NMPRA Annual National Meeting! Sat., Oct. 9th, 2004

The Med-Peds News

Official Newsletter of the National Med-Peds Residents' Association

SAN FRANCISCO!

NMPRA Annual National Meeting

By Emery H Chang, MD, NMPRA Treasurer & Heather Toth, MD, NMPRA President

NMPRA is excited to have its 2004 Annual Meeting in San Francisco. It's a vibrant, progressive city with so much to do. The meeting will be held on the evening of Sat Oct 9th, the first night of the AAP's National Convention.

Last year's Annual Meeting was a tremendous success with over 50 people from around the country attending the dinner banquet in New Orleans. We are excited to have the meeting at the renowned Bacar Restaurant at 448 Brannan Street in the SoMa (South of Market) neighborhood of San Francisco.

As we expand our educational programs for NMPRA members, we are adding selected Med-Peds case presentations to our Annual Meeting and special Med-Peds career development information.

Looking for some distractions? The NMPRA meeting and convention center is in the heart of Union Square. This area is a shopper's paradise with many boutiques, big fashion houses and other eclectic shops of San Francisco. Theatres are plentiful and during the meeting, consider getting tickets to the Lion King or other performances. Chinatown is a short walk away, with amazing food and shops. Considering doing Dim Sum for brunch on Sat or Sunday. It's a Cantonese brunch of little delicacies such as shrimp dumplings, springs rolls, custard tartlets, steamed BBQ pork buns and other exotic dishes for the more adventurous. Finally, Fisherman's Wharf is just a cable car ride away.

Itching to get out of the tourist areas? Catch the MUNI tram down Market street and head towards the Castro, the gay and lesbian Mecca, but can be fun for everyone. Lots of good restaurants, dessert bars, and fun bars abound.

Head into the Mission: this area is full of amazing ethnic and traditional restaurants and hip shops. My favorites are Ti Couz for crepes (3108 16th St.) and right next door to Picaro (3120 16th St.) for Tapas. There are many little Mexican and other Latin restaurants throughout the area for quick, yummy but very affordable meals.

San Francisco's "summer" is in September & October, so why not head to the parks and beaches? Take the MUNI to the end of the line and go to China or Ocean Beach. Or head towards Golden Gate Park or the Presidio. Regardless of how warm, the Pacific and Golden Gate are beautiful.

Have an outdoor itch? Head across to Marin County, which has many secluded, ocean-view hikes through the San Francisco hills. Consider renting mountain bikes and taking the Ferry across for a day trip. Stop off in Sausalito for some shopping and great Bay views.

To help facilitate NMPRA members in planning their trip to San Francisco, we have blocks of rooms at the acclaimed, newly built Hotel Adagio as well as the Maxwell Hotels. They are in Union Square and have special NMPRA discounted rates available. Further, Northwest Airlines has discounts on all fares booked through their Meeting Services Desk. For deals, contact treasurer@medpeds.org or checkout www.medpeds.org.

We are excited to see all of you at the Annual Meeting !

In Brief:

What: A quality medical education conference, career development, and networking opportunity for Med-Peds residents, faculty, and interested medical students.
When: October 9th, 2004, 6:30-9pm
Where: Bacar: 448 Brannan Street, San Francisco, CA #415-904-4100 www.bacarsf.com
Cost: Free to first 50 NMPRA members that RSVP. Non-members will be charged $15 to become a member, which includes the dinner. (You may also remind your Residency Programs that it is only $150 for the entire program to join). Non-residents will be charged $40.
RSVP to rsvp@medpeds.org by Friday, September 24th, 2004 or go to www.medpeds.org and follow the National Meeting link where there is information about the RSVP and NMPRA member benefits such as hotel and airline discounts. *On the RSVP, please include:* your name for the name tag, preferred email, Residency Program, contact information such as cell phone or hotel (if known), preference for a vegetarian meal

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Inside This Issue

Special Guest Column

Med-Peds Accreditation

By Tom Melgar M.D. Past President, Allen Friedland, MD President, Med-Peds Program Directors Association (MPPDA)

The big news in the medicine-pediatrics world this year has been centered on accreditation. For the first time since the creation of med-peds programs in 1967 the Accreditation Council for Graduate Medical Education (ACGME) is looking toward accrediting all combined programs starting with med-peds. Prior to this, med-peds programs have been approved prospectively and reviewed periodically by both the American Board of Pediatrics and the American Board of Internal Medicine, but not accredited by the ACGME. The ACGME has decided to pursue accreditation of combined programs at this time for a variety of reasons. Reasons cited include: graduates have reported having difficulty obtaining licenses in some states, difficulty of graduates being recognized outside of the United States, resident complaints about duty hours, lack of coordination between departments and concerns about excessive service requirements. Currently during Residency Review Committee (RRC) site visits of the core programs (internal medicine and pediatrics), med-peds residents are included in the survey and interview and there has been variable involvement of the med-peds program director(s) with the site surveyor.

