With the recent passage of the health care reform bill, it has become the topic of discussion nearly everywhere I go. While you and I realize that being a doctor or medical student doesn’t automatically make us experts on reform, our patients, family and friends don’t! If you haven’t already had someone approach you, at least once, asking what it all means, then it’s only a matter of time. Given that we are increasingly looked to as experts on health care reform, I thought it would be fitting to use my last segment as President to make sure that you are well prepared for the questions you will undoubtedly be asked. I have pulled information from several sources, including the actual reform bill itself and from the Kaiser Family Foundation (www.kff.org) and chosen 8 specific areas on which to focus. This is by no means all-inclusive, but it does include what I felt to be the meat of each section, and is a representation of what is present in the bill, free of bias or personal opinion.

How does the health care reform bill affect existing federally funded programs like Medicare and Medicaid?

Medicare

- It closes the “donut hole” in Medicare prescription plan D by 2020, and allows those who have already reached the donut hole by 2010 to receive a $250 rebate
- It will get rid of all co-payments and deductibles for preventive services effective January 1, 2011

Medicaid

- It expands coverage to all individuals under age 65 at 133% of the federal poverty level (~$29,327 for a family of 4) and will require no state contribution of funds (100% federal funding) to cover newly eligible individuals from 2014 to 2016.

- Illegal immigrants will not be eligible for coverage.

How does the bill affect existing insurance companies?

- Starting 6 months after enactment, insurance companies cannot deny coverage to children with preexisting conditions.
- As of 2014, insurance companies cannot deny coverage to anyone with a preexisting condition, and cannot drop individuals if they become sick.
- It will ban lifetime caps on coverage and also restrict annual limits on coverage (especially important for patients who become ill with diseases that require expensive treatments, such as cancer).
- If you already have coverage through an insurance company you will not be required to change.

Continued on Page 2
How exactly will the bill create insurance coverage for those currently uninsured?

Health Insurance Exchanges

- Health insurance exchanges, which allow individuals to pool risk and therefore benefit from lower premiums, will be created for individuals and/or the self-employed and self-insured. These exchanges will be separate from those created for small businesses.
- Subsidies will be available for individuals making 100-400% of the federal poverty level to purchase in the exchange (but they cannot be eligible for Medicare, Medicaid, or insurance coverage through an employer.)
- Individual contribution caps will be based on a sliding scale.
- Illegal immigrants will not be eligible to participate even if they are willing to pay 100% of the cost of coverage.
- The bill will require the Office of Personnel Management to contract with insurers to offer at least 2 multi-state plans in each exchange. At least one must be offered by a non-profit entity and at least one must NOT cover abortions. Multi-state plans must be licensed by each state, must be offered separately from the federal employee’s health benefits program and must have a separate risk pool.

Consumer Operated and Oriented Plan (CO-OP) Programs

- The bill will create CO-OP programs to foster the formation of non-profit, member-run health insurance companies in all 50 states and the District of Columbia that will offer qualified health plans.
- A CO-OP program must not be an existing health insurer or be sponsored by state or local government.
- Governance must be subject to majority vote of members, operate with a strong consumer focus, and any profits must be used to lower premiums, improve benefits, or improve the quality of healthcare delivered to its members.
- $6 billion will be allotted to finance programs and award loans and grants to establish CO-OPs by July 1, 2013.

What specific plans will be offered?

- Bronze — minimum coverage and provides essential benefits; covers 60% of benefit costs with out of pocket limit equal to the current Health Savings Account (HSA) law limit (~$5,959 for individuals and $11,900 for families).
- Silver — provides essential benefits and covers 70% of benefit costs of the plan with HSA out of pocket limits.
- Gold — provides essential benefits and covers 80% of benefit costs of the plan with HSA out of pocket limits.
- Platinum — provides essential benefits and covers 90% of benefit costs of the plan with HSA out of pocket limits.
- Catastrophic coverage — only available for those up to age 30 or those exempt from the mandate to purchase coverage. Coverage level will be set at the HSA law levels except prevention benefits and coverage for three primary care visits would be exempt from the deductible.

How will the government mandate coverage?

- By 2014 everyone must purchase health insurance. Failure to do so will result in a $695/year (or 2.5% of the household income) fine. Some exceptions would be made for very low income individuals.
- Employers of >50 employees must provide insurance or pay a $2,000 fine per worker per year if any employee receives government subsidies instead.

