Winter, 2004 Vol. 5 No. 2

NMPRA Officer Elections, May 2004 . . . See page 2 for details.

The Med-Peds News

Official Newsletter of the National Med-Peds Residents' Association

The Big Easy

NMPRA Annual Meeting Report

By Kimberly Granwehr, MD, NMPRA Secretary

NMPRA's 7th Annual National Meeting was a smashing success! Our meeting was held during the week of the AAP National Conference and Exhibit in New Orleans last November. Located inside Mother's Restaurant, a local favorite eatery, a gathering of fifty Med-Peds physicians, interested students, and supporters enjoyed a gastronomical delight of gumbo, red beans and rice, crawfish etoufee, roast beef with debris, bread pudding and other N.O. delectables.

The affair was kicked off by a Med-Peds 'Jeopardy'-style trivia challenge compiled by Dr. Tommy Cross. Dr. David Kendrick then launched into a brief review of the Med-Peds Universe, detailing the history and current state of NMPRA and other Med-Peds organizations such as the Med-Peds Program Directors Association (MPPDA)

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Members of the NMPRA Executive Committee at the annual meeting in New Orleans. From left, Emery Chang, treasurer, David Kendrick, president, Kim Granwehr, secretary, David Kaelber, president emeritus, and Heather Toth, president-elect.

Inside This Issue

Northeast Regional Med-Peds Meeting

Featuring: Keynote address by Dr. John Chamberlain, Chairperson, Med-Peds Section Executive Committee, American Academy of Pediatrics

What: A free, quality medical education conference and career development opportunity for med-peds residents, faculty, and interested medical students
A great chance to network with regional med-peds residents and faculty
A jolly good time

When: **Saturday, March 13, 2004, 9:00 AM – 4:00 PM**

Where: Chestnut Surgery Center at Baystate Medical Center, 759 Chestnut Street, Springfield, MA
Directions and Map at: www.medpeds.org, click on **Northeast Med-Peds Meeting**

How: Please RSVP: Janet.Williams@bhs.org
Information on accommodations: Janet.Williams@bhs.org or (413) 794-3998

Registration: No Fee. Light Breakfast (8:30 AM) and Lunch Provided

Sponsored by: Bay State Medical Center
Tufts University School of Medicine
NMPRA

A Student's Discipline

By John K. Chamberlain, MD, FAAP, FACP
Chair, AAP Med-Peds Section

The history of Med-Peds is that of a discipline driven by its learners. It is rather unique in that way. The generalist specialties evolved as practitioners sought to enhance the care of patients by narrowing their age focus while fostering excellence (Internal Medicine and Pediatrics) or by formalizing their training curriculum (Family Practice). The surgical specialties, and the modern era of extensive sub-specialization, were driven by expansion of knowledge and evolution of new instruments. Though each discipline needed to attract students to perpetuate, none had at their roots a vision conceived by learners and teachers.

The concept of combined training in Internal Medicine and Pediatrics had its origins from 1949 to 1961 in the form of a two-year rotating internship. Although initially successful, the program gradually lost faculty and resident support and was replaced by one year post graduate options combining Medicine-Pediatrics, Medicine-Surgery, and Medicine-OB/Gyn. The two latter programs were discontinued in the late 1960s because of lack of student and faculty support. In contrast faculty, resident, and medical student interest in combined Internal Medicine-Pediatrics training remained and flourished following endorsement of the American Board of Internal Medicine and the American Board of Pediatrics of the concept of combined training leading to dual Board eligibility in

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President's Column

Have a Med-Peds moment . . .

By David Kendrick, MD, NMPRA President

A couple of months ago, I was at a conference attended by physicians from a number of different specialties when a particular family physician, whom I happened to know and respect, asked me "Med-Peds . . . hmm. So what is the purpose of your specialty anyhow?"

