledge and performance relative to other residents.
- There was always healthy competition amongst the residents.
- They ask for the reports when you apply for fellowship, and this may be very important in their decisions. Also, it is very important in how you are looked upon during the residency: the low scorers will be continuously picked upon, while if you have good scores, you are more likely to get away with some mistakes... Overall I think it matters more than it is intended to...
- Those residents in my program who scored in the 90th percentile or above were recognized publicly at the annual graduation dinner and given a token award.
- Those residents scoring 90% and above received an award at the end of the academic year
- Those who scored >80th percentile were acknowledged at end of the year dinner
- To assess whether I would pass the ABPN certification exam
- Your scores served as a ranking amongst other residents

15. What is your area of fellowship training?

Other (please specify):

- Sleep medicine (12)
- Sleep (7)
- Epilepsy (4)
- Neuro-oncology (3)
- Headache (2)
- Neuromuscular (2)
- Neuromuscular medicine (2)
- Stroke (2)
- Clinical Pharmacology/Pharmacogenomics
- Combined cerebrovascular and neurocritical care

- Continuing into clinical research fellowship in epilepsy
- EMG
- Epilepsy and EEG
- Epilepsy, sleep
- Headache and face pain
- Neurogenetics
- Neuromuscular/ALS
- Neuromuscular disorders and EMG
- Neuro-oncology – both clinical fellowship and clinical research fellowship
- Neurorehabilitation
- Otoneurology
- Pain management (anesthesia department)
- Palliative care
- Pain
- Pain management
- Pain medicine
- Pediatric
- Pediatric neurology
- Peripheral nerve/EMG
- Sleep disorders

16. How long is your fellowship? (Please mark only one)

Other (please specify):

- 6 months
- 6 months (will not be boarded in this area)
- One year of stroke followed by one year of critical care
- This question is not written correctly

17. At the end of your fellowship, what type of practice do you expect to enter? (Please mark only one)

Other (please specify):

- Another fellowship
- Fellowship in interventional neuroradiology
- Mostly clinical, part academic
- Neuromuscular fellowship
- Pain medicine fellowship
- Private with teaching affiliation
- Second residency: ophthalmology
- Sleep fellowship
- U.S. military

18. How did you select a fellowship program?

Other (please specify):

- AAHPM website
- Applied and visited at the recommendation of many mentors
- Applied to programs in my city
- Attending from rotations as resident
- Chose by hospital location
- Clinical interaction with patients in my chosen field
- Colleagues
- Desire to stay at home institution
- Direct email
- Elective rotation as a resident
- Familiarity from medical school
- Fellow resident
- Friend at the institution
- Internet searching
- Interviews
- Location
- Location due to spouse employment
- My program director and a mentor in another institution (the institution I am at for fellowship)
- Personal research on the web
- Personally contacted program
- Picked randomly
- Random
- Same institution
- Searched for interesting programs at good institutions
- Talked to a neurologist in industry
- Wanted to improve my EMG/EEG knowledge

22. Please provide any comments you may have on the topic of this survey.

- Although the ACGME duty hours have really helped the residents, I think there should be stricter rules regarding work hours because in a subspecialty such as peds neuro there is not enough staff, and the fellows are overburdened as was in my program. I don't remember any time to study for the RITE therefore did poorly in the RITE exam. I feel during my fellowship I was overworked all the time – having to do a lot of work for the attendings.
- Fellowship application and offers should be more regulated. I was offered a position and had to accept before I was able to interview at half the programs I was interested in applying to. Dates should be set for applications, interviews, offers and responses.
- Good survey, brief and to the point
- I cannot complain. I had a superior neurology training even though in a small program (2 residents per year). I am currently in 1st year private practice and feel totally competent and comfortable and, in my opinion, better trained than many established neurologists. Not to brag, I do feel that way. I trained at the Cleveland Clinic Florida.
- I could not be happier with my residency. I feel like I am a very well prepared competent neurologist with an excellent foundation. Especially now that I see how other residents are

trained, I feel that the education I received was as good if not better than anything out there. My criticism is of the fellowship process. I interviewed for both cerebrovascular and interventional fellowships. It is sheer and utter chaos. No one interviews at the same time or even publishes this information. On attempting to contact the different programs you commonly only get to talk to a secretary who usually knows less than you with regards to the interview process at their institution. The AAN website was often outdated or all together inaccurate. If you managed to interview at the various programs and get offers, because of the non-uniform process you could be forced to take a position that ultimately you did not want just to ensure that you received a fellowship. As much as I hate to say it, consideration should be given to a MATCH system for this process, or at the very least, a standardization of timing for the interview and offer process to occur.