Despite these issues there is little within the current system that is either broken or needs fixing. With this in mind accreditation needs to be as unobtrusive as possible and in the context of the accreditation of the two core programs. The ACGME and Medicine-Pediatrics Program Directors Associations (MPPDA) agree that a separate RRC for combined programs is neither desirable nor necessary. The MPPDA has been invited to make several recommendations to the ACGME regarding our wishes for the process and have worked with the Association of Program Directors in Internal Medicine (APDIM) accreditation committee, the Association of Pediatric Program Directors (APPD), the American Board of Internal Medicine and the American Board of Pediatrics in developing these requirements.

Med-Peds programs should maintain a balance between the two categorical departments with continued recognition that they are part of both. The process of accreditation should support existing program directors and relationships within their institutions that work well (integration and coordination must be apparent). There are several areas where the RRC requirements for each of the categorical programs are in conflict with one another and we hope that specific and clear med-peds requirements will resolve these conflicts. We feel that new requirements where possible should be competency based.

The new requirements for combined programs need to empower the director(s) of the combined program to advocate for the residents in their program. Combined programs can be enhanced by the process if reviews are not limited to the parts relevant to each of the categorical departments. Reviews should also address the coordination, communication and synergy that results from combined training.

Our relationship with you and NMPRA is critical. This article is meant to inform you of national items that your med-peds program director(s) have been working on to improve the education and climate of resident training in med-peds. Our next article will be on recruiting efforts by MPPDA. Stay tuned….

Northeast Med-Peds Conference Report

By J. Thomas Cross, MD, NMPRA Non-Resident Advisor

The Northeast Regional Med-Peds conference was held on March 13, 2004 and was hosted by Baystate Medical Center in Springfield, MA. This meeting brought together Med-Peds residents, faculty, and interested students from approximately 15 programs. Approximately 85 attended.

After an entertaining introduction by Brendan Kelly, Associate Med-Peds Program Director and Host, the keynote address was given by John Chamberlain, Chair of the Med-Peds Section of the AAP. His talk was "Sustaining Your Career Over Three Decades". Dr. Chamberlain provided a great review of the history of Med-Peds as well as tips for ensuring a vibrant and energetic practice for over 30 years. His words were very moving and provided a professional "refueling" into the joys of being a practicing Med-Peds primary care physician even during the current battles over reimbursement and practice overhead.

Dr. Chamberlain's talk was followed by "A Review of Sport Injuries: Treatment and Rehabilitation" by Dr. Herbert Bote, a volunteer physician for the US Olympic team, with great pictures of Ski/Snowboard resorts!

Valuable break-out sessions were held in the late morning and early afternoon and consisted of "Choosing a Primary Care Specialty," geared towards medical students. The session was run by various faculty from the participating programs at the meeting. A breakout session for residents and faculty/practitioners was "Paying and Compensating the Doctor." Other breakout sessions included "Approach to the Patient With Abnormal Serum Sodium" and "The Nephrologists Approach to Hypertension and Diabetes".

The final sessions were two outstanding panel discussions on "How to Choose and Get into a Residency" and "Things to Find Out About Your Job Before Signing on the Dotted Line". The former was led by current residents from participating programs of the Northeast and Mid-Atlantic region of the U.S.

The meeting concluded with open networking time for faculty, practitioners, residents, and interested medical students to confer and mentor.

All are looking forward to next year's meeting which will be hosted by Harvard's Med-Peds program.

The Clinician's Corner

Chronic Hypertension: What's the evidence?

By Gitanjali Srivastava, MD Mount Sinai, NY

In this country, coronary artery disease (CAD) and stroke are the first and third leading causes of death in persons over the age of 65, respectively. Hypertension is directly related to these diseases and currently affects more than 50 million Americans. More importantly, 30% of adults remain undiagnosed. Hypertension has become the "silent killer" because it is often asymptomatic and can subsequently cause serious disease if left untreated for a prolonged time. Physicians and patients alike must understand that the primary goal of treating hypertension is to reduce the significant morbidity and mortality from cardiovascular causes including CAD and congestive heart failure (CHF). However, the clinician must realize that different antihypertensive therapies may not reduce the risk of cardiovascular disease equally. An overview of current topics and trials in hypertension management is presented below:

JNC VII

In May 2003, the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure came published its seventh report (JNC VII) for defining hypertension. The JNC VII quotes data from the Framingham Heart study and states that normotensive adults aged 55-65 will have a 90% lifetime risk of developing hypertension if they survived to age 80-85. The JNC VII also reports that cardiovascular disease (CVD) risk doubles for each increment of 20/10 mm Hg beginning at 115/75. Patients with diabetes or renal disease will likely require two or more antihypertensive medicines to reach their optimum blood pressure goal. The report concludes that for uncomplicated hypertension, the first line of therapy should be a thiazide diuretic, either alone or in combination with any other antihypertensive therapy.