How will the healthcare reform bill affect quality?

- This bill will establish a nonprofit Patient-centered Outcomes Research Institute to identify and conduct research that compares clinical effectiveness of medical treatments.
- It will award 5 year demonstration grants to states that develop, implement, and evaluate alternatives to amend tort litigation.
- It will establish a national Medicare pilot program to develop and evaluate paying a bundled payment for an episode of care spanning 3 days prior to hospitalization to 30 days after discharge.
How does the healthcare reform bill address prevention of disease?

- It will establish the National Prevention, Health Promotion and Public Health Council to coordinate federal prevention, wellness and public health activities. It will also develop a national strategy to improve the nation’s health and create a Prevention and Public Health Fund to expand and sustain funding for prevention and public health programs.
- It will establish a grant program to support the delivery of evidence- and community-based prevention and wellness services designed to strengthen prevention activities, reduce the rates of chronic diseases, and address health disparities, especially in rural areas.
- It will improve prevention by covering only proven preventive services and eliminating copayments and deductibles for preventive services in Medicare and Medicaid. It will also require qualified health plans to provide, at a minimum, coverage without copayments or deductibles for preventive services such as recommended immunizations, preventive care for infants, children, and adolescents and additional preventive care and screenings for women.
- It will provide Medicare beneficiaries with access to a comprehensive health risk assessment and creation of a personalized prevention plan. It would also provide incentives to Medicare and Medicaid beneficiaries to complete behavior modification programs.
- It will provide grants for up to 5 years to small employers that establish wellness programs, and will permit employers to offer employee rewards (in the form of premium discounts, waivers of cost-sharing requirements, etc) for participating in a wellness program and meeting certain health-related standards. Employers would be required to offer alternative standards to individuals who cannot reasonably meet the standard.
- It would require disclosure of nutritional content from chain restaurants and manufacturers of foods sold from vending machines.

Lastly, how are we supposed to pay for this?

- Funding will come from several sources: 10% excise tax on indoor tanning, 40% excise tax on high-end insurance plans (> $27,500 families/$10,200 individuals)
- Also, Medicare payroll tax will include unearned income as of 2010 (3.8% tax on investment income for families making > $250,000/yr or individuals making > $200,000/yr)
- It would also increase taxes on distributions from Health Savings Accounts (from 10% to 20%) or Medical Savings Accounts (from 15% to 20%) not used for qualified medical expenses
- It would impose new fees on the pharmaceutical manufacturing and insurance sectors and a 2.3% excise tax on any taxable medical device

While not all-inclusive, this list of details hopefully includes many of the questions that are most frequently on the minds of our patients and friends—and maybe even our own. The topic of healthcare reform is a heated one, and understandably, we as health care providers tend to be especially opinionated about the issue. Whether the current plan will be as effective as the creators have promised is yet to be seen. Until then we are left with only our best guesses and opinions. My only hope is that we will be well-informed so that each of our opinions is based on facts and not sound bites from our favorite news channels. So now when our patients, families, friends and colleagues ask us about healthcare reform, regardless of whether we agree with the plan or not, we can provide them with an informed opinion, as is expected of us as physicians.

Med-peds named in healthcare reform

Internal Medicine and Pediatrics was included in the definition of a primary care residency program in the new health care reform legislation. Thanks for your advocacy efforts!
This year’s NMPRA Midwest Regional conference was phenomenal! Our theme for this year was transitional care. We started out the meeting with brief introductions to NMPRA and Med-Peds.

Our keynote speaker was Dr. Mary Ciccarelli, who spoke to us on the importance of the role of Med-Peds providers in transitional care. We learned that Med-Peds providers are perfect for transitional care given our dual training. However, there are not enough Med-Peds physicians to cover the needs of transitioning patients. We learned that we need to educate other physicians on the needs of complex pediatric patients and the importance of proper transition.

Morning breakout sessions allowed attendees to choose between didactic sessions with the following topics: transitioning cystic fibrosis patients into adulthood, congenital heart disease survivors transitioning into adulthood, and childhood cancer survivors and adult health maintenance. After a quick coffee break, the group divided into half for pediatric or internal medicine board review.

Lunch served as a time for networking and a career fair. There were several hospitals and recruiting firms present to talk with the Med-Peds residents about potential career options.