- I feel that the 80 hour work week is not an improvement. I feel that education suffered a lot. I felt that I didn't know my patients very well and often covered for other residents. I had the experience of having a first residency in pediatrics where there were no restrictions. I felt more confident when I completed that residency. Although my mentors in the pediatric side were excellent, I didn't feel prepared for practice when I was done with three years and thus took another year of training in neurophysiology. I feel that if the 80 hour work week continues, residencies will need to add an extra year for proper education.
- I got great training in academic neurology at my residency institution. However, it's not a good program if someone wants to go into private practice. (I don't, so it's not an issue for me, but it may be for others). There is nothing taught about the practicalities of practice (billing, malpractice, etc.) in the real world outside of an academic practice.
- I had an outstanding residency training; the comments provided are with the hope of further strengthening and sharpening an amazing place, with fantastic colleagues and mentors.
- I have worked in a residency without work hours restrictions (Pediatrics) that switched to compliance with a night float system. Then I did a peds neuro fellowship in which my adult neuro time was Q4 call and my peds neuro was home call one week on/one week off. I feel that work hours restrictions do not interfere with patient care if done in the right way - the nightfloat system and home call were by far the best systems for continuity. Nightfloat, for in-house call, offers continuity during the day and night, in a way no other system can. Residencies are reluctant to do them because of the problem scheduling and keeping up requirements (a 1 month elective becomes 3 weeks elective 1 week nightfloat), however a Q4 system takes a week worth of days from an elective just not in a row. So I think it really is a problem of the ACGME accounting of requirements that prevents more nightfloat systems being used.
- I think it would be helpful if AAN reaches out directly to residents more, rather than going through program director, because some program directors are more pro-active than others. In our institution we saw participation in conferences and publications increase dramatically when we changed program directors and heard about opportunities available to residents.
- I think feedback that is provided for the RITE exam is an excellent idea. Will this be done for the board exams too? Is there guidance on CME acquisition and maintenance (where to go/look for it to keep up with requirements) after graduation?
- I think the program can benefit from more outpatient experience and more time in EEG/EMG. Also, the research requirement could benefit from better mentoring and a way to expose residents to the different projects they could participate in.
- I think there should be a section for residents' feedback on ABPN Neuro Boards, e.g. in regards to timing, training with respect to residency etc.
- I think this survey is important and I hope it will be useful for someone in the future...
- I very much enjoyed my child neurology fellowship, excellent faculty, great didactics, strong research. Areas of improvement – better variety of patients (too much migraine, not enough epilepsy). Overall my training was top notch however.

- I wish the AAN had publicized more and helped programs develop a basic sciences and basic literature review skills (epidemiology). Perhaps teaching tools online that program directors or chief residents could use would have been good.
- I wished there was more direct interaction between residents and senior faculty in rounds and didactics and discussion of management during M&M
- It is a crime that the AAN and the ACGME and RRC allow the neurology program to function at Medical College of Virginia (5-6 residents have left in the last couple years)
- My residency was in a large metropolitan area in Los Angeles with an amazingly diverse patient population (socioeconomically, culturally) with 75% of patients from Latin American and Asia which provided endless opportunity to see and treat diverse neurology issues. This was its biggest strength (along with clinical independence). However, our attendings varied greatly (from world-class to downright poor) therefore our teaching and preparation for academic endeavors was not as strong as it could be.
- NB: psychiatry requirement is something that should be accomplished in the intern year. It would be much more helpful early on in the residency than it was as a PGY-4.
- Nice survey, brings out points that we should be more interested in e.g. coding/ reimbursement issues
- No comments
- Not enough mentoring for academic careers, I have excellent background for academic career, but somewhere in my last year of residency and fellowship lost the charm, I think mostly because of not enough mentoring. Program mainly interested in residents doing lot of work and get good scores on RITE. No help in writing grants. Some help though provided for posters, but not enough to turn them into papers.
- Overall a good neurology program. Good pathology and variety of neurologic cases. Could have stronger teaching and mentorship, some more emphasis given to board exams.
- Overall a very busy and wide-ranging clinical exposure, but that volume of clinical responsibilities took away from didactic time.
- Overall busy program with lots of hands on experience. Strongly oriented towards vascular and critical care neurology. Could use more residents per year, especially for NeuroICU rotations. Overall, well prepared for inpatient neurology. Need to improve on outpatient spectrum.
- Overall, the residency training was excellent despite major changes after hurricane Katrina with loss of essential faculty and resources.
- Practice management is definitely a deficiency.
- Residencies designed to prepare residents for academic careers will likely not concentrate on practice issues, and perhaps should not be required to do so. They should, perhaps, be held to higher standards for preparing residents for academic careers - perhaps by teaching research methodology skills and/or administrative skills.
- Residency could have been better at teaching EMG/EEG.
- Residency was somewhat complicated by Hurricane Katrina; however, given the circumstances I was very satisfied with my training and the ability of my program to recover.
- Some of the questions are too broad to answer with a check box – work hours are not entirely applicable if you take call from home. Work hours are not the panacea they would seem to be. I don't think that is the solution. Despite any sort of barriers or issues though, I was generally very happy with my program and especially my program director (Sid Gospe, University of Washington, pediatric neurology)
- Thank you. I see many people use their position to please/promote religious, ethnic or other interests (may be it is normal or not "big deal?") but still US is a blessed country, much better than many, many others.

- The fellowship in University of California San Diego is the worst of all my experiences. It was considered as movement disorder fellowship but now the MS clinic director forced us to cover her clinic also. They are fully abusing fellows and threatening to prevent us from having a position in the community if we don't cover MS clinic because she knows all local neurologists.
- The RITE exam needs to be more clinically practical. It shows too much bias towards certain subspecialty authors.
- The RITE exam would be much more useful if at least some (if not all) of the questions were released to the examinees.
- The program did not provide any preparation as how to run a private practice and bill. It was solely confined to providing training in clinical neurology and patient management.
- There needs to be more diversity in the resident clinic. At this time the resident clinic consisted of all the patients the subspecialty clinics declined to see, and so there was a large percentage of psychogenic and chronic pain patients.
- Would appreciate if any board review courses are offered.
- You should allow email submissions!