Dear Fellow Med-Peds Colleagues,

After a successful National Meeting in Atlanta, NMPRA is proud to head into the new year with some exciting new projects. We will be giving our website, www.medpeds.org an overhaul with a new look for 2007. NMPRA welcomes any suggestions for helpful links or other resources. Watch your mailboxes for an upcoming email outlining funding for residents to increase med-peds awareness among medical students in specific areas of the country, and for new med-peds grants to conduct research in both adults and children.

In other news, NMPRA continues to work actively with the AAP Med-Peds and Resident Sections to improve resident life and to increase post-residency opportunities. Finally, we are pleased to be sponsoring the Northeast Regional Med-Peds conference this spring. Details will be published in the next issue of The Med-Peds Perspective, so stay tuned.

If you have any concerns or ideas for the upcoming year please do not hesitate to contact me at Kenneth.remy@uhhs.com. We look forward to another successful quarter, and NMPRA sends you and your families warm wishes for a happy holiday.

Sincerely,

Kenneth E. Remy MD

National Med-Peds Resident’s Association President
In the 1970’s only a handful of med-peds residencies existed. The 1980’s saw a dramatic expansion of med-peds residencies to a peak of over 100 programs and over 450 HO-1 positions offered in the match by 1999. Since that time, a number of programs have closed, mainly citing financial and administrative reasons, so that in the 2006 match, there were 84 programs offering 376 HO-1 positions. 78% of these positions were filled by US medical school seniors, the highest rate among primary care specialties, rivaling competitive residencies such as dermatology. However, this fill rate was bolstered by the accompanying drop in programs and positions offered, begging the question: have we right-sized or is there room for expansion?

Answering this question depends on our goal. With attrition rates from med-peds programs around 10%, we should heed the advice of Stephen Covey and “begin with the end in mind.” While this rate compares favorably with the other primary care residencies (internal medicine 14%, pediatrics 4%, family medicine 8-18%), our goal should be to increase the output of board certified med-peds practitioners, not to increase the input of matched US seniors to med-peds programs. The latter is a myopic view and could lead to a higher percentage of dissatisfied med-peds residents leaving programs. These would not be our best ambassadors. Rather, our goal should be to expose 100% of US medical students to the concept of combined training in internal medicine and pediatrics. Our job should not be to talk as many students into applying to med-peds as possible, but to provide realistic expectations of residency and fellowship training and potential employment. This strategy would minimize attrition and expand graduation.

Why do students choose med-peds? The most common reason cited by recently matched med-peds interns is to receive in-depth training in the care of both adults and children. In balancing med-peds with other primary care options, those matching to med-peds state they want the whole age spectrum, the ability to subspecialize, more pediatrics exposure, and less obstetrics and surgery training than a family medicine residency provides. This is the type of student that is ripe for med-peds training, and is the type of student we should be focusing our efforts at reaching.

How do I recruit? Med-peds residents are our most important and successful recruiters. 80% of med-peds applicants come from medical schools with a med-peds residency program. Also, 2/3 of med-peds applicants identify an advisor who is med-peds trained, most often this person is a med-peds resident. It would appear then, that our best course is to match up our best ambassadors (satisfied med-peds residents) with the ripest students. This can be done with minimal effort at medical schools with a med-peds residency. Simply making yourself available to medical students through lectures, PBL sessions, and electives is a great start. Identifying yourself as a med-peds resident at the start of these sessions helps, but if done in an oppressive manner can be a turn off. Offer to help interested students think through whether med-peds is right for them. To avoid a bad match of student to career, cite the reasons students who actually match into med-peds programs give for entering our field. Work with already existing medicine and pediatrics interest groups, or perhaps even start your own local med-peds interest group.

Medical schools without a med-peds residency deserve special mention. If we were to draw the same proportion of medical students from the schools without a med-peds residency program that we do from schools with a med-peds residency program, there would be 50-100 more applicants each year matching into med-peds. While this seems like a worthy endeavor, med-peds residencies don’t exist and have closed at medical schools for a variety of reasons. Making personal connections with the clerkship directors or the advisors of the categorical interest groups is my best advice, particularly if you graduated from that medical school.

