

National Med/Peds Residents' Association

Newsletter

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Editor's Column

by Jeff Bates, MD

There were five important meetings which took place in April, 98. The Med/Peds Program Directors Association Annual Meeting, the American College of Physicians Annual Meeting, the Association of Program Directors of Internal Medicine Annual Meeting, the National Association of Inpatient Physicians (Hospitalist) First Annual Meeting, and the National Med/Peds Residents' Association First Meeting. Each of these meetings took place in San Diego and many physicians were able to attend more than one. There were many common issues at each of these meetings with Hospitalists and their implications taking the forefront. Some of the many issues brought up include: What will hospitalists do to graduate medical education? Will they divide internal medicine and worsen the identity crisis of what an internist is? If there are inpatient internists and outpatient internists then how does an outpatient internist differ from a family practitioner? Will the non-hospitalists lose their skills?...

The Med/Peds oriented meetings also brought up the issue of how well-suited Med/Peds graduates are for a hospitalist position and how recruiters have called some program directors looking for graduates. Many at the program directors meeting noted that we don't want to be pigeon-holed into such a specific area. This issue strikes at the core of the Med/Peds identity crisis and made me realize that there are several types of Med/Peds physicians. First, there are the primary care oriented who choose not to do Obstetrics or Surgery. Their plans for practice are not unlike many who go into family practice although their philosophy, needs, and expectations may be quite different. Second, there are those who want to master two disciplines and take care of the more complicated patients (outpatient and/or Hospitalist). Third, there are those who wish to specialize in medicine or pediatrics or both, and who realize the benefits of two boards in terms of preparation, marketability, job security, etc. Overlaid on top of these three primary reasons for going into Med/Peds, exist the reasons of academic appointments, research, and overall job flexibility which can apply to any of the three paths.

NMPRA had a warm response at the Med/Peds Program Directors Association meeting where I was not only invited to attend the meeting as a NMPRA rep but I was also given the opportunity to present myself, the Newsletter, NMPRA and our plans for the future. There was a great deal of support from the program directors and I believe that NMPRA should continue to nourish this relationship and ally ourselves with their organization. There were also discussions with Dr. Chamberlin and Dr. Kan who have created the AAP Med/Peds Section which has become the Med/Peds Practitioner's Association. During the week of meetings, the issue of "Why Residents need an Organization and a Newsletter?" and "Why don't the Residents just work through the AAP resident section if we really do have any needs?" came up. I believe that the 1500 or so residents who make up about 50% of the Med/Peds in the world deserve our own organization and means of communication. I also have found that many of our goals have been easily achieved with less organizational infrastructure and NMPRA has accomplished in a short period of time things that could not or have not been done in the 30 years that Med/Peds has been around. I believe that NMPRA will benefit Med/Peds as a whole and will ultimately serve to improve the quality of the Med/Peds Practitioner's Association. I believe that NMPRA can continue to do great things for Med/Peds and have discussed these concerns and issues with the reps who were at the meetings. At this point the consensus seems to be that NMPRA should stay our own separate organization. But, if at some time in the future we believe that our needs could be better served through the AAP, the Med/Peds Practitioner's Assoc., or some other organization, then we can merge with them and share our accomplishments.

NMPRA will be having another meeting for the East Coast in Chicago, Saturday, June 13. This will give us the opportunity to share our ideas for the goals of this organization. We will try to arrange a guest speaker to give us more insight into Med/Peds. Let us know if you are interested in attending. We will continue to work on a large meeting in October with the AAP in San Francisco. It looks like many Med/Peds Residents will be able to attend this meeting.

MD's Seeking JD's

by Lisa V. Bates, JD

Why would a doctor go to law school? This is the question I asked myself when I heard that this year's first year law school class at the University of Tulsa included two MD's. I tracked them both down and asked them why they were pursuing a law degree in addition to their MD. What I found was two physicians on two different quests. Their motives and career plans are very different and very interesting.

Dr. Lee Taylor is a board certified Vascular and General Surgeon and has spent the last 20 years practicing medicine in a small town. Practice, experience, and working as a chairman of finance for another physician who is a congressman, taught him the impact of the law in regards to medicine. Dr. Taylor is specifically interested in law as it relates to health insurance and governmental funding. He was inspired to seek a JD as well as an MBA in order to work among the business and legislative aspects of medicine.

