“We're IMGs, and We're Often Seen as Human Garbage”: Rejection and Reproduction of Status Hierarchies in Medical Education

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ABSTRACT

The fact that status inequality exists between different types of medical trainees and physicians is widely accepted within medicine, and leads to differences in both treatment and quality of training. One important status difference exists between high-status USMDs, who are receiving an allopathic medical degree in the US, and low-status non-USMDs, who are either receiving an allopathic medical degree internationally, or an osteopathic medical degree. Little research has been conducted on how this status hierarchy is introduced and reproduced throughout medical education. In order to better understand this status (re)production, I qualitatively analyzed an electronic support forum on Reddit, called “Name and Shame 2019,” where 4th-year medical students discussed their experiences with status during residency interviews. Drawing from these students’ stories and discussions with their peers, I found that residency programs often reinforce this unequal status hierarchy to students during the interview process. Students then responded to this reinforcement in different ways: while lower-status non-USMD students were often able to reject these status hierarchies through discussion with their peers, higher-status USMD students tended to reproduce the reinforced status beliefs that benefited them. These findings shed light on how and why status hierarchies are constructed, reproduced, and rejected within medical education, while raising questions about how status inequality affects the equity of medical education, and the overall quality of medical care.
INTRODUCTION

The medical school residency application process is advertised as an efficient and straightforward process, equitable and fair to all who apply\(^1\). Medical students apply to residency programs in their fourth year of medical school as a necessary step in their training towards practicing medicine independently. After taking the United States Medical Licensing Exam (USMLE)\(^2\) Step 1 and Step 2 standardized exams in medical school, prospective residents submit applications to the Electronic Residency Application Service (ERAS)\(^3\), with the hope of receiving interviews at specific residency programs. When these interviews are completed, students rank order the programs they wish to attend, and programs submit their rankings of their top candidates. What follows is colloquially referred to as The Match\(^4\), where the National Residency Matching Program (NRMP) computerized system ‘matches’ students with programs using their separate ranked lists, and each student receives one offer for a spot at one residency program.

The NRMP puts out a list of rules and regulations each year to prevent discrimination or bias in this application process. However, a Reddit forum thread, created by medical students called “Name and Shame 2019,”\(^5\) accounts various violations and inappropriate behaviors perceived by medical students at dozens of programs during interviews in the 2019 Match cycle. The existence of this forum reveals that discrepancies and unfairness are perceived in a process that is touted as impartial and rational. Not all medical students fare equally in the residency matching process, as research has shown that medical students graduating from allopathic schools in the US (USMDs\(^6\)) are more likely to Match into prestigious residency programs than medical students graduating from international or osteopathic schools (non-USMDs\(^7\)) (Jenkins 2018, 2020; Jenkins & Reddy 2016; Jenkins et al. In Press). Despite these observations of status differences between members of the medical community, little research has been dedicated to studying how
this treatment affects and is internalized by the people most strongly affected—the medical students currently trying to Match into residency programs. By observing how these students describe and communicate with their peers about status within medical education, one can see that USMDs and non-USMDs, students of different statuses, view status hierarchies in different ways. From this, we can begin to understand how the status differences between USMDs and non-USMDs are handled, and possibly reproduced, within medical education, and what the future effects of status reproduction may be.

To that end, in this study I draw upon data in the form of medical student comments on the “Name and Shame 2019” forum thread, in order to illuminate the status beliefs of medical students. I find that, according to these students, residency programs present their status beliefs about the inferior quality of non-USMDs throughout the residency interview process, reinforcing medical education status hierarchies. Moreover, I show how the medical students respond to this reinforcement in two central ways, depending on their own status position. Non-USMDs, who are negatively affected by these status beliefs, internalized their lower status when individually reflecting on their experiences, as shown through the stories they told on the forum; however, after communicating with peers about their experiences, they were able to instead reject these status hierarchies. USMDs, on the other hand, who benefit from the higher status within medical education, tended to uncritically reproduce these status hierarchies through their comments and reflections on the forum. These findings raise questions about the effects of status inequality in the residency interview process, along with its effects on medical education, and medicine as a whole.
**BACKGROUND**

