# National Med/Peds Residents' Association

## *Newsletter*

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**June-July 1998**

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## Happy "New Year"

*By Annette Gonzales,*
*NMPRA Coordinator*

July 1 marks the beginning of a new academic year and, thus, will bring many changes to your residency experience, regardless of your training level.

***New interns*:** Welcome to the next stage of your medical education! This next year will be an exciting (and trying) time for your as you acclimate yourselves to perhaps new cities, new homes and new medical institutions. As if these "personal" changes aren't enough, you'll now be overwhelmed with weeks of orientation sessions, policy & procedure overviews, and a multitude of manuals and books to fill your new labcoat pockets (which will hopefully be big enough to carry them all!) Interns will begin their first rotation in either Internal Medicine or Pediatrics, only to start a new learning process in 3-6 months when "the switch" is made to the other department. Rest assured, while this transition from medical school to your residency program may be hectic and a bit overwhelming, it doesn't last long. You'll soon be feeling at ease as things fall into place. Communication with your Med/Peds peers is critical during these early stages of your training. First, you and your fellow interns can help each other by passing on information about current rotations which have yet to be experienced by all. You can also depend on your upper level and Chief Residents to give you advice on both educational rotations and your questions about personal issues. Remember, they've been through the same situation of dealing with a major life change and will be more than happy to give advice. Finally, remember you can always "spill your guts" to your program coordinator/residency assistant. Your coordinator will most likely be able to answer a wide variety of questions; anything from your conference or rotation scheduling to recommending a good day care or school for your children. You'll find that your coordinator can be one of your strongest allies in your program. He or she will be a great resource for information or just someone to lend an ear when you need it.

***New 2nd & 3rd Years*:** This year will also bring transition for you. During your first six months, you'll be busy orienting new housestaff and your assistance to them will be vital. After completing your intern months, you will be considered an upper level. Adjusting from your role as an intern to that of an upper level will be a major step. You may find it difficult watching your fellow (straight) Pediatric and Medicine residents beginning their upper level roles in July, often earlier than you. However, time will quickly pass and in no time you'll be just as confident in this capacity. Hang-in there and remember to communicate with your chief residents and program directors for moral support.

***New 4th years and Chief Residents*:** This will be your final year, although you may find it difficult to fathom. Your perseverance has paid off and you can now see the light at the end of the tunnel. Although you'll be busy enough with teaching, mentoring and dealing with the dreaded schedule changes, there are also a few personal issues you need to be working on: Fellowship or practice plans should be well underway and now is the time to register for any Board Review courses you're interested in attending. You'll also need to decide if you'll take both Medicine and Pediatric Board examinations immediately following graduation next Fall or if you'd rather take them one year apart. Ask your program director or recent alumni if they've noticed a trend in pass rates with both options or if they have any advice. The decision is yours to make. If the stress of testing in both fields in two consecutive months is too much to handle, you may opt to sit for

one exam immediately following graduation and schedule the other exam for the following year. However, you may feel that taking both exams immediately after completion of your residency, while the academics are fresh on your mind, would be more advantageous. Another deciding factor is a financial one. Yes, you'll have to pay fees for both examinations. You'll need to contact both the ABP and the ABIM individually to inquire about the registration deadlines and fees. Do this as early in the academic year as possible, as deadlines are usually December or January, and you'll need time to budget these finances!

Med/Peds is a rewarding career and we those who choose this field are "head and shoulders" above others. ENJOY YOUR YEAR, and remember -- the good times will outweigh the stressful ones as you continue this phase of your education.

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## Residency Choices & Career Counseling

*by Lane Cox, M.D.*
*Univ of Oklahoma, Tulsa*

This time of year is often very difficult for fourth year medical students. They are facing decisions in regards to residency that will guide their career track for the rest of their lives. These decisions are based on personal experiences, biases, backgrounds, and associations. The initial decision between surgery, psychiatry and ob/gyn is often easy and straightforward. However, the decision to study adult medicine, the possibility of one of the subspecialties, and the consideration of seeing pediatric patients can be more difficult. Adult medicine can be divided into three separate residencies that make the decision more difficult: family medicine, internal medicine, or med/peds (combined internal medicine and pediatrics). This brief review is intended for fourth year medical students contemplating careers in adult medicine and for those that advise them.