The ALLHAT Trial

Antihypertensive and Lipid-Lowering Treatment to Prevent Heart Attack Trial was a randomized, double-blinded, placebo-controlled, ten-year trial involving 42,418 participants. It was designed to test whether clinicians should first treat hypertension with a calcium channel blocker (amlodipine), an ACE inhibitor (lisinopril), an alpha-blocker (doxazosin), versus the "standard" treatment, a diuretic (chlorthalidone). In January 2000, ALLHAT discontinued the doxazosin arm of the study because of increased risk of secondary endpoints of combined CAD, CVD, CVA, and CHF as compared to chlorthalidone. ALLHAT concluded that thiazide-type diuretics should continue to be the first-line treatment of hypertension. Other important conclusions of the study were: 1) Thiazides were shown to be lower in cost and more effective than other drugs in prevention of cardiovascular disease (decreased CHF as compared to amlodipine and decreased CVD as compared to lisinopril), 2) For patients who cannot tolerate diuretics, calcium channel blockers and ACE inhibitors should be considered, and 3) Diuretics should be part of any multidrug anti-hypertensive therapy regimen.

The HOPE Trial

The Heart Outcomes Prevention Evaluation trial randomized participants into a multicenter prospective study and addressed whether the ACE inhibitor ramipril was effective in reducing the incidence of stroke, cardiovascular death, and myocardial infarction in high-risk patients. The study found a 22% relative risk reduction [RR 0.78, p-value <0.001] in primary cardiovascular outcomes, including a 34% relative risk reduction in newly diagnosed cases of diabetes [p-value <0.001] as well as decreased complications of diabetes. Of note, the ARIC trial (Atherosclerosis Risk in Communities) demonstrated a 28% increase in the incidence of new diabetes with the use of beta-blocker therapy. In the past, thiazide diuretics have been shown to have a hyperglycemic effect, although in higher doses (>50 mg) compared to the 12.5 and 25mg doses often prescribed. However, the benefits of beta-blocker therapy have been well documented and one should weigh the risks and benefits before initiating a particular therapy.

Calcium channel blockers (CCBs)

CCBs can be divided into two classes: the *dihydropyridines* (amlodipine, bepridil, felodipine, isradipine, nicardipine, nifedipine, nisoldipine) are peripheral vasodilators and the *nondihydropyridines* (diltiazem and verapamil) which act as negative ionotropes and affect the AV-node. A controversy was previously sparked over concern that CCBs increase risk for cardiovascular events, cancer, and suicide. However, these concerns were based on small trials and observational studies which did not risk stratify mortality and morbidity due to CCBs. Current evidence from meta-analyses such as those published by Pahor M., et al. and the Blood Pressure Lowering Treatment Trialists' Collaboration (BPLT), both of which appeared in the Lancet in 2000, show that there was no statistically significant difference in cardiovascular outcomes or overall mortality between CCBs and other first-line hypertensive therapy. CCBs reduced the risk of stroke but had a non-significant increase of CAD, CHF, and MI. We can conclude from these studies and meta-analyses that CCBs are not to be used as first-line therapy in those at high risk for cardiovascular events. However, in an older patient at risk for stroke in whom thiazides may have failed, CCBs would be a reasonable choice.

The DASH diet

The Dietary Approaches to Stopping Hypertension trial showed that a diet reduced in total saturated fat, rich in fruits and vegetables, and which uses low-fat dairy foods can reduce the risk of coronary artery disease by approximately 15% and the risk of stroke by approximately 27%. It consisted of 459 participants, average age 44.6 years with a baseline blood-pressure of 132/85. Fruits and vegetables were effective in lowering systolic blood pressure while a combination diet lowered both systolic and diastolic pressures. The effects of the diet were significant within one week and reached their full benefit potential by two weeks.

(continued on page 4)

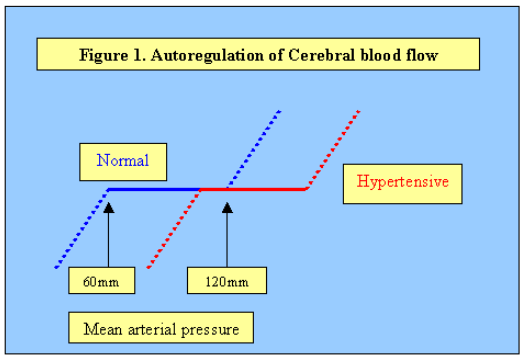
Table 1. Classification and management of blood pressure for adults aged 18 years or older (from JNC VII)

BP Classification	Systolic BP* (mmHg)	Diastolic BP* (mmHg)	Lifestyle Modification	Initial Drug Therapy	
				Without Compelling Indication	With Compelling Indications
Normal	Less than 120	Less than 80	Encourage	No antihypertensive drug indicated.	Drug(s) for compelling indications. ‡
Pre-hypertension	120-139	80-89	Yes		
Stage 1 Hypertension	140-159	90-99	Yes	Thiazide-type diuretics for most. May consider ACEI, ARB, BB, CCB, or combination.	Drug(s) for the compelling indications. ‡ Other antihypertensive drugs (diuretics, ACEI, ARB, BB, CCD) as needed.
Stage 2 Hypertension	160 and above	100 and above	Yes	Two-drug combination for most† (usually thiazide-type diuretic and ACEI or ARB or BB or CCB).	