Afternoon sessions started with a lecture on how to talk to parents about transitioning pediatric patients into adulthood, as well as a Med-Peds update by Dr. Allen Friedland. Breakout sessions included global health topics, actuary science, and financial planning for both medical students and residents. The conference concluded with a Med-Peds career panel including hospitalists, traditional outpatient practice, academic physicians, and non-traditional career pathways.

The evening was wrapped up with a post-conference party at the Milwaukee Ale House. We learned about the process of making beer and enjoyed tasting the expansive appetizer menu that was served.

Overall, the Midwest conference was a great success and a time for learning and networking. We are looking forward to next year’s event! Stay tuned for more information on next year’s conference.

Midwest Regional Conference
Saturday, November 7th, 2009
Milwaukee, Wisconsin
at the Medical College of Wisconsin

Students, residents, and attendings at the Midwest Regional Conference in Milwaukee. Jessica Wilson, pictured far left, is a PGY-4 at the Medical College of Wisconsin and the NMPRA Immediate Past President.
On February 27, 2010, residents, medical students and attending physicians met in Miami, Florida for the first annual NMPRA Southeast Regional Conference. Hosted by the University of Miami/Jackson Memorial Hospital Med-Peds Residency Program, the conference began with a brief introduction by residency program director Dr. Stefanie Brown, followed by a moving keynote address by chief resident Dr. Toni Eyssallenne. Dr. Eyssallenne first gave an overview of the Jay Weiss Residency in Global Health Equity and Social Medicine, a unique residency track offered by the University of Miami that aims to train leaders in health advocacy for the underserved both domestically and abroad. She then shared her remarkable experience as Chief of Medicine in a makeshift university field hospital in Haiti directly after the January earthquake which devastated the country’s capital city, Port au Prince.

The day continued with great events including an overview of the history of Med-Peds, an update on diagnosis and treatment of cystic fibrosis, Infectious Disease Jeopardy, and an update from NMPRA President, Dr. Kierstin Cates Leslie. The U. of Miami program was also able to showcase two innovative initiatives (the procedure team and DOCS) in an effort to share creative ideas in resident education and community service. The procedure team is a resident elective aimed at improving competency and reducing complications in common internal medicine procedures, and DOCS is a medical student-run organization aimed to providing effective healthcare screening and appropriate follow-up for thousands of South Florida’s uninsured population.

In true Miami fashion, the conference ended with a night of dinner, drinks and dancing. The conference was a great success and we would like to thank all of those who participated. We hope to continue the tradition for years to come and look forward for next year’s conference being bigger and better!
Wright State: Program Interrupted

With the nature of the economy at the present time, there’s probably very few of us who have remained untouched. Among those affected are the residents and program faculty at Wright State University’s (WSU) Med-Peds Residency Program in Dayton, Ohio.

The Internal Medicine and Pediatrics program at WSU was opened in 1980, and remains one of the first programs to be accredited by the American Board of Internal Medicine and American Board of Pediatrics. For the past 30 years, WSU has trained strong Med-Peds physicians who pursue a variety of pathways including primary care and subspecialties. During this time period, there has always been a close kinship between the residents and the faculty, similar to other Med-Peds programs throughout the country.

What began as a promising year, both from an academic and recruiting standpoint, turned into a very challenging time for faculty and residents. The program is partially funded by Premier Health Partners, a large health-care network located in southwest Ohio. Premier Health Partners decided to revamp their focus for medical education away from primary care by placing more emphasis on subspecialties. As a result, Wright State’s Med-Peds program had to cancel current recruitment efforts and will eventually be forced to close their combined clinic. This news came as a shock to everyone, and was particularly unfortunate as the program recently got reaccredited after a RRC visit.

In spite of the grim news, Wright State’s Med-Peds program has continued operating fully and will do so until the current intern class completes their residency requirements. Residents continue to be fully welcome and integrated in both categorical programs. The program continues under the stellar leadership of Dr. Marc Raslich (Combined Med-Peds Program Director), Dr. Virginia Wood (IM Program Director), and Dr. Ann Burke (Pediatric Program Director). The combined continuity clinic will continue for the next calendar year, with a tentative plan for residents and patients to be dispersed among local categorical clinics. However, the goal to maintain a combined clinic for their patients (who are predominantly Medicaid, Medicare, and uninsured) is a priority.

These changes came as a complete surprise, and Wright State’s program continues to face day-to-day challenges. Our goals continue to be optimizing patient care and resident education. Although there will not be a new class in 2010, the program continues to work with another community-based hospital in the Dayton area, which may be able to incorporate part of the Internal Medicine training so that the program can welcome new classes and continue in the future.