The *American Journal of Medicine* ("The Green Journal") published a series of articles earlier this year that answer questions that are often asked, and some that are not but should be. This series can be found in Volume 104, February, pp 109-113, March, pp 215-218, April, pp. 323-329.

The first article was written by Chairs or program directors of three different programs. It is the most objective article of the series and lists specifics such as goals, accreditation, certification, and curriculum. There are two graphics that do a very good job of comparing the curricula of the three choices side by side.

The second article discusses the history and current practice patterns of the various choices and speculates on future needs and opportunities. It essentially speaks to where the various specialties have been, where they are, and where they are going. It was authored by a pair of primary care researchers.

Philosophical difference between the various programs are the focus of the third article. Written by Chairs of the different fields, many of the authors' personal thoughts and perspectives are provided. Many quotes from mavens of medicine that had an impact on these individuals are included.

The fact that this review is being read at all indicates an interest, involvement or biased towards medicine/pediatrics. It is difficult for those of us that have already made our career choices not to assert our own biases on those who are looking for guidance. This series of articles does a very good job of giving objective, subjective, and personal guidance that may help individuals seeking direction or for those called upon to advise them.

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## Perceived Competencies

An interesting look at how practitioners view themselves and their abilities was published in a 1993 article. These perceived competencies were compared among all of the primary care fields; Med/Peds, family practice, internal medicine, and

pediatrics. As is often the case in life, those who feel most competent are not necessarily the best. In fact, they can be the most dangerous as they often don't know their own limitations. All things considered and with a grain of salt, the study still provides some interesting information.

The specific differences that stood out were that family practitioners felt significantly less comfortable than Med/Peds when it came to a "complex delivery room case". FP's were also less comfortable than med/peds with specific complex internal medicine problems. Med/Peds had higher confidence ratings in areas of complex cases of neonates and adults. Interestingly enough, there were no issues in which pediatricians felt more comfortable than Med/Peds. However, this was not true for internal medicine issues.

The flip side was as follows. FP's were more comfortable than Med/Peds with the routine care and psychosocial aspects of adolescent health care. There were also several issues in intensive care management of acute MI with which internal medicine physicians were more comfortable than Med/Peds.

While it is hard to draw conclusions from this study perhaps this can help us to guide our curriculum in these areas of less perceived confidence. While the guidelines already require a full month of adolescent care, the ICU experiences are limited to 4 months in each field. These months should be maximized.

*Biro FM, Siegel DM, et al. A comparison of self-perceived clinical competencies in primary care residency graduates. Pediatric Research. 34(5):555-9, 1993 Nov.*

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## The Making of a Med/Peds Program

*by Munish Khaneja, MD*
*NMPRA Regional Committee Coordinator*
*SUNY Brooklyn*

The combined internal medicine/pediatrics program at SUNY Brooklyn has been around for many years. Many of the graduates have gone on to do subspecialties, open up their own practices and become great successes - all without having had our own program director, missing the one point-person who is often been considered the key component in producing a successful program. This July 1st, we welcomed a new person to the med/peds program at SUNY Brooklyn - Anne Leibling, MD, med/peds trained, dual med/peds rheumatologist, and the new Program Director at SUNY Brooklyn.