After slowly counting to 10, and biting my lip until it bled, I recounted, once again, the purpose of and niche occupied by our profession. I told of the need to have better transition

care to adulthood for those with chronic diseases of childhood, and I spoke of the level of expertise that we have in managing patients with complicated disease processes across the age-spectrum. I noted the flexibility that our profession provides us—the ability to practice virtually anywhere, from a rural solo practice to an urban academic hospital, and in a wide variety of settings, ranging from nurseries to nursing homes and everywhere in-between. Finally, in a crescendo of gesticulations and with no regard to the spittle forming at the corners of my mouth, I brandished my favorite device for the Med-Peds non-believer—the *Med-Peds moment.*

As a physician in our fair specialty, I'm sure you've experienced that moment of epiphany, that point at which you realize that the diagnosis or intervention you just made could not have been made by a categorical physician. That moment of pure joy when you realize that you just diagnosed heart failure in a teenager, based purely on a physical exam that reminded you of a VA patient you saw the day before—and you know that the pediatricians would have diagnosed the patient with liver failure based on the signs of liver congestion. The unparalleled feeling of competency you experience when you are called to see a 29 year old patient with an apparently un-repaired congenital heart lesion, and inform the panicking adult cardiology fellow that it's OK for the O_2 sats to be in the mid 80s. This is what I call the Med-Peds moment, and it's something that I find very special about our profession. These are the moments when you realize that the synergies of your combined training have indeed yielded a physician that is better than the sum of your independent experiences in Medicine or Pediatrics.

Needless to say, the family physician was impressed, or at least shocked by the ferocity of my outburst . . .

I beseech you, go out and have a Med-Peds moment— you'll feel a lot better about having to sit for two boards.

Gat a Med-Peds moment you want to share? Perhaps a case that you'd like to see in print? Email it to president@medpeds.org and we'll print it here.

Announcing:

NMPRA Officer Elections: May, 2004

Positions Available:

President Elect (will serve as President for 2005-2006)

Secretary

Treasurer

Election Timeline:

May 14: Platform (500 words max) and bio (250 words max) due to election@medpeds.org. Please feel free to email each officer for more information (i.e. president@medpeds.org, secretary@medpeds.org, etc.)

May 21: Online voting begins with emailing of ballots to all NMPRA Members

May 27: Online Polls close

May 31: Winners Announced

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and the Med-Peds Sections of AAP and ACP. A financial report by Dr. Emery Chang revealed that over two-thirds of NMPRA's funding comes from the combination of job postings and membership dues, so keep up your recruiting efforts!

The following speaker was Dr. John Chamberlain, FAAP, FACP and current Chairman of the Med-Peds Section of AAP and ACP. His overview of the Med-Peds section was an inspiring reminder of the fact that a small group of determined people can in fact move mountains such as the AAP and ACP to include our interests.

Attendees were then treated to an overview of the Med-Peds Program Directors Association, and informed that we as Med-Peds residents do have representation on the ACGME. Following that, Dr. David Kaelber reviewed job resources available for Med-Peds residents, and Dr. Tommy Cross unveiled the long-awaited Fellowship Guide compiled by NMPRA officers. Leadership opportunities within NMPRA were reviewed by Drs. David Kendrick, Heather Toth, and Kim Granwehr and volunteers were unearthed after discussing the various available posts within NMPRA. Finally, the NMPRA awards presentation wrapped up the evening.

It was, by all accounts, the most successful annual meeting to date. We hope that you will join us in the challenge to have an even better and bigger conference next year in San Francisco!

Guest Column

Disability Insurance: What you need to know before you buy

By Lawrence B. Keller, CLU, ChFC, RHU

You may have heard that the disability insurance policies available today are dramatically different from those available a few years ago. Although this is true -- especially for physicians who perform invasive procedures -- quality coverage can still be found. It is important to understand how policies are offered and to know what provisions should be included in an individual disability policy.

How Policies Are Offered

Types

Disability insurance can be purchased on an individual or group basis. Group insurance is usually provided by an employer or purchased individually from a sponsoring medical association. Although initially low in cost, group policies do have limitations. They can be canceled (by the association or insurance company), rates increase as you get older, and premiums are subject to adjustments based on the claims experience of the group. In addition, group and association contracts often contain restrictive definitions of disability as well as less-generous contract provisions.

