National Med/Peds Residents' Association

Newsletter

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ACP Meeting & NMPRA

The 79th Annual Session of the American College of Physicians is being held this year in San Diego, CA, and we're making plans to attend! The conference begins on April 2nd and continues through April 5th. As you may already know, there will be a "Med/Peds Theme". On Thursday, April 2nd, there will be a session entitled "Hospitalists: Boon or Bane for Internists and our Patients". On Friday, April 3rd, there is a workshop scheduled on *ADHD: Children & Adults*, by Dr. Howard Schubiner. On Saturday, April 4th, there will be a Med/Peds Panel Discussion with Dr. Howard Schubiner and Dr. John Chamberlin. Great things are happening in the field of Med/Peds, thanks to these "pioneers" of our specialty, and their sessions should be very informative.

While it maybe too late now for anyone to plan to be at the meeting, those who are already attending the meeting (both Med/Peds practitioners and residents) are invited to get together one evening for a social gathering with an informal discussion about the newly formed National Med/Peds Residents' Association and the Newsletter. We will meet in the Hospitality Room in the San Diego Convention Center on Thursday, April 2nd, from 4-5 p.m. *(Special Thanks to Kelly Lott at the ACP for her help with this arrangement!).* This won't be a formal "meeting" by any means. We'd just like to get as many people together as we can and basically "put names with faces", discuss ideas, and formalize plans after these first few months of communication.

Upcoming National Meetings

and NMPRA Meetings

American College of Physicians (ACP)

April 2-5, 1998 San Diego, CA

American Medical Association (AMA)

June 14-18, 1998 Chicago, IL

American Academy of Pediatrics (AAP)

October 17-21, 1998 San Francisco, CA

Programs in Touch

After the last issue of the *Newsletter*, response from program directors, coordinators, and residents has escalated. To date,

47 residency programs have been in touch with us. We have also received lists of residents from 23 of these program directors and/or coordinators wanting their residents to be included. Recently, we contacted residents at various programs who have been designated as "Program Representatives".

If your program has not yet designated a Program Rep, please contact us via e-mail at HeyNMPRA@aol.com. Each representative needs to have access to the internet and must have an active e-mail address in order to communicate effectively with the association.

Duties of the Representatives will be to advise the board on all issues, make formal recommendations to the Board of Directors, and maintain an open line of communication between their program's residents and the other representatives. They must also be willing to attend official meetings (when possible), to assist with ideas for future newsletter articles, and act as liaison between their program and the association.

Joint Listings by Insurers

by Gary Onady, M.D., Ph.D., Med/Peds Program Director
Wright State University - Dayton, Ohio

During their December meeting, the AMA House of Delegates voted to support a resolution I had drafted to urge HMO's, Medicare and Medicaid to list Med/Peds physicians as both internal medicine and pediatric care providers. In most areas of the country, we have been listed under one heading only, which puts us at a competitive disadvantage with other primary care specialists that also see both adults and children.

As you can imagine, this resolution met with some aggressive opposition from Family Physicians at the AAFP. Fortunately, the ACP and AAP representatives spoke in glowing support for the passage of this resolution. I also attended both Section and Reference Committee debates. I offered my own personal testimony (I was the only Med/Peds physician attending the AMA meeting that followed this policy through the process) providing a grass roots account of the difficulty in balancing a practice in such a managed care setting.

Comments were made such as "Med/Peds is a withering specialty and, therefore, the AMA need not take the time in considering such policy"; "Med/Peds physicians practice only one or the other anyway, so what's the issue here"; "Most Med/Peds physicians are not primary care providers and, therefore, such listings are unlikely to influence their practice settings significantly".

I responded with the facts citing the recent surveys by the ABIM and ABP. I also references the AAFP website statistics being based on data from the early 1980's which are of historical interest only and no longer relevant. I testified that the statements in the AAFP website from the Sorum article were stated out of context and then gave the accurate data from this article that demonstrated once individuals saw Med/Peds physicians, the majority of patients enrolled their entire families into the care of the Med/Peds physicians, and that "Yes, Virginia, there are Med/Peds physicians and they also care for families" (The meeting was nearing the Christmas Holidays).

I testified that in my own practice setting, after the first year of practice, 95% of my patients were adults. After troubleshooting the reason for such an imbalance, I discovered it was because I listed my first specialty as internal medicine and the second specialty heading as pediatrics (as Internal Medicine - Pediatrics was not a coded entry). My practice only became balanced after several years when I learned to play the game of listing myself with one HMO as an Internist and with another as a Pediatrician. Such listings may additionally preclude a subscriber who sees you as their internist to have their child see you as a pediatrician for the simple reason that their computer systems are not programmed to recognize this option. Patients are therefore placed at a disadvantage by not being able to have a single physician provide care for the entire family. This also places the Med/Peds physician at a competitive disadvantage with family practice physicians.