From the perspective of a second year med/peds resident, this is an interesting change. The program I interviewed at was one without a director, but one where I saw many other points of value. There was the inner city environment which I learned to love, having been a medical student at SUNY Brooklyn as well. There was the proximity to the city no one can hate - Manhattan. And there was a good connection between the respective Internal Medicine and Pediatric departments. This point is one to note. A good med/peds program is dependent on the people running it and the residents in it. Although having a single person, either a wonderful secretary ("mother/sister hen"), a chief resident, or an actual program director who handles all of the issues specific to med/peds within (and outside of) the institution is ideal, it is not required. Some combination of the above is even better, but again, not the making or breaking point of a program. This first year at SUNY Brookyln has shown me some important things in how a program can be successful. There has been support for NMPRA related issues - the ACP meeting in San Diego in April, the Chicago region med/peds meeting at the AMA Resident Meeting in June, and the upcoming AAP Fall Meeting in San Francisco--all have med/peds representatives from SUNY Brooklyn. The purchasing of med/peds materials (including those famous lapel pins), changing the stress-inducing 6-month switchover to a more manageable 3-month one, a med/peds resident social fund and the installation of our program director are all a result of a good connection between the two departments. Often enough, in many of the med/peds programs across the country, one of the two programs, medicine or pediatrics, is the stronger one, and thus decides the way the program is run. This is not true at SUNY Brooklyn, as the two separate departments are almost equivalent.

A point to note here is that the program has not always been so well run; the chiefs from each service often did not know the ever-changing requirements of med/peds programs and thus had schedules missing many of those important things. Getting the departments together for any type of meeting was near impossible. It was not a pretty sight. The senior residents have many war stories to attest to that.

As in each program, there is a great level of change from year to year. SUNY Brooklyn is no different. The change here has helped to produce what looks to be a good program, ready to face the future changes in med/peds. In going through the intern year at SUNY Brooklyn, I have learned a little bit about the making of a med/peds program. There are over one hundred others in the country. Each one has its own little story to tell.

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## NMPRA Regional Rep Structure

We have divided the country into 5 Med/Peds regions in the interest of improving communication locally. With the help of our new Regional Committee Coordinator, Munish Khaneja from SUNY Brooklyn, we have designated each region as follows:

**REGION I**: Virginia, North Carolina, Georgia, Florida, Alabama, Tennessee (South Carolina)

**REGION II**: New York, New Jersey, Delaware, Maryland, District of Columbia, Pennsylvania, Connecticut, Rhode Island, Massachusetts, (Vermont), (New Hampshire), (Maine)

**REGION III**: West Virginia, Kentucky, Ohio, Indiana, Michigan, Illinois, Wisconsin, Minnesota, (Iowa)

**REGION IV**: Texas, Louisiana, Mississippi, Arkansas, Missouri, Nebraska, Kansas, Oklahoma

**REGION V**: California, Arizona, Utah, Hawaii, (New Mexico), (Colorado), (Nevada), (Idaho), (Oregon), (Washington), (Montana), (North Dakota), (South Dakota), (Wyoming), (Alaska)

(States listed in parentheses do not currently have Med/Peds residency programs)

We have delegated a Regional Rep for each region. These regional reps will serve as the contact point for their designated states and are responsible for passing on information about NMPRA to current members, as well as contacting those programs who have yet to join us.

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## *MED/PEDS ALUMNI*

We'd like to keep in contact with Med/Peds alumni and would be happy to continue sending the NMPRA newsletter to them after graduation. Please forward us the names and addresses of your program's graduates. Let us know if any went on to fellowships and where they are.

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## Important Program Features

A 1989 survey looked at the features residents felt were most important in the selection of a Med/Peds program. The top

three issues listed were:

- Ambulatory training sites
- Having a specific coordinator for the program
- University affiliation

These were followed in importance by Med/Peds faculty role models, a tertiary referral center, a combined Med/Peds clinic, the presence of a Children's Hospital, and community based ambulatory training sites.

*Schubiner H, Schuster B, et al. The perspectives of current trainees in combined internal medicine-pediatrics. Results of a national survey. AJDC 1993; 147:885-889. vol 147 (1993).*

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## Med/Peds International Effort

**NMPRA** is still trying to coordinate a Med/Peds relief effort. This would count as education time and be appropriately supervised by Medicine & Pediatric practioners. We have some limited options available through a Texas A & M Univ/Scott & White Hospital trip to Mexico, but we are interested in other possibilities. Does your program have something already set up? Would you be interested in such a trip? Let us know.

