



# APPD NEWSLETTER

Fall 1999

*Association of Pediatric Program Directors*

## EDITOR'S COLUMN

*Edwin Zalneraitis, MD, Program Director,  
Connecticut Children's Medical Center*

It seems to me that there was a time not so long ago, and this may be a figment of my not so young imagination, when the Program Director's duties were episodic in nature. Residency program activities were intense around such times as recruitment, orientation or reaccreditation; while at other times there was a relative lull in activity that allowed us to plan and polish our work. For any number of reasons, it is now my perception that this pattern has been replaced by a constant assault of pressing issues and duties that have usurped those important interludes that I imagine I had. However, the loss of obvious opportunities to press ahead with academic enrichment should not result in our abandonment of these efforts. What can we do?

To some extent, we might extend our time commitment, rearrange our duties or look to colleagues for help. As the millennium draws to a close, however, the extent to which these options meet our personal and program needs is also becoming more and more limited. One of the important alternatives remaining, of which we should certainly all be taking advantage, is collaboration. Hopefully, we are all engaging administration and faculty in our own departments, and we are enjoying support and linkages within our respective institutions. Beyond that, and from a fresh and independent point of view, we should be looking to each other. The APPD and its Regions organizations can provide the most obvious and direct opportunities for our collaboration, and I hope that we are all able to participate as fully as possible in these interactions.

As the summer draws to a close, and hopefully there has been some chance for a well-deserved rest, I hope that your new residents' groups have settled in nicely. This will provide you with an advantage as you continue to cope with the next RRC accreditation, institutional accreditation, interval review, documentation of activities, documentation of

*(See EDITOR on page 2)*

## PRESIDENT'S COLUMN

*Robert J. Nolan, MD, Program Director, University of Texas Health  
Science Center, San Antonio*

The lazy days of summer are nearly gone. The application and interview season, the increasing clinical workload and the, as yet undiscovered, house staff performance problems loom. Will ERAS, which will certainly shrink the size of our physical file cabinets, serve as the labor saving devices of the past simply to accelerate our lives? Time will tell. The busy season is upon us.

By the time you receive this newsletter, the final recommendations of FOPE II should be posted on the AAP WebPages. The major criticism of FOPE I was lack of a process for implementation and follow through. The APPD, with its unique focus on graduate education, is positioned to play a vital role in implementation of many of the FOPE II recommendations. This effort will require the energy and commitment of the entire membership.

Planning for the spring meeting has begun. Consistent with the millennial theme of nearly everything we are seeing in the media, we hope to revamp the plenary session with several longer presentations around the topic of the turn of the century - "Pediatric Graduate Medical Education Looking Back and Looking Forward." The spring meeting will also feature the results of the first contested elections of officers.

## CALL FOR NOMINATIONS

*The Nominating Committee is soliciting nominations for the following positions:  
President-Elect; 2 Councilors; and 2 members to serve on the Coordinators  
Executive Committee*

### **President-Elect**

To serve 2 years as President-Elect, 2 years as President; 2 years as Immediate Past President

(Carol Berkowitz, MD will be finishing her term as Immediate Past President)

### **Councilor**

2 positions open, each to serve 3 years

(Replacing Edwin Zalneraitis, MD and Gail McGuinness, MD)

### **Coordinators Executive Committee**

2 vacancies open — each to serve 3 years

(To replace two open positions)

**All nominations should be sent to the APPD National Office by November 5<sup>th</sup>.** Please include the individual's name and institution. Once all nominations are received, the nominees will be asked for their willingness to run for office. Should they agree to run, they will be requested to submit a brief biography and their plans should they win. The ballots will be mailed to the membership in January of 2000.