*Status Hierarchies & The Medical Profession*

Status hierarchies exist within almost every modern organization. Status is defined as the position of a social actor within a hierarchical order (Podolny 2010); actors are sorted into this hierarchy based on status characteristics, or properties associated with groups that determine their status (Berger 2002). These status characteristics can be associated with group quality, as groups of one status are expected to have different capabilities than groups of another status, independent of the capabilities of individual actors (Berger 2002, Podolny 2010). As these status hierarchies are solidified, a social framework begins to form within an organization, integrating status into its structure (Berger 2002). Actors within groups who have attained a high status are also often given a higher quantity and quality of opportunities than low-status actors, who are more limited in their choices and excluded from high-yield opportunities (Sauder 2012). To ensure the exclusion of low-status actors from high-benefit opportunities, groups of differing statuses are often structurally segregated from each other; this also prevents the changing of status beliefs through exposure to other groups (Podolny 1993, Sauder 2012). This exclusion still occurs when no measurable quality difference exists (Lynn 2009).

Many different status hierarchies exist and overlap within the medical profession, including status differences between female and male physicians (Lorber 1984), white and minority physicians (Davis et al. 2013), and physicians of different specialties (Hindhede et al. 2019, Norredam et al. 2007). Within the physician training process, status hierarchies remain present, as medical students and residents are often separated by the pedigree of their medical school, thus creating the categories of USMD and non-USMD (IMGs, USIMG, and DOs) (Jenkins 2020). Despite filling 45% of the residency positions nationwide (NRMP 2018), non-USMDs are viewed
as having lower status compared to USMDs. They are considered lower quality physicians and are
associated with low program prestige (Atsawarungruangkit 2017, Boulet et al. 2009, Knobel et al.
1973, Reeves & Burke 2009).

The effects of these biases are clear: non-USMD medical students, especially IMGs, are
less likely than USMDs to Match, despite performing similarly to their US-citizen counterparts on
their standardized Step exams (NRMP 2018). When they do Match, non-USMDs are funneled into
lower-status residency positions, such as Family Medicine and Internal Medicine, keeping them
out of some of the most prestigious specialties, and filling in the gaps in US healthcare (NRMP
2018, American Medical Association [AMA] 2010, Jenkins 2018). Even within these specialties,
non-USMDs match into lower-status, community-based residency programs, as compared to
USMDs, who match into higher status, university-based residency programs. These status-derived
practices lead to segregation in training between the two groups (Jenkins 2018, Jenkins et al. in
Press), and differential treatment of non-USMDs residents within their programs (Jenkins 2018,
Chen 2010). Despite the widespread effect of the status differences between USMDs and non-
USMDs, there has been little investigation of the construction and perception of these status
differences among medical students.

*Status Reproduction in Medicine*

Very little work has been done to understand how residency programs come to construct,
and medical students come to perceive, this status hierarchy in medicine. In order to unpack this
process, symbolic interactionist theory can be used as a way to show how status—and status
hierarchy—construction occurs through social interaction (Becker et al. 1963, Mead 1934, Stryker
2008). Once integrated into an organization, these status hierarchies are resistant to change, due to
replication of status beliefs through further social interaction (Edelman 1964, Ewick & Sarat 2004,
Stryker 2008). While literature exists on how socialization and status replication occurs through both interaction with and imitation of superiors (Vaidyanathan 2015, Jenkins 2018), and through communication with peers (Hafferty 1988, Martimianakis 2018), none of this work has focused on how specifically the interview process affects social interaction between these groups. There has also been no investigation on how online communication shapes status reproduction and socialization among medical students (Park 2013).

The analysis below targets two forms of communication—reports of interactions with superiors in the medical system, and interaction with peers—with the goal of increasing our understanding of how status hierarchies are introduced, enforced, and rejected within the medical education system. Residency interviews are a critical juncture in a student’s journey to becoming a full-fledged physician; focusing on this vulnerable time reveals how students are receiving messaging from the medical organization about status hierarchies, and how that messaging is processed and turned into individual status beliefs through peer communication. It is important to understand this process in order to fully begin to unpack the effect status has on individuals within and surrounding the medical profession.