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## A Med/Ped in Family Practice

*by Norman E. Toy*
*Med/Peds Recruiter*

When I first spoke with William Feldmann, MD, he was in search of a Med/Ped opportunity in Southeastern New Hampshire. I was able to find him a practice which he was satisfied with, and where he has been working for the last year and a half. We spent some time recently talking about aspects of his search, and the results.

***NT: When we first spoke in July of 1995, you had just finished your residency program, and were beginning your chief residency in pediatrics. Before you actually began your job search, what was your original idea of what kind of practice you were looking for?***

WF: I was looking very clearly at primary care practice. I saw myself as "Old Doc Feldmann", where everybody brought their problems, from lacerations to MI's, and whatever. I was definitely looking to set up an office and take all comers. In large measure, that's how it worked out.

***NT: Did you have an idea what the composition would be of the group you would work with?***

WF: No, not really. When I first started residency, the thought of call coverage and having partners, really wasn't something that I thought too much about. I certainly didn't think at all about the business aspect of it. All I really knew was that I loved taking care of kids, but I felt the pediatrics alone would not be sufficiently stimulating. But it's an awful lot of fun. So, I added in the medicine to keep things a little more interesting.

***NT: When you first talked to me, you were looking for a practice where there was a predominance of children. Is that the case where you are?***

WF: It is now. It wasn't when I started. In fact, when I joined, I joined essentially just one family practitioner, and he was distinctly uninterested in doing pediatrics. So he had a very small pediatric practice, and was perfectly happy to give me all of his patients. But when I started, probably only ten percent of the practice was pediatrics. And in a year and a half, I

would say it's probably sixty percent now.

***NT: What does the group consist of now? Is it still just you and one family practitioner?***

WF: No. It is myself, and two family practitioners. One is sixty-four years old. Very sharp. And really keeps up. And is very open to learning new things. This has been his practice for years and years. We have kids coming in who are grandchildren of people he took care of. And then there's another family practitioner who came out of residency about a year ago now. We also have a family-practice trained Nurse practitioner. So there are three doctors and a nurse practitioner.

***NT: Being the only Med/Ped within a group of family practitioners and mid-level family practice-trained staff, are there distinct advantages and disadvantages?***

WF: There are both. The main things that I find lacking in my training, and which I'm fortunate enough to be able to pick up from the family practitioners, are certain procedures that we don't often get to do. In particular, dermatological procedures that I never really did during my residency. And I knew during residency that I wasn't getting enough Orthopedic training to be a primary care person, so I actually used some of my very precious elective time during residency to do orthopedics. And that was probably the smartest thing I ever did in residency. I actually spent another month doing dermatology as well, for the same reason. So I've been able to pick up some procedural tricks, because the family practice people get to do more surgery, derm, and ortho than we do. The flip side, of course, is that I'm just more intensely trained in the things that I do, and we sort of have a division of labor in our practice. I pretty much take over how we do pediatrics. The other family practice people do see some well-child stuff, but I totally revamped how we did immunizations, well-child checks, routine blood testing, TB testing, etc. Basically, just getting them up to speed with what the current recommendations are. There are other things that they just don't feel as comfortable with. For instance, I'm the only one in the office who will do official readings of EKG's.

***NT: Concern over pediatric coverage seems to come up the most when Med/Peds consider working with family practitioners. How has this been handled in your group?***

WF: Our group is unusual in that forty to fifty percent of the total group practice is urgent care. And we are open extended hours. So, given the volume of people, and the fact that we cannot control the flow of patients, this group does not do any admissions. We have a group of cardiologists in town who do all of the internal medicine admissions, and we've arranged with a pediatric group to do the pediatric admissions. That is not how I would like to do it. I would prefer to do my own admissions, but given the way this office is set up, that's not feasible right now. As you probably know, the way pediatrics is going these days, there's very little in-patient. Most things are taken care of on an outpatient basis. In the year and a half I've been here, I think I've admitted six or seven pediatric cases. So, it has not been as big a deal as I thought it would be.