In light of the economic difficulties and tenuous status of primary care, it is quite possible that Wright State is not the only Med-Peds program that will face this type of situation. However, we plan to continue to emphasize the importance of primary care and perform as excellent Med-Peds Physicians. Nationally, Med-Peds physicians share a special relationship, and it is clear that this spirit continues with the faculty and residents of Wright State!

Dhaval Desai is a PGY-2 and Erin McConnell is a PGY-4 at Wright State. Dhaval is the Wright State NMPRA Program Representative.
The end is near with residency coming to a finish and you’ve got some leads on a job. There are many issues and possible pitfalls that can happen with any job but getting details ironed out ahead of time can save you lots of headache.

The most important step is to first think about what you want. What are your priorities? Is it making lots of money, vacation time, weekends off, type of medicine you’ll be practicing? This will help focus you in your job hunt and contract negotiations.

THE FINE PRINT

Of course, what is in writing is what counts. Make sure that all the details are in writing. This includes call time, salary, production bonuses, benefits, (including health, disability, dental, vision, life, and malpractice insurance, 401(k) or other retirement benefits (hopefully with some matching funds), moving expenses, production requirements, holiday and CME time, partner track, covered expenses (such as DEA, medical licenses, board exams, society memberships, cell phone), dates of employment and time needed for termination of the contract, and if there are limits to legal fees or process for disputes.

LAWYER

It is always a good idea to have an experienced lawyer review the contract. The prospective employer, of course, wrote the contract in their favor and especially if the agreement is complex, advice from someone on your side is important.

NON-COMPETITION

Frequently, there may be non-competition clauses in the contract which is intended to limit you from joining another group or starting your own practice in a defined geographic region. This may also limit you from moonlighting as well. Be very careful, since most people leave their first job and you don’t want to limit your future options.

DOCUMENT YOUR CONVERSATIONS

Often most of our negotiations are verbal and may not make it into written forms. After each important conversation, send an e-mail to those involved that summarizes the decisions that were made. This gives them a chance to correct any misunderstandings and if there are later disputes, you have some documentation of what had been agreed upon.

DON’T BE AFRAID

Ask for what you want and for what is important to you. Many doctors don’t ask for more money, even when the offer is clearly low. Of course, you may have to give up some things for other priorities, but make sure you advocate for yourself.

As always, neither NMPRA nor I are financial experts and advise that you consult your own personal law and financial experts prior to making any decisions based on the information in this article.
AAP MED-PEDS SECTION CORNER:
BY BINNEY MCCAGUE, MD

AAP MED-PEDS CLINICAL CASE COMPETITION

The AAP Med-Peds Clinical Case Competition is back! Clinical cases are presented as posters at the American Academy of Pediatrics Med-Peds Section Meeting during the AAP National Conference and Exhibition. This year’s meeting will be Sunday, October 3rd, in San Francisco. Abstracts will be accepted until April 16 via the AAP site at http://aap.confex.com/aap/2010/cfp.cgi. Travel grants of $500 will be available for two residents to present at the AAP meeting. Any case with a unique med-peds twist (diagnostically or therapeutically) is appropriate. If you have questions, contact this year’s co-chairs, David Kaelber, MD, PhD, MPH, FAAP (dkaelber@aap.net) or Kimberly Tartaglia, MD, FAAP (kimtartaglia@gmail.com).

ACP NATIONAL CONFERENCE

The American Academy of Physicians (ACP) conference is April 22-24 in Toronto, and Med-Peds will be there! We will be discussing continuing collaboration with other organizations dedicated to Med-Peds, the 2010 AAP National Conference and Exhibition, and resident and student outreach. Visit http://www.acponline.org/meetings/internal_medicine/2010/ for more information or to register for the conference.

THE MATCH IS OVER...

And Med-Peds did great! There was a 3.1% increase in positions filled compared to last year, for a total of 98.9% of positions filled nationwide. 84.2% were filled by US medical graduates, and 15.8% by international medical graduates. Only 4 positions went unfilled in the match, and they were all filled in the scramble. This compares well to the 98% and 97.5% of first year spots filled in pediatrics and internal medicine, respectively. For more information, see http://aap.org/workforce.

Binney McCague is the resident member of the AAP Section on Med-Peds Executive Committee. She is a PGY-1 at the MetroHealth System Campus of Case Western Reserve University in Cleveland, Ohio.

