
APPD NEWSLETTER

Fall

Association of Pediatric Program Directors

1997

EDITOR'S COLUMN

Edwin Zalneraitis, MD

As a new councilor to the APPD, I have had the opportunity to attend my first Executive Board meeting this past May as part of our annual meeting in Washington, D.C. At that board meeting, we agreed that we would transition the role of editor of our APPD newsletter between Dr. Bob Kamei and me. In addition, we would attempt to further enhance communication between program directors by having three issues of the newsletter each year. As one who has never been a prolific writer, or good at encouraging others to write, this will be a challenge. With help and encouragement from Bob Kamei and Laura Degnon, I'm sure we will succeed.

I will continue the effort that Bob began in moving the newsletter to a more interactive and useful format, put together through Laura's expertise and energy. In this issue, we will continue such regular notes as those from Dr. Carol Berkowitz as President of the APPD and reporter on RRC activities, introduction of new councilors, a response to questions about the ABP from Dr. Walter Tunnessen, and updates from our annual meeting, including an update and progress report on the development of the electronic resident procedure log.

As much as possible, however, I would like to reiterate and move forward with Bob Kamei's intent for this newsletter to be a vehicle for exchange of ideas among program directors and coordinators. We will try to summarize activities since our last meeting, and discuss upcoming events, but we will look to you as members for questions and ideas for the content of future issues.

With your comments and input, I hope that future issues will include much more material devoted to answering your questions and
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PRESIDENT'S COLUMN

Carol D. Berkowitz, MD

The annual meeting of the APPD had a record number of participants this year. On April 30, 1997, the Directors of Small Programs, Directors of Med-Peds Programs, and Program Coordinators all had the opportunity to meet. In the evening, some of the regions got together informally.

The Plenary session followed the usual format with reports from the major pediatric organizations including the AAP, ABP, RRC, and PCOC. A report from the Program Coordinators was given by Jeri Whitten, program coordinator at West Virginia University, Charleston. The program coordinators will begin meeting with the program directors in May, 1998, and in the future will have a separate column in the newsletter.

An additional report was given by Robert Beran, Ph.D. from the NRMP. He presented the results of a study which evaluated the difference between an applicant driven and a program driven match. The program directors voted overwhelming to support an applicant driven match algorithm.

The lunch time talk focused on resident bonuses, and was presented by Dr. Steve Wassner, with comments from Dr. Elizabeth McAnarney, representing the Association of Pediatric Medical School Department Chairs (AMSPDC). A summary of the discussion is found on page 7 in the newsletter.

The APPD also took time at the annual meeting to work on the issue of procedure logs. There was a workshop that demonstrated a sophisticated computer-based log, led by Drs. Leslie Mihalov and John Mahan. Drs. Mihalov, Mahan, Berkowitz and Nolan met with Dr. Michael Anderson (AAP Resident Section Chair), Dr. Errol Alden (AAP) and Dr. Walter Tunnessen (ABP), and representatives from Ross Laboratories to try to develop and disseminate a uniform procedure log to all residents. The hope is that this will be accomplished by the fall, 1997.

On May 2, 1997 there were a series of committee meetings held which addressed issues such as the Handbook (how to update, revise and disseminate it), along with the planning of the fall meeting for new program directors.

Lastly, I want to comment how valued our opinion as program directors is
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PRESIDENT'S COLUMN *(continued from front page)*

about resident education. After our meeting, I returned to Washington, to help the genetics community address the issue of how genetics can be better integrated into primary care residency training. This is indeed a challenging area, given the wealth of new genetics information that becomes available on almost a daily basis. I think we as program directors will be asked to take a leadership role in this arena.

Similarly, I'd like to share with you the results of a survey that many of you completed about Curricula in Behavioral Pediatrics and Adolescent Medicine. As of April 29, 1997 about half the programs had responded. Over 95% of the programs had block rotations in developmental pediatrics and adolescent medicine, but about half needed additional faculty. Programs were interested in case-based teaching, and some programs had supplied topics that were poorly covered in the curriculum. Eight cases are presently under development.

