NMPRA Annual National Meeting: Saturday, October 27, 2007 in San Francisco, CA

The Med-Peds Perspective

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From the Desk of the President

Arlene Chung, MD

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Dear Med-Peds Colleagues,

Congratulations to all our med-peds graduates; best wishes as you start your careers! It's time for new beginnings again as our med-peds interns start their journeys into our amazing specialty. It is an exciting time of year for NMPRA as we inch towards our national meeting in October 27th.

After a year of hard work, we are happy to announce that NMPRA's website, www.medpeds.org, will has a new look and updated information. Our website continues to be the most visited med-peds site, and an important source of information for medical students applying for med-peds. In addition, our jobs board and fellowship guides continue to be vital sources of information.

Remember to mark your calendars for our 11th annual national NMPRA meeting on October 27 in San Francisco which will be held in conjunction with the AAP National Conference. We invite all med-peds residents, faculty, and students interested in med-peds to join us for our dinner meeting. We are pleased to announce our airline and hotel discounts for the national meeting, which can be found at our website at www.medpeds.org/national_meeting.htm. Don't forget to submit your interesting cases to our abstract competition and don't forget to join us in Chicago at the 2nd Annual Med-Peds Midwest Regional Conference hosted by the University of Chicago on October 6th!

In addition, this year we are introducing various NMPRA special interest groups and webpages, including Global/International Health, Hospitalists, Transitional Care, Community Service & Advocacy, and Caring for Adults with Congenital/Childhood-onset Diseases. We hope that this will provide another avenue for med-peds residents, fellows, and medical students to share and provide information about these topics with each other.

This year, we are looking for 100% participation from each med-peds program and we look forward to your ideas and support to make for a successful year! Please don't hesitate to contact me at president@medpeds.org if you'd like to become more involved in NMPRA or if you are interested in becoming your program's NMPRA representative!

I hope to see everyone in San Francisco on October 27th!
Arlene E. Chung, MD, MHA
NMPRA President

Check out our new and improved website at:
www.medpeds.org

- *Dr. Tom Faber opens a window onto his life as a Med-Peds physician on the Zuni Reservation.* *See page 6.*
- *Interns, want to know what is in store for you this year?* *See page 4 for details!*

Inside this issue:

Meet Our New NMPRA Board

Arlene Chung, MD, MHA, NMPRA President

Arlene Chung is the eldest of two children from Eastern North Carolina. She has a younger sister, who also is a med-peds resident. Growing up in a small rural farming community had a lasting impact on her, and from an early age she hoped to pursue a career in 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 the 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.

Throughout medical school, Arlene was active in the medical student council as a class officer, through the Reach Out and Read program, at the Greenville Community Shelter Clinic, and through 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 Community Service. But, more importantly, this honor was a culmination of her childhood desire 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. One of Arlene's pride and joys is the ECU Med-Peds Interest group. She started the 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 them realize that they should choose Med-peds! She looks forward to an exciting year serving as NMPRA president and hopes to pursue academic medicine in the future.

Jessica Wilson, MD NMPRA President-elect

Jessica Wilson was born in Evanston, Illinois and received a B.A. in Spanish from the University of Illinois and an M.D. from the Rosalind Franklin University of Medicine and Science/Chicago Medical School. She is currently a second year resident at Medical College of Wisconsin. Jessica has been on the Executive Committee and also has served as the President of the Student National Medical Association. She has been a member of her medical school's Admissions Committee and has also served on her school's Lottery Committee, which facilitated third and fourth year rotation selections. Prior to medical school, Jessica was a bilingual education teacher for the Waukegan Public High School. Jessica is fluent in Spanish and enjoys reading, moving, spectator sports, singing in her church choir, and traveling.

Paras Khandhar, MD
NMPRA Treasurer

Paras Khandhar is a third year resident at Rainbow Babies and Children's Hospital/Case Medical Center in Cleveland, Ohio. As a native of the city of Chicago, Paras is an avid Chicago sports fan and enjoys returning to the "windy city" as much as time dictates. A graduate of Creighton University School of Medicine in Omaha, Nebraska, Paras is interested in a career in critical care. In his spare time, Paras enjoys being a DJ and making music mixes for people to enjoy.