METHODS

While interviewing is a commonly used method for collecting information on personal beliefs within medicine and student communities (see Olsen 2019, for example), this type of methodology does not provide information on peer-to-peer discussion of shared experiences. To address this limitation, others use focus groups as a tool for studying group communication; however, this still does not capture interaction that is unaffected by the researcher. Collecting data from an online community—“electronic field research”—allows observation of organic
interactions between community members in a social group, without influence or disruption of these conversations in any way (Barker 2008). For this study, data on status beliefs was collected from 4th year medical students from an online forum post: “Name and Shame 2019”.

**Creation of the Data - “Name and Shame 2019”**

“Name and Shame 2019” is one small example of widespread online medical student communication. This post was created on a forum dedicated to students in medical school (r/medicalschool); the forum is run through the larger website Reddit, which houses thousands of forums, called ‘subreddits,’ each populated by a community discussing a niche topic. The medical school subreddit is focused on the topic of making it through the hardships of medical school. The “Name and Shame” discussion post was created on r/medicalschool in March 2019, right after the conclusion of the 2019 Match. The instructions for participating in the thread were listed at the top: “NAME AND SHAME the programs that did you dirty this interview season- whether it was a match violation, a terrible PD interaction, or just a plain ol’ giant red flag.” The post served two main purposes: (1) to provide a place for current graduates to pass on information about unprofessional programs to younger students, and (2) to allow the students to vent their feelings on interviewing and the Match, and discuss their experiences with their peers.

Students in the forum commented over 1300 times on the post over three months, with the majority of the comments occurring within two weeks of the original post. Comments mainly came in two types: M4s telling stories about their experiences while interviewing, and other members of the forum community discussing these stories, agreeing or disagreeing with the original poster, both giving advice to others on the thread. Both forms of these comments were used in identical ways in data collection and analysis. In order to ensure anonymity, the moderators of the forum
offered the option of creating “throwaway accounts,” where students could use disposable website accounts to tell their stories.

**Data Collection & Analysis**

The forum was ‘archived’ (closed off from commenting) sometime between March and June of 2019, and the data were collected in July 2019\(^1\). The data was collected using NCapture, a data scraping web extension from NVivo 12, a qualitative data analysis program. Due to the anonymous nature of online commenting, especially on Reddit, no demographic analysis was done of the posters or commenters. I did not participate in the thread, and no commenters on the forum were asked for any further information, other than what was posted on the thread. The project was deemed exempt by the Temple University IRB.

**FINDINGS**

In the “Name and Shame” forum post, the unique transition from medical student to resident can be observed through the eyes of the students themselves as they discuss their interview experiences with their peers. Three separate social processes can be deduced from these interactions: (1) how status is reinforced within the interview process; (2) how non-USMD students reflect on this exposure, and either accept or reject these status beliefs; and (3) how USMD students reproduce accepted status hierarchies within medical education.

**Reinforcement of Status: Status Hierarchies within Interviewing Practice**

The majority of the comments on the post detailed negative interactions the students had with residency programs while interviewing—a finding which makes sense, given that the purpose of the forum was to provide a space for these students to vent their feelings with their peers. Although the types of negative behavior described were varied, many of the students told stories
where program employees made their status opinions on types of applicants clearly known. Students observed these beliefs by watching the programs status-driven behavior (presented in the form of negative assumptions and comments) towards lower status applicants, specifically non-USMDs. This behavior was deemed inappropriate by the majority of the students on the forum, especially when directed towards the commenter themselves.

During interviews, students reported that residency programs made it clear what medical students were higher-status than others. Program behavior regarding non-USMDs, especially IMGs, clearly reveals the separation of medical students by school status. Overall, the perception of residency programs on non-USMDs was overwhelmingly negative, confirming their lower-status position within the hierarchy of medical education. This low status position then supported program beliefs that having a non-USMD resident would be detrimental not only to program status, but quality. Here are the stories of two students:

“An interviewer tells me how happy he is that there's all these new US medical schools so he won't have to talk to another foreigner in a season soon and how lucky I am to be interviewing this season. The program director... tells me I have about a 50% chance to match and how competitive the other people in the "FMG\textsuperscript{13} interview" are because we all have at least a 250 on steps\textsuperscript{14}.” (Student 1.1, non-USMD)

“One of my interviewers...told me my personal statement was worthless because ‘nobody who applies to pathology speaks English anymore and pays someone else to write them.’” (Student 1.2, USMD)