EDITOR'S COLUMN *(continued from front page)*

addressing your problems. To do this, however, we need your responses.

You can address your questions, issues and ideas to me at The Center for Education, Connecticut Children's Medical Center, 282 Washington Street, Hartford, CT 06106, fax to 860-545-9975, or Email to ezalner@ccmckids.org. Alternatively, you can send your comments to our national office or Email them to Laura Degnon at degnon@aol.com. We look forward to hearing from you.

Association of Pediatric Program Directors Officers and Councilors

President: Carol D. Berkowitz, MD

President-Elect: Robert J. Nolan, MD

Secretary-Treasurer: Julia A. McMillan, MD

Past-President: Kenneth B. Roberts, MD

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Councilors: Bradley J. Bradford, MD;
Gail McGuinness, MD; Richard A. Moriarty, MD;
Edwin Zalneraitis, MD

QUESTIONS/ANSWERS COLUMN

Walter W. Tunnessen, Jr., MD, Senior Vice-President, American Board of Pediatrics

Question: Procedure competence. The ABP and the RRC lists of technical skills in which each resident is required to achieve competence do not fully correspond. Some of the skill requirements are unachievable in many residency programs, while others seem outdated. Is the ABP planning to try to develop a unified and updated list of required procedural competencies?

Answer: The ABP is planning to review and revise its handbook for program directors on the evaluation of residents. Over the years since the original handbook was written, much has changed in pediatric training. The evaluation of residents' has improved considerably, particularly since the RRC required that programs keep written documentation of resident performance. Competence in procedures is part of the evaluation of residents. There is movement afoot to develop a means of documenting performance of and competency in technical skills, similar to the logs required by other specialties. The log is being developed by members of the APPD, along with input from the APP and the ABP, with support from Ross Laboratories.

The ABP has asked a number of program directors to assist in the review and revision of the original handbook. The procedure skills section will certainly be revised and will almost certainly be in concert with the RRC requirements. The issue of competence itself will also need to be addressed. How will competence be defined for these skills and other aspects of clinical training? Remember that the ABP relies on your assessment of residents' clinical competence. You must verify that they are ready to assume responsibility for the independent medical care of children. We work together to provide assurance to the public that a certified pediatrician has met training and other requirements to assume this important role. Similarly, the ABP would appreciate the expertise of the APPD in helping to develop ways to define, measure and help residents achieve competence. We look forward to working with you.

Please send ABP questions for the next Newsletter to the editor: Ed Zalneraitis, MD, The Center for Education, Connecticut Children's Medical Center, 282 Washington Street, Hartford, CT 06106, fax to 860-545-9975, or Email to ezalner@ccmckids.org.

IL 372: A MESSAGE FROM COPE

Edwin Zalneraitis, MD

At this year's meeting of the Council on Pediatric Education, there was a detailed discussion on the status of IL 372- the Medicare rules defining the criteria for billing Medicare for patient services in the teaching setting. A heavily attended session was held at our May meeting in Washington, D.C. this year to address this issue as well. These rules mandate that a provider be recognized as the primary provider of care in order to bill in a Medicare setting. The exception has been primary care, where a provider may bill if the resident physicians seeing the patients independently have 6 months minimum experience, the provider is immediately present and reviews all care, and there are no more than four residents per provider in the setting at the time. The rules have been applied to all services, even those without Medicare support, by academic institutions.

Several issues have been raised. First, the impact on education, particularly in the office setting, could be compromised. The interpretation and application of these rules have been varied widely and inconsistently, even in the same program. This has made it difficult for programs to comply, even when supported to do so. Finally, there are ongoing retrospective reviews by the federal auditors, with substantial fines and penalties, that have been halted in selected cases but not all instances.

Dr. Jimmy Simon, the Chair of the COPE, made a plea on behalf of the committee to all program directors to contact their representative AAP District Chairs to voice the strong desire for this to be resolved in a fair and uniform way. The AAP is looking to the program directors to indicate that this is an important issue for the AAP to address nationally. **Please contact your AAP District Chair as soon as possible.** Let them know that it is critically important to stop the retrospective reviews uniformly, and to define the implementation clearly and in a way that does not undermine educational efforts of programs.