Coverage Limits

Most insurance companies will issue disability insurance coverage equal to approximately 60 % of earned income; however, interns, residents, fellows and physicians just entering practice are provided with "special limits." These special limits permit them to purchase benefits in excess of what their current earnings would normally allow.

Cost of Disability Insurance

Premium rates are based on several factors including age, gender, monthly benefit amount, riders added to the policy and the occupational classification the insurance company assigns to your medical specialty.

The younger you are when the purchase is made, the lower the cost of the insurance. Therefore, you should purchase a policy as early in your career as possible to lock in lower premium rates.

Although women are better risks for life insurance coverage, this is not the case with disability insurance. Rates for females are substantially higher and their policies can cost 50 to 75 % more than men.

The occupational classification assigned by the insurance company to your medical specialty will significantly impact the premium rates as well as the policy provisions offered to you. Generally, if you perform invasive procedures, you will be placed in the "surgical" category; where the definition of disability may be more restrictive and the premiums charged will be higher as compared to those of a non-invasive, non-surgical physician. Each insurance company has their own occupational classification guide and insurance companies may treat the same medical specialty differently.

What to Look for in a Disability Policy

The renewability provision is one of the key features of an individual disability income insurance policy. This provision defines your rights when it comes to keeping your disability policy in force. If you purchase a policy that is *Non-Cancelable* and *Guaranteed Renewable*, you can remain in control of your financial security. The insurance company cannot cancel, increase your premiums, change any provisions or add restrictions to the policy -- even if the issuing company no longer offers similar policies in the future.

If you purchase a policy that is Non-Cancelable and Guaranteed Renewable, you can remain in control of your financial security.

Definition of Total Disability

Arguably, the definition of disability is the most important aspect of a disability policy. As a physician, you must pay careful attention to the definition of disability found in your policy as it will ultimately determine how any claim you make for benefits will be judged. There are three definitions of "disability" commonly found in the insurance industry, and each has significant differences.

"Own-occupation"

Although difficult to find, "Own-Occupation" (also known as true or pure "Own-Occupation") is usually the definition of choice for physicians as it is the most liberal definition of total disability available. This type of policy pays benefits if you are disabled and "not able to perform the material and substantial duties of your occupation." Therefore, you would be considered *totally disabled* if you could no longer practice your medical specialty, even if you are at work in some other capacity, as long as you are not able to perform the material and substantial duties of your specific medical specialty.

Modified "Own-occupation"

This type of disability policy has become the most prevalent in the industry today and typically pays benefits if you are "unable to perform the substantial and material duties of your occupation and you are not working." Although benefits are still contingent upon your ability to practice your medical specialty, this definition generally will not allow you to continue receiving full disability benefits if you are at work in some other capacity.

"Any Occupation"

This definition is the most restrictive -- it is commonly found in group or association policies. Under this definition, you are eligible to receive benefits only if you are found to be "unable to work in any occupation which you are reasonably suited to by your education, training or experience." Unfortunately, it is the insurance company that makes this determination and physicians, being as educated and well-trained as they are, will find it extremely difficult to collect benefits on this type of policy. You should take every precaution to avoid purchasing a policy that contains this definition.

Hybrid Definitions

Many policies offered to physicians today might incorporate an "Own-Occupation" with a Modified "Own-Occupation" definition. Here, the policy would contain a true "Own-Occupation" definition for a limited time period (typically one, two or five years), and then convert to the more restrictive Modified "Own-Occupation" definition described above. Until recently, in certain states such as California and Florida, and for certain medical specialties, this often was the best definition of disability made available.

Optional Riders

Residual Disability Rider

Unless your policy contains a residual disability rider, you may have to be totally disabled to collect any benefits. While an "Own-Occupation" policy protects your ability to practice your medical specialty, it may not sufficiently protect your income level. There are many disabilities that might allow you to continue working in your occupation, on a limited basis, while suffering a loss of income. Adding a residual disability rider to your policy would allow you to continue receiving benefits, proportionate to your loss of income, if you returned to your medical specialty on a part-time basis.