Ariel Frey, MD, MAT
NMPRA Secretary

Ariel Frey grew up in Acton, Massachusetts and stayed close to home when she attended college at Harvard University. There, she was very involved in community service through teaching an enrichment curriculum to local children at an after-school program. She also participated in Harvard Model Congress as a moderator for mock congressional sessions for high school students in both Boston and Paris and went on to co-found a similar model congress program for underserved Boston area high school students. She graduated with a degree in neurobiology.

Her dedication to the underserved and to education led Ariel to become a Teach for America Corps Member directly after college. She taught third grade in inner-city Baltimore and was a member of the Teach for America Corps Member Board in Baltimore City. She reflects on her Teach for America experience as one of the richest and most challenging she has had, and while she remains committed to education and underserved communities, she wanted more of a one-on-one experience with individuals than classroom teaching was offering her and so she proceeded to go to medical school.

Ariel did her medical training at Yale University, where she volunteered in and subsequently ran an in-school health program for high school students. She also co-ran the Yale Family Medicine Interest Group, putting on events for students to educate them about family medicine and primary care. While she initially thought she would go into family medicine to pursue her interests in working with underserved urban families and communities, she started looking into med-peds as a possible career choice when she was exposed to the field through two med-peds physicians who led her first and second year tutorial on how to take a history and do a physical exam. She was excited by the way these physicians had used med-peds training to create careers which allowed them to practice primary care while being involved in academic medicine; after doing more research on the field, Ariel decided to go into med-peds herself.

Ariel is currently a third year resident in the Massachusetts General Hospital Med-Peds Residency Program. There, she is active in the med-peds community and has started a Harvard Med-Peds Student Interest Group. She is also involved in the Internal Medicine Curriculum Committee and the Pediatrics Advocacy Group. She hopes to eventually work in primary care and precept medical students and residents as a clinician educator. She is very excited to get involved in med-peds at the national level and looks forward to serving NMPRA as its secretary.

A Year in the Life of a Med-Peds Resident: Intern Year

Paul Hyman, MD

Stage I - Pre-orientation

My med-peds residency experience actually began before residency even started. In the months leading up to my med-peds orientation, I repeatedly found myself in the following conversation:

"So, what type of medicine are you going in to?"

"I am starting a residency in med-peds."

Look of confusion and awkward silence.

I found I often had to explain what a med-peds residency is and why I had chosen it.

Stage II - Orientation

Here I learned that 1+ 1 = 3. I had to go to three orientations, (medicine, pediatrics, med-peds). To be fair, I also was invited to three welcoming parties. But how was I ever going to learn the names of all of these residents, nurses, and hospital staff? And how were they ever going to learn to recognize me, who popped in and out of their orientation, their conferences, their floors of the hospital? And how could I avoid three different programs all insisting on placing a PPD?

Stage III - Starting on the wards

I started on medicine. There is nothing uniquely med-peds about this stage, which is what's nice about the first month of internship. No matter whether you are med-peds or categorical, you don't know where anything is and you can't remember anything you learned in medical school. But at least you are not alone—the hospital is filled with other interns like you.

It was during this stage that I first began to ponder how to outwardly express my med-peds identity. Should I wear all 6 of my badges? (I chose not to, for fear I would lose them all at once in a moment of absentmindedness.) Should I wear my med-peds white coat or one of the pediatrics or medicine coats? (I chose not to wear any white coat). It was also during this stage that I started actively seeking out other med-peds residents, as I found that they understood the unique difficulties surrounding decisions like whether it was acceptable to put SpongeBob stickers on your nametag and still call yourself an internist.

Stage IV - The first transition

The switch from one discipline to another is a very "med-peds" experience. For me, the switch was from medicine to pediatrics. Walking onto the wards the first day kind of felt like walking into a party that has already started. Everyone turns and looks at you and wonders who you are. You then go up to the fridge and open it up to grab yourself some food only to realize it isn't really that kind of party—it is more the kind of party where the host helps get the food for you. You then go over to some of the people at the party and try to make some jokes only to find that the jokes don't go over too well.