In summary, med-peds is a career for those interested in caring for people of all ages after receiving in-depth training in both internal medicine and pediatrics. The ability to subspecialize and avoid obstetrics and surgery is a bonus. To recruit medical students to our field, we should put our best foot forward, most often a satisfied med-peds resident. To avoid increasing attrition, our cause is best served by focusing on students whose interests match the field. Simply exposing students to the concept of med-peds is a great first step, especially at medical schools without a med-peds residency program. Happy hunting!
More than 70 residents, medical students and attendings participated in the first annual Midwest regional med-peds meeting on September 9, 2006 at Rainbow Babies and Children’s Hospital in Cleveland, Ohio. The day began with a welcome breakfast and then transitioned to some exceptional lectures including Dr. Claudia Hoyen’s “MRSA: A Growing Epidemic,” and Dr. Robert Schilz’s “Pulmonary Vascular Disease For The General Practitioner.” These were followed by the highlight of the day: two sickle cell patients who presented a talk entitled “Successful Transition Of Care With Model Of Sickle Cell Disease: What Went Wrong And How To Fix It.” Also in the morning were breakout sessions for medical students to learn about combined internal medicine and pediatrics residency, and for residents to learn about life after residency. In the early afternoon Jason Brock, JD and Norman Toy, med-peds recruiter, discussed how to obtain the perfect post-residency position and create a successful contract. The final presentations of the meeting were “Common Pediatric Orthopedic Complaints,” by Dr. Keith Boyd and “Updates In The Treatment Of Hypothyroidism For The Practitioner,” by Dr. Armand Krikorian. Winners of the Midwest Med-Peds Resident Case Competition, Drs. Moises Auron, Devangi Desai, and Vivek Subbiah presented their unique med-peds cases. At the end of the day, the only question left unanswered was where to hold the second annual Midwest regional med-peds meeting! The meeting was sponsored by Merck Pharmaceuticals, Metrohealth Hospital System and University Hospitals of Cleveland.
Congratulations to the Following
NMPRA Award Winners!

Each winner received a $250 educational stipend and $250 travel grant to the National NMRPA Meeting, Atlanta, sponsored by NMPRA

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<th>Gary Onady Award</th>
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<td><strong>Ranya Sweiss, MD</strong></td>
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This award honors a resident physician making extraordinary, lasting contributions to leadership within NMPRA and/or to a Med-Peds specialty at the national and/or regional level. It is named for Gary Onady, MD, PHD for notable, extraordinary, lasting contributions to the Med-Peds profession. In the words of Dr. Onady, “The resident recipient will have made a contribution that has moved the Med-Peds specialty to the forefront of medical care policy, curriculum, or contributions to the quality of medical care, encompassing the spectrum of training reflected by the Med-Peds specialty.”

Ranya is a graduate of the University of Michigan and is currently a first year Fellow in Cardiology at Northwestern University. She has been active in Med-Peds as both the president of the national house officer association at University of Michigan and Immediate Past President of NMPRA from 2006-2007.

<table>
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<th>Howard Schubiner Award</th>
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<td><strong>Stephanie Zia, MD</strong></td>
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This award honors a resident physician making extraordinary, lasting contributions to leadership within NMPRA and/or to a Med-Peds specialty at the local and/or state level. It is named for Howard Schubiner, MD, for notable, extraordinary, lasting contributions to the Med-Peds profession. In the words of Dr. Schubiner, “a resident who exemplifies the highest standard for excellence in Med-Peds, including exemplary clinical care of patients, compassion and humanism in relationships.”

Stephanie is a PGY3 at the Los Angeles County and University of Southern California. She is actively involved in her med-peds program and helped to establish a combined med-peds clinic. She states “I envision further expanding the Med-Peds sector on the West Coast and desire to raise more national awareness of the Combined Medicine-Pediatrics specialty to medical students around my region, especially in the setting of a country now experiencing a shortage of primary care physicians.”

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Interested in Contributing to the Med Peds Perspective?
Have an Interesting Med-Peds Case?
Experienced an Interesting Travel Rotation?
We are Looking for Exciting Articles for each Month!
If Interested Contact Rebecca Northway at secretary@medpeds.org
MONEY MATTERS: Time for a Respite

Emery H Chang, MD
NMPRA Travel Advisor

So as we head into the Winter months, I have ski slopes and beaches dancing through my head. Since I’m a travel fanatic, I’ve developed multiple ways of maximizing my travel plans at as minimal cost to me.

WHERE TO GO?
So the world’s your oyster, if you have a passport. These are easy to get but would plan on 6-8 weeks to get them so if you are even thinking of going abroad (including the Caribbean, Mexico and Canada which will require a passport in the near future). Good deals include Europe in the Winter and Spring with lots of very low airfare. Thailand, once you get there is great value for your money. Doing hotel and airfare packages can also yield a great deal. Subscribing to newsletters like travelzoo.com and emails from other airlines can keep you up-to-date on the latest deals.