### ***INSIDE:***

*NRMP Update ~ Federation Meeting Update ~ Ask the ECFMG  
~ Welcome New Program Directors ~ ABP Question/Answer Column  
~ Coordinators' Corner ~ MPPDA Update ~ 1999 Annual Spring Meeting  
~ Ask the RRC ~ AAP Section on Residents ~ Regional Structures*

**(EDITOR continued from front page)**

procedures and competence, using ERAS, updating your program information, starting recruitment, identifying program resources, improving faculty morale and development, sustaining resident morale and progress and...did I say development and implementation of curriculum or personal development? Oh well, you all get the idea. To help you meet these challenges and help keep you up to date, here is your next edition of the *APPD Newsletter*:

Our APPD President, Dr. Bob Nolan previews our upcoming Third Annual APPD Fall Meeting and gives us news from the NRMP, Executive Director, Ms. Laura Degnon, issues the call for nominations for election of officers and urges us to all try to attend the coming meeting. President-elect Dr. Carol Carraccio provides an update from the Federation Meeting, Dr. Gail McGuinness fields questions directed to the RRC, Ms. Aida Velez, Program Coordinator from the University of Connecticut, updates progress on the Pediatric Coordinators' Handbook, Ms. Eleanor Fitzpatrick answers questions for the ECFMG, Dr. Walter Tunnessen provides us with responses to inquiries of The American Board of Pediatrics, Dr. Keith Boyd keeps us up to date with the activities of the Medicine-Pediatrics Program Directors, Dr. Scott Shipman brings news and comments from the Resident Section of the AAP, and I provide a view of the planning process for enhancing our regional development.

In addition to the *Newsletter*, I hope that you have all visited our web site, [www.appd.org](http://www.appd.org), so we can begin to use this more as an added resource. Thanks again to Drs. Bob Kamei and Glenda Lindsey for keeping our Listserv exchange flowing, and I hope that more and more of you are availing yourselves of these opportunities for interaction. I think we all recognize and appreciate the enormous effort of Laura Degnon, and all those at APPD National Headquarters, who keep us on target with all of our activities, especially our annual meetings. The remaining collaboration that we can exploit, and for which we have enjoyed only modest success, is our regional development. For some of our Regions, regional association has been a very productive. For many other programs, regional collaboration has not been available as desired or available at all. In addition to providing a venue for local interaction, a strong and broad-based regional infrastructure would enhance the effectiveness of the APPD as a whole. Therefore, it is very important that we finally move ahead in our effort to establish identifiable, strong and productive regional groups across our membership.

Finally, I still haven't received any letters to the editor about any of the areas listed in the last issue or otherwise. Unlike the Maytag repairman, however, I am not one to be daunted by this. I recognize that many of our usual features, that place members in touch with the important organizations with whom we interact, also provide valuable opportunity to have your issues addressed in a form other than a letter to the edi-

tor. So thank you for your interest, and I look forward to seeing as many of you as possible in Virginia.

**NRMP UPDATE - JANUARY 7, 2000**  
**PROGRAM QUOTA DEADLINE**

*Robert J. Nolan, MD, Program Director, University of Texas Science Center, San Antonio*

The National Residency Matching Program has announced a number of important process and deadline changes affecting the 2000 Match. The NRMP is continuing to move to an entirely web based service delivery system. This year the directory for the 2000 match will be posted to the NRMP website. The 2000 directory will not be published and distributed as in the past.

The deadline for programs to submit final information on quotas and withdrawals has been advanced to January 7, 2000. In the past the deadline for quota changes was the same as the deadline for applicants to submit their rank order lists. This change was prompted by complaints from applicants (largely for the surgical specialties) that program quotas had been reduced at the last minute depriving the applicant of information perceived to be important in their decision making. The January 7 deadline will allow applicants nearly five weeks until the rank order list deadline of February 16, 2000, to consider changes in program size. In addition, the listing of unfilled programs will only be posted on the web. It will not be printed and distributed to unmatched applicants and programs.

**REPORT OF THE FEDERATION MEETING**

*Carol Carraccio, MD, Director, Pediatric Graduate & Undergraduate Education, University of Maryland*

The highlight of the Federation of Pediatric Organizations meeting on September 9th centered on the discussion of recommendation #34 of the report from the Future of Pediatric Education II (FOPE II) which reads as follows: "The FOPE II Task Force recommends that the oversight for implementation of the recommendations in this report be vested in the Federation of Pediatric Organizations (FOPO). The Task Force further suggests that FOPO hire an Executive Director and appropriate staff to coordinate implementation. Additionally, FOPO should consider delegating recommendations from this report to various appropriate organizations within the pediatric community for implementation and monitoring."