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REPORT FROM THE RRC

Carol D. Berkowitz, MD

The new requirements for residency education in Pediatrics went into effect in February, 1997, along with the new program information forms. Some programs have already undergone a site visit, and the first set of programs to be evaluated under the new requirements will be reviewed in October, 1997. During the time period of transition, the RRC recognizes good faith efforts on the part of programs regarding resident education and Board eligibility.

Dr. Berkowitz gave the RRC report at the annual APPD meeting. She noted that the current composition of the RRC in Pediatrics includes 7 men and 3 women, program directors as well as department chairs, representatives from 9 different states, 8 medical school programs and 2 public hospitals.

Over the last year, the RRC reviewed 73 core pediatric programs, 52 of which were undergoing a first review (not a reconsideration for additional information, progress report, etc.). There were 2 proposed adverse actions and 2 confirmed adverse actions. Citations dealing with curricular content often include the following: inpatient population, continuity clinic population and panel size, excessive NICU, too many adult patients in the ED. Process and related issue citations include: poorly completed forms and inconsistent information, lack of written goals and objectives, lack of adequate mechanism for evaluation and/or implementation, and resident workload/service orientation/call rooms/support services. Problems in the subspecialty areas include: quality of research, not having recruited subspecialty residents for a number of years, not having the full complement of faculty, insufficient exposure to diagnostic procedures.

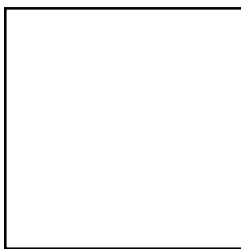
There were 138 subspecialty programs reviewed, as well as 15 programs in the newly accredited subspecialty of pediatric rheumatology. Pediatric Infectious Disease programs underwent their initial review in June, 1997, and 65 applications were submitted. Adolescent Medicine and Pediatric Emergency Medicine are still in the process of finalizing their program requirements.

A number of Pediatric Subspecialties are up for consideration of their program requirements. These include: cardiology, critical care, endocrinology, hematology/oncology, pulmonology, neonatology, nephrology.

WELCOME - 2 NEW COUNCIL MEMBERS

In May during the APPD Annual Meeting, Dr. Robert Kamei (University of California at San Francisco) and Dr. Timothy Schum (Medical College of Wisconsin) each finished their three year term as a Council Member of APPD. We thank them for all they did during their tenure and look forward to their continued involvement as active members of APPD.

We would now like to welcome our two new Council Members and let the membership of APPD know a bit about each of them. Following please find briefs of both Dr. Gail McGuinness and Dr. Edwin Zalneraitis -- welcome aboard!!



GAIL A. MCGUINNESS, MD

*Associate Chair for Education,
Director of the Pediatric Residency
Training Program, University of Iowa
Hospitals and Clinics*

I received my medical degree at Tufts University School of Medicine in Boston in 1972, followed by a pediatric residency at the University of Iowa and neonatology fellowship training at both the University of Colorado and the University of Iowa. My academic career has been at the University of Iowa where I was initially appointed an Assistant Professor in 1977 and promoted to full Professor in 1990. I have been director of the residency program in pediatrics at the University beginning in the late 1970s. After a hiatus of several years, I resumed that position when I was appointed Associate Chair for Education for the Department of Pediatrics. My responsibilities include the development, coordination, and oversight of all general pediatrics educational programs conducted by the department, including student, resident, and continuing medical education efforts. I have been a member of the Association of Pediatric Program Directors since its inception and currently serve as the University of Iowa College of Medicine's liaison to the Group on Resident Education of the AAMC. As a member of the American Board of Pediatrics, I serve on the Credentials Committee of that organization and since 1995, I have been a member of the Residency Review Committee and currently serve as the Vice-Chair.