FREQUENT FLIER & HOTEL PROGRAMS:
Earn the miles that you already pay for, sign up and it’s really easy to get a free award ticket. I try to fly on the same airline alliance so that all the miles from say Northwest, Continental, and Delta (along with the other 6 airlines in Skyteam) go to my Northwest account.

ELITE PROGRAMS
So, most airlines and hotels reward their most frequent customers with elite memberships. Most require that you fly at least 25,000 flight miles in a calendar year. Northwest gives free domestic first-class upgrades, 50-125% bonus miles for each flight, and many other VIP benefits. If you fly an international flight or two, 25,000 miles isn’t too hard to do. This can pay off if you try to stick to one airline and their partners. The hotels often provide better rooms and extra points.

CREDIT CARDS:
Earn miles for airline miles or hotel points. Most hotels and airlines have credit cards that earn miles with each purchase. I look for deals that offer 1 year no annual fee with something like 15,000-20,000 bonus miles (eg Delta’s AMEX and US Airways new MasterCard). The best deal are the hotel cards (eg Starwood’s AMEX or Hilton’s AMEX) which give free hotel nights for as low as 2,000 points. Usually, $1 equals one point or mile. Just make sure you know if there is an annual fee or not.

GUIDEBOOKS
There are many guidebooks out there, but for me the Lonely Planet has been incredibly reliable, easy to use, and has great, accurate suggestions. Spending an afternoon at the bookshop looking through each guidebook is helpful and also a good way to figure out where you want to go. Just make sure that the guide was recently published, otherwise, the info might be completely outdated.

AIRLINE TICKETS
As you all know the best fares are usually found on the web. My strategy is to first do a broad search on orbitz.com. It’s fast and gives a great comparison of all the airlines and gives a sense of what the prices can be. Once I find an acceptable price, I’ll double check a few other websites (there are too many to list) and make sure I look at the specific airline’s site because often you can at least save the booking fee that orbitz and the other sites charge. Finally, some airlines will give you a voucher if the airfare drops after you purchase. I did this with Northwest last year getting a $161 voucher to use at a later date. They obviously never advertise this great feature.

MORE QUESTIONS?
Google it of course. There is lots of info and reviews out there. Also you can browse and post questions at flyertalk.com which is a very active community about all aspects of travel from specific airlines, hotels, cities, gay/lesbian travel, and dining. Also, the lonelyplanet.com has a great post a question forum which seems very active.

Enjoy your next trip and make sure you don’t pack too much into your vacation since it is your time to relax and recover from busy months on the wards and unites. I’m off to Rwanda and Tanzania using up my miles and points!
Arlene is the eldest of two children from Eastern North Carolina. She has a younger sister, who also is a med-peds resident. She witnessed the struggles of those with inadequate access to healthcare through her father, a family physician. Growing up, she also was inspired by her mother’s compassion for serving others. From an early age, Arlene knew that any future career would have to involve helping others.

Arlene graduated from Duke University with a Bachelor of Arts in Literature and Minor in Asian and African Languages and Literature. In college, she enjoyed being active in campus, regional, and national leadership activities, especially in the Asian American community. At Duke, she founded an Asian American Theater Group and Korean Fan Dance Group, and helped organize numerous conferences and events. She also was very involved with her church, and helped lead the children’s ministry.

With a desire to help the underserved, Arlene pursued a master’s degree in Health Policy and Administration with concentration in Health Information Systems and Management at the University of North Carolina at Chapel Hill. While in graduate school, she found that her true passion was embodied in providing direct healthcare, and decided that becoming a physician was career path for her. While applying to medical school, Arlene spent a year working in healthcare I.T. consulting and enjoyed living in the DC area and spending time with her grandparents.

She matriculated into the Brody School of Medicine at East Carolina University on a full four-year scholarship as a Samuel Brody Scholar. She also had the unique opportunity to experience medical school with her younger sister, Aimee, who was her classmate. Throughout medical school, Arlene was active in the medical student council as a class officer, Reach Out and Read, the Greenville Community Shelter Clinic, and various other community service activities. At the end of her second year of medical school, Arlene was awarded the Albert Schweitzer Fellowship and created a project to improve access to care for the homeless and underserved population in Pitt County. Her work as a Schweitzer Fellow won her recognition and first place at the national AMSA/NIH/National Health Services Corps Poster Competition in the Community Service. But, more importantly, was a culmination of her childhood desires to help others.

After hearing about med-peds from a resident her 1st year of medical school, she decided that other students should learn about the specialty. Thus, she started a Med-Peds Interest Group at her medical school to help improve awareness, exposure, and interest in the specialty. She currently serves as an advisor to the interest group, and continues to enthusiastically spread the word about med-peds. She enjoys teaching medical students and helping those pursuing med-peds as a specialty. Arlene also looks forward to working to help other med-peds residents and programs through NMPRA.