There was conceptual approval given by all the organizations represented at FOPO that it be the home for the implementation of the FOPE II recommendations and that an Executive Director be hired for oversight of this tremendous task. Each organization will be expected to contribute

to the funding of this important educational endeavor according to the means of the individual organization, but voting will remain one vote per organization regardless of capacity for financial backing.

The APPD will be represented in all preliminary discussions regarding implementation and, like the other six organizations represented at FOPO, have a seat on the Board of Directors.

The final Task Force Report will appear as a supplement to *Pediatrics* in January of 2000.

## **ASK THE ECFMG**

*Eleanor Fitzpatrick, Manager, Exchange Visitor Sponsorship, ECFMG*

### **QUESTIONS:**

We have been warned that residents training on J-1 visas may not do any “moonlighting.” This seems to make their training opportunities different from other residents. What is the rationale for this policy? Is there anything that we can do to remedy this situation?

In the past, we have replaced “moonlighting” with “additional time in the program for an additional stipend.” That is to say, residents may take additional assignments in the program, in places where they already train, on assignments where they will be evaluated, for an additional stipend. We were told that, since this adds to the base salary in their contract, J-1 holders may no longer do this. Is this the understanding of ECFMG?

Is it possible to offer J-1 visa holders a “more clinically intensive experience,” (which would include mandatory participation in program activities, previously designated “moonlighting” activities) available for any resident who volunteers, at a higher base salary?

### **ANSWERS:**

It is important to understand that the J-1 visa is utilized for training only. There are other immigration visas reserved for employment purposes (i.e. H-1B). The primary objective of the exchange visitor physician’s training in the United States is to enhance his/her skills in the field of medicine for the benefit of the home country. Participation in a structured residency program serves to meet this objective by strengthening and improving the individual’s knowledge of American techniques, methodologies and expertise in a particular medical specialty/subspecialty.

J-1 visa sponsorship, which is documented by Form IAP-66 and issued by ECFMG, authorizes a specific training program and financial compensation for participation in that training program. Moonlighting activities and/or compensation outside the defined parameters of the approved training

program are not permitted.

The Federal Regulations clearly state that the program sponsor must “...ensure that continuous supervision and periodic evaluation of each trainee is provided.” Furthermore, it prohibits sponsors from “... placing a trainee in positions that are filled or would be filled by full-time or part-time employees.” See 22CFR§514.22. Moonlighting typically involves independent patient care services for which no direct supervision/evaluation takes place.

Additional reference to *employment* in the Regulations indicates:

(a) An exchange visitor may receive compensation from the sponsor or the sponsor’s appropriate designee for employment when such activities are part of the exchange visitor’s program.

(b) An exchange visitor who engages in unauthorized employment shall be deemed to be in violation of his or her program status and is subject to termination as a participant in an exchange visitor program. 22CFR§514.16

ECFMG recommends that Program Directors familiarize themselves with the Federal Regulations governing the Exchange Visitor Program, 22CFR§514. They can be viewed on the web site of the United States Information Agency (USIA) at [www.usia.gov](http://www.usia.gov). See J Exchange under General Counsel – Go to number 3, J regulations. Program Directors must refer to the ACGME in determining what constitutes appropriate activities within residency training programs.

## **WELCOME NEW PROGRAM DIRECTORS!**

**Floyd Culler, MD**

*University of California (Irvine) Program*

**Mary Fairchok, MD**

*Madigan Army Medical Center*

**Ram Kairam, MD**

*Bronx-Lebanon Hospital Center*

**James Kirk, DO**

*University of Florida Health Science Center/Jacksonville*

**Katherine Ling-McGeorge, MD**

*Children’s Hospital of Michigan*

**Michael Lotke, MD**

*Mount Sinai Hospital Medical Center of Chicago*

**Steven Princiotta, MD**

*Keesler Medical Center*

## **ASK THE ABP**

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

1. **Question:** What is the current status of the professionalism project?