My clinical and educational responsibilities revolve around duties in the Division of Neonatology. I have attending and teaching responsibilities in both the neonatal intensive care unit and the intermediate care nursery and am actively involved in the education of fellows in our division.

My scholarly activities in recent years have been as a member of a group of investigators (The Newborn Lung Project) conducting a multi-center study investigating risk factors for bronchopulmonary dysplasia, which describes the overall outcome status of a cohort of very low birthweight infants.



EDWIN L. ZALNERAITIS, MD

*Associate Professor of Pediatrics and
Neurology, Assistant Dean for Educa-
tion, University of Connecticut School
of Medicine, Connecticut Children's
Medical Center*

I received my medical degree from Brown University School of Medicine in Providence in 1975. My Pediatric training was at Children's Hospital in Boston, and I went on to complete my neurology and child neurology training across town at the Massachusetts General Hospital. I stayed on at the Massachusetts General Hospital for an additional year of neurology fellowship in the immunochemistry of Huntington's disease.

I began my academic career at the SUNY Stony Brook neurology program as an Assistant Professor and assistant to the residency program director in neurology in 1981. I moved to the University of Connecticut in 1984, and was promoted to Associate Professor of Pediatrics and Neurology in 1990. I was appointed Pediatric Residency Program director in 1990, and Assistant Dean for Education in 1996. I am currently a candidate for full professor this Fall.

My responsibilities include the coordination and oversight of all pediatric education programs for the University of Connecticut and Connecticut Children's Medical Center, at the medical student, resident, fellow, and continuing education levels. I have been a member of the Association of Pediatric Program Directors since 1990, and with the tremendous encouragement and expertise of Dr. Ken Roberts, helped to found the regional APPD group Northeast Pediatric Program Directors in 1992. I have served to chair that group since 1993. The latter group has been active in incorporating program coordinators and chief residents into our ongoing activities that include twice yearly meetings around the northeast.

My clinical and educational activities are in with general pediatrics and pediatric neurology. I have attended the neo-

natal intensive care follow-up clinic for 13 years, and have a general pediatric neurology practice as well. I attend both as the general pediatric ward attending, and as pediatric neurology consultant. My teaching is in neonatal and pediatric neurology, as well as general pediatrics to all levels of our pediatric community. I have a major focus in curriculum design and implementation.

My other scholarly activities, in recent years, address clinical outcomes and issues in neonatal neurology, development of curriculum for serving children with disabilities, and assessing and developing programs for teaching advocacy in pediatrics. Along with our chief residents and through the Northeast Pediatric Program Directors group, I have the opportunity to examine our regional approaches to a number of pediatric training issues.

MED-PEDS DIRECTORS MEET WITH APPD

Edwin Zalneraitis, MD

The Medicine-Pediatrics Program Directors Association (MPPDA) held their annual meeting with the APPD this past May in Washington, DC. The MPPDA ties to both the APPD and the Association of Program Directors in Internal Medicine (APDIM) have resulted in them meeting in alternate years with the annual meetings of the APPD and APDIM. The current President of the MPPDA, Dr. Mary Cicarelli, facilitated a very well-attended meeting on Wednesday, April 30, from 1:00 to 5:00 PM.

The group first addressed administrative issues. They have defined themselves, through their executive committee and bylaws, as a functional, working group. An Educational Program Committee was charged to put together next year's meeting with APDIM. Dues have been changed from \$50 per program to \$100 per year for an open membership.

The 1997 match was reviewed.

	Positions Offered	Positions Filled
Pediatrics	2019	1990
Med-Peds	464	433
Internal Medicine	4594	4399
Family Medicine	3262	3039

It was noted that the Med-Peds programs had the highest percentage of all programs in matching with U.S. medical

school graduates. Med-Peds programs are concentrated in the East, with the largest concentration of positions in the Southeast. The number of programs and positions have grown from 82 programs and 280 positions in 1993, to 102 programs and 464 positions in 1997. It was felt that the HCFA decision not to fully fund the PGY-4 year had no identifiable impact on the match.