Drug abbreviations: ACEI, angiotensin converting enzyme inhibitor; ARB, angiotensin receptor blocker; BB, beta blocker; CCB, calcium channel blocker.

† Initial combined therapy should be used cautiously in those at risk for orthostatic hypotension.

‡ Treat patients with chronic kidney disease or diabetes to BP goal of <130/80 mmHg.



(Continued from page 3)

Although the overall goal of any antihypertensive therapy such as those described above is tight and effective control of blood pressure to prevent further complications, therapeutic changes to blood pressure must be made gradually. The clinician must be aware of the physiologic changes which occur in chronic hypertension. It is important to note that cerebral perfusion remains constant due to vascular autoregulation. However, in chronic hypertension, the autoregulatory curve is shifted to the right [Figure 1]. Therefore, any acute lowering of the blood pressure may precipitate cerebral ischemia. As always, the clinician is obligated to encourage his or her hypertensive patients to participate in proper diet and exercise, as even mild to moderate weight loss has repeatedly been shown to lower blood pressure.

⇐source: www.lifeclinic.com

INTEREST IN MED-PEDS

ANSWERS TO STUDENTS' FREQUENTLY ASKED QUESTIONS

By Kim Granwehr, MD
NMPRA Past Secretary

Medical students faced with the decision of "career choice" and subsequent navigations through the residency application process will often have many important questions. These questions tend to be answered "on the fly" by colleagues, mentors, family members, and even perfect strangers. As the coordinator of the NMPRA-sponsored email link "Ask A Med-Peds Resident" (askaresident@medpeds.org), I have come across a group of questions asked by multiple students interested in pursuing a combined Internal Medicine-Pediatric residency. Many are collected and addressed here.

Why Med-Peds and Not Family Medicine?

This is the trickiest and most personal question to answer, as well as being somewhat politically charged. The reason many students give for asking the question centers around "Why spend the extra year in residency when I can do it in three years and just drop the obstetrics part in practice?" While three years is significantly less than four in terms of training time, most Med-Peds residents will answer that there are several reasons we chose Med-Peds. First, the training is more in-depth in both pediatrics and internal medicine (two years in each field as opposed to spending a maximum of one year apiece, which many do not feel provides adequate training for their future practice). In line with this, Med-Peds residents have no intention of practicing obstetrics, and thus do not wish to waste an entire year spending long and demanding hours training for something they will not put into practice. Second, Med-Peds training allows for full board certification through the American Board of Internal Medicine and the American Board of Pediatrics, and allows a resident to subspecialize in any branch of the two disciplines individually or in combination (i.e., Med-Peds Infectious Diseases, Adult Cardiology, Pediatric Hematology-Oncology, etc.)

None of this is to say that Family Medicine does not have its place in the medical world, as many communities depend upon the excellent care of their Family Practitioners. It simply comes down to a student's future plans (which may still evolve over time during residency) in choosing primary care vs. specialty care, and the depth of training needed to attain a desired level of comfort with one's clinical acumen.

Are My (blank) High Enough? (Grades, Board Scores, Class Ranks)

While grades and scores are important pieces of the rank-order puzzle, they are not the only thing selection committees look at. Let's address them first in order to ease everyone's mind. Failing a class due to external circumstances (family illness, etc) is almost universally overlooked if the circumstances are genuine and the class was repeated (or otherwise made up) with good scores.. High grades are nice to see, but the more important reflections will be found in the comments on students' clinical rotations. It is always wise to follow mom's advice to keep your nose clean (read: be on your best behavior) at all times on your rotations (even the down time spent with residents, as they often have input into your grade and evaluatory comments).

Failing a USMLE or COMLEX exam is almost universally looked down upon, and may weigh more heavily than expected in the final analysis. Programs will likely still rank an applicant who failed a board exam, but at a lower position than that applicant might have enjoyed otherwise. The same follows for passing with minimal scores. Solution? Study, study, study for your boards. The old adage "Two months (for USMLE Step I), two weeks (for USMLE Step II), two pencils (for USMLE Step III)" is not something to take too seriously, as I have personally reviewed the file of a candidate who did an outstanding job on his *second* USMLE-II after studying for it (the first attempt ended in failure studying for only—you guessed it—two weeks).

What About that Dean's Letter?

A Dean's letter is a Dean's letter is a Dean's letter. The weight of this letter is miniscule in proportion to the amount of stress in a student's life at the time of its creation. The only times it will sway a selection committee's opinion is if it's REALY BAD or REALLY GOOD. The "bad" letters rarely have an outright negative tone, but rather have subtle indications that the Dean (and others at the student's school) hope that the student in question matches anywhere other than their medical school. I have only seen one such letter. The "good" letters (rare, but not as rare as the "bad" ones) sing the praises of the student so loudly that it is made quite clear the student will be highly ranked at their medical school's residency program. To be very frank, 95% of Dean's letters (if not more) sound almost the same as all other Dean's letters and represent little more than a formality. To any

Dean who may be reading this, thank you for all the time and effort you put into the letters, and please accept my apology for calling them a formality.