**Answer:** The ABP Program Directors Committee met in June 1999 to review the responses to the survey on professionalism distributed at the April 1999 APPD meeting. Using the responses and comments to the survey, an eight-point "evaluation" form was constructed. Committee members have been asked to provide vignettes that may be used for teaching concepts of professionalism to residents and other physicians. The vignettes will be reviewed at the next meeting of the committee, February 2000, with a plan to send the evaluation form and vignettes to program directors before the next APPD meeting. The goal of the committee is to provide a tool to assist program directors in evaluating professionalism of their trainees and, through the vignettes, to provide scenarios for discussion and education. The ABP will not request that evaluation forms be returned by program directors. Professionalism is an integral part of physician competency and moral/ethical behavior, which all program directors are asked to evaluate as part of their recommendation of candidates for the certifying examinations.

2. **Question:** In the context of the forthcoming recommendations of the Task Force on the Future of Pediatric Education (FOPE II), would you either predict or expect that the ABP will change the content and/or format of the Certification Examination in order to more closely reflect the evolving role of the practicing pediatrician in the next century?

**Answer:** One would not expect major changes in the content of the certifying examination in general pediatrics in response to FOPE II recommendations. The General Pediatrics Certifying Examination Planning Committee reviews the content of the certifying examination yearly. As medical/pediatric knowledge expands new content areas are added and current ones modified. The committee has the responsibility of constructing a cognitive examination that best reflects what a pediatrician should know to ensure the optimum care of children. FOPE II recommendations that relate to the cognitive knowledge base of the pediatrician will certainly be part of the Planning Committee's review. The multiple choice question format of this examination will not change in the near future, although the feasibility of administering the examination at computer testing centers is reviewed on a yearly basis.

## **COORDINATORS' CORNER: THE PEDIATRIC RESIDENCY PROGRAM COORDINATOR'S HANDBOOK UPDATE**

*Aida Vélez, Center for Education, Connecticut Children's Medical Center*

The Pediatric Residency Program Coordinator's Handbook is no longer a notion waiting to be developed, but a reality that is in production. Through the contributions of the Pediatric Program Coordinators, the handbook will soon be a helpful resource that will not only capture the essence of the program coordinators' diversified job roles, but will also serve as an informational aid to everyone involved in pediatric residency programs.

A survey, distributed to the pediatric program coordinators, initiated the production of the handbook. It focused on three areas: information on the existing pediatric programs, the program coordinators' responsibilities, and their opinions on the ideal handbook. Out of the 172 surveys mailed, 92 responded. The survey results revealed that the majority of the residents are categorical and that 60 out of the 92 respondents have a combined Med-Peds program. In each of the 13 job related categories, more coordinators indicated these as part of their responsibilities, than those who did not have these tasks as part of their duties. Responsibilities outside the realm of the coordinator's role were also very common. Twenty-eight additional job responsibilities were reported. These responses represent diversification of the coordinator's role, and added duties in addition to being coordinator. A notable consensus among the coordinators was the avoidance of duplication between the Program Directors and Program Coordinator's handbook; although, both handbooks should have a common focus.

The survey results were used as the basis for the "Development of a Pediatric Residency Program Coordinator's Handbook Workshop." The program coordinators engaged in an interactive activity, which allowed them to collaborate as a team on the various tasks that pertain to the survey categories. The program coordinators were encouraged to use creativity, think outside the box, and come up with innovative ideas. A representative from each work group reported out the information gathered in their brainstorming session. The workshop ended with several program coordinators volunteering to further develop the survey categories.

Presently, the handbook Co-Chairs are in the process of collecting additional information from the program coordinators. Information gathering and editing will be an ongoing process for the next few months. The expected date to present the Pediatric Residency Program Coordinator's Handbook Draft is scheduled for the 2000 APPD Spring Conference. For those who have not volunteered and would like to share ideas and/or contribute to the handbook's production, please e-mail Aida Vélez at [avelez@ccmckids.org](mailto:avelez@ccmckids.org) or Pat Schmidt at [pschmidt@peds02nt.maryland.edu](mailto:pschmidt@peds02nt.maryland.edu).