These anecdotes of program status beliefs confirm the medical status hierarchy between USMDs and non-USMDs discussed in the literature. USMDs were highly valued as additions of residency program in comparison to “foreigners,” even when the non-USMDs in question were extremely competitive based solely on their objective scores. The second quote, which targeted IMGs specifically, goes even further, and shows how biases and discriminatory behavior on the individual level tap into the status hierarchies within medical education. Residency programs
valued the status that USMDs have within the medical social framework, and made decisions that reflected these status hierarchies. The interview process gave these programs an opportunity to make their views on the status of non-USMDs clear to medical students who were interviewing, thereby reinforcing the students’ place within the status hierarchy in an attempt to maintain the organizational structure. After the interview, the students were left to process this important socialization that has just occurred.

**Reflection on Status: Non-USMD Placement into Status Hierarchies**

Within the stories of their experiences, students mixed in self-reflection on the interview process and the behavior they encountered. For non-USMDs, this reflection allowed processing of the information on status they encountered during their interview experience. Posting it on the forum allowed discussion of these experiences with their peers, and helped non-USMDs make sense of, and form opinions about, their own location in medical status hierarchies.

Many students reflected on feeling powerless when facing the medical system due to their lower status as non-USMDs, and felt pressure from programs to accept this lower-status position. The behavior and beliefs they faced during their interviews affected their own understandings of both the medical system, and their place within it, and many students were discouraged at their lack of ability to control how they were judged during this process. After their interaction with a status-driven program that funneled all of their non-USMD applicants into their one-year preliminary\textsuperscript{15} training program, despite originally having applied to the more prestigious 3-year categorical program, Student 1.1 from above reflected on the powerlessness they felt after their interview, and how they internalized harmful beliefs:

“By the time I left I really hated myself and thought I was worthless and wouldn't match. I was even going to rank their prelim\textsuperscript{15} I never applied to above certain categorical programs because I legitimately thought it was the best I could do...my girlfriend had to unbrainwash me over a few days.” (Student 1.1, non-USMD)
Because of the perceived actions and beliefs of the residency program, this non-USMD not only reflected on how they felt, but admitted that this behavior had caused them to accept and internalize their lower-status position. Although they described that they were able to mitigate some of these beliefs, this behavior had an obvious internal impact on the student, which they were then forced to come to terms with after the completion of the interview.

This pressure to internalize the status beliefs of programs shaped the ways non-USMD students weaved themselves into broader medical status hierarchies. Some students, for example, seemed ready to concede that a non-USMD identity would keep them from performing well in the Match process as a USMD, due to the different status characteristics associated with both identities. As described by one student:

“We're Imgs [sic] and we're often seen as human garbage outside of primary care.”

(Student 2.1, non-USMD)

In this quote, one can see that this student has previously been introduced to their low-status, internalized this position, and accepted that their identity as a non-USMD will continue to define how they are perceived throughout the medical community.

However, instead of internalizing their low-status positions, many non-USMD students expressed pride in their status. These students were able to reject the status beliefs they encountered while interviewing, and both voiced how hard they have worked to get this far in a system where they are at the bottom, and questioned the existing status structure. These two excerpts show this status-infused pride:

“I never got this [stigma against IMGs]. I'm an IMG. Proud to have gotten where I am and proud of the journey that got me here.” (Student 2.2, non-USMD)
“As a Caribbean IMG this pisses me off. Sure, we went offshore for a reason but we still have plenty to be proud of because we made it to residency. Besides, if we don't take pride in where we're from, why should anyone else?!” (Student 2.3, non-USMD)

Discussion with their peers therefore allowed low-status students to publicly question status hierarchies, and redefine this stigma as collective pride.