What Can I Do to Separate Myself From the Crowd?

Interesting experiences are always, well, interesting. Expand on them. There are more in your history than you remember, so ask your friends and family to jog your memory. Interesting experiences may also include events that inspired you to go into medicine—tell us about them! Interesting research will be important if you are applying to a research-oriented facility or plan to continue research in your career. The most captivating part of an application is the personal statement. I know from semi-recent experience that there are "formats" to writing a personal statement, and even used that boring old format myself. Forget about it—circular file it, please. It helps you blend in with the crowd rather than stand out. My eyes glossed over every time I read "I am interested in a Med-Peds career because I like to diagnose and treat patients across the spectrum of ages" blah blah blah. And "What I'm looking for in a residency is" statements are rarely helpful, either, as most applicants say the same thing. Tell me a story, give me insight into your nature, make me laugh, make me cry. Yes, I actually cried as I was reading a personal statement telling a story that was so moving it "moved" the applicant straight up the rank list. Give me anything but the boring old format, please!

I've Been Offered an Interview…Now What?

Mom, again, is still right about being on one's best behavior—even on the tour, or other "down time" events such as lunch or dinner. Little comments that seem to innocently slip out during these events have a way of being amplified during rank-order sessions of selection committees. Examples actually do include excessively asking about call schedules or "what time do residents leave when not on call", etc. Face it, residency is hard and will demand much of your time. The RRC work-hours regulations will make many program work-hours even more homogenous than they already are (and most programs have work-hours and call schedules that even out in the end with other programs anyway, so the point is almost moot to begin with). You don't want to appear as though you won't be a good team player, or that you won't care for your patients in their hour of greatest need.

Other comments that I have seen amplified in ranking sessions included derogatory comments about foreign medical graduates or physicians in other specialties. Again, these people will be your colleagues (like it or not), and comments are best reserved for private conversations *outside* the application and interview trail. A more severe example, one applicant went so far during an interview as to say (s)he wouldn't go into a certain specialty because (s)he "refused to take care of patients who don't take care of themselves." The conclusion of our selection committee was that this applicant should consider a career outside of medicine altogether, and while the applicant's credentials were fine, (s)he was not ranked. Solution: Keep your nose clean, sit up straight, and give a firm handshake ("Yes, Mom".)

On tours or rounds (if invited), please act interested but keep quiet. Residents and faculty have an unspoken rule not to "pimp" applicants as they are already in a stressful situation. A reverse unspoken rule should apply: Applicants should not pipe up during morning report or rounds, as almost invariably they will appear arrogant (if the answer or question is insightful or correct) or unintelligent (if the answer or question is not insightful or is incorrect or altogether on the wrong track). You can't win, so have bright eyes and nod your head or smile when appropriate, but as Lincoln said, "Better to remain silent and appear a fool than to open one's mouth and remove all doubt."

The Interview's Over, So Now I Can Relax, Right?

Almost. You're in the home stretch. Now is the time to hand-write thank-you notes to your prospective Program Director and key interviewers. Do not write the exact same note to the above-mentioned persons (seen it). Do not have your spouse write your note as well as his/her own (seen it—the selection committee compared handwriting and that was the butt of all jokes for the remaining five hours of "rank night". We didn't rank either of them!) It seems old-fashioned, but it's still appreciated by selection committees.

If you know you're going to rank a program first, tell them so. I cannot express how many times I heard that so-and-so "really wants to come here," and while technically committees are not supposed to take that into consideration when creating a rank list, I think it colors our perceptions of applicants favorably to some degree. In the end it may not necessarily move you *up* the rank list, but it will almost never move you down. Phone calls or emails have the same effect, and we like hearing positive feedback from our interviewees (as long as they are not harassing the secretarial staff).

Final Thoughts

It's hard to hear, since it's been ringing in your ear since kindergarten, but folks, it's still true: Study, do well academically, be a well-rounded person, tell a good story, be honest, be attentive, be on your best behavior at all times, opt for "silence" rather than "appearing a fool", have a firm handshake, and say "please" and "thank you."

Congratulations to the Elected NMPRA Officers for 2004-2005

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President Elect: Ranya Sweis, MD, University of Michigan, Ann Arbor

Secretary: Lori Porter, DO, Medical College of Wisconsin, WI

Treasurer: Emery Chang, MD, Tulane, New Orleans, LA

International Medicine, Part I

International Health for the Med-Peds Resident

By Paul M. Lantos, MD, NMPRA Member-At-Large

Crouched in a dome-shaped hut of sturdy thatch, surrounded by millet and corn stalks found on the border of Ghana and Burkina Faso. I had taken a short bicycle tour of some small villages on both sides of the border, visiting plantations, markets, and a sacred crocodile pool. But now, in this small Fulani settlement, I found myself looking at three children in their open, fly-blown hut. They were sick, coughing, and through their wasted little frames I could see their chests struggling to breathe. After months working in poor countries it was clear to me that these children had pneumonia. I implored my guide to send this family to a doctor. His response: "But there is no doctor here."