Walking onto the pediatrics floor the first day, I felt uncomfortable. Everyone seemed to know each other and I didn't know anyone. To my relief, people welcomed me and the awkwardness quickly disappeared. I then needed to adjust to the culture of pediatrics, which can be very different from that of medicine. There is often a lot more thought and discussion before each decision. What is taken seriously and joked about is also very different. I learned to be very sensitive to my surroundings. At the same time, I felt as if I were starting internship all over again. The peds residents had already done some time on pediatrics, but I was starting fresh, trying to find the bathroom and wondering where I left my Harriet Lane.

While on pediatrics, another concern of mine was whether I should still be trying to learn adult medicine. Copies of the *New England Journal of Medicine* would arrive on my doorstep weekly with great articles on adult medicine. During this first pediatrics block, I found it very hard to read about internal medicine. There was so much pediatrics to learn! But, to be honest, I found it very hard to read about pediatrics. I found it very hard to read at all. How was I supposed to read and somehow manage to eat, sleep, work, and spend time with my family and friends all in the same day? The reading usually fell by the wayside. At the beginning of the year, I found it best to focus on the rotation I was on, reading about patients that came to me as I could and not worrying too much about everything I wasn't reading about pediatrics—never mind medicine. As the year progressed, I found it easier to integrate the two disciplines, reading and thinking about medicine while on pediatrics and vice versa.

Stage V -The next transition

If the first transition is like walking into a party late, the second transition is like going to a concert of a band you used to like. Everyone seems to know each other and is singing the lyrics and you can't remember one word. What was the dosing for enoxaparin? For metoprolol? My co-interns were talking a mile a minute and had a million tricks up their sleeves. I was still thinking about Tylenol in mg/kg and thought that getting a CT or giving morphine was a serious issue that I needed to think about for hours and discuss with everyone in the hospital. Don't worry, re-acculturation happens quickly. A few days and it was like I had never left.

This medicine block was the hardest part my intern year. The winter was cold, long and dark. I felt exhausted. I was definitely somewhat depressed. Some skills I learned along the way to help:

"If the first transition is like walking into a party late, the second transition is like going to a concert of a band you used to like. Everyone...is singing the lyrics and you can't remember one word."

1. Take time for yourself. For me, being a med-peds resident made this especially hard. Because med-peds was a set up for falling behind in your learning when compared to your categorical colleagues, I felt I had to read more and study more on my free time. It was only after I had a "forced" break of a couple days off that I realized how important a break was. After a break, I would return to the wards with more enthusiasm and energy. As for the reading and studying part, I learned to give myself a break on that as well. You are learning so much by doing in your first year, and you are so over-worked and exhausted, that there is little time to read. And that's fine. You are learning, even when it feels like you are not.

2. Spend time with your co-residents. This can be especially challenging for med-peds residents, as we straddle three programs. We may rarely see our med-peds colleagues since our schedules are so different. But you absolutely need to spend time with people who are going through the same experience. You need someone to who will say to you "Oh, I had something similar happen" or "No, you are not crazy."

3. Look to the future. For me, residency was very different from medical school. I saw residency as a job. And I have to admit, it wasn't *always* the greatest job. I had a lot of responsibility and worked quite hard. To keep myself motivated during residency, I found I needed to think about what I wanted to do after residency. To the extent possible, I tried to continue to involve myself in activities that kept me connected to my career interests.

Stage VI – The Light at the End of the Tunnel

I am sure that at this point in the year, the end of internship feels like forever away, but believe it or not, time will pass, you will defrost from your winter deep freeze, and you will emerge seeing the light at the end of the tunnel in clear view. On the one hand, come June I was ecstatic to think about fewer Q4 calls, fewer notes to write, and the opportunity to run a team. On the other hand, I was terrified—I would no longer be the lowest person on the totem pole and a brand new set of interns would be turning to me for answers. Would I have any answers? Was I ready to be a junior with all of the categorical residents who would have had twice as much time in each specialty as I had? If you end up feeling this way, don't worry. It is a common med-peds feeling. Hang out with your med-peds classmates and you will realize you are not alone. And you know, so far this junior resident thing hasn't been so bad. Make some decisions, do some teaching, and sit back as your intern wakes up early, scribbles away, and looks to you for guidance. I am starting to feel like a doctor, maybe. . .