MED-PEDS CLINICAL CASE FILE LIBRARY

An electronic file of interesting Med-Peds cases has recently been created at http://www.aap.org/sections/med-peds/caselibrary.cfm. These cases were selected from case reports submitted through the Clinical Case Competition. Use these cases to learn, teach, and get students excited about Med-Peds.

JOIN THE AAP SECTION ON MED-PEDS

The American Academy of Pediatrics (AAP) Section on Med-Peds is the group within the AAP that supports our specialty. All Med-Peds residents and attendings, as well as interested students are invited to join this section. You first have to be a member of the AAP (most residency programs already provide AAP membership). Once you are an AAP member, you can join any section that makes sense to you for $10. The link to our section is http://www.aap.org/sections/med-peds/.

The form can be sent in via fax, e-mail, or mail. Or, you can just click to join! The section can help you find a mentor, connect you with job and fellowship search tools, and provide you with opportunities to be involved in issues surrounding med-peds. We’d love to hear from you!

Contact Binney McCague at bmccague@gmail.com with questions.
I have always wanted to work and live in Haiti. As a first generation Haitian-American raised in a proud family, the beauty of my people, culture and country was never in question for me. I had visited the island nation with both my mother and father when I was younger and remember being so moved by the poverty that was in juxtaposition with the rich history that I knew and loved. Before my father died, we had talked at length about going to Haiti and strategized to make our contributions to a country we would not forget; he would create businesses and jobs, and I would work on improving health care. The University of Rochester School of Medicine and Dentistry helped me nurture my love affair with Haiti. Out of all the medical schools that I had the opportunity to attend, U of R was the only one whose international medicine program included a site in Haiti.

Being from southern Haiti, neither I nor my family had even heard of Borgne, a small town on the country’s north coast. But I was excited to finally be on the road toward getting to know my country of origin better. Through my introduction to Dr. Rose-Marie Chierici, a professor of anthropology at SUNY-Genesee and director of the Rochester-based nongovernmental organization (NGO) H.O.P.E. (Haiti Outreach Pwojè Espwa), I began the process of understanding the needs of impoverished Haitians not only in terms of health, but how the relationships between environment, politics, social structures, and culture influence these needs.

Borgne is an extremely poor and isolated town. Although I had seen poverty before, this was a full immersion and it affected me deeply. Despite the naked, pot-bellied children, dilapidated shacks, mothers in rags and men young and old fishing for a dwindling catch in the hot sun, every morning I was awakened not only by time-challenged roosters, but the beautiful sound of voices singing the praises of God, sincerely thanking Him for yet another day of life. Amazing.

As I placed my survival items from my cart onto the cashier’s conveyor belt, I began to receive what seemed like hundreds of text messages about a 7.0 earthquake in Haiti.“

On January 12, 2010, I was preparing for my last trip to Borgne as a resident. In addition to working in the hospital as I had in the past, I was excited about finishing a family planning assessment project. As I placed my survival items from my cart onto the cashier’s conveyor belt, I began to receive what seemed like hundreds of text messages about a 7.0 earthquake in Haiti. The previously defunct government hospital in the town would now operate through a partnership between the two. Today, this hospital stands as the central health care institution in the region and serves a population well over 100,000.

My interest in international medicine, particularly as it relates to Haiti and the Haitian population, drew me to do my Internal Medicine-Pediatrics residency at Jackson Memorial Hospital/University of Miami in Florida. Fortuitously, the university had recently inaugurated a global health residency focused on international health and health disparities. The program bears the name of the late philanthropist Jay Weiss, who was dedicated to serving the underserved in South Florida. As a Med-Peds resident in this track, I have been able to not only continue my work as a volunteer physician in Borgne, but have also traveled to other countries including India, Peru and the Dominican Republic to examine their unique health problems and health care systems in the context of their social, environmental, political and cultural structures.

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onto the cashier’s conveyor belt, I began to receive what seemed like hundreds of text messages about a 7.0 earthquake in Haiti. I couldn’t believe it. Knowing the damage 5.0 and 6.0 earthquakes cause in the United States and knowing the condition of the majority of Haitian housing, I knew that a 7.0 earthquake was going to be devastating. And in Port-au-Prince, the heart and center of the entire country? A million thoughts ran through my head; my goodness, I still have family in Port-au-Prince! And friends! And friends that have family and friends in Port-au-Prince! An earthquake in Haiti? Why can’t this country catch a break? Didn’t we just go through four hurricanes in a row? What? A tsunami watch too?! Thankfully there was no actual tsunami, but the magnitude of this cataclysm in terms of lives lost, displaced, and changed cannot be overstated.