## **NOTES FROM THE MED-PEDS PROGRAM DIRECTORS' ASSOCIATION**

*Keith M. Boyd, MD, MPPDA President*

Change is something we in medicine have come to expect; no doubt, there's more to come. For the Med-Peds Program Directors' Association (MPPDA), the last ten years has brought much *positive* change; we have come a long way since being formed a decade ago.

Active membership in the MPPDA has grown significantly. We are a member of PCOC (the Primary Care Organization's Consortium). We have successfully formed as a subgroup of the Association of Program Directors in Internal Medicine (APDIM). We have held preliminary discussions with the APPD leadership regarding the possibility of becoming a section of the APPD. Along with a number of other individuals and organizations, the MPPDA contributed to the successful lobbying of Congress to provide full Federal funding for all four years of combined Med-Peds training.

Although I am still correcting my father when he refers to me as a "family physician," the average medical student no longer asks, "What is this Med-Peds thing anyway?" Cooperative efforts of the MPPDA, the NMPRA (National Med-Peds Resident's Association), and the Med-Peds Section of the AAP have just begun to tap into the resources and talents of their memberships.

The MPPDA continues to work to advance the educational objectives of combined Med-Peds residents. Training is provided through an integrated program dependent on the two parent departments. For Med-Peds physicians, the whole is greater than the sum of the two parts: pediatric training enhances the practice of internal medicine and internal medicine training enhances the practice of pediatrics.

I won't bore you with a lot of statistics except to say combined Med-Peds continues to thrive on a number of fronts. A few facts, however, may surprise you.

- *Of the pediatric residents nationally, 17% are Med-Peds residents.*
- *Over half the institutions with pediatric residency programs have combined Med-Peds programs.*
- *The average age of Med-Peds programs nationally is now 11 years.*
- *The database of the Med-Peds Section of the AAP includes over 2,200 practicing Med-Peds physicians.*
- *The number of Med-Peds physicians will double in the next 5 years.*
- *We now have the data to prove what we have known*

*all along: the overwhelming majority of Med-Peds physicians care for patients with routine and complex problems over the entire age spectrum in both inpatient and outpatient settings.*

*·Med-Peds graduates score as well on the certifying exams as their categorical counter-parts.*

We hope the future brings further cooperative efforts between the APPD and the MPPDA as we advance our common goal to provide outstanding training for all pediatric residents.

### **October 2-3, 1999 Fall Meeting**

The 3<sup>rd</sup> annual fall meeting for New Program Directors/Coordinators – and anyone preparing for an RRC visit – is scheduled to take place October 2-3 at the Ritz-Carlton Hotel, Tysons Corner. For more information please visit the APPD web site ([www.appd.org](http://www.appd.org)) or contact the APPD office.

### **May 11 – 13, 2000 Spring Meeting**

The APPD 2000 Spring Meeting will be held May 11 – 13 in Boston, MA. Workshop submissions are due October 15, 1999. Workshops are tentatively scheduled to take place on Friday, May 12; and each workshop will be 2-hours in length. Please contact the APPD National Office for a workshop proposal form.

Housing and registration material for the May 11-13 meeting is scheduled to be mailed mid-December. Be sure to keep an eye out for this mailing!

## ASK THE RRC

*Gail A. McGuinness, MD, Chair, RRC for Pediatrics*

1. **Question:** The ACGME requires that the various RRCs consider revision of their program requirements on a five year cycle. In 1994, the RRC solicited commentary from the APPD membership on the proposed program requirement revisions. Does the RRC intend to solicit program director input during the upcoming revision cycle?

**Answer:** The development of the program requirements is one of the major responsibilities of the RRC. At least every five years the committee must carry out a complete review of the document and present it to the ACGME for approval. Following the revision of the requirements, the document is simultaneously distributed to the sponsoring organizations of the RRC, which for pediatrics includes the American Academy of Pediatrics, the AMA, and the American Board of Pediatrics. It is viewed as good accreditation practice by the ACGME to allow those who will be evaluated by the criteria to have some input into its development. For this reason, an early draft of the revised program requirements is sent to all program directors in the specialty so they will have an opportunity to comment before the document is submitted for final approval.