In her free time, she enjoys playing the violin, piano, and saxophone, painting, and spending time with family and friends. After completing residency, she plans to pursue a career in academic medicine and work with med-peds residents.

President Elect: Arlene Chung, MD MHA, Brody School of Medicine at East Carolina University (Pitt County Memorial Hospital)

Our New Board Members

Treasurer: John Meier, MD, PGY3 University of North Carolina

John is a native of St. Louis, Missouri. He attended St. Louis Country Day School, was active in many sports, band and curriculum associated groups. Outside of school, John worked as crew member and eventually as a captain of a corporate yacht. Summers were spent on the Great Lakes cruising and enjoying the long summer evenings.

After high school, John attended Princeton University and had every intention of pursuing his interest in medicine by majoring in molecular biology. Interests outside of class included rowing which lead to an opportunity of a life time, to sail and work with
the 1987 Stars & Stripes America’s Cup team. John took a two year leave of absence beginning in the fall of 1985 to train with the team first in San Diego, then Hawaii and finally Australia. The team won and after packing up the camp and loading the cargo ship, John set off to back pack around the world for six months. Eventually, John made his way back to Princeton and pursued his new interest in international political economy at the Woodrow Wilson School.

Medicine remained in the back of his mind, but John then earned his MBA at the University of Chicago and was active in the LEAD program and other curricular issues. He then entered the big corporate world for five years in positions of manufacturing, purchasing and finance. After big corporate America it was time for small corporate America and John served as the Executive VP and Chief Financial Officer for two small paper recycling companies in Indiana. Time away from the office was spent riding, traveling and shooting skeet.

However, his original dream of being a doctor resurfaced and after volunteering at a children’s clinic, he took the plunge, applied to medical school and matriculated at the University of Chicago. At Pritzker, John pursued his interest in teaching, volunteering at a local clinic and remaining active in curriculum issues. Now a third year Med-Peds resident at UNC-Chapel Hill, John enjoys volunteering at SHAC, a community clinic, as well as participating in curriculum and teaching opportunities. Future interests include PICU or some form of combined critical care with the intention of working with children, adolescents and adults with chronic illnesses.

**Secretary: Rebecca M. Northway MD, PGY2 University of Michigan**

Rebecca (Naglik) Northway grew up in Michigan outside the Detroit area. She likes chocolate, long walks on the beach, and dogs…! While most of this is true, she would rather run, and is married. The eldest of two children, her brother is an engineer and her parents are a dietitian and a teacher. Originally, she planned to be a veterinarian, but changed her mind in high school. Always loving to serve people in many areas, she worked with Habitat for Humanity in Michigan and the Appalachian areas, Detroit homeless shelters and food gathers, and volunteered at Alzheimer’s assisted living homes. This influenced her decision to pursue a career in medicine.

She attended a small liberal arts college, Albion College, and received a Bachelor of Arts in Chemistry. There she also met her future husband who has watched and cheered from the sidelines throughout all the crazy tests, financial commitments, interviews, stress and joys of the journey toward a medical degree. While at Albion she was the president of her class, was involved in fraternity philanthropy and student union activities. She was also very active in alcohol awareness and safety on the campus, recruiting speakers and organizing educational activities. Her biggest commitment was cross-country and track, which she started in middle school and continued at the collegiate level. She also worked as a rehabilitation aide and nurses’ aide during college and medical school.

At Michigan State College of Human Medicine, she was active in helping at the local homeless shelter and free health clinic. She also co-coordinated the first annual Michigan Health Care Rally that discussed health care disparities, focused on active organizations providing public resources, and called on legislators to make health care changes. Other activities involved AMWA, tutoring, and hosting interviewees. She has continued her love for running, training with her colleague and competing in three marathons and has continued to develop her Spanish skills.

Med-Peds was a new specialty to her and with the help of her mentors, Drs. Melissa Davidson, Tom Melgar, Mark Loehrke, and Dilip Patel she discovered the breadth of the patient encounters and medical knowledge. She remains active in her residency program at the University of Michigan, sharing with students the wonderful career opportunities available when choosing a diverse specialty.