Furthermore, with policies such as Modified "Own-Occupation" or "Any Occupation", this rider might allow you to continue receiving benefits if you decided to work in another capacity, or if the insurance company deter-

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mined that you could work in another "reasonable" occupation with reduced earnings.

Cost of Living Adjustment Rider

A COLA rider is designed to help your benefits keep pace with inflation after your disability has lasted for 12 months. This adjustment can be a flat percentage or tied to the Consumer Price Index. Ideally you want a COLA that is adjusted annually on a compound interest basis with no "cap" on the monthly benefit. Although important, if cutting the cost of coverage is an issue, this might be the first optional rider to consider excluding from your policy.

Future Purchase Option Rider

This rider is a must for young physicians. It provides you with the ability to increase your disability coverage, regardless of your future health, as your income rises. It is important to know when you can increase your coverage, as well as by what increments, on any given option date. Some companies may allow you to use your entire option in one year as long as your then current income warrants the increase; others, however, may limit the amount that you can purchase.

Summary

Purchasing a high-quality disability insurance policy has never been easy. Unfortunately, due to adverse claims experience, the individual disability insurance marketplace has become even more complicated for physicians. Policies vary greatly in terms of the definition of disability made available, the contract provisions offered and the premiums charged. It is more important than ever that you take the time to compare each of the policies you are considering, and understand how and why they differ. The best approach is to employ the services of a professional insurance agent who specializes in working with physicians. He or she will not only be familiar with your occupation, but with which companies' policies are best suited to your particular specialty. Then you and the agent can decide which insurance company's policy best meets your individual insurance needs.

Lawrence B. Keller, CLU, ChFC, RHU is the founder of Physician Financial Services, a New York City-based firm, specializing in insurance, investments, and financial services for physicians. He can be reached toll-free at (866) 4-BEST-DI (866-423-7834) *or by sending an e-mail to lkeller@physicianfinancialservices.com.*

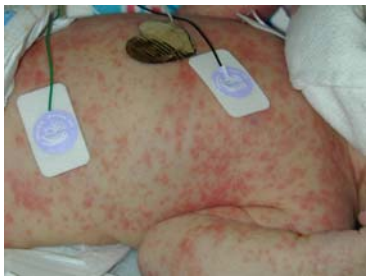
Emery Chang, NMPRA Treasurer, and Cheryl Dempsey, NMPRA Executive Coordinator take a break during the annual meeting.

The Clinician's Corner

Neonatal Exanthems

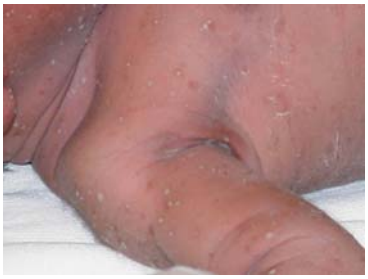
By Gitanjali Srivastava, MD Mount Sinai, NY

Some of the common problems parents and physicians face during the newborn period are rashes. Most are essentially harmless and can include everything from *erythema toxicum neonaturum* to drooling rashes. These rashes usually resolve on their own and do not require any therapeutic intervention. Parents often require reassurance from their physician. The differential diagnosis is vast and includes the following:



Erythema toxicum neonaturum is found in 30-70% of all infants, less common in premature infants. It resembles a flea-bitten follicular, yellowish/whitish papulovesicular rash of the newborn, usually 1-2 mm in diameter and evanescent in nature. The palms and soles are spared. It is most common at day 2 of life, although the rash can manifest itself from birth to 2 weeks. No laboratory tests are required although a CBC will show eosinophilia. The rash is thought to occur because of the skin's regulatory response to extra-uterine life. The white or yellowish bumps surrounded by a circle of erythema usually frighten the parents who must be reassured that the condition is not contagious, benign, and will spontaneously resolve on its own.