Med-Peds Physicians in the Community: A Day at the Zuni Indian Health Service

Tom Faber, MD

My days on call all seem to start the same way. I walk out of my front door and begin down the short road to the Zuni Indian Hospital. In the distance I am greeted by a sacred Zuni mountain, Dowa Yalanne, a majestic structure which sheltered the entire Zuni pueblo for over 13 years as they resisted Spanish control in the 1600s. After a year of living here I am still amazed by the landscape, which is filled with countless reminders that this area has been home to the Zuni people for over 1200 years. The sky is usually perfect in the mornings, and I try to use this time to get ready for the day ahead because, while it begins predictably, I know that once I walk in the door anything can happen.

The hospital is located on the Zuni reservation, a rural area of mountains, high mesas and pine forests located in western New Mexico. We have 25 inpatient beds, a small OB unit, an ER and a full outpatient facility. We care for Zuni patients as well as those from the surrounding Navajo reservation. I start the day by rounding on my primary care patients who are in the hospital. Today I have three patients to see. The first is a 72 year old Zuni man admitted with weight loss and hypoxia who was found to have pulmonary fibrosis and an acute pneumonia. I knew he was doing better today when he started to complain of pain over the broken ribs he suffered last week after falling off of his horse. He's anxious to get back to his sheep but agrees that he's a bit too weak to leave today. The next patient is a 60 year old Navajo man who was diagnosed with renal cell carcinoma last year. He underwent a nephrectomy which was thought curative until a few months ago when he presented with a malignant pleural effusion. He had been doing well recently but was admitted the day before with pneumococcal meningitis. At his bedside is a constant vigil of family spanning four generations. His condition is tenuous, but formally discussing end of life wishes is complicated by a traditional belief that mentioning bad events may cause them to occur. I think the family understands his long term prognosis and assure me that "we will all decide" this morning. My last patient is a four day old baby boy admitted yesterday with hyperbilirubinemia and mild dehydration. I saw his mother, who is 17 years old, for all of her prenatal care. I was hoping to do the delivery, with a family practice doc providing backup, but I was out of town at the time. She is settling into the role of mom with amazing ease. Her boyfriend is holding the baby looking every bit the proud father but he reluctantly hands me the baby to examine. Fortunately, I know there will be a seemingly endless supply of Zuni grandmothers and aunts to care for this baby, and I have yet to sense any stigma or shame felt by teenaged parents here. The baby's mom is planning to finish high school and then "see what happens." I finish seeing the baby just in time for "rounds," the morning meeting where we discuss the previous day's admissions and review the inpatients.

> "When my friends from residency...ask me why I came to Zuni, I tell them that I wanted to 'practice full spectrum Med-Peds,' but there are times when I must admit I didn't know how 'full' that spectrum was going to be."

There are 16 doctors on the medical staff, mostly family practice with 3 Med-Peds docs and one psychiatrist. I always look forward to rounds because it's a chance to see friends and learn from each other. The doctors usually occupy a conference table in the center of the room with the nurses, community workers and other staff sitting in a wider circle. Last night there was a delivery of a healthy baby girl and a transfer (by airplane) to the Pediatric Intensive Care Unit in Albuquerque of a 13 year old girl who presented in severe diabetic ketoacidosis. Today we also spend a while discussing the case of a 52 year old man with a history of alcoholism and cirrhosis who was admitted last week with dyspnea and refractory hypoxia. His case has puzzled us this week, but we agree that he appears to have hepatopulmonary syndrome. A community nurse brings up the fact that he lives in a house with his brothers who are all actively drinking and suggests that we work on finding alternative housing, which the social worker agrees to do. As rounds adjourn, my pager goes off requesting my presence in the Emergency Room (ER) … it's started already.