The Med-Peds Physician Association has been given provisional status as the 43rd section of the AAP. Members were urged to join the Med-Peds section, and can do so by email to smuncha@aap.org. A list server is now available for MPPDA members, and an up to date data base was distributed. A call for officer nominations was made. The President and Secretary arrange monthly calls and the group meets twice yearly.

Board certification for Med-Peds residents was discussed. The ABP and ABIM require a separate Med-Peds selection and promotion committee. There must be monthly Med-Peds resident meetings, and periodic curriculum review documented to be specific for Med-Peds. There must be four months of electives in subspecialty pediatrics, four months of documented supervisory experience, and emergency medicine must include EMS. A month rotation in consultation must be documented. Both boards need to be informed about training sites that are unique for Med-Peds residents (categorical pediatric and medicine residents do not rotate to these sites), and about any combined inpatient and out patient rotations.

Of interest, among the many other topics covered during this meeting, was a survey of Med-Peds ambulatory training. Sixty-three of ninety-three surveyed programs responded. Fifty-eight percent had hospital based ambulatory training, 19% were community based and 21% had both. Forty-five percent of programs had combined pediatric and medicine ambulatory experience, while 42% had all ambulatory experience in separate pediatric and medicine rotations. Ambulatory experience includes health maintenance in all programs, acute "walk in" care in 86%, gynecology in 80%, orthopedics in 55%, and surgical procedures in 45%. Fifty nine percent of programs have requested HCFA exemptions to IL 372, 41% have not. We look forward to the publication of this interesting study in its entirety.

“NORTHEAST” PROGRAM DIRECTORS MEET AS PART OF ANNUAL APPD PROGRAM: SERENDIPITY OR JUST COINCIDENCE?

Edwin Zalneraitis, MD

When the New England Pediatric Program Directors (NEPPD) began to include the pediatric residency program for Albany Medical College (realizing that Albany was not in New England) they changed their name to Northeast Pediatric Program Directors (still NEPPD). This created some confusion, on the evening of April 30, when the program listed a meeting of the regional “Northeast Pediatric Program Directors” on the agenda. The meeting was attended by program directors from both the NEPPD and the New York area group, as they rightfully saw themselves as part of a “northeast” group. Of course, both groups were pleased to meet together, and the discussions proceeded in a spirited and thought provoking way.

The group addressed the “etiquette” of residents changing programs. It was felt appropriate, when a resident wished to do so for whatever reason, for a resident to change programs. It was felt improper for a program to recruit a resident away from another program. Several specific examples and dilemmas were presented and discussed.

The demographics and characteristics of program directors and assistant program directors were discussed. Dr. Ed Forman, from the program at Brown University, had been surveying NEPPD members about the “job description” for these positions. No program directors on the survey or present did only program duties. All had administrative support and most had someone who helped with some aspect of the program. The program directors had a wide range of ages, and had not experienced difficulty with promotion. Most program directors were pediatric subspecialists. Financial support came from the office of GME to the department in most cases.

Staffing of inpatient services was addressed, and it was indicated that many of these services would be prohibitively expensive to maintain without residents. Rather than totally replace residents with mid-level practitioners and faculty hospitalists, it was suggested that the teaching day could be reorganized. It was acknowledged that the inpatient services were changing, with increased volume, acuity and technology; but decreased length of stay and numbers of service cases. The solution included decreasing traditional teaching conferences, and increasing time with patients and problem based learning at the bedside. It was noted that this would require some faculty development and increased

self-study by residents.

The last topic addressed was identification and management of the problem resident. Dr. Tom Kennedy, from the Yale program at Bridgeport, had led a discussion of this topic at the NEPPD Spring meeting. A number of valuable sources of information were cited as useful in identifying problem resident: chief residents, other residents, public complaints, and nurses. While “teaching attending” was not felt to be a particularly valuable resource in this regard; ambulatory nick, pick and ED attendings had been useful via their close interactions with residents. Management of problem residents usually included a mentoring and advisory system that informed residents of problems, and supervised mediation programs. Continuity preceptors were also felt to be helpful in these efforts, and a diagnostic approach was recommended. This could include psychological or educational intervention. Detailed examples and approaches were discussed.