As NMPRA Secretary, she plans to develop a newsletter for residents that have updates about NMPRA, clinical cases, and highlights of other residents through their personal journey. This year, NMPRA will focus on recruitment of resident involvement in NMPRA, as well as increased awareness of med ped as a career option for medical students. Any ideas for an article on any topic relevant to med ped and/or residency can be forwarded to her. Please do not hesitate to contact her with your suggestions at secretary@medpeds.org.
Multiple national medical groups including the American Academy of Family Physicians, the Pediatric Infectious Diseases Society, the American College of Allergy, Asthma, and Immunology, and the American College of Preventive Medicine, oppose the Mercury-Free Vaccine Act and legislation restricting the use of thimerosal in vaccines (Letter to Congress: April 3, 2006). Anti-vaccine groups lobby federal and state legislature and post information on the internet blaming thimerosal for causing autism and other neurologic ailments in children (www.thimerosal-news.com and others). What are the facts about thimerosal? What do you need to know as a Med-Peds physician when ordering vaccines for infants?

Thimerosal, a substance metabolized to ethyl mercury, has been used in many vaccines as a preservative. In 1999, the American Academy of Pediatrics and the U.S. Public Health Service called for the removal of thimerosal from vaccines because of the neurotoxic effects chronic exposure to methyl mercury is known to cause. Based on the number of vaccines infants receive, concern was raised that they would be exposed to more than the U.S. EPA-recommended safe intake level for methyl mercury.*

Estimates of health risk from thimerosal in vaccines were based on the assumption that ethyl mercury (thimerosal) is toxicologically similar to methyl mercury. Although thimerosal can cause delayed-type hypersensitivity reactions and high dose exposure has been linked to neurotoxicity and nephrotoxicity*, studies examining vaccines containing ethyl mercury have failed to demonstrate consistent or convincing evidence of harm. In addition, federal safety guidelines for intake levels of mercury are based on the pharmacokinetics of methyl mercury. The half-life of ethyl mercury is less than one week, whereas methyl mercury has a half-life of 1.5 months (WHO and others). Therefore, applying methyl mercury standards to ethyl mercury exposure is problematic.

Five large studies have compared the risk of autism in children who received vaccines containing thimerosal to those who received vaccines without thimerosal. Findings from the studies were consistent, clear and reproducible — the incidence of autism was the same in both groups. The five studies are: 1. Hviid, et al., Association between thimerosal-containing vaccine and autism, JAMA 2003;290:1763-1766; 2. Verstraeten, et al., Safety of thimerosal-containing vaccines, Pediatrics 2003;112:1039-1048; 3. Heron, et al. Thimerosal exposure in infants and developmental disorders, Pediatrics. 2004;114:577-583; 4. Andrews, et al., Thimerosal exposure in infants and developmental disorders: a retrospective cohort study, Pediatrics, 2004;114:584-591; 5. Fombonne, et al. Pervasive developmental disorders in Montreal, Quebec, Canada: prevalence and links with immunizations, Pediatrics 2006;118;139-150.

Thimerosal has been removed from most vaccines used in the United States. In many areas of the world, access to thimerosal-free vaccines is extremely limited. Even in the United States, there are vaccines in use that contain more than trace amounts of thimerosal. Vaccines that come in multiple dose vials have more than trace amounts of thimerosal. Other thimerosal-free vaccines are manufactured in very limited quantities and are significantly more expensive than those containing thimerosal. Multiple groups have stated that prohibiting the use of these thimerosal-containing vaccines will pose a public health threat by limiting vaccine availability and access to vaccines.

In 2005, the Mercury-Free Vaccine Act was enacted. This Act requires that mercury containing vaccines with more than 1.25 micrograms of mercury per dose are to be banned commencing on January 1, 2006. In January, 2006 the Illinois Department of
Public Health issued an exemption declaration for the following vaccines:

- Japanese Encephalitis Vaccine. Travelers to areas where Japanese encephalitis is endemic or epidemic during a transmission season are advised to be immunized with this vaccine. The manufacturer presently has no plans to change to a thimerosal-free formulation.
- Combined Tetanus-Diphtheria Vaccines. There is one preservative-free combined tetanus and diphtheria vaccine available containing only trace amounts of thimerosal. Other distributors offer a product that exceeds the thimerosal content mandated by the Mercury-Free Vaccine Act. The thimerosal-containing product is less expensive and has been more readily available than the thimerosal-free product.
- Meningococcal Vaccine. The multi-dose formulation exceeds 1.25 micrograms of preservative. In the event of an outbreak of meningococcal disease, it is critical to provide protection for at risk individuals without delay.

In August 2006, the IDPH issued another exemption declaration to the Mercury-Free Vaccine Act for the following vaccine:

- Influenza 2006/2007 multi-dose preparations. The Department cited the fact that current manufacturing processes limit the total amount of preservative-free product that is available to private and public sector providers.