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The health care needs of the developing world are abstract to most Americans. As our medical journals herald the coming age of stem cell and gene therapies, we too often overlook the uncounted millions of humans who still suffer from diseases of poverty, hygiene, and neglect. It is in these poorest countries, however, that the relevance of Med-Peds training is most self-evident. To provide effective care often requires an astute clinical instinct; and as Med-Peds trainees we employ this synthetic approach as we alternate between disciplines and age groups. In addition to providing valuable clinical care, to volunteer in such settings can be an exciting and moving supplement to our training. Overseas one is faced with different cultures, languages, and health care beliefs, unfamiliar diseases and therapies, and often limited diagnostic and therapeutic resources.

The heartache of human deprivation – an inescapable emotion in poor countries – is countered by the thrill of seeing people, traditions, places, and lifestyles that are wholly unfamiliar. But perhaps most interesting is learning how similar, in the end, all humans really are.

Medical facilities in the developing world vary from tiny clinics with few amenities to vast tertiary care centers with subspecialty care, CT scanners, and ventilators. The setting can range from the dense urbanity of a capital city to scattered villages and settlements. The environment may coastal, jungle, desert, or mountain. Correspondingly, the clinical responsibilities of a volunteer can range from mere shadowing to highly independent patient care. My personal experiences illustrate these many venues.

My first international elective, as a senior medical student, was a two month clinical research project in The Gambia, a tiny country in West Africa. I worked at a British medical research facility that, like most referral centers in the developing world, provided the visiting clinician with an overwhelming exposure to tropical diseases. Most pediatric inpatients were treated for combinations of malaria, measles, pneumonia, dysentery, meningitis, and malnutrition. Most adult patients had tuberculosis, AIDS, malignancies, or rheumatic heart disease. Despite the availability of modern laboratory facilities for research personnel, the clinical resources were quite limited. The CT scanner, for example, had lain in disrepair for several years.

Two years later, as a second-year resident, I had a vastly different experience working at a small clinic deep in the Amazon jungle of northeastern Peru. My daunting challenge was to independently provide primary care in a second language to patients from an unfamiliar culture. Our preventative medicine, which was essentially targeted to pediatric patients and pregnant women, included large vaccination clinics, routine physical exams, and dental care – all of which were reimbursed by the Peruvian government. Infectious diseases comprised the bulk of our urgent care, and included pneumonia, dysentery, wound infections, and the occasional case of malaria or cholera. Orthopedic, ophthalmologic, obstetric, and dental emergencies were all initially managed by our clinic. Anything beyond our level of care had to be seen at the nearest hospital, six hours by public boat up the Amazon River – and transportation was arranged and paid for by the patients' families. Other interesting presentations included snake and arthropod bites and a farmer with widespread dermatitis from carrying cleared jungle foliage on his bare shoulders.

To focus only on the clinical experience, however, ignores the greatest opportunity of all – to learn about a different place, with the curious, scavenging eyes of a visitor, and integrate these observations into both medicine and life

I returned to West Africa the following year to spend an elective at an urban hospital in Ghana. Malaria and typhoid fever were by far the most common illnesses in both adults and children. I visited one large teaching hospital in which the pediatric house staff admit 40 to 60 children per night, virtually always for malaria. Noncommunicable diseases were common and severe, and included diabetes, hypertension, stroke, and congestive heart failure. As a more senior trainee at this point, I was able to lend some of my own experience to the care of these familiar illnesses.

To focus only on the clinical experience, however, ignores the greatest opportunity of all – to learn about a different place, with the curious, scavenging eyes of a visitor, and integrate these observations into both medicine and life. I have made the acquaintance of a shaman in the Amazon, met a black magic practitioner in an African market, seen an 800-year old mosque made from mud and sticks, traveled through tiny villages and great cities, and seen landscapes, plants, animals, and people whose variety and richness bursts through the limitations of language.

I hope that I have been able to repay my patients even a fraction of what I've gained by knowing them. As Med-Peds residents, we are assimilators by nature – and to give ourselves such meaningful moments can not only make us better doctors, but better *humans*.

International Medicine, Part I cont.

A Day in Guatemala

By Heather Toth, MD, NMPRA President

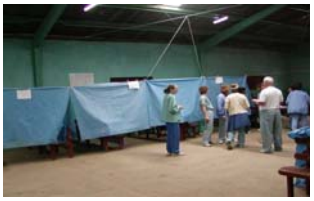
It is 3am and I must have been sleeping. Roosters are crowing and it takes a few moments to remember where I am. Is this a call room? Am I at home? Then I realize that I am in the middle of Guatemala, excited for the sun to rise and another day to begin. At 6am I approach the shower and wonder not only if there will be hot water, but if there will be water at all. I then head out to the street where children greet me selling small worry dolls, purses or asking to shine my shoes, even though I am wearing sandals. Surrounded by other volunteers, I head to a small restaurant for breakfast before loading up the chicken bus with medications and supplies. By 7:30am we are on our way to a small village where health care access is limited and I am not sure yet what problems to anticipate.