The meeting seemed to be informative and interactive, and though fairly spontaneous, was a reasonably successful exercise. This raised the issue of regional meetings at our future APPD programs. For those programs that already meet and interact regionally, could the APPD meeting afford an opportunity to have two or three regional groups meet and share ideas? Since these regional groups have programs separately, those activities could be used to generate agenda items for the inter-regional meetings as part of the APPD program? Please let us know your thoughts, so we can include them in planning next year’s time for regional activities.

DO WE HAVE YOUR INFORMATION LISTED CORRECTLY? PLEASE BE SURE TO UPDATE THE APPD NATIONAL OFFICE WITH ANY CHANGES IN YOUR PROGRAM. BE SURE TO INCLUDE PROPER ADDRESS, PHONE, FAX, AND EMAIL.

A SURVEY OF ADDITIONAL BENEFITS ("PERKS") PROVIDED DURING RESIDENCY TRAINING

Steven J. Wassner, MD

In addition to the salary provided, many programs offer additional inducements to prospective residents. These inducements, often called "perks," may be provided for a variety of reasons; to pay for moving expenses; provide meals; encourage learning; reward exceptional performance; or simply as a signing bonus. In an effort to survey the amount and types of perks being offered, Drs. Steven Wassner and Carol Berkowitz devised a questionnaire which was sent to members of the APPD who had preregistered for the 1997 annual meeting. Replies were received from 65 pediatric and Med/Peds programs. Since some programs had multiple registrants the reply rate is approximately 30-35%.

A wide range of programs replied with many listing themselves under multiple headings. Thus, 55% classified themselves as University affiliated, 23% as Children's Hospitals, 17% Community Hospitals, 9% Public, 5% military and 5 replies being left blank. The mean number of residents trained within each type of program varied from a high of 43 (± 20) in the University programs to 27 (± 10) in the Military programs the average number trained in all responding Peds programs was 38 (± 23). The number of trainees in the Med/Peds programs was somewhat smaller averaging 16 (± 11) per program.

Overall, 60 out of the 66 responding centers provided additional benefits, either in cash or as free meals, book/travel funds, etc. Because many of the programs grouped book/journal and travel funds, these have been considered together. Sixty programs provided an average of \$1300 (± 1500) for books and travel over the three years of residency. Children's hospitals provided the largest book and travel funds (\$1936) followed by Community (\$1608), Public (\$1308), University hospitals (\$1289) and military hospitals (\$500). Two programs listed loan repayment with one providing \$3,400 to its PL-3 and PL-4 residents and the second noting, "if allowed through State program." Six non-military programs pay for moving expenses with amounts ranging from \$250 to \$1000.

Fifteen programs provided their residents with unlimited meals with one program providing unlimited meals plus an additional \$175. Three other programs provided an unlimited number of meals but capped the total dollar amount with two programs providing \$2,100 and a third \$1,000.

Three provided free lunch at conferences and one additional program stocked a refrigerator with drinks and sandwiches, etc. The remaining respondents either checked on-call or left the space blank.

Five programs provided their residents a cash signing bonus. Over the course of three years the amounts provided ranged from \$2,400 to \$15,000. One program provided \$200 as an advance on the first month's salary. There was no relationship between the type of program and the provision of bonuses with University, Children's, Community and Military hospitals all represented. Additional comments were provided by several of the respondents. Two of the programs currently paying bonuses plan to discontinue them within one to two years and one program noted that they stopped paying cash bonuses because they did not think it made a difference.

Finally, a number of other perks were listed. Three programs paid for all or part of the ABP exam; two provided a copy of Nelson's Pediatrics; four provided free parking; one entertainment tickets and \$20/month if there were no delinquent charts; a personal spending account (no amount specified); and short and long-term interest free loans. Several programs offered either cash awards or free meetings to "the best resident-teacher." One offered a personal favorite, "Great teaching and a great environment." The wide variety of perks makes it impossible to calculate a dollar figure for the entire package but for those where a dollar amount was listed the average was \$2064 for the three years ranging from 0 to \$18850. Public hospitals averaged the lowest (\$1308) and community hospitals the highest payments (\$2408).