All these efforts met with success, as the AMA House of Delegates adopted this Resolution at the close of the session.

(Dr. Onady is also a former President of the Med/Peds Program Directors' Association and continues to be instrumental in

fostering awareness of Med/Peds nationwide.)

NMPRA Lapel Pins

The lapel pins for the *National Med/Peds Residents' Association* have been ordered and will be ready by the end of March. We will have them available at the ACP meeting in San Diego and will take orders via e-mail from those not attending the meeting. The cost of the pins will be $5.00 each, or $4 each if ordering 10 or more pins (plus a $2 shipping & handling charge). Please contact us via e-mail at HeyNMPRA@aol.com with any questions and/or orders. The color scheme will be red & white with gold trim.

Explaining your Specialty

Last month, a question was posted on the *Med/Peds Forum* (the mailserver for Med/Peds physicians) regarding answering the many questions we all receive about our specialty. A resident in Texas wondered if anyone else had difficulty with patients (and other hospital personnel) questioning his "profession" due to the fact that his lab coat was embroidered with "Internal Medicine - Pediatrics".

A response was posted by **Dr. Michael Farrell**, a Med/Peds physician at the University of Michigan in Ann Arbor. We felt that his suggestions were very helpful and wanted to publish his response for those of you who do not yet have access to the *Med/Peds Forum*.

The biggest source of confusion (in my experience) has been with healthcare workers. My favorite question has been something like, "When you are finished, will you be a pediatrician?" This is asked by adult nurses, with the converse true of pediatric nurses.

I often identify myself by name and specialty almost every time I go into a room. There is good data to suggest that people both want and need a re-introduction, even in some cases every morning. I omit this with patients who know me very well, of course. If reintroducing yourself feels uncomfortable or inappropriate, you can also call out your name as you knock on a cracked door (another courtesy we often omit). This has the advantage of identifying you by name before they see you.

I usually say "I'm both an internist and a pediatrician", and sometimes even identify myself as the appropriate specialist for the patient at the time. In that case, I might say "I also work as a pediatrician (or an internist)". This "also" phrase tends to score points, I think. People want to know something about the person that is taking care of them. Dr. Goldman, in a recent Annals editorial [Goldman L. Adult (not internal) Medicine [editorial]. [Editorial] Annals of Internal Medicine 127(9):835-6, 1997, November 1] makes an interesting case to refer to us as specialists in "adult medicine". A few years back, my resident's clinic decided to call ourselves "Adult Medicine and Pediatrics". I was unsure at the time, but the idea has grown on me.

I have often found that the word "internist" is confusing to people, who often get it confused with the word "intern". When a barber asks me what I do, I say I'm a pediatrician!

When people confuse me with a family practitioner (not as bad a confusion as some might make it seem), I usually patiently explain things with enough emphasis that they understand that this distinction is important to me (usually with satisfying results).

I have some ethical concerns about omitting your specialty from a name badge. Some institutions use the word "physician" on their badges for everyone. My home university can put up to a certain number of characters on a name badge, and most of the appealing variations don't fit on a name tag. It has been my experience that anything unclear with the letters "PEDS" in it will be interpreted as pediatrics (especially by suspicious older patients). For most of my residency, I actually put my own sticker label OVER the name tag label. That way I could say whatever I wanted. I could also have said "Internal Medicine/Pediatrics" or "Adult/Ped Medicine". Lastly, some institutions use the word "physician" on their badges for all M.D.'s.

The most important thing about your name tag is this: WEAR IT. Patients love name tags. They also like it at eye level, despite the fact that mostof us prefer to wear it on our belts. I once heard a dear older attending complain that he was uncomfortable looking down in the area of the "crotch". I laughed long and hard, but have felt odd looking at belt name tags ever since!

Hope this helps. I remember this whole issue being very irritating as an intern, but I've learned to be patient with patients.

(We'd like to thank Dr. Michael Farrell for allowing us to publish his response. Dr. Farrell is a Robert Wood Johnson Scholar and a Med/Peds physician at the University of Michigan in Ann Arbor.)

Next NMPRA Meeting in June 1998

We're thinking of meeting again at the Annual AMA Meeting in Chicago, scheduled for June 14-18, 1998. We'd like to hear from you regarding potential attendance if we're able to work out details. How many of you are resident delegates to the AMA and are planning on attending the meeting already? If we meet over the weekend preceeding the AMA meeting, would it be easier for you to arrange your schedules? We're still in the early planning stages, so let us know your thoughts.

NMPRA Home Page

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Last Updated March 5, 1999 by Jeff Bates