

# National Med/Peds Residents' Association

## *Newsletter*

**Vol. 1, Number 3**

**December 1997/January 1998**

### **Formation of NMPRA**

As you may notice from the new heading on this newsletter, we have decided to form the national organization for Med/Peds residents. After 30 years of having no such association, NMPRA ("nam-pra"), The National Med/Peds Residents' Association, has a lot of catching up to do. Our first two newsletters have sparked interest among roughly half of the programs across the country and we're receiving feedback from program directors, individual residents, faculty, and graduates. However, we'd like to hear from all of you! Once the residency programs forward us lists of their housestaff, we address individual copies of the newsletter to each resident and send them in bulk to a single responsible party. Until then, we're counting on program directors and coordinators to make copies of the newsletter and forward them to their residents. We also have a new **NMPRA** website, an e-mail address (**HeyNMPRA@aol.com**), and a newsletter website with the full text of all the newsletters to date. As for those who haven't received the newsletter, they can go to Yahoo or Alta Vista on the internet, search for Med/Peds & find us. We check our e-mail daily, so keep sending us your comments, suggestions and questions.

In our last issue, we discussed the idea of creating a Med Students' Guide to Med/Peds. It turns out that Gary Onady, M.D., M/P Program Director at Wright State University and former President of the MPPDA, and his colleagues Keith Boyd, M.D. and Samuel Borden, M.D., have already produced such a guide and copies are available. Please e-mail Dr. Keith Boyd at [kboyd@rush.edu](mailto:kboyd@rush.edu) and he can provide you with a written copy or a diskette from which you can produce multiple copies. Providing your Med Students with this publication will be a great asset to Med/Peds in the long run.

We're now working on the promotion of Med/Peds. We have a text only logo (see above on the wall), and we are producing a graphic design which is still in draft form at publication. We will offer coffee mugs and stickers with the above logo and will be producing lapel pins with the new graphic design soon. The cost will be minimal and will increase our budget infinitely. The items will promote med/peds and help give us all a much needed sense of identity. E-mail us if you are interested and can't wait.

Until we formalize our association and see what kind of response we receive, we have named "acting officers" to help with the transition of forming a true organization. The future plan will be much like other residency associations. We will be governed by three senior officers, Immediate Past-President, President, and President-Elect and with Senior Representatives to the major boards and organizations. We will also have Representatives from each Med/Peds residency program. The primary goal of the organization is to represent the interest of Med/Peds residents and medical students interested in Med/Peds to the larger organizations and associations in Medicine, and to provide services to its members. In the words of our forefathers our priorities should be *Networking*, *Advocacy*, and *Exposure*. Type a brief paragraph explaining the purpose of this web page.

### **Med/Peds Practice Options**

*By Deborah Wald, M.D., Primary Care Med/Peds*

*Massachusetts General Hospital - Revere Health Care Center  
Harvard Combined Med/Peds Residency Program*

In the first issue of the newsletter, it sounded like students and residents still encounter advisors who consider med/peds training an act of insanity that leads to no conceivable career direction. I may not be able to refute the first point, but think I can reassure you on the second.

Interviewing for jobs before I chose this one, I found a range of opportunities for people interested in combining primary care practice and teaching. Yes, you may still have to explain to people *what* you are, but once they understand it, they want it!

In the first year after I finished residency, I did urgent care while studying for the boards. I then traveled and did various jobs, including two months as the only pediatrician in a rural hospital in Colombia and three months doing urgent care in a former Indian Health Service hospital in rural Alaska. Combined training was an asset in applying for both of these positions.

In August 1995, I started working 3/4 time in a community health center affiliated with a teaching hospital that has a Med/Peds residency. There are two other Med/Peds physicians in this practice, as well as several pediatricians and internists. Eight of the residents in our Med/Peds program have their continuity clinics here, so all three of us are involved in precepting. I also do some administrative work for the residency program (that accounts for the other 1/4 of my time).

I see both adults and children in each of my clinical sessions. I have about 25% pediatric patients by numbers; about 40% by visits. I care for a lot of families. Only about 15% of my patients are over 60. My guess is that that's partly because of being a young doctor and partly because of seeing a lot of parents with young children.

In choosing a primary care practice, definitely hold out for a position that will allow you to have an integrated internal medicine and pediatric practice. I know people who have started out with split clinics (separate sessions/locations for Pediatrics and Medicine) and it's not as good.