At the time of the last revision of the requirements (effective February, 1997), the RRC made the process much more inclusive than is technically required by the ACGME. The committee requested input from groups it is not required to contact, such as the Association of Medical School Pediatric Chairmen (AMSPDC) and the Ambulatory Pediatric Association (APA). As our membership knows, the APPD was extensively involved with review and comment prior to the development of the final document. I would anticipate that a similar process will be followed at the time of the next review of the requirements.

The committee has not yet begun to discuss future program requirement revisions. The cycle for review begins five years after the date of the last approval of modifications of the program requirements, although review can begin at an earlier date if the RRC desires.

2. **Question:** Some of our residents are claiming that other pediatric programs will consider the first month's pregnancy leave as either a newborn medicine or developmental medicine rotation and give credit for that month toward the program requirements. Is this acceptable to the RRC?

**Answer:** The responsibility of the RRC is to accredit residency programs which would include the formal rotations of the program. It does not approve or evaluate arrangements made in specific cases for individual residents. The ABP is responsible for determining whether individuals have met the requirements for board certification, which would include issues related to a resident's leave time away from the pro-

gram. If an arrangement such as you describe were proposed as part of the formal curriculum, it would not be approved by the RRC. Some programs do develop bona fide elective experiences for those on maternity leave, but this would not replace required experiences such as the newborn nursery rotation or a rotation in developmental and behavioral pediatrics. It should be noted that electives are intended to enrich the educational experience of residents in conformity with their needs, interests, or future professional plans. They must be well-constructed, purposeful, and effective learning experiences with written goals and objectives. It is up to the program director to determine whether a proposed elective meets these requirements.

3. **Question:** During the last 24 months of training, the program must require at least five months of supervising the activities of the more junior residents in both inpatient and outpatient settings. It has become increasingly difficult for many programs to meet this requirement in the outpatient setting because of the HCFA rules requiring closer faculty supervision. Evaluations by medical students, junior residents, senior residents, and faculty cannot be accomplished in the time allotted for an outpatient visit. The supervisory experience of our senior residents is with medical students rather than junior residents in this setting. Is this acceptable?

**Answer:** The RRC takes a broad view of the supervision of junior trainees and would find this to be acceptable. In fact, there was past language in the RRC requirements which included both junior residents and medical students as appropriate trainees to be supervised by senior residents, but this language was eliminated because many training programs are not affiliated with medical schools.

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## **INTERNATIONAL MEDICINE: WHAT IS ITS ROLE IN US GRADUATE MEDICAL EDUCATION?**

*Scott A. Shipman, MD, Robert Wood Johnson Clinical Scholars Program, Johns Hopkins School of Medicine, Baltimore, MD*

Residents and medical students are increasingly interested in spending time overseas during their training. Is this appropriate? Is it valuable? Should these experiences be promoted, or discouraged? Some of the pros and cons follow:

With the expansion in knowledge that science and technology have provided, there is precious little time to learn everything about the state of the art in pediatric care. To take approximately a month to train in a setting where the practice of medicine is unlikely to be up to U.S. standards detracts from the limited training time that is available.

Funding presents another challenge to the value of an international rotation. Some would argue that, since GME is funded by U.S. tax dollars through the Medicare system (except in the case of free standing children's hospitals), paying a salary to a resident who is providing care halfway around the world seems to miss the intended target. Anyway, there are plenty of health care needs right here in the U.S. that could be served with that resident's elective time, the argument goes.

International rotations can be expensive, with transportation, housing, and food costs. Supervision is entrusted to a proxy that may have little understanding of the expectations of a resident on a working rotation. Language barriers can make communication between visiting residents and their patients nearly impossible, and cultural differences add to this barrier. Medications have different names. A different spectrum of diseases are likely, some probably never before (and perhaps never again) seen by the resident. Different diagnostic modalities are used depending on the resources available. In short, it's a completely different experience – foreign in every sense of the word – than the resident would experience in his or her residency.

I can think of no stronger argument for seeking an international experience.