On the opposite end of the spectrum is Dr. David Eakins' story. He was seeking a career change after practicing medicine for many years as a radiologist. Dr. Eakins has retired from medicine but is planning on using his medical training in an ancillary manner to support a career in trial law. Currently, he has been engaged by a medical malpractice defense firm who anticipates utilizing him in insurance law cases as well.

Each of these men bring their unique personal experiences to law school. Their academic training will be put to good use. Law school requires massive amounts of reading, legal analysis, and writing. By pursuing a law degree, these two doctors are widening their span of knowledge, narrowing the focus of their specific career interests, and increasing their ability to serve the community.

NMPRA Resident Rep Update

by John Scheitler, M.D.

NMPRA Resident Rep, East Carolina University

I wanted to take this opportunity to update each of you about the first NMPRA meeting which met on April 1-4 in San Diego.

Jeff Bates, a resident at Texas A&M, started NMPRA and the Med/Peds newsletter we've been getting for several months now. Jeff, along with myself and several other residents from SUNY-Brooklyn, U. Cincinnati, and UC-San Diego met informally at this past ACP meeting in California. Many issues were discussed, but more importantly, an initial social and professional framework was established. It was good talking with other med/peds residents and hearing what their programs were like.

Some residents at other programs said that they don't have any support and are left to meeting the residency criteria by themselves. Also, many other programs are much smaller, with as few as 2 per year. No one at their institution understands what med/peds is about. Although the magnitude may vary, it became obvious that we all seemed to share similar problems. These were some of the major problems elicited along with potential solutions:

Problem #1 - Lack of Organization: This is both locally and nationally. There are currently about 1700 med/peds practitioners nationwide with another 1700 currently in training. It seems that we have reached a critical mass to start to organize and require representation. While AAP and ACP provide an avenue, there are certain issues that occasionally present themselves unique to Med/Peds. For example, seeking a reduced rate for board certification and re-certification since we must take 2 board exams. Also, gaining listings under HMO plans as Internists and Pediatricians (many will only let you list one). These are only a few example of the the issues which are sure to come up.

Solution: On a national level, the Med/Peds Program Directors Association has traditionally been the only national organization related to Med/Peds. Obviously, NMPRA is a new effort under way to address issues of Med/Peds residents and to help bridge the gap between medical students and Med/Peds practitioners. Dr. Brian Kan from Cedar Sinai in Los Angeles, CA, has started a Med/Peds Physicians Association which will encompass all practicing med/peds physicians (academics, private practice, etc.). The future of NMPRA is currently very flexible, and one proposal was to eventually become a subcommittee of the Med/Peds Physicians Association, the AAP Resident section or the Med/Peds Program Directors Association. However, there are many advantages to having our own organization and this is an issue for a later date.

On a more local level, I think some simple efforts can be made to contact other programs and Med/Peds physicians in our own state. I think it may be beneficial to have some outside speakers for our own journal club. This would be a good way to establish statewide communication on Med/Peds issues as well as network with other Med/Peds physicians for future job opportunities or rotations.

Problem #2 Who Are We?: A common problem everywhere seems to be a lack of understanding about what Med/Peds physicians do. Medical professionals, insurance companies and patients always think we are Internists or Pediatricians, but there's no way we could be both! After realizing how few Med/Peds physicians there are nationally, there is a lot of public relations work to be done. However, with the growing numbers and interest in our specialty, this does not seem to be an insurmountable task.

Solutions: Be visible!!! We can post all of the "Med/Peds Rocks!!!!" flyers we want, but people are only going to know who we are and what we do by working with us and seeing us every day. Get involved with committees in the Medicine or Peds departments. Serve on hospital committees. Join and be active in local or national medical societies like the AAP, ACP, AMA and most importantly NMPRA. Make an effort to attend functions related to both the medicine and pediatric department. Another way is sporting your NMPRA Med/Peds lapel pins (a.k.a. the Med/Peds Stop sign). This will help to identify you. There are currently efforts to organize a solely Med/Peds national, or even regional, meeting. One proposal is at the program in Toledo, OH which last year started a local Med/Peds day. Next year they are planning to invite other programs in their region. I will pass on more information as it comes along.