We would like to thank all of the members of the APPD who were kind enough to fill out yet another questionnaire and return it to us for analysis.

A TRAINING PROGRAM FOR PEDIATRIC RESIDENTS IN PROCEDURAL SKILLS AND A SYSTEM FOR TRACKING COMPETENCY

John D. Mahan, MD (Program Director) and Leslie Mihalov, MD (Associate Program Director), The Ohio State University/Children's Hospital Program, Columbus OH

On May 2, 1997 we had the opportunity to present our experience in pediatric residency procedure training and tracking. This presentation highlighted our use of a specially designed Pediatric Residency Program Procedure Logger. This PC-Windows based computer program was designed for us by New Innovations (Akron, OH) and provides a method to track resident procedures over time. The presentation included a comprehensive system for teaching procedural skills (utilizing step by step instructions and commercially available manikins) and the computer-based tracking system. Over 90 attendees viewed this presentation and participated in a lively discussion about this program and the merits of procedure tracking for pediatric residents.

Improved teaching of procedural skills and tracking of competency in procedures is of interest to many Pediatric Residency Program Directors. Preparation for success in Pediatrics must include more than clinical opportunities and acquisition of knowledge. Procedures performed by pediatricians in clinical practice remain a special province for the pediatrician and an essential link between the pediatrician and his patients. Residency training is the appropriate time for the pediatrician to acquire experience and mastery in the procedures necessary for children. The American Board of Pediatrics has recognized this importance by expanding the evaluation of clinical competence to include the mandate that each applicant should be proficient in 44 specific procedures relevant to pediatrics. Each applicant must be evaluated by the Program Director for procedural competency before the applicant can sit for the Pediatric Boards. Procedure tracking would assist in competing requests for procedural experience and competency from hospitals and health care companies as pediatricians apply for staff privileges. An additional concern in the era of more limited hospital based procedures is the need to know that adequate numbers of procedures are available for residents in each institution.

The presentation included a review of the procedure training and assessment developed at The Ohio State University/Children's Hospital Program. The computer-based tracking system was then demonstrated. This system allows entry into a Microsoft Access data base from multiple computer sites and provides a list of desired procedures,

and goals for the number of successfully completed procedures for each resident per year of training. In our institution this system is located on the hospital computer network, each resident is responsible for entry of each completed procedure. With the menu driven program, entry time is less than 1 minute per procedure. Acceptance by our first year residents has been excellent. A secretary can enter the data in this system, if needed, at a single computer terminal. The program can also be accessed via the Internet, allowing programs based at multiple sites to keep resident procedure records in one accessible database. The system generates reports of procedure completion for each resident suitable for on-going review by the PD as well as yearly and end of training procedure records. The list of desired procedures and numerical goals can easily be altered by the Program Director or database administrator to individualize the records for each program.

A lively discussion then ensued that addressed the benefits of better procedure tracking for residents, the increasing demands to document adequate experience for each resident, the risk-management benefit for programs and institutions to having this data and the usefulness of such a computer based system for record keeping. Good questions about the applicability of such a system at other programs and the ease of data entry and resident acceptance were addressed. Attending supervision for procedures and accuracy of entries into the database were also discussed. There clearly was great interest in such a program from the Program Directors in attendance.

We will continue to increase our experience with this system in the current year. Ross Laboratories has discussed sponsoring a Pediatric Resident Procedure Tracking Program for residency programs. Sponsorship could include log cards, procedure record books and computer tracking software such as this program. A proposal now in discussion would commit Ross Labs to provide computer software to 10-15 pediatric programs of varying sizes and types to trial this approach in different environments. Anyone with any comments or potential interest in a Pediatric Resident Procedure Tracking Program Trial, please feel free to contact us at lmihalov@chi.osu.edu or jmahan@chi.osu.edu.