Thus, although student self-reflection did produce feelings of powerlessness and acceptance of lower-status, this method of discussion with peers also helped non-USMD students express feelings of pride about their status, and brought back power stripped from them by status beliefs during the interview process. One student summed up this reclamation of power:

“I just wanted to...say how proud I am of this class for actually naming these programs. This thread happens year after year... It's about time these shitty practices are exposed.” (Student 2.4, unknown type)

**Status Reproduction: The Beliefs of the USMD Students**

While many non-USMDs on the forum firmly rejected the status beliefs of residency programs, for their part USMD students tended to *reproduce* status distinctions by reinforcing their difference from their lower-status peers. This becomes apparent when the USMDs revealed their thoughts about non-USMDs and other low-status aspects of the medical system, such as placement into preliminary\(^\text{15}\) positions. This integration of existing medical status hierarchies into the thoughts and behaviors of the higher-status students shows that status beliefs are being reproduced within this new generation of USMD physicians, as seen in forum discussion.

The status beliefs about non-USMDs are embedded within USMD comments. Non-USMDs were seen as having lower status than USMDs, without consideration for any other characteristics other than their medical school type. Programs that ‘end up’ with non-USMDs were viewed as lesser options for USMD applicants. This view is shown with the following comments from USMD students:
“You know damn well [program] is not my first choice, most of your "residents" are previously trained anesthesiologists in other countries.” (Student 3.1, USMD)

“Clearly he [the program director] didn't get his wish of matched applicants- he got a DO this year...” (Student 3.2, USMD)

The students also associated program quality issues with programs having high concentrations of non-USMDs. For example:

“Apparently members of their first class can’t write in English well...not surprised given that they filled after the match with all IMGs.” (Student 3.3, non-USMD)

Although surrounded by non-USMD peers, USMDs do not hold back from expressing how they truly feel about non-USMD applicants. Even though these views are discriminatory, with some drawing on both racist stereotypes of international students and quality differences not supported by research, USMD students understood the status differences that exist within medicine, and drew from their experiences within the interview experience to continue to align their status beliefs about non-USMDs quality with the hierarchies currently in existence.

This status difference led to USMDs perceiving and expressing themselves as higher status and better-qualified applicants than non-USMDs, independent of any other characteristic:

“Expected them to completely throw themselves at any US grads because they were interviewing tons of FMGs\(^\text{13}\) (no offense to my FMG fam, but they were even struggling to get competitive FMG applicants)...” (Student 3.5, USMD)

As seen in the example above, students often included qualifiers when expressing negativity about non-USMDs, in order to differentiate their status beliefs from those expressed directly by the residency programs. Yet, the same status beliefs are there, and USMDs used these to place themselves higher than non-USMDs within medical status hierarchies, reinforcing these status beliefs as their own.
Negative status beliefs of non-USMDs also leaked into the USMD perception of other aspects of medical education. An example of this was matching placement into one-year preliminary positions\textsuperscript{15} in fields like medicine and surgery, which were viewed as far inferior to three-year categorical positions\textsuperscript{15}, and were often associated with non-USMDs:

“I went to 6 prelim interviews … I didn't like the feel...here were FMGs\textsuperscript{13} at the prelim interview who had 260-270 step scores\textsuperscript{16}, [were] established surgeons in their home country …[they] had the mentality of just needing a foot in the door [and] ate up the psychological tricks at the interview. (Student 3.6, USMD)

This student makes a point to connect their preliminary interviews, which were perceived as worse than categorical interviews, with the non-USMDs they met while interviewing; they also make note that the “FMGs” are being “tricked” into believing that these positions were a “foot in the door” while applying to residencies, confirming the predatory and status-driven behavior programs were accused of above. It is difficult to determine if non-USMDs lower the status of preliminary programs, or if being in a preliminary program lowers the status of non-USMDs, but the post shows that, for USMDs, these two status characteristics are closely linked, and help further reproduce the place of non-USMDs within this status hierarchy.

Thus, although non-USMD students were inclined to reject their low-status identity, USMDs, who have inherent privilege due to the higher status of this identity, tended to comment in ways that affirmed and reproduced the status beliefs exhibited by the residency programs in non-USMDs’ stories. Comparing these two reactions shows how status hierarchies can be rejected or reproduced, dependent on the relative status of the actor, and the importance of peer communication in both socialization and the status hierarchy reproduction process.
DISCUSSION

In this study, I have found that the comments posted on the “Name and Shame” forum reveal three important components of the perpetuation of status hierarchies through generations of physicians: (1) the behaviors and status beliefs that medical students observe through residency interviews; (2) the reflection on, and resistance to, those beliefs that goes on among lower status (non-USMD) students, as they make sense of their own place in the status hierarchy; (3) the reproduction of those beliefs and behaviors by higher-status (USMD) students. The way these three components interact can help shed light on how status hierarchies are negotiated and reproduced. Students of all backgrounds discussed status hierarchies and beliefs through online communication with their peers, connecting with one another through similar experiences, independent of status.