***NT: Within the office itself, do you all pretty much equally handle pediatric patients?***

WF: Oh, no. I have the vast majority of pediatrics in the office. The older physician that I joined hasn't much interest at all. He hears someone coming into the office crying... (laughs)

***NT: (calling) William!***

WF: Absolutely!

***Editors Note:*** *Given our limited space here, the balance of this interview with Dr. Feldmann will be printed in the next issue.*

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***Finally a source for Med/Peds job opportunities!***

# PRACTICE

# OPPORTUNITIES

ALABAMA - Med/Peds needed to join existing group of one Med/Peds, and 3 Pediatricians. Coverage for medicine with 9 internists and 1 pulmonologist. New hospital. Good schools.

***Contact*:**

**Pam Rice**

**1984 Alabama Hwy 157, Suite 330**

**Cullman, AL 35058**

**Phone: (256)739-3838**

**Fax: (256)739-8350**

**CONNECTICUT** - Med/Peds trained physician (Baystate Medical Center residency grad 1995) working in New Milford, CT (small town environment) seeks a partner to join office practice. Employed position, excellent compensation and benefits. One call night per week and every 7th weekend. Very little hospital-based work and superior primary care support system with affiliation to Danbury Hospital. Ready to start now!

***Contact*:**

**Marc Legris, M.D.**

**E-mail: Marc.legris@danhosp.org**

**phone: (860)355-6949**

**fax: (860)354-9593**

**KENTUCKY** - Two Med/Peds physicians needed to join existing primary care group serving the areas of Barbourville and Pineville. 17 miles off Interstate 75 via 4-lane Route 25E running through beautiful and historic Cumberland Gap of the Appalachian Mountains, near the converging borders of Kentucky, Virginia, and Tennessee. Salary guarantees, benefits, and incentive bonuses.

***Contact*:**

**Greg Davis**

**E-mail: gdavis@bhsi.com**

**Phone: (800)398-0058**

**Fax: (606)278-1202**

**NORTH CAROLINA** - Sudden opening for Primary care Med/Peds physician in the world renowned Research Triangle area. Full-time, office based, shared call, some hospital. Great opportunity for right person. Need board certified and ready to move STAT.

***Contact*:**

**Cory Annis, M.D.**

**Phone: (919)471-8166**

**E-mail: doc cory@aol.com**

**OHIO** - An exceptional opportunity is available for an Internal Medicine/Pediatric physician within the OhioHealth Hospital System located 48 miles north of Columbus, Ohio. OhioHealth includes eight Ohio hospitals, 2,500 physicians and more than 2,000 volunteers. An attractive salary of $140K+, productivity bonus and a full benefit package is being offered. This practice is located in a beautiful, upper middle income area that has a new building with modern facilities and strives to continue the proud tradition of providing patients with high-quality health care. Crawford County is home to Mohican State Park, Mid Ohio Sports Care Auto Racing, snow trails (snow skiing near Mansfield, Ohio), also Clear Fork Ski area, and you are only 50 miles away from Lake Erie.

***Contact*:**

**Julie Hotchkiss,**

**Physician Recruiting, OhioHealth**

**E-mail: hotchkj@ohiohealth.com**

**Phone: (800)368-7548**

**Fax: (614)566-3646**

**PENNSYLVANIA** - The Penn State Geisinger Health System currently offers Internal Medicine/Pediatric opportunities through northeastern and central Pennsylvania.

Penn State Geisinger Health System is a not for profit health system serving 40 of Pennsylvania's 67 counties. Our health system consists of two system-owned tertiary care centers, one acute care medical center, two children's hospitals, two research centers, a medical school and more than 80 community-based health groups. We employ more than 1000 physicians.

***Contact***:

**Penn State Geisinger Health Sys**

**Professional Staffing**

**E-mail: skfisher@psghs.edu**

**Phone: (800)845-7112**

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***Limit one ad per recruiter. (75 word maximum)***

NMPRA Home Page

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