WELCOME NEW PROGRAM DIRECTORS

L. Lorraine Basnight, MD

East Carolina University School of Medicine

Annamaria Church, MD

Henry Ford Hospital

Denise FitzSimon-Williams, MD

Texas A & M - Scott & White

Susan Guralnick, MD

Children's Medical Center at Stony Brook

Valera L. Hudson, MD

Medical College of Georgia

Frederick T. Klingbeil, MD

University of Missouri-Kansas City

Kathleen A. Reeves, MD

Crozer-Chester Medical Center

William J. Riley, MD

Driscoll Children's Hospital

Ajovi Scott-Emuakpor, MD, PhD

Michigan State University

Hobart Wiltse, MD

Crighton-Nebraska Universities Health Foundation

ANNOUNCEMENT

John M. Olsson, MD

The Pediatric Residency Training Program of St. Joseph's Hospital, Phoenix, AZ, requests your help in an important survey. We need your input to help make a decision whether or not to provide hotel accommodations for applicants interviewing for our Program. For the past 122 years, we have paid for an overnight stay for each applicant. However, because of recent budgetary constraints, there is a need to reevaluate this policy. We would appreciate you faxing us at 602-406-4102, calling us at 602-406-3122, or E-Mailing our Residency Coordinator at jgaffne@mha.chw.edu with your response. We would be happy to share the results of this survey with other programs at their request.

Thank you for your willingness to share your thoughts. We appreciate your cooperation.

APPD COMMUNICATIONS COMMITTEE

Bob Kamei, MD

The Communications Committee met at the Annual meeting to discuss ways of increasing the opportunities to interact with other program directors, and disseminate information. We plan to distribute an email list which could be used to send out messages to one another. Eventually, a moderated listserv will be developed to keep members informed and allow ongoing interactive discussions of topics useful to program directors. Dr. Glenda Lindsey from Charles Drew University Program in Los Angeles has agreed to assist with this.

Of course, the other technology useful in the dissemination of information is the Web. Dr. Bud Weidemann from Children's National Medical Center is looking into development of a web page for the APPD. Potential uses of a web page might be listing of current program directors and numbers, with links to pediatric programs and other information useful to program directors. We are currently looking for the site to place the Web page, and the technical expertise (a webmaster) to maintain it. We are exploring different options, so please let us know if you possess the talent, interest and resources to help us with this task. You may email me at kamei@itsa.ucsf.edu with comments.

The APPD Newsletter
is published three times a year
by the Association of Pediatric
Program Directors with the
cooperation of Degnon Associates.

Comments and suggestions are invited.
Remember, this is YOUR Newsletter. The
deadline for submissions for our next Newsletter
is January 16th, 1998. Please send
correspondence to: Edwin Zalneraitis, MD
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APPD September 14-15, 1997 Fall Meeting - It's Not Too Late to Sign Up!

You can still sign up for our 1997 Fall APPD meeting course: **Orientation and Training for Program Directors and Program Coordinators, and Preparation for a successful RRC Experience.**

The meeting will be held at the Ritz-Carlton Hotel at Tysons Corner, Virginia on September 14 & 15, 1997. If you are a new pediatric program director or soon to be program director, this program is for you. If you are a pediatric program coordinator interested in becoming more effective in promoting the functioning of your program, this program is for you. If you are going to be reaccredited and site visited by the RRC, or want to enhance your program's activity in a core area, you should consider attending this program.

This program will be practical and interactive, and you will be pleased that you chose to attend. Your program will benefit from your participation! We look forward to seeing you in September. If you plan to come, but haven't yet enrolled, please contact Laura Degnon at 703-556-9222.

WHO SHOULD ATTEND?

- ◆ **New Program Directors and their Coordinators**
 - ◆ **Associate Program Directors**
- ◆ **Individuals considering becoming a Program Director**
- ◆ **Individuals interested in a comprehensive update**
 - ◆ **Individuals preparing for a RRC site visit**
 - ◆ **Individuals assisting Program Directors**