I'm always nervous when I am called to the ER. As the "on call" doctor today my job is to handle all the emergencies and admissions. As the only hospital in the area, this means that I literally have to be ready for anything. As I enter the ER, I see a young woman on a backboard with a cervical collar with blood covering her entire face. Her face has several deep lacerations. I try to remember the basics and forget the fact that only a year ago, as a senior Med-Peds resident, I was essentially a bystander during major traumas. Fortunately she is talking to me and has normal vital signs, but as I examine her face, it is obvious that she has unstable facial fractures and is beginning to choke on her blood. The closest Computed Tomography (CT) scanner is an hour away, and she will clearly need transfer to a trauma center. Without even really knowing what happened I ask someone to call the flight team for transport to Albuquerque and prepare the equipment for intubation. The Emergency Medical Technicians (EMTs) report that she was the unrestrained back seat passenger of a car that swerved off a dirt road to miss an elk. She was unconscious for 10 minutes and there are "other injured" on their way. When my friends from residency, who are mainly sub-specializing, ask me why I came to Zuni, I tell them that I wanted to "practice full spectrum Med-Peds," but there are times when I must admit I didn't know how "full" that spectrum

was going to be. Fortunately, the intubation went smoothly despite the bleeding and she had no other significant injuries. The other passengers were wearing their seat belts and were not seriously injured. I called the trauma center later that day and learned that my patient was stable but with a subarachnoid hemorrhage, basilar skull fracture, and Le Forte II facial fracture. She was going to have surgery the next day.

After I change my scrubs and get some lunch, things seem under control. I catch up on paperwork and call some of my primary care patients. Since traveling five hours round trip to see a specialist is both logistically and economically impractical for the patients, I do the vast majority of my consulting over the telephone. Today I arrange radioactive iodine thyroid ablation for a patient in whom I had diagnosed Graves Disease, discuss the starting dose of methotrexate with a rheumatologist for a patient recently diagnosed with rheumatoid arthritis, and speak with a pediatric nephrologist regarding a 6 year old girl with persistent hematuria and hypertension. Later a patient calls me and asks if he can come in this afternoon. He's a 35 year old man named Sonny who was diagnosed with metastatic gastric cancer two months ago. I met him after he presented with abdominal pain, jaundice and an obviously palpable abdominal mass. Since then he's been receiving palliative chemotherapy as well as traditional Zuni medicines and healing rituals. We formed a fast friendship of sorts, probably because of our similar ages and the fact that we each have small children. Since then we have seen each other every week or so. As always he's here with his wife, but today he looks much weaker than usual. He has a low grade fever and is obviously confused, dehydrated, and dyspneic. I make arrangements to admit him to the hospital, and I can sense that both Sonny and his wife realize how sick he is. I know that over the next few days his hospital room will be filled by female relatives who will take turns comforting, massaging and "guiding" him much in the way they support women in labor as they "welcome" a new baby. I am glad that I am able to easily bring him into the hospital where I can make sure he's comfortable and not subjected to a long ER wait and impersonal hospital care.

"I have no doubt that this experience is making me a better doctor by shifting my attention away from lab values and imaging studies, sharpening my clinical judgment, and teaching me to treat the whole family as my patient."

The rest of the day and night are steady with calls and a couple of admissions: a 10 year old boy with an asthma exacerbation and 45 year old man with diverticulitis. At 9:00 pm I am relieved by the night call doctor and we chat for a while before I fill her in on the patients in the hospital. I walk out of the hospital and begin my familiar walk back home, this time under a blanket of innumerable stars. While my "on call" mornings are usually filled with anticipation, at night I reflect on what an amazing place this is to practice medicine. It's a place where the care of adults and children is integrated into the care of families and communities and where one can focus on the patient rather than bureaucratic obstacles. As it becomes increasingly obvious that the "health care system" is dysfunctional, I can't help but look at this small Indian Health Service hospital as a model for providing excellent care with few resources. I have no doubt that this experience is making me a better doctor by shifting my attention away from lab values and imaging studies, sharpening my clinical judgment, and teaching me to treat the whole family as my patient. The inability to refer my difficult problems away has forced me to expand my knowledge in ways that I have not had to do since my internship. I am constantly humbled by the trust and welcoming spirit offered to me my by the Zuni and Navajo people. While this job is certainly not for everyone, as I look back on the day, there is no other place that I'd rather be working.