Talk with medical students about Med/Peds. There seems to be very little information out there for students interested in the field and even more difficulty finding it if your medical school does not have a Med/Peds program. NMPRA is starting a collection of "Why I Chose Med/Peds" essays and your submissions are welcome. NMPRA also has information for medical students on their constantly updated web page. (Search YAHOO! for Med/Peds)

Problem # 3 - Where Are We?: Part of the problem concerning organization is that there does not seem to be any kind of listing nationally of Med/Peds physicians or residents, thus it is difficult to find our colleagues.

Solution: The NMPRA reps have made it the main goal for the upcoming year to make sure each program has been contacted and has a representative that can provide up to date information on their residents, graduates, and faculty, as well as disperse information back to them. Hopefully, a directory can be established of Med/Peds physicians. I'm responsible for contacting those in the Southeast. If anyone already has names, addresses or phone numbers of other Med/Peds residents in this area, let me know.

These are only some of the issues addressed at the first NMPRA meeting. There are still many other obstacles and solutions. If you are interested in getting involved or have any good ideas, let me know. *(Taken from a Memo to Med/Peds Residents at ECU)*

Finding A Practice Arrangement with Call Coverage

by Norman Toy

As a Med/Peds recruiter, one subject I spend a lot of time discussing with the majority of Med/Peds residents searching for their first job is "What about the Call Coverage?" The main objective of most of my Med/Peds candidates is to find a practice opportunity with other Med/Peds. With their unique mix of internal medicine and pediatric training, it is only natural to want to work with like-trained physicians. This has certainly created a challenge for me. I look high and low; and far and wide for every Med/Ped practice I can find. The fact is, however, there are not enough opportunities available for all of the 400 or so graduating Med/Ped residents to join other Med/Peds groups. The obvious reason for this is that there have not been enough Med/Ped residency programs putting physicians out into the field until recently. So, what's the alternative?

While I have made no formal survey, I think I can safely say that the majority of Med/Ped residents take jobs either with family practice groups, or with some mix of primary care doctors -- internists, pediatricians, and family practitioners. This latter arrangement seems to be the most acceptable alternative to joining a group of Med/Peds, but also requires a creative solution to sorting out who gets the pediatric patients, who gets the medicine patients, and who covers for pediatrics when the Med/Ped is not on call. Having a few family practitioners helps with the call arrangements since they, like the Med/Ped, can cover both adults & peds.

Many Med/Ped residents object to working with family practitioners and I always ask the question "Why?". One concern I hear is that if a family practice group brings in a Med/Ped then the Med/Ped will only get the sick patients and not a more traditional cross-section of patients. One Med/Ped recently told me he actually appreciates these special cases because that is what he is trained for. He finds that seeing difficult cases keeps things interesting, and diminishes the potential for boredom. Similarly, another Med/Ped candidate told me that she did not go through four years of training in medicine and pediatrics to be a family practitioner. But, everyone does not feel this way. Another Med/Ped candidate of mine recently told me that she would have taken a critical care fellowship if she wanted to be an intensivist. The bottom line is, it is important to find out what the group's expectations are before you make the deal.

Another concern I have heard about family practice groups is that the pediatric component might be weak. Some Med/Peds are reluctant to turn their very sick kids over to the group's family practitioners when they aren't on call or when they go on vacation. I have been told that this is a very real concern but can be worked out as long as the family practitioners are open to input from their Med/Ped colleagues. Once again, this openness needs to be judged before joining the group. The office dynamics, the "chemistry" between the doctors, and the philosophy of the group has to be right. If there is a sense that one's work will be compromised, then the search must go on. Obviously, each of these concerns can be overcome and family practice and Med/Peds can complement each other because I hear of Med/Peds joining family practice groups every day.

When it comes to call coverage, quality of life issues can be as important as quality of care. Being on call every night, or every other night, is becoming a thing of the past. If a community fails to meet the challenge of providing a mix of internists and pediatricians, and does not have a Med/Ped within their network, it is important to remember that there is still a "pioneer" aspect to Med/Peds. If the geographical area is right, the contract offer is fair, and the medical community is strong and supportive, you must keep in mind that someone has to be the first Med/Ped in an area; and it might not be so terrible if that someone is you.

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