The exemptions issued by the Illinois Department of Public Health are consistent with opinions and actions of other governing bodies and professional organizations. In fact, multiple organizations have expressed opposition to legislation at federal and state levels to restrict access to vaccines containing thimerosal. On July 10, 2006, the Governor of Hawaii filed a Statement of Objection to a bill restricting the use of vaccines that contain mercury. On April 3, 2006, multiple national organizations, including the American Academy of Family Physicians, the Pediatric Infectious Diseases Society, the American College of Allergy, Asthma, and Immunology, and the American College of Preventive Medicine expressed their opposition in a letter to Congress. As stated in the letter, the legislation, if enacted, has the potential to do the following:

1. “Perpetuate false and misleading information that vaccines are not safe.” Studies of methyl mercury, not ethyl mercury (the metabolite of thimerosal), are cited to draw an association of ill effects on the developing nervous system of infants with preservative-containing vaccine usage. Nearly all methyl mercury exposures in the U.S. occur through eating fish and shellfish. Thimerosal vaccines do not expose individuals to methyl mercury. There is no documented scientific evidence that ethyl mercury exposure from vaccines cause any risk to health.
2. “Potentially result in on-going vaccine shortages or inability to deliver care as healthcare providers are forced to seek vaccine formulations that are either free of thimerosal or contain only reduced quantities, both of which would be in short supply.”
3. “Limit the nation’s ability to quickly administer influenza vaccine in the U.S. when a pandemic strikes.”
4. “Lead to increased costs for vaccines.”
5. “Add more complexity to our present vaccine delivery system.”
6. “Profoundly affect global immunization programs, as do many U.S. vaccine policy decisions.”

In conclusion, there is no evidence that exposure to thimerosal in vaccines is harmful. Multiple groups have outlined reasons that restricting access to thimerosal-containing vaccines will be harmful to the United States and global population.

References:

Look for our Newly Designed Website, Coming Soon To WWW.MEDPEDS.ORG!
Congratulations to our NMPRA National Clinical Case Competition Winners!

From left to right: David Kaelber MD NMPRA Advisor, Rupesh Raina MD, Sunita Pillai MD, and Arlene Chung MD current President Elect.

Sunita and Rupesh were chosen from multiple clinical case submissions to present at the National NMPRA meeting in Atlanta, Georgia, October 7, 2006.

Sunita Pillai MD is a fourth year resident in Medicine and Pediatrics at MetroHealth Medical Center/Case Western University in Cleveland Ohio. Her interests include Pulmonary Medicine, Critical Care, and International Health. She currently plans on pursuing a hospitalist after graduation in 2007.

Rupesh Raina is a fourth year resident in Medicine and Pediatrics at MetroHealth Center/Case Western University. His medical interests include erectile dysfunction. He plans to be the chief next year.

Look for their case articles to follow in the next issue of the Med-Peds Perspective.

Keep Up To Date on Upcoming Events at our website:
MEDPEDS.ORG
Annual Northeast Regional Meeting
to be in Spring of 2007
Information to follow in upcoming Med-Peds Perspective.
Life After Residency: A crash course on the job hunt for the PGY4s

By Gitanjali Srivastava, MD
NMPRA Member-at-large, PGY-4
The Mount Sinai Hospital, New York, NY

I had the opportunity to interview Dr. Kristin Kaelber, who finished her med-peds residency in June 2006 and now works in an inner-city primary care med-peds practice. It is part of Cambridge Health Alliance, an Harvard affiliated academic teaching hospital system. She is now a few months into her new job. She provides insight for the fourth–years now in the job hunt, and what she wishes she would have known.

1. Q: Is there something you wished you had known, now that you are in practice?
   A: It is extremely important to be flexible and always ask ‘where do you think the direction of the practice is going?’ The job description you may have signed up for in February may be slightly different than the one you start in July. For example, you may have extra weekend hours, since the practice may have decided to open during the weekends. You might do more or less hospitalist work than originally planned. Job descriptions CAN change. A critical question to ask is ‘how many hours does it take to do this job well?’ The job may entail 60 hours a week, but how many of those hours or beyond those hours are spent making phone calls, following up on labs, charting, and paperwork. Every job is going to entail more time than what is indicated in the contract. Ask, for example, how much work are your partners doing at home during the night? Bottom line: Be flexible and know that your job description can change.

2. Q: Which is better: the electronic medical record or paper chart?
   A: Definitely, electronic. It is the “wave of the future.” However, keep in mind that the transition period can be quite painful, if you are not already used to an electronic medical system in the primary care setting. However, there are certain advantages. For example, alerts will pop up when you see a patient, reminding you to give a flu shot since the patient is diabetic or reminding you that a patient is behind on a pap smear. An important question to ask is ‘how is charting done?’