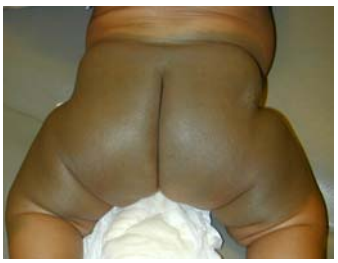
Infantile seborrheic dermatitis (cradle cap) is a yellowish, greasy, scaly, and patchy rash found in newborns. Cradle cap is infantile seborrhea dermatitis confined to the scalp. Infantile seborrehic dermatitis can also be found in various other areas such as the axilla, behind the ears, and in skin folds. In its classic form, it is non-pruritic. The condition may persist up to 6-7 months of age. Maternal hormones can overstimulate the baby's sebaceous glands leading to increased production of oil. There also seems to be a relationship to the skin yeast *Malassezia*. Parents should be advised to wash the baby's scalp regularly with mild baby shampoos or with selenium sulfide 2.5% shampoo followed by the topical application of mineral oil to the scalp and combing. Application of baby oil or mineral oil softens the scales. If the condition seems to worsen or does not show marked improvement with frequent washing, parents can obtain a ketoconazole containing shampoo and a weak hydrocortisone cream from their physician. Infants with severe generalized seborrheic dermatitis, recurrent diarrhea, and failure to thrive should be evaluated for Leiner's disease.



Transient neonatal pustular melanosis is more common in black infants (4.4% incidence compared to white infants 0.2%). The rash is widespread and can include the palm, soles, face, neck, and extremities. It presents as 2-4 mm pustules containing neutrophils which rupture into a hyperpigmented macule with scale during the first few days of life. It can also present at birth and can be seen at the time of delivery. The hyperpigmented macules resemble freckles which will fade in 3 weeks to 3 months without treatment. Again, parents must be reassured.

Neonatal acne is a benign condition resolving on its own over the course of a few months. It consists of erythematous papules and pustules without comedones, with striking similarity to adolescent acne. Neonatal acne is most common on the cheeks and forehead although it can manifest itself in other parts of the body. Parents should be asked to be patient since infantile acne tends to disappear by 6 month of age. A mild, fragrance-free soap for sensitive skin such as Dove unscented, Cetaphil, Basis or Purpose can be used on the baby's skin. If the baby develops cysts or if the condition persists beyond 8 months of age, parents should consult their physician.

Milia are miniature, white, hard, papules most commonly found on the baby's nose and chin. Milia are found in approximately 40% of newborns. They are caused by small sebaceous retention cysts and will disappear on their own without treatment.



Mongolian spots occur in dark-skinned babies of African-American, Asian, and Indian descent and are due to increased collection of melanocytes. Melanocytes which are closer to the skin surface appear dark brown, while deeper melanocytes appear bluish in color. These melanocytes can appear dark-brown, bluish-black, or gray in color, thus giving the appearance of "bruises." Mongolian spots were previously misdiagnosed as child abuse because of this very bruise-like appearance. Mongolian spots are prominent on the buttocks and lower back area. They usually fade during the first four years of life.

Stork bites, salmon patches and "Angel's Kisses" (when found on the eyelids) are types of congenital capillary malformations known as *nevus flammeus*. They present as tiny, flat red or pink patches on the baby's eyelids, the upper lip, or the back of the neck and are found in over 50% of newborns. The name has its origin from the back of the neck where the "stork" may have picked up the baby. A stork bite consists of a concentration of immature blood vessels. The capillary hemangiomas are most visible when the baby is crying. No treatment is necessary; these lesions will generally fade on their own.

Forceps marks can be bilateral or unilateral. They are scar-like circular depressions on the face, most commonly the cheeks, resembling forceps. Rarely, the baby's facial nerves may be temporarily injured. The resulting drooping of facial muscles almost always recovers completely in a matter of weeks. In cases of severe trauma secondary to forceps delivery, enzymatic fat necrosis can occur. Also, it is worthwhile to note that a certain congenital condition known as Setleis Syndrome can be confused with forceps marks. Setleis Syndrome (a.k.a. facial ectodermal dysplasia, bitemporal forceps marks syndrome, focal facial dermal dysplasia type II) is an extremely rare inherited disorder characterized by bitemporal circular depression marks on the face, missing eyelashes or multiple eyelashes, periorbital edema, and wrinkled skin among others.