Interested in learning more about being a med-peds physician at an I.H.S. location or looking to learn about doing an elective with the Zuni I.H.S.?
Contact Tom Faber, MD at: tjfaber@gmail.com

NMPRA Advocacy Award Winner Essay: Literacy for End-of-Life

Joshua Dower, MD discusses the project for which he won the NMPRA Advocacy Award

I believe that as physicians, we have a duty to help children and families not only in the treatment of their illnesses, but also in their ability to cope with illness, grief, and death. The program entitled "*Literacy for End-of-Life*" is intended to promote awareness of currently available age-appropriate end-of-life themed children's books, and to recognize their potential use in the physician-patient relationship.

I developed the concept for this project when I reflected on two patients that I cared for early in my career who impacted my life and helped to shape the way I view death and dying. The first child was a 12 year-old boy with the diagnosis of epidermolysis bullosa. He would develop blisters with any abrasive trauma to his skin and lived with chronic open skin wounds and unimaginable pain. He was an extremely bright child with an interest in politics and was a pleasure to visit. His parents were the most remarkable caregivers and child advocates I have seen to date. We had encounters at every level of my training, from medical school to residency, and developed a personal relationship. I was deeply saddened when his father called me with the news of his son's death last year. I attended his "celebration of life" and mourned the loss of a truly special young man.

I encountered the second child about a year later in my career. He was a 9 year-old boy who was transferred emergently because of nausea, vomiting, and lethargy. A CT scan revealed a large brain mass. I met his grandmother and learned that his father was ill with leukemia and his mother was incarcerated. I recall the grandmother's deep faith and belief that things would turn out okay. I also remember my disappointment with his unfortunate medical outcome. I watched his grandmother provide heroic care for him as he remained neurologically devastated for 5 years. During that time, his mother died. I met his grandmother the day she came to "let him go home to be with his mom and be a boy again." I sat with her and shared moments of reflection and he died peacefully. That week I created this project. These two boys had amazing caregivers who taught me about true sacrifice for children facing death. I grieved alongside them and hoped that I was able to provide some comfort and support..

I was looking for an opportunity to use the insight I had gained from working with these families to help families in similar situations when I learned about "bibliotherapy." I thought how helpful it would be to use children's books to help my patients express themselves and stimulate conversations. I read an excerpt from a book titled, "*Crisis Management and the School Community*" by Mardie Whitla describing bibliotherapy as a way to help in trauma recovery:

> "A good story attracts the reader and carries him or her to distant times and places, while distancing the reader from him or herself. Stories or tales are metaphors that use symbols, helping students (and adults) to reach new interpretations of reality, and a way out of the state of feeling stranded, helpless and out of control. They take the students to a state of flexibility and a feeling of having some control over the situation." (p.116)

I became motivated to review the available children's literature on the subjects of death, grief and bereavement and thought about ways to incorporate these resources for use in my community. I thought more broadly about the inclusion of children into the experience of death with their immediate family or with a member of the community. I thought about how death impacts the way children shape their world. Although I am trained in Internal Medicine and Pediatrics, I realized that I am guilty of not asking my dying adult patients if there are any children involved and if they need guidance or recommendations for their inclusion. I also realized that I was ill-equipped to give this guidance. I recognized that using existing literary resources could help solve this deficit and have applications for multiple other physicians including obstetricians, surgeons, internists, and pediatricians.

I decided to build a lending library and name it to honor the two families described earlier. The "Fogg and Mills Memorial Library" will be established at WVU Children's Hospital in Morgantown, West Virginia. It will primarily serve the local community, but there are plans to purchase a second set of books to mail to any family in need across the state of West Virginia. Through it, I hope to provide resources to ease the hardships that many families experience without proper guidance and support. This collection of resources will give families tools to involve children in the experience of death. This will require significant organization, grant funding and community support.