We stop at our "home base" first – the Salud y Paz (Health and Peace) clinic that has a Guatemalan physician year-round. The walls greet patients with informa-

tion as shown above.

This sign is a reminder to take caution, because you never know what is in the water and you must boil it before drinking. The letters below the Spanish language are "Quiche" which is a Mayan Indian dialect passed down by oral tradition. The people in this region state that it became a written language just 15 years ago.

We move on to the next village where the sign pictured to the far right marks our coming. Patients have already been waiting in line for hours. We hope to have time to see everyone that is waiting today.



We set up triage, examining rooms, supplies and pharmacy with rope and drapes as above. I find myself looking around for a volunteer firefighter or community elder that is fluent in Quiche to translate from Spanish for me today. As pictured below, we

make do with the resources and space available to examine a woman with 10-year history of abdominal pain who graciously agreed to be photographed.

Outside, the dental clinic is underway, and any free time is spent

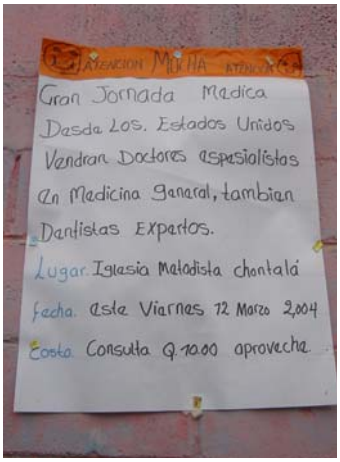
teaching basic hygiene and tooth brushing techniques. The children are thrilled to receive toothbrushes and toothpaste, and the villagers coming through the clinic receive vitamins for their entire families.

The problems we see today are very diverse and include abdominal pain, headaches, backaches, spina bifida, bronchitis, diabetes, scabies and much more. I also learn more about homeopathic medicine as another woman (pictured below) enlightens me with the importance of herbs and leaves to healing and well being. Herbs, stuffed into her ear canal, have been helping her earache which I personally would have diagnosed as otitis externa and treated with otic antibiotics.

I thanked them from the bottom of my heart for the wonderful experience and the privilege to serve and learn.

We leave the small village after hugs and grateful smiles, and children run waving after the chicken bus. At the end of the day as we return to "home base" after dusk, I feel an incredible sense of peace. What a privilege to be allowed into a small part of their lives and culture. The following weekend as we return to the airport, check in on a computer, fly home on an expensive jet and return to modern medicine as we know it, I am left with several thoughts. First and foremost, I am reassured as to the real reason to choose medicine as a career. Whether spending millions of dollars in our ICUs with ECMO and other high-tech equipment or in a foreign land with limited access to health care,

the basic patient needs are equal. Secondly, I feel fortunate to be able to serve others while remembering the importance of the history and physical exam where laboratory and x-ray studies are less available. Seeing first-hand the natural progression of disease is quite remarkable. Despite the challenges we face in medicine both at home and abroad, it is still rewarding to provide patient care no matter where we are. The Guatemalan people thanked us with all their hearts, but I thanked them from the bottom of my heart for the wonderful experience and the privilege to serve and learn.



A place to call your own: Home buying tips for residents

By Emery Chang, MD, NMPRA Treasurer

So the time has come. You're sick of throwing thousands of dollars away to the slumlords. You're ready to set your own rules, paint your room whatever color you want and show off a place of your very own.

Benefits of Owning

There are many financial benefits of owning. If an average rent is $700 per month, over a 4-year Med-Peds residency, you will have spent over $33,000. This is money you will never see again. In contrast, the principal of your mortgage payment should return when you sell the home and the interest is tax-deductible if you itemize your taxes. Further, home values have been skyrocketing in most markets, so you could very well make a good chunk of change at graduation day. Plus after living in the house for two years, any profit is tax-free!

The Big Unknown: The Mortgage

Mortgages come in many shapes and sizes. Shop around locally and nationally for the best rates and deals. When doing so, ask for a "Good Faith Estimate" which will detail your payments, interest, and outline all the expected closing costs. This can help you compare the details of all the different packages. The estimate is free and be suspicious of those that will not provide them. Also, get pre-approved. This will let you know how much you can afford and makes you a more attractive buyer if you have your financing already started.

Will They Give Me Credit?

YES! You are a doctor and basically a great candidate for banks given our future earning potential and job security. Tell the bank that your gazillion dollars of student loans are deferred. They really only care that the loan burden you are actively paying on is no more than about 30-40% of your income. Check out your credit reports for a number of reasons. First is to know how good your scores are so you can negotiate better. Second is to make sure that there are no errors in the report. Your credit score tells your potential lender how well you manage credit that is given to you including paying your bills on time and having a good history with lenders.

Adjustable? Fixed rate?