Acrocyanosis is a bluish discoloration of the hands and feet attributed to a newborn's immature vascular system. It is normal when the baby is cold or crying. Again, parental reassurance is required.

The Ides of April? Of death and that other thing . . .

By Emery Chang, MD, NMPRA Treasurer

April 15th is just around the corner. UGH! It's Tax Time…

The dreaded tax season is fast approaching. Though I am not a tax professional, I have found lots of little tips over the last three years in preparing my own taxes and wanted to share some of my first-hand experiences.

Moving expenses

Did you just move from one city to another for your residency? Or will you be moving to a new city for your first job or fellowship? Moving expenses are tax deductible if the move is greater than 50 miles for both who itemize or take the standard deduction. You can deduct the full cost of the move including movers, U-haul rental, and the gasoline. You can either go by mileage or actual cost of the gasoline if you have the receipts for it. Of course, you cannot deduct what your employer reimburses.

Student Loans

Interns, most likely you paid interest during the same year you started internship. This qualifies you to take many deductions as well as qualifies you for some tax credits such as the Hope and Lifetime Learning Credits. (A brief aside: What's a credit vs. deduction? A credit is like a rebate, if you qualify, you get x amount of money given to you. A deduction just means you don't pay taxes on that money that you could deduct.). Also, if you received any student loan money that same year, you likely paid origination fees (e.g. Federal loans have a 1-3% origination fee, so if the loan was for $10,000, you got a check for $9,700-9,900). That $100-300 can likely be considered as interest and can be deducted as such.

Of course, all qualified student loans (i.e. money that is taken out as student loans, used only for educational expenses) can be deducted as well. Keep an eye out for the 1098-E that the lender should send you. Also note, if you had interest "capitalize" into your principal, that often can be considered as having "paid" that interest (i.e. interest had accrued and was not paid, so the lender added it to the principal amount you owed, and therefore you paid it with an increased loan amount. This often occurs when you move from deferment/forbearance into repayment or consolidate loans).

Itemizing vs. Standard Deduction?

This can be a tough question if you don't own a home and pay a mortgage. What I did was to quickly add up what I would deduct; health care expenses, business expenses and see how much that adds up to. The standard deduction may end up being greater than what you would itemize, but I'd argue you don't know until you do the math. If you do own a home, the amount of interest you pay on your home may itself be as much or greater than the standard deduction and therefore very worthwhile to itemize.

Business Expenses

Generally, everything that you spend for your job is a business expense. For residents, there are many non-reimbursed expenses that we can deduct if you itemize your taxes. These include the USMLE, board tests, license fees, journal subscriptions, texts, medical conferences, medical equipment, traveling from one hospital to another (but not to and from home), PDAs, cell phones, and computers used primarily for work, and possibly fellowship interviewing expenses. If something is part personal use and part business use, then you can deduct the appropriate percentage of cost. Of course, you cannot deduct what you are reimbursed for.

Last thoughts

Take time and read the 1040 instructions step-by-step. You will learn lots and hopefully save lots money. If you have questions, call the IRS, they are very helpful. KEEP YOUR RECIEPTS! Also, consider using a tax professional or software that will help you file your taxes. Pissed off that you didn't know about some of these tips from previous years?? Go back and look at what you did in previous years. If you missed tax credits or other deductions, you can go back, amend your return and get that money back.

The author and NMPRA are NOT tax experts and not responsible for the accuracy of the information provided. Consult your tax professional to see how your individual situation applies. The ideas presented in this article have many rules and details and are only intended to give some basic awareness of things to look into.

NMPRA Pins On Sale!

A. 

B. 

Pin A: $5 and Pin B: $4

Place your order by e-mail at
nmpracoordinator@medpeds.org.