I began to seek out mentors and form strategic partnerships with individuals in my community who have knowledge and experience with the fundamental requirements of such a project. I have been thrilled and grateful for their offers of assistance and support. I especially appreciate the support of my wife. Her background in education and specialty training in reading have been invaluable. I gained the support of my program director and sought the assistance of a fellow resident. Together, we began to write for grant support. We have been encouraged by the NMPRA's recognition of our project and hope that this story inspires you to advocate for children in your community and pursue your ideas with passion. (*continued on the following page*)

(continued from previous page) We want to leave you with our project vision and hope to see you at the National Med-Peds Resident Association Conference in October.
We envision a time when a comprehensive program exists to identify and eliminate the unmet needs of children who are dying or experiencing the death of a loved one. Special attention will focus on children struggling with illness, death and grief. All families will have access to age-appropriate information to support suitable inclusion of children in end-of-life situations, and these experiences will be accepted as normal, healthy aspects of life.

Money Matters:
How to Avoid Being Taken Advantage of By Your Bank

Emery H. Chang, MD, NMPRA Travel Adviser and Past Treasurer

We work hard for our money. And many work hard in trying to take it away from us. Many businesses have exorbitant fees that don't get you anything in return.

ATM Fees Most ATMs will charge you up to $4 per transaction and then your bank will charge another few dollars. Particularly if you are only taking out a few dollars you'll lose a lot of money for these small withdrawals. Instead, use you own bank's ATMs when possible and know where lower fee ATMs are near your home and the hospital. Pick a bank that has ATMs near you or just don't use cash when you can.

Overdrafts A small mistake can cost you $40 or more. Keep a buffer amount of cash in your checking account to prevent bounced checks. Balance your checkbook so you know how much is there. Some banks have free overdrafts from your savings account, which often don't incur a fee. Others will set up a line of credit instead. However, make sure you understand what fees or interest that would occur if the overdraft happens. Banks made over $10 billion last year on bounce protection alone! Also, when you do overdraft, fix the problem ASAP. Often, they'll charge you a fee for each day you have a negative balance. Sign up for email alerts in case you have a low balance or overdraft so you know sooner, rather than later.

Foreign Currency Transaction Fees Many credit cards charge 2-3% on all foreign transactions, which add up quickly. Using debit cards can avoid these fees, but check with your bank beforehand. Also Capitol One and a few other banks don't charge them; just ask before you go on vacation.

Credit Card Fees and Interest Rates Credit cards can be a great way to manage your money and are easy to use. Plus you can get hotel points, airline miles or cash back. However, if you don't pay your full balance each month, you can be in for hefty interest charges, which will negate those benefits. Pay more than just the minimum balance, which is often set so low, you'll never pay off what you owe. Further, once you carry a balance or become late, you can suddenly lose those great promotional rates and pay close to 30% interest rates. In fact, often, they will retroactively charge you the high non-promotional rate on previous balances if you miss a payment.

Mortgages Often adjustable rates have better interest rates initially but the rates can readjust to significantly higher market rates later on. It's key to take this into account so that you know that you'll be afford the payments a few years down the road. Also, often you can renegotiate the terms of the loan without refinancing through a customer retention program so that you can reset the adjustable rate for another few years.

Student Loans Not all loans are created equally. Pay off higher interest loans, usually the private loans that are not federally backed (e.g. MedCap Extra). An extra $50 per month can finish the loan a few years early and you'll hardly miss it. Consider consolidating your federal loans to lock-in lower interest rates for the life of the loan. Otherwise, the interest rate will adjust every year on July 1st. Make sure your payments are on time so that you can qualify for interest rate rebates for on-time payments, and avoid late fees and credit report dings.

Open Your Mail It's easy to be post-call and to just throw your mail into a corner and forget it. Weeks later, I've often been looking for something else then voila, it's that bill again. Of course it's very late now and late fees have been tacked on with interest. Plus, it could have been reported to the credit agencies. After a few painful forgotten bills, I made it a rule to pay the bill the day I got it. Suddenly, no more late fees…

Ask For It Back If a simple mistake happens on your part, call up the bank or company to see if they'll waive the fee that was charged you. Often, they'll cut you some slack if it's a first time mistake or if you just ask nicely. Don't like the answer of the first person you talked to? Call back and ask the next person again. Remember, you're the customer and they need you to make money.