The next 24 hours were consumed with phone calls and emails trying to find a way to get to Haiti. Dr. Barth Green, a neurosurgeon at the University of Miami and co-founder of Project Medishare, an NGO that works in Haiti’s Central Plateau, chartered a private plane and was in Haiti less than 24 hours after the earthquake with a surgical team. The United Nations had erected two tents where they had placed over 200 injured people, and they needed doctors. The Association for Haitian Physicians Abroad (AMHE, French abbreviation) e-mailed a request for physician volunteers and I, along with my good friend from Internal Medicine, was at this makeshift hospital by 11:00 P.M. on January 14.

Little did I know that we, along with an ophthalmologist and another Haitian academic internist, would be the only doctors available to relieve the surgical crew that had been working non-stop for the last two days. We had no nurses and our medications were limited. Everyone was in pain. Everyone needed a new IV bag. Everyone needed immediate attention at the same time, now. Our triage system evolved from red and yellow dot stickers to writing on the patients to writing on scrap paper and taping it to the cot, or in some cases, to the patient. Sleep was an impossibility. How could you sleep? There was too much need. There were wounds that one would think only happened in Hollywood films: crush injuries, open fractures, pelvic fractures, facial and internal traumas.

Graciously, physicians from Martinique came in those first few days and selected critical patients to evacuate to their island in order to help their northwestern neighbor. Political tensions aside, the Dominican Republic took in a few as well, and those on death’s door were evacuated to the United States. The Israeli military came in like ninjas and had a fully operational tertiary care hospital system in three days and took some of our patients too. Doctors, nurses and medics from Colombia and Portugal came to lend a hand. And as the days progressed, physician groups from all over the United States had come in. It was incredibly moving to see such an outpouring of support for this traumatized country.

We received new patients as fast as we evacuated, however. Patients were being dropped off by the dozens by ambulance, pickup truck or other vehicle. Children had been burned by boiling food, water, or oil in pots and pans overturned by the earthquake. Lungs were collapsing, pelvic fractures were causing urinary retention, and people of all ages were coming in unable to move, some just their legs, and others their arms too. We lost several patients that first week, some old, some young, and all heartbreaking.

Continued on Page 11
THE PERSPECTIVE

And the amputations...how will they resume their lives? There are no wheelchair ramps or elevators, and barely any prosthetics. How will the market women travel to sell their wares now? They usually have to walk for miles and miles carrying pounds and pounds of merchandise. How will they support their families? Unfortunately, these were questions that we couldn’t think about that first week. One surgeon said over and over, “we are in damage control. Save as many as you can as fast as you can, any way you can.” Those decisions are difficult.

In the second week, the hospital moved from the UN base to a field in Haiti’s domestic airport. It now stands as the University of Miami Hospital in Haiti with an operating room, a pediatric and adult ward, ICU, wound care, x-ray machine and pharmacy. Physician and nurse volunteers of all specialties can be found working in these tents. Physical therapists work sun-up to sun-down showing these survivors how to walk again.

I spent three weeks in this hospital. My happiest moments were when simultaneously, both tents burst into prayer, song and dance rejoicing in their love for God and His mercy on them and when my 21-year-old, one month post-partum patient with a broken back and broken pelvis walked down the aisle of the hospital with command of her walker and the smile of light that young Haitians are famous for. After the dust settles and time has rolled on, it is so easy to for the world to forget. When the media has lost interest because there are no more opportunities for award winning photographs of despair and destruction, the suffering continues.

Just the other day in my continuity clinic in Miami, a mother came in with her seven-week-old son who had been hospitalized for a urinary tract infection. She was smiling and attentive as I give her instructions on how to care for her baby. And then I asked the question that I have come to ask all my Haitian patients: is your family all right? Having had a casualty in my own family, I knew the likelihood of an affirmative response was small. “No”, she says as her eyes welled up with tears. She lost her mother and her two brothers. Her original plans of going back to Haiti after her baby was born had been thwarted; she had to send for her two other young children who, up to this point, were having normal lives. She is staying with her aging aunt now. She is separated from her husband and is faced with having to fend for herself and her three children alone in a country she doesn’t know using language she doesn’t speak. She then wipes her tears, takes a deep breath, sits up straight and smiles as if to say, “We will be ok.”