After experiencing reinforcement of medical status hierarchies by residency programs during their interviews, the response of students on the forum to these status beliefs diverged, dependent on the relative status of the student as determined by their USMD or non-USMD identity. Non-USMD students expressed having been deeply affected by negative status beliefs expressed to them by residency programs, to the point of internalizing and accepting their lower status within the medical profession. However, as a reaction to their experiences, many non-USMDs also expressed rejection of these beliefs, and instead found pride in their stigmatized status, an outcome that stemmed from communication from their peers. For their part, USMD students had a very different reaction to the status hierarchies they encountered: on the thread, they often reproduce the same negative beliefs about their non-USMD counterparts as observed within residency programs. USMDs also associate programs with non-USMDs as lower status, lower quality, and unacceptable for higher-status USMD students (Riley et al. 1996, Stillman et al. 2016,
Jenkins 2020). This reproduction makes sense, as having a higher status allows USMD students to potentially have an easier time navigating the medical education system. It is an advantage that benefits USMD students throughout their careers as both residents and physicians, and that would disappear if these status hierarchies were fully rejected.

Following the insights of Mead (1934) and Stryker (2008), we can interpret the communication between the USMD and non-USMD peers on the forum as aiding in the construction of the USMDs’ understanding of their high-status positions, therefore further affirming their beliefs that non-USMDs have low status positions. This reproduction, in turn, is supported by the medical system, which first reintroduces and socializes the students to these status beliefs during residency interviews by focusing on their structurally divergent paths. Crucially, as Podolny (1993) and Sauder (2012) note, structurally separating groups further affirms status hierarchies: therefore, as non-USMDs and USMDs proceed in their training, these hierarchies can become more pronounced. However, the rejection of status beliefs also occurs through peer communication. While previous research may examine the construction of high status via communication or the structural reinforcement of status hierarchies, I draw attention to an understudied phenomenon, which is the way in which lower status students interact with – and make sense of – their lower status. Although non-USMDs are socialized to accept their lower status by residency programs, these students are able to use this form of online communication to expose the status differences between USMD and non-USMD students, gain support from their peers, and at times, reject their assigned lower status.

These findings illuminate the role of communication in the reproduction of status within medical education. Both the rejection and reproduction of USMD/non-USMD status beliefs have implications for the future of medicine. The medical system currently relies on lower status non-
USMDs to fill in gaps in medical care, as non-USMDs are placed into less prestigious, less resourced residency programs (Jenkins & Reddy 2016). This placement is made regardless of how well these residents fit into these roles, or how this separation may affect future education and training. Such segregation represents a form of inequality in medicine, one whose full effects remain unclear, either on patients or on doctors themselves. Status is deeply ingrained within the systemic processes of medical education; however, this does not mean that accepted status beliefs couldn’t change, especially with the goal of improving the equity and quality of medicine as a whole. Further studying how this status inequality is reproduced within medical education, and how it might change over time, is valuable in the fight for equity and meritocracy within medicine. These findings provide a glimpse into how students perceive inequality early in their careers, and how they are rejecting or reproducing this status inequality based on their experiences with this medical system.

**Future directions**

Although limited in scope, this study raises new questions about the full impact of status hierarchies within medical education, and paves paths for future research. First, while the “Name and Shame 2019” forum post shines light on both the perceived status beliefs of residency programs involving USMDs and non-USMDs, and how different these types of students process and act upon this messaging, the data cannot provide a clear answer for exact mechanisms of status reproduction and replication. Further research could focus on examining these processes through more in-depth student interviews, with the goal of finding the reasoning behind their thoughts about USMDs and non-USMDs, creating full narratives about the development of their status beliefs. Second, this forum only focuses in on one point in the status reproduction process; although residency interviews are a critical area to investigate, it would be beneficial to further
confirm these findings at different points in a student’s medical career, or throughout interactions on the entire medical school forum. Lastly, although the anecdotes used in the findings of this study are not verifiable, the comments on the forum represent how each interaction was perceived through the eyes of the students. In future research, it is important to approach the study of status through those most affected by these inequalities, and give recognition to those able to reject strong systemic forces of socialization. Further studying the status differences faced by USMDs and non-USMDs within the medical system is a vital step towards equity in treatment and training between both of these groups.
REFERENCES