While about 2/3 of our graduates are in primary care, a few of our program grads have chosen to do fellowships. These include developmental pediatrics, rheumatology, epidemiology, infectious disease, and the sequential marathon fellowship in adult and pediatric cardiology. I should also note that all of our primary care graduates are still doing both internal medicine and pediatrics.

Rest assured, there are a wide range of opportunities out there for the med/peds graduate!

## **The Stress of "The Switch"**

A survey of Med/Peds programs in 1989 showed a trend in which programs that switch disciplines on a more frequent basis (i.e., every 1-4 months) are less stressful on the residents than those that make "the switch" only once or twice a year. This survey also showed that the stress of "the switch" was usually worse in the first 24 months of training and steadily improved in the 3rd and 4th years. While 35% reported no differences in switching from IM to Peds vs. switching from Peds to IM, 37% reported more difficulty in switching from Peds to Internal Medicine. (Only 18% reported more difficulty in switching from Medicine to Peds.) The most common problems associated with "the switch" were the various differences in diagnoses, treatment decisions, and drug dosages. Those few programs that still switch after 6, 8 or more months may want to reevaluate these numbers and speak with residents from other programs about their experience.

*Schubiner, H, Schuster, BL, Moncrease A, Mosca C. The perspectives of current trainees in combined internal medicine-pediatrics: results of a national survey. AJDC 1993;147:885-889.*

## **What is a Med/Peds Physician?**

*By Norman Toy  
Medical Recruitment Director, Global Medical Search, Inc.*

During the course of any given day, I am asked that question numerous times. I am the recruitment director for a national physician search firm, and my particular focus is Med/Peds. That means, my job is marketing Med/Peds nationwide. I have had the rare opportunity of observing first hand the emergence of the Med/Peds specialty in the employment marketplace. Almost every resident I have spoken to has told me of the many experiences they have had with people who have never heard of their specialty. I, too, have had my share of experiences with administrators, hospital and group recruiters, and office managers who have never heard of Med/Peds. I cannot tell you how many times I have had to explain myself when presenting Med/Peds candidates. "No, I didn't say 'Ped', I said 'Med/Peds'...dually trained...internal medicine and pediatrics...board eligible in both...a four year residency..." ,etc. Invariably, their interest, like a red glow on the horizon, begins to rise. I can almost feel them imagining the possibilities. Before I know it, they want to see a CV, go to the board, or some such authority. That is exactly how this specialty has grown. And it is growing!

Several years ago, about 80% of the people I talked to asked me, "What is a Med/Ped?" Each year, the question is asked much less frequently. Now, the percentages have reversed themselves, and about 80% have heard of Med/Peds. Not everyone knows what to do with them yet, however, and that poses the next problem, and it can get a bit complicated. It is often necessary to get the approval, whether formal or otherwise, of local internists, pediatricians, and/or family practitioners, before bringing a MP physician into the community (which, for various reasons, is not always a given). If there are no MP physicians there already (and, lets face it, there are a limited number out there in practice), then the new MP will need the cooperation of the existing primary care providers, or they might find themselves on call every night. In addition, the patients need to be educated. How aggressively and effectively will the hospital market the new addition? Will the Med/Peds be willing to share call with internists and pediatricians, not to mention family practitioners? In the case of the former, how will that be structured in order to avoid a double call group? These are some of the questions and issues that arise when a M/P appears on the scene for the first time.

Fortunately, I am happy to say, there are some very creative solutions being sought and implemented allowing for the transition of this relatively new specialty into mainstream primary care networks. Flexibility is the key -- on the part of both the hiring facility, as well as the incoming physician. When I can, I try to encourage hospitals to form Med/Peds groups, promising them they will achieve a primary care coup in the process. This simple solution to some complicated issues surrounding bringing in this specialty, however, is usually either too simple, too costly, or just premature.

In any case, with the 100+ programs generating several hundred Med/Peds residents per year, the medical community will have no choice but to notice -- there is a new wave in primary care called Med/Peds, and it is time to put a roof over their heads, welcome them into our midst, and let them loose in our communities. The patients will come....

[NMPRA Home Page](#)

Return to [Table of Contents](#)

*Last Updated March 5, 1999 by [Jeff Bates](#)*