After rotating in two developing countries (Belize and Nepal), I can vouch for the amazing educational value of an international rotation, particularly during residency. The experience is such an assault on the senses that the visiting doctor is forced to re-evaluate everything they view as “standard” medical care.

Medical books and journals are scarce, and usually outdated. Diagnostic skills often lie in the history and physical examination alone. Though some basic laboratory tests are available, one's examination skills are tested as never before. Treatment relies as much on educated creativity as textbook knowledge, since the “usual” approach often is unavailable. “That is our only infant sized endotracheal tube, so rinse it off for

the next delivery.” “24 gauge catheters, gauze, and new batteries for the flashlight are expected next week, we think.”

It is likely that the resident will learn much and also teach much during their interactions with the local medical staff, and a mutual respect will develop. Residents will see the benefits they are providing patients, often in dramatic, even life-saving ways. Of course, the resident must be mature enough seek help when necessary and be a respectful and responsible guest in the foreign land.

To discourage the experience because it doesn't provide care for U.S. citizens is a myopic view. The resident will make significant gains from learning a new system of care, adapting to the limitations of that system, and providing a much-needed service for children and families with scarce resources. They will return to the U.S. with greater competence and versatility in dealing with challenging situations as they care for children in our country. They will have approached medicine from the perspective of the individual as well as the population. Upon their return, residents will have learned to look beyond the walls of the medical center, into the community, for solutions to problems here at home.

The International Section of the American Academy of Pediatrics has provided two small grants to help offset out-of-pocket expenses for pediatric residents interested in pursuing an international rotation. Residents considering such an opportunity are encouraged to apply for one of these grants. Rest assured, they will return with a new perspective on the practice of medicine, a renewal of the altruism that initially led them into medicine, an appreciation of our ability to provide for the needs of a vast majority of our nation's children, and an expanded sense of obligation to assist all children, regardless of geographic borders.

### **Association of Pediatric Program Directors Officers and Councilors**

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**Secretary-Treasurer:** Harvey W. Aiges, MD  
**Past-President:** Carol D. Berkowitz, MD  
**Newsletter Editor:** Edwin Zalneraitis, MD  
**Councilors:** Gail A. McGuinness, MD;  
Michael E. Norman, MD; Theodore Sectish, MD;  
Edwin Zalneraitis, MD



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## **UPDATE ON APPD REGIONAL STRUCTURE**

*Edwin Zalneraitis, MD, Program Director, Connecticut Children's Medical Center*

There are many barriers to strong regional association between member programs of the APPD: distance, cost and inertia are just some. However, there are also many compelling reasons to overcome these barriers and create these associations: sharing common problems and solutions, providing infrastructure for enhancing our national organization, and linking to other regional groups and activities are some of these reasons. It might be valuable, therefore, to examine some of the things that can be used in establishing and sustaining regional groups and activities.

Linking APPD Region activity to other meetings is probably one of the most effective ways to overcome the distance barrier between member programs. It can also be effective in addressing cost limitations, as it allows participants to attend without added travel costs, and affords the opportunity to seek institutional or perhaps commercial support. Examples of possible program linkages include: to state or regional medical societies or to medical school meetings, to APA or AAP Regions or chapter meetings, or to other regularly planned regional workshops and programs.

In establishing a regional group, it is important to define group goals and the interactions that are best suited for member's needs. A simple set of rules for interacting is valuable, and it sets expectations for support and longevity of the association. Proportionate sharing of costs can be helpful in keeping costs down and gaining departmental approval for participation. It is important to identify individuals who can and will be responsible to ensure that busy schedules do not prevent regular meetings from occurring. It is also helpful to include a broad spectrum of program participants to ensure a productive and critical mass for your regional meetings and interactions. For example, as with the APPD itself, including Coordinators, Chief Residents and Medicine-Pediatrics Program members in regional groups may contribute immeasurably to the success and continuation of meetings and activities. Certainly the regional group to which I belong, the NEPPD (Northeast Pediatric Program Directors) has been energized and sustained by adding a Chief Resident and Coordinator component to all of our meetings and activities, as well as by providing an annual Chief resident retreat, timely educational activities for coordinators e.g. hands on ERAS experience, and an informational data base for all members.