I continue to be amazed and proud. Haiti has been through hell, and it continues to stand. A common theme throughout this tragedy has been the resilience of the Haitian people. I have always believed that Haiti has the ability, and I continue to hold on to that belief. In addition to the collaboration of Haitians in Haiti and abroad to make that a reality, we will need a government that will finally be willing to change for the sake of its people. I have learned many things from this experience. The first thing I have learned is that nurses are truly a godsend. I learned that in a crisis, many people have the ability to be extraordinarily and genuinely selfless. And the biggest lesson that I took home is that if Haitian people, after all they have been through, can rejoice and be thankful for their lives in the face of extreme poverty, hurricanes, and their houses falling down and crushing their bones and taking out their loved ones, I have no reason to ever complain about anything ever again.

Daniel Pust, MD, a trauma surgeon who worked tirelessly in Haiti, Junior Clermond, an earthquake survivor who was treated at Jackson and Toni Eyssalienne, MD in Miami (left to right).
The National Med-Peds Residents' Association is a resident-driven organization dedicated to providing information, opportunities, and programs to current and future Med-Peds residents. Want to get involved? Read on to see where you fit in!

**Program Representatives**

The NMPRA Program Representative is elected by each individual Med-Peds residency program and serves as a channel of communication between the NMPRA executive board and their program throughout the year. We currently have about 40 residency programs with active Program Representatives! Program Representatives receive direct communication from the NMPRA executive board regarding Med-Peds happenings on a national level and also help to bring national attention to events and issues within their residency program. Program Representatives may serve until their graduation from residency unless otherwise dictated by their individual program. To learn more, or to become your program’s representative, email president@medpeds.org.

**Advocacy/Community Service Grants**

NMPRA annually awards 1-2 grants of $500-$1000 to Med-Peds residents who seek to improve the lives of children & adults in their communities through an advocacy or service project. In the spirit of fostering service and advocacy, applicants should propose the design and implementation of a broadly-defined project that addresses the needs of both children and adults in their community. Grant recipients will be asked to present their project at the NMPRA Annual Meeting in San Francisco on October 2, 2010. Applications are due **July 15, 2010**. More details are available at www.medpeds.org.

**Clinical Case Abstract Competition**

All residents are invited to submit abstracts of noteworthy Med-Peds clinical cases for the Annual Med-Peds Clinical Case Abstract Competition. Two cases will be chosen for oral presentation at the NMPRA Annual Meeting in San Francisco on October 2, 2010. Cases should be interesting clinical presentations pertinent to Internal Medicine and should also display significant educational value to the Med-Peds audience. Cases that have been previously presented locally (but not regionally or nationally) may still be submitted. The current deadline for abstracts is **July 15, 2010**. Be on the lookout for good cases! More details are at www.medpeds.org.

**2010-2011 Executive Board**

NMPRA is electing new officers to serve on the 2010–2011 Executive Board. Any resident member of NMPRA is eligible to apply. The current elections are for the positions of: President-Elect (3 year commitment), Secretary (1 year commitment), and Treasurer (1 year commitment). Applications are due by **April 30, 2010** and require a 500-word personal statement as well as a CV/Resume. Applications are submitted online via the portal at http://www.medpeds.org/about/elections.asp. Voting will be open to all NMPRA members in May and new officers will be announced by June. Email president@medpeds.org with questions.
NMPRA has always encouraged international electives as a way to broaden your education and clinical skills. The 2010 NMPRA Executive Board is proud to announce its newest award: the NMPRA International Health Travel Grant.

Each academic year, NMPRA will award $500.00 to a Med-Peds resident planning to complete a clinical Internal Medicine or Pediatric elective in the developing world during residency.

Applications for the International Health Travel Grant will be due July 15, 2010. The NMPRA Executive Board will serve as the selection committee and the award winner will be notified within a month of this deadline.

Good luck and happy traveling!

Submitted by Jessica Wilson, Immediate Past President, on behalf of the NMPRA executive committee.
A resident-driven organization dedicated to providing information, opportunities, and programs to current and future Med-Peds residents.

For general questions about NMPRA, e-mail nmpra@medpeds.org

To contribute to the next Perspective, e-mail secretary@medpeds.org

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