Traditional mortgages are 15 or 30 years and have a fixed rate for the life of the loan. Interest rates are at all time lows so many are taking advantage of this and locking in these rates. Adjustable rates ("ARM" adjustable rate mortgage) are fixed for a period of time (usually 1, 3, or 5 years) then become adjustable every year afterwards. The rates tend to be much lower initially compared to a fix rate mortgage. You must consider how long you plan on living in the house to best answer this question. I would argue you would only live for a few years in the first home that you buy. You are likely to move after your residency either to a new city or upgrade to a bigger house. An ARM may be in your best interest.

Points?

I think of points as buying a lower interest rate, or in other words, paying interest up front. It requires more money up front so it might not be feasible for the new med school grad. However, points are tax-deductible.

Private Mortgage Insurance?

This is a waste of your money as it is designed to protect the bank if you stop making payments, but alas, doesn't protect you from losing your home. They are often required if you don't put 20% down and are very expensive (mine was $70 a month). Shop around as many lenders will have "professional" loans that don't require PMI. If you can't avoid it, you can get rid of the PMI when you have 20% equity or loan-to-value (i.e. you own 20% of the house). I got rid of mine after 1-½ years because the value of my house had increased and just had to pay for a reappraisal of my home. Keep track of this, as often banks don't get rid of PMIs automatically.

Get a Realtor

This is especially important if you don't know the city. Good realtors will work hard, be flexible to your schedule and should be showing you a variety of homes. Ask for referrals from friends or other people in the program. If you don't like the realtor you have or don't feel like you trust him or her, get another. Remember they are working for you and get a large percentage of the sales price. However, I'd suggest only working with one at a time. Although they will have a lot of knowledge, you still need to do your own research.

Like a Home?

Some suggestions before you make the offer: 1) Visit the neighborhood during the day and night 2) Talk to the neighbors 3) Check around the surrounding blocks 4) Check out the city's police website for crime maps and 5) Trust your instincts.

Final Thoughts

Consider taking a home-buying class. There are usually non-profit organizations that have worthwhile classes to walk you through the process of looking, buying, and maintaining your house. Further, you can make some connections with realtors, home inspectors, and handymen/women. Finally, have fun. It's an exciting process.

NMPRA Pins On Sale!

Pin A: $5 **and** **Pin B: $4**

Place your order by e-mail at

nmpracoordinator@medpeds.org.

Contact NMPRA:

Please note our address & phone number:

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We thank our NMPRA Member Programs!

Without you, we could not exist!

*Albert Einstein Medical Center, PA
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Case Western Reserve University (MetroHealth) Cleveland, OH
Case Western Reserve University (University Hospitals) Cleveland, OH
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University of North Carolina Chapel Hill, NC
*University of Rochester Rochester, NY
Vanderbilt University Nashville, TN
William Beaumont Royal Oak, MI
Yale-New Haven Medical Center New Haven, CT

***These programs have renewed their memberships for 2004-2005 (as of 8/31/04). Thank you!**

The other programs listed were members last year, but membership has now expired.

Has your program renewed?

To view the latest active program list, go to www.medpeds.org/Membership/ResidencyDir.asp

To renew your program's membership, go to www.medpeds.org/Membership/Membership_Renew.htm

Memories of Last Year's Annual Meeting

By David Kendrick, MD, NMPRA Past-President

The National Meeting in New Orleans last November was a smashing success. Located inside Mother's Restaurant, a local favorite eatery, a gathering of fifty Med-Peds physicians and supportersenjoyed a gastronomical delight of gumbo, red beans and rice, crawfish etoufee, roast beef with debris, bread pudding and other N.O. delectables.

The affair was kicked off by a Med-Peds 'Jeopardy'-style trivia challenge compiled by Dr. Tommy Cross. Dr. David Kendrick then launched into a brief review of the Med-Peds Universe, detailing the history and current state of NMPRA and other Med-Peds organizations such as the Med-Peds Program Directors Association (MPPDA) and the Med-Peds Sections of AAP and ACP. A financial report by Dr. Emery Chang revealed that over two-thirds of NMPRA's funding comes from the combination of job postings and membership dues, so keep up your recruiting efforts!

The following speaker was Dr. John Chamberlain, FAAP, FACP and current Chairman of the Med-Peds Section of AAP and ACP. His overview of the Med-Peds section was an inspiring reminder of the fact that a small group of determined people can in fact move mountains such as the AAP and ACP to include our interests.

Attendees were then treated to an overview of the Med-Peds Program Directors Association, and informed that we as Med-Peds residents do have representation on the ACGME. Following that, Dr. David Kaelber reviewed job resources available for Med-Peds residents, and Dr. Tommy Cross unveiled the long-awaited Fellowship Guide compiled by NMPRA officers. Leadership opportunities within NMPRA were reviewed by Drs. David Kendrick, Heather Toth, and Kim Granwehr and volunteers were unearthed after discussing the various available posts within NMPRA. Finally, the NMPRA awards presentation wrapped up the evening.

It was, by all accounts, fabulous annual meeting. We hope that you will join us in the challenge to have an even better and bigger conference this year in San Francisco!

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(The views expressed in this newsletter are those of the authors and not necessarily those of NMPRA)