Announcing the Annual NMPRA National Meeting
Saturday, October 27, 2007
San Francisco, CA

Please join us for the 11th Annual National Med-Peds Residents' Association's National Meeting. The Meeting will be held over dinner during the AAP National Meeting in San Francisco, CA.

Saturday, October 27th
6 to 10pm
Sir Francis Drake Hotel
450 Powell St
San Francisco, CA
www.sirfrancisdrake.com

We welcome students, residents, and faculty to our annual meeting. This is an excellent opportunity to meet your med-peds colleagues from around the country and hear from our exciting keynote speaker.

Meeting Fees (you may pay at the door with cash or check)
Residents (members): $5
Non-member residents: $20
Medical students/premedical students: $5
Faculty: $20

Please RSVP to Jessica Wilson at president-elect@medpeds.org by October 22!

Please check our website for information on flight discounts and updates on the National Meeting, including information on who our Keynote Speaker will be!
Questions? Email Arlene at president@medpeds.org

Join us for the Second Annual NMPRA Midwest Regional Conference At the University of Chicago

"From Microscopes to Mankind: Using Research to Advance Pediatric and Adult Care"

October 6th, 2007
7:30 am – 4:30 pm

Biological Sciences Learning Center, Hyde Park
924 East 57th Street
Chicago, IL 60637

Events will include speakers, patient panels,
Break-out sessions on fellowship and career planning,
And clinical/research vignettes

Cocktail hour to be held October 5th, 2007 for conference attendees

Please RSVP before Sept 15th to uofcmedpeds@gmail.com

Hotel information:

Hilton Garden Inn – Midway Airport
6530 S. Cicero Avenue,
(708)496-2700

International House at the University of Chicago
1414 E. 59th St
(773)753-2270

Shuttle service will be provided on the day of the conference

THE UNIVERSITY OF CHICAGO

Exciting CME Opportunity Available at the First Annual Practical Med-Peds Symposium Brought to you by Baystate Medical Center

September 28-30, 2007 • Ocean Edge Resort, Brewster, MA

A continuing education program specifically designed for specialists in the care of adults and children.
Sponsored by Baystate Medical Center, The Western Campus of Tufts University School of Medicine

GOAL
The goal is to give the primary care physician or practitioner a practical update on clinical issues relevant to both adults and children.

TARGET AUDIENCE
Internists and Pediatricians working in ambulatory and hospital settings. Primary Care physicians and mid-level providers working in the ambulatory setting. There are no prerequisites for attending.

Location

This course will be held at Ocean Edge Resort & Club on Cape Cod, Route 6A Brewster Massachusetts 02631, Phone (508) 896-9000, Room Reservations: (800) 343-6074
The Ocean Edge Resort, in Brewster, was originally a private mansion built in 1890. This 426-acre property, which is on the National Register of Historic Places, is a three and-one-half star luxury resort getaway for families and couples. The Ocean Edge Resort and Golf Club perches on a bluff overlooking Cape Cod Bay and entertains guests with six pools, a top-ranked championship golf course, eleven tennis courts, bonfires and private beach.

For more information, contact Baystate Continuing Education at 413-794-3466 or check out the website at www.baystatehealth.com/learn.

Interested in contributing to the Med-Peds Perspective?

This year, we will have two ongoing features, as introduced in this issue. The first is the "A Year in the Life of a Med-Peds Resident" feature in which we will highlight one year of med-peds training in each issue. The second is the "Med-Peds in the Community" feature in which we will explore different ways med-peds physicians are contributing to their communities. If you would like to contribute to these features, or have other med-peds news to report, please let us know! We are also happy to advertise your upcoming conferences or events.

If you are interested in writing for the NMPRA Official Newsletter, please contact Ariel at secretary@medpeds.org.

The Official Publication of the National Med-Peds Residents' Association

www.medpeds.org

Not a NMPRA member?
To join go to http://www.medpeds.org/members/Membership_New.htm

The Med-Peds Perspective

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