NOTES

1. See NRMP description of the application process here: http://www.nrmp.org/about-nrmp/.
2. The USMLE runs the Step 1 and Step 2 standardized Board exams. Step 1 is usually taken at the end of the 2nd year of medical school, before students start their clinical rotations, and tests students on knowledge learned during these two years. Step 2 is usually taken at the end of the 3rd, or start of the 4th, year of medical schools, and tests students on clinical skills and patient interactions. Both Step 1 and Step 2 are exactly the same for both USMDs and international students; DO schools have their own licensing exam option although around 2/3 of DO students still take these USMLE exams. Although both Step 1 and Step 2 are weighted in residency application, Step 1 is colloquially more important. Learn more about these exams here: https://www.usmle.org/.
3. International applicants actually use a different service, the Educational Commission for Foreign Medical Graduates, or ECFMG. Learn more about ECFMG here: https://www.ecfmg.org/. Learn more about ERAS here: https://www.aamc.org/services/eras-for-institutions. See note 13.
5. The link for the original thread post: https://www.reddit.com/r/medicalschool/comments/b1uo8q/name_and_shame_2019_rmedicalschool_match/.
6. USMDs are residents or physicians who have studied at an accredited allopathic medical school within the United States of America. Although USMDs include international students who study at US medical schools and Canadian students, these groups are statistically much smaller than US students who study at these programs.
7. In this study, the category “non-USMD” includes International Medical Graduates (non-US citizen residents or physicians now working in the US, who attended an international medical school), US International Medical Graduates (US citizens who attended medical schools internationally, most notably in the Caribbean Islands), and Doctors of Osteopathic Medicine (US citizens who attended an accredited Osteopathic Medical School).
8. IMG: International Medical Graduate; see note 2.
9. USIMG: United States International Medical Graduate; see note 2.
10. DO: Doctor of Osteopathic Medicine; see note 2. Compared to allopathic medicine, osteopathic physicians focus more on whole-person treatment of disease. Learn more about osteopathic physicians here: https://osteopathic.org/about/.
11. Between these two times, many of the comments on the original post had been deleted, either due to the expiration of throwaway accounts, deletion of Reddit accounts, or the commenter deciding to remove their communication from the mix. Thus, the website ‘removeedit’ was used to restore the deleted comments. This process was simple and free: the original post https://www.reddit.com/r/medicalschool/comments/b1uo8q/name_and_shame_2019_rmedicalschool_match/, when changed to “removeedit.com/r/medicalschool…””, provided access to all of the comments that had been deleted between the two times.
12. In this analysis, I will further support my argument and findings in this study with more data from throughout the thread, and I will with expand upon the themes covered in the paper.
13. FMG: Foreign Medical Graduate. An out-of-date term used to describe what the community now refers to as IMGs (see note 8). This term was historically associated with poor quality “foreign” physicians (see Knobel 1973).
14. 250 on Step 1 was in the 84th percentile for 2018; 250 on step 2 was in the 65th percentile. See more data here: https://www.usmle.org/pdfs/transcripts/USMLE_Step_Examination_Score_Interpretation_Guidelines.pdf

15. Prelim: Preliminary program. Preliminary programs are 1-year training programs for students right out of medical school. There are two types of preliminary programs: with one type, students are automatically placed into a categorical position after completion; these are also called advanced positions, and are considered equivalent to an intern year. However, some programs only consist of one year of training, and after completion of this program, students try again to match into a categorical residency position to receive their full training. These are the positions that are considered lower in prestige. Learn more about categorical vs. preliminary programs here: https://residency.wustl.edu/residencies/categorical-vs-preliminary/.

16. 260 for Step 1 was in the 96th percentile for 2018, while 270 was in the 100th percentile. 260 for Step 2 was in the 86th percentile, while 270 was in the 97th percentile. See note 14 for more Step score data.