3. Q: What flexibility do you have starting out your job, when you have to move and cope with taking the boards?
   A: I wanted to start in October, but my job wanted me to start in July. So, you have to work with them and come up with a compromise. I ended up starting part-time, 2 days per week, and scheduled my 1 month vacation around the boards. It is OK to say that you are willing to work part-time until your boards.

4. Q: When should you take your boards?
   A: It is really up to the person taking the boards. I am glad I took just one. However, having said that, there are plenty of people who pass both boards at the same time. From July 1 to August 27, I studied every day for at least 4 hours/day. Prior to taking the medicine boards, I must have done at least 3000 questions! Do lots of questions.

5. Q: Was it difficult to juggle working and building in time studying for the boards?
   A: Actually, it worked out to be a break to go to work while studying. It is also a good way to ease into your new job.

6. Q: What was the hardest part during your transition into your new job?
   A: The hardest part is how isolated you can be from a specialist and a tertiary care center. It’s hard all of a sudden not being able to curbside specialists and to develop a network of specialists to bounce ideas off of.

7. Q: What have you done to make this transition easier?
   A: I’m making an effort to go to Grand Rounds at the main hospital. There, you end up meeting specialists face to face so that you can feel comfortable emailing them with questions later. My advice is to NOT be afraid to ask for help with the transition.
Everyone remembers how rough the transition is. Remember, the people in your job want you to like your job and to succeed, because they too have invested lots of energy in finding you and training you. You have been wanted by this group and they want you to enjoy your job. Support is extremely important.

8. Q: Did your residency prepare you for “real life?”
A: A lot of what you learn in residency may not be helpful in real life. You learn by osmosis and experience. Many common, bread & butter questions pop up, which you may not have encountered in residency. For example, how do you treat a menopausal female who complains of “hot flashes?” What do you do with a population of dizzy, Brazilian ladies?? Be upfront with patients. Say “I’m new here and I just moved here, and I’m going to ask my colleague” or say “Excuse me.” All things do NOT have to be answered right away. If patients walked into the clinic, you generally have time to help them fix their medical complaints. Come up with a list of questions, identify a mentor, and meet with them on a regular basis. The list of questions is good because then you will not need to bombard them with questions every 5 minutes.

9. Q: What was the lowest point in your career, thus far?
A: Definitely, the narcotic-seekers for chronic back pain. My neighborhood knows there is a new physician, and they will test you. Come up with a strategy about answering questions about narcotics. It will definitely come up in your practice. Develop a protocol for addressing this issue. Our practice had an entire discussion on this issue, and we developed a pain contract. Eventually, many people will move on or trust your judgment and start coming back for genuine medical problems.

10. Q: What was your highest point, or your happiest point, thus far?
A: A patient came in for a routine medical exam. He was very content with the medical care I provided. Now, I’m also the primary care provider for his girlfriend and 18 month-old son.

11. Q: How do you factor in learning and reading time?
A: Read up on a patient when you do not know what to do. Attend Medicine and Pediatrics Grand Rounds, if possible. Much of this also comes from residency reading habits. Every other week, we have a CME hour in our practice. Our six med-peds providers meet with specialists who give a talk on something that we feel we need to hear more about. It is great, because it is driven by what we see in our practice, and it is a great way to meet the local specialists. Develop your own way of keeping up with things. Remember that just because you have finished residency does not mean that you are supposed to know everything yet. Keep learning!

12. Q: Is teaching compensated?
A: Teaching ends up being a voluntary activity at my institution. However, you can tailor it in such a way that is adds to RVU equivalents.

13. Q: What are RVUs?
A: RVUs are relative value units. They measure the “energy” involved in seeing patients. If you are good at coding, you can increase your RVUs. Many times performance bonuses depend upon them. For example, a new patient visit has more RVUs than an established follow up patient. There are guidelines of how many RVUs you should generate each month and each year. Most jobs give a “grace period” in your first year. After that, your salary can decrease if you have not generated enough RVUs. Bottom line: LEARN AS MUCH AS YOU CAN ABOUT CODING.