These people do not endorse this article, but they sure had a great time at the NMPRA Annual Meeting in New Orleans.

NMPRA Welcomes New At-Large Board Members

By Kim Granwehr, MD NMPRA Secretary

The NMPRA Executive Committee is proud to announce the addition of three At-Large members. These residents have volunteered their time and effort as ex-officio members of the Executive Committee, dedicating their time and efforts to advancing the NMPRA and Med-Peds goals.

Paul Lantos, MD

University of Connecticut

Dr. Lantos is originally from a small town in central Connecticut. He graduated from Vassar College in 1996 Cum Laude with a degree in biochemistry. During college he spent a semester abroad in New Zealand. He attended medical school at the University of Connecticut, where he stayed for his residency in Med-Peds. He has been very involved in international volunteering; between medical school and residency he has done electives and research in Gambia, Ghana, and Peruvian Amazon, and with Alaskan Natives in Juneau. Next July he will begin a fellowship in Pediatric Infectious Diseases at Boston Children's Hospital, and is devoting this year's application season to securing a concurrent adult Infectious Diseases fellowship. His fiancé, Dr. Gretchen Green, is Chief Resident in Radiology at Yale, and their wedding will be in Newport, Rhode Island next November. Weather permitting, they spend most weekends sea kayaking off the Connecticut coastline.

Sarah Corathers, MD

University of Cincinnati

Dr. Corathers is originally from Cincinnati, but went to college at Barnard College/Columbia University in New York City to receive her degree in Art History. Afterwards, she spent two years doing neurobiology research at New York University before returning to Ohio for medical school at Wright State University. At Wright State she met several wonderful Med-Peds mentors, including Gary Onady. For residency she moved back home and is very much enjoying the program at the University of Cincinnati as well as getting to know her home town again as an adult. She is married with two golden retrievers and two cats, and when not at work she enjoys spending time with her husband and family, taking ballet classes, reading, and gardening.

Alexander Nettles, MD

University of South Alabama

Dr. Nettles was born in Monroeville, Alabama. He graduated from the United States Military Academy in West Point, NY in 1990 with a Bachelor of Science degree in International Relations with a concentration in special operations and terrorism. He then served in the Infantry in Schweinfurt, Germany. He returned to Alabama in 1993 and received a Bachelor of Science degree in Biology from Springhill College. While attending the University of Alabama School of Medicine, he served as a founding member of the honor committee and was selected by the American Medical Student Association to participate in the Washington Health Policy Fellowship Program at the Department of Health and Human Services, where he was a contributing author to *Healthy People 2010*. Dr. Nettles remains active in the Alabama Army National Guard as a captain and flight surgeon in the Medical Corps. He lives in a quirky historic home in midtown Mobile with his wife and two young daughters, and plans to practice Med-Peds in rural Alabama.

(Continued from "A Student's Discipline," page 1)

1967. They adopted as its original curriculum the content that had been chosen by its earliest learners.

One measure of the quality of an institution's training programs is how successful it is in retaining its own best medical students. As Med-Peds programs germinated, they became a benchmark for institutions. Many of the best students found dual training appealed to them. To retain them, medical schools developed their own Med-Peds programs. As they matured, the institutions found they enhanced the experience of their categorical residents and faculty. Funding sources were permissive, and Med-Peds grew rapidly. That growth was guided by Med-Peds role models, who shaped the curriculum and the image of what a Med-Peds practitioner is. Those ambassadors were residents. And that is the rest of the story.

Ask any medical student applying for Med-Peds residency who their dominant Med-Peds role model was, and more often than not they will identify a Med-Peds resident. They see in them a skill set to be emulated, a synthesized knowledge base to aspire to, and a presence worth emulating for the rest of their career. The more role models they have had, the more sophisticated their view of a career with endless possibilities. They come to appreciate the diversity of Med-Peds, far more than students from institutions without such role models do. Such students sometimes first encounter those role models on the 'interview trail'. That exposure is invaluable. Indeed, ask any program director their greatest recruitment tool, and they will specify their own Med-Peds residents.