14. Q: What exactly is administrative time?
A: It is time given for you to attend to all the paperwork that comes with maintaining a busy practice. You may also be expected to better the practice during this time. For example, someone may be assigned to develop the most effective strategy to improving patient flow in the waiting room, whereas someone else may work on improving the electronic medical record system for the “benefit of the community.” Always ask, “how many committees will I be expected to serve on?” or ‘how many additional meetings outside of work will I be expected to attend every week?’ or ‘are you expected to be in your office during the administrative time?’ Inquire what would happen if you put in extra time at the end of each day for administrative time…would that imply that
you can take your official administrative day off? Remember, there will be several unpaid requirements in which you will have to invest your time. There is a lot of paperwork which is very different from residency (i.e. phone calls, prior authorization forms, etc.).

15. Q: How long is your day?
A: I see patients 7 half sessions per week. I spend about 10 hours per day at my job including working on my administrative day. Efficiency with charting is already getting better with time and experience. You will have to develop your own way of approaching your patients’ complaints and this initially takes time. I spend a lot of time reading and talking to my partners about how to handle things.

16. Q: What should we know about the ancillary support structure?
A: Yes, extremely important question. You MUST ask the following: will I have secretarial support? How many physician’s assistants do you have? What is the nursing to physician ratio? Who handles patient phone calls? How many phone calls do you receive when you are on beeper call? How often is call? Do you have a nurse triage phone call system for pediatric questions? Also, of equal importance, is the question ‘who do you share call with?’ Some practices may be covering for other practices during off-hours.

17. Q: How do you negotiate a salary?
A: There is not much to nudge in academic institutions where salaries are predetermined. However, you can try to negotiate moving expenses, start date, board exam passing bonuses. It may be different for private practices.

18. Q: Now that you are in practice, did you find any discrepancies between what you perceived of the practice partners during your interview vs. now?
A: Not really. A dinner interview with the providers is a good way to get to know them and for them to know you. It is really

More Pictures from the National NMPRA Meeting in Atlanta!

Keynote Speaker Aditya Nadimpalli, MD from Tulane University who spoke about his international experiences as a Med Peds doctor.

From left to right: President Elect Arlene Chung, Secretary Rebecca Northway, and Current NMPRA President Ken Remy.
important. Most providers in our practice have families and kids. Ask yourself: can you invite these people over to your place for dinner and have a good time with them? This may not be important to you but it was for me.

19. Q: Do you socialize with your colleagues outside of your practice?
   A: Primary care is very busy. We are young physicians with young children, so time is short. However, our practice makes an effort to get together on a regular basis. So far we have met for a summer swimming picnic and a fall apple picking. These events are great for bringing people together and bonding.

20. Q: How is your schedule organized?
   A: I have slots which become open only one day before for urgent care. Most of my slots are filled up weeks to months in advance. What is in the news in primary care is open access scheduling. What this means is that patients call the week before they are seen for their appointments, rather than scheduling 1-3 months in advance.

21. Q: How many patients per day do you see, and is that number overwhelming to deal with coming fresh out of residency?
   A: I see 10-15 patients per day. However, those are mostly new patients. Since, we have a large Spanish and Portuguese population, there is double-time allotted (i.e. 1 hour) for those patients since it does take more time. We do have on-site translators which work with us. Also, the electronic medical record system makes it easier. You can type while speaking to the patient, whereas in residency it may take more time writing up the note after seeing the patient.

22. Q: Any final words?
   A: Read the Med/Peds job guide by Dr. Chamberlain under the NMPRA website. Keep an open mind. Your learning never ends. It’s very exciting! Being done with residency is good. There IS life after residency. Please feel free to email me with any questions. My email address is: kkaelber@comcast.net

Dr. Kaelber, muchos gracias! As Med-Peds residents, we have embraced a specialty where there are diverse options, and the career possibilities are infinite from a career’s perspective. Some of us choose to go on to primary care, some go on to fellowships in one respective specialty or another, some chose to do a dual fellowship, and of course, the vast majority of us are still deciding. For all med-peds residents, this is the perfect time to explore your options.

Explore the following websites from NMPRA, ACP, and AAP. Most residents are already members of AAP, since the fees are paid for by the program directors. But did you know there is a Med-Peds section of the AAP? Sign up for the Med-Peds resident section of the AAP ($10 membership fee) for networking and other benefits:

www.medpeds.org  NMPRA website has a special Med-Peds job guide, Med-Peds fellowship guide, Med-Peds job opportunities, and several other search engines and links. The Med-Peds job guide is extremely thorough in taking you through the entire process.
www.pedsjobs.org/pedsjobs/  (AAP membership required)
www.acponline.org/jobs/  (American College of Physician)

Stay Tuned for Information Regarding the 2nd Annual MidWest Meeting
Scheduled for Fall of 2007
Date and Location still to be determined!
Not a NMPRA member?
To join go to http://www.medpeds.org/Membership/Membership_New.htm

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