In recent years there has been some pullback of student interest in the primary care disciplines. Med-Peds has not been immune. The decline in interest has roots in economics (student debt) and perceptions of professional life style. Paralleling it, funding sources are no longer permissive. Institutions must choose where to focus their training repertoire, as to grow any program now requires shrinking another within the institution.

Combating this decline in interest is a task Med-Peds' traditional ambassadors will be less successful in addressing alone than we can collectively. Students need to hear of the sustenance that comes from a lifelong relationship with 3 or 4 generations of the same family. They need to perceive the rich texture of shared experiences one develops with those families that render real meaning to the terms 'my doctor' and 'my patient'. They need to sense the esteem that comes from participation in patient's lives at their most vulnerable moments. They need to palpate the joy of having the background to follow unfettered your evolving professional interests over a 3 or 4 decade career. Those things can only be appreciated by exposure to Med-Peds practitioners walking that walk. Concurrently, students need continued exposure to the next generation of Med-Peds practitioners, who in defining their identity will define ours.

We perceive an opportunity to make those least aware of Med-Peds more conscious of the wonders it holds. The Med-Peds Program Directors Association (MPPDA), NMPRA, and the Med-Peds Section of the AAP and ACP have taken on the task of developing out-reach teams to the 50+ medical schools that do not have affiliated Med-Peds training programs. Each organization will contribute its strengths and networks to the process. We conceive teams composed of a Med-Peds resident, program director, and practitioner making site visits on a longitudinal and regular basis to each of these schools. We are evolving the tools to facilitate their task.

I hope you will join the process. David Kendrick, MD (president@medpeds.org) and Alison Kolody, MD (a.kolody@att.net) will be coordinating recruitment of residents who wish to participate. Please contact them. The Med-Peds community needs your skills, experience, and perceptions. You are the history of Med-Peds. You continue to shape its future.

We thank our NMPRA Member Programs! Without you, we could not exist!

Baystate Medical Center	Springfield, MA
Case Western Reserve University (MetroHealth)	Cleveland, OH
Case Western Reserve University (University Hospitals)	Cleveland, OH
Christiana Care Health Services	Newark, DE
East Carolina University	Greenville, NC
Greenville Hospital System	Greenville, SC
Harvard University	Boston, MA
Hurley Medical Center/Michigan State University-CHM	Flint, MI
Loma Linda University	Loma Linda, CA
Louisiana State University Medical Center	New Orleans, LA
Marshall University Joan C. Edwards School of Medicine	Huntington, WV
Marshfield Clinic- St. Joseph's Hospital	Marshfield, WI
Medical College of Wisconsin	Milwaukee, WI
Michigan State University	Kalamazoo, MI
Ohio State University	Columbus, OH
Rhode Island Hospital	Providence, RI
Rush-St. Luke's Medical Center	Chicago, IL
University of Michigan	Ann Arbor, MI
St. Louis University	St. Louis, MO
Saint Vincent's Medical Center	New York City, NY
Staten Island University	Staten Island, NY
SUNY at Buffalo	Buffalo, NY
Texas A&M—Scott & White	Temple, TX
Tulane University	New Orleans, LA
University of Michigan, St. Joseph's Medical Center	Ypsilanti, MI
University of Alabama at Birmingham	Birmingham, AL
University of Cincinnati	Cincinnati, OH
University of Connecticut	Farmington, CT
University of Massachusetts	Worcester, MA
University of Minnesota	Minneapolis, MN
University of Mississippi Medical Center	Jackson, MS
University of North Carolina	Chapel Hill, NC
University of Rochester	Rochester, NY
Vanderbilt University	Nashville, TN
William Beaumont	Royal Oak, MI
Yale-New Haven Medical Center	New Haven, CT

These programs have renewed their memberships for 2003-2004 (as of 2/29/04). Has your program renewed?

To view the latest active program list, go to www.medpeds.org/Membership/ResidencyDir.asp

To renew your program's membership, go to www.medpeds.org/Membership/Membership_Renew.htm