APPD NEWSLETTER

Spring 2000

Association of Pediatric Program Directors

EDITOR'S COLUMN

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

The Match lists are submitted, and our first year with ERAS is behind us. Spring cannot be far behind! This seems like a good time to give some thought to both the recruitment efforts just completed, and the other challenges which we already face. In addition, though, it may also be time to look forward to the changes that we are also sure to face in the near future. I hope this issue of our Newsletter and our upcoming meeting in Boston will provide the stimulating information and interaction that will allow us to look back thoughtfully, and to plan productively for the future. I hope you all enjoy the topics presented here, and once again, you are all invited to provide your comments and feedback on these and all other pertinent issues.

There seems to be a generally favorable response to the use of ERAS this year, and many of us have developed creative approaches to its application to our recruitment efforts. I hope we can share these nationally and regionally at our upcoming meetings, or as an article in our next Newsletter. There is not only room for improvement in our applications of ERAS, but also in ERAS itself. The AAMC is open to our thoughts and suggestions as first time users of the system, so please let us or them know if you have ideas about changes that might be implemented.

Even as we continue to direct our programs, get them accredited and certify our residents in the ways we have come to know well, there is significant change on the horizon. After several decades of defining our goals and objectives for teaching pediatrics, we are now asked to extend our educational purview to identifying ways to document what is learned. As you all know, this is not an easy task. Nonetheless, these performance based outcomes will become the criteria by which our programs are accredited in the future, and the way which we will certify residents as competent to take the ABP qualifying examination. Hence, both the ABP and the ACGME/RRC (pediatrics) are anxious to help us develop the ways to accomplish this important task, and thereby improve resident education.

The good news is that we will be helped to "fill our toolbox" with tools to transition to competency based accreditation of programs and assessment

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PRESIDENT'S COLUMN

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

Change has come fast and furious since our last annual meeting in San Francisco. The anticipatory anxiety which some of us had regarding ERAS has long since been dispelled by the efficiency of the system and the outstanding support residency programs have had from the ERAS central office in troubleshooting. As we await the results of the match, the NRMP has asked for our input regarding the proposed two-phase match. Just as when the APPD endorsed the NRMP's changeover from the hospital-selecting algorithm to the student selecting algorithm, I believe our long-term best interest lies with making the match as "student friendly" as is reasonably possible.

The ACGME Outcomes Initiative continues. The accreditation process for our programs and institutions has the potential to change more over the next few years than it has over our tenure as program directors. There has been good news this year with the beginning of some federal GME funding for residents in children's hospitals and problematic news in the form of the National Labor Relations Board's ruling on house staff unionization. How much time, which we otherwise could devote to the educational needs of our house staff, will be diverted to dealing with newly organizing resident unions financed by the deep pockets of the AMA and AFL-CIO?

I remain, as ever, an optimist. Over the past 15 years, the APPD has become a credible voice for pediatric graduate medical education. As President over the past two years, I hope that I have served your needs well. I look forward to seeing you in May in Boston and for many years into the future.

Evening skyline view of Boston

INSIDE:

(EDITOR continued from front page)

of residents. Drs. Berkowitz, McGuinness and Sectish will be presenting a workshop in Boston to facilitate us in getting started, and there will be many more efforts on a national and regional level to promote our ability to respond. Ultimately our ability to educate and evaluate residents and our programs should be enhanced. The bad news is that these changes will take time and effort in program and faculty development, and in faculty and program director participation. Given that time is in such short supply, and we are already over-extended in our efforts, it is imperative that we work together in APPD and its regional groups to share the burden of this transition.

In this issue of the Newsletter, Dr. Bob Beran, who will represent the NRMP at our spring meeting, previews his presentation of the changes proposed by the NRMP. There is a special announcement for "Taking Healthy Steps for Child Development." Dr. Carol Carraccio summarizes the discussions that occurred during the recent meeting of the Program Director's Committee of the ABP. There are the usual features, including Dr. Bob Nolan's President's Column that provides an APPD update and a preview of our spring meeting. Massachusetts General Hospital's Pediatric Coordinator Therese D'Agostino, one of the host coordinators for the Boston meeting, sends a preview of the meeting for the Coordinators' Corner. Dr. Scott Shipman once again provokes our thoughts with input for the Resident Section of the AAP, while Dr. J. Thomas Cross brings us information from the Medicine-Pediatrics Program Directors Association. Dr. Walter Tunnessen provides question and answer feedback for The American Board of Pediatrics, Dr. Gail McGuinness for the Pediatric RRC and Ms. Eleanor Fitzpatrick of the ECFMG.

I hope that you enjoy this issue, and that you feel free to e-mail, snail mail, fax, phone or page me with any comments or questions. If you wish to respond to these articles, or submit new material for the next Newsletter, please contact me. Our next edition will be out after the spring meeting. Please make every effort to come to the meeting; I hope to see you there.

ABP PROGRAM DIRECTORS COMMITTEE MEETING

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

The Program Directors Committee of the American Board of Pediatrics met on February 4th and 5th to finalize the document on professionalism. Thanks to the many program directors who contributed their thoughts and ideas at last year's spring APPD meeting during the workshops on teaching professionalism. Your comments were of great value. The document on professionalism will be sent to all program directors in the near future. Included in the document will be an introduction with suggestions on how these materials may be used, a series of vignettes to initiate discussion with the residents on various aspects of professionalism, and an evaluation form, which may be used to document each resident's performance in areas critical to his/her development of professionalism. The Board anticipates a redesign of the verification of clinical competence form that we complete on all residents before they can sit for the American Board of Pediatrics Certification Examination. Professionalism will be addressed on the updated form.

As you are well aware, the Accreditation Council for Graduate Medical Education (ACGME) in conjunction with the American Board of Medical Specialities (ABMS) has defined six domains of competence that must become part of all residency training experiences as of July, 2001. The six domains are clinical skills, medical knowledge, professionalism, practice based learning and improvement, interpersonal and communication skills, and systems-based practice.

Dr. Walter Tunnessen, Senior Vice-President of the ABP, sits on the task force on competence of the ABMS. He solicited our comments regarding the language that is being incorporated into an evaluation tool that can be used both as a formative and/or summative measure of competence with the six domains. At the upcoming spring meeting in Boston, Drs. Berkowitz, McGuinness and Sectish will be doing a workshop entitled "Filling the Toolbox: Implementing a Competency Based Approach to Program Accreditation." This will give members of the APPD a chance to interact and exchange ideas that will be helpful in the evaluation of these six domains of competence as they relate to pediatrics. Your feedback will be most helpful and much appreciated!

RRC WORKSHOP FOR SUBSPECIALTY FELLOWSHIP PROGRAMS

Gail A. McGuinness, MD, Chair, RRC for Pediatrics, University of Iowa Hospitals and Clinics

The APPD is sponsoring a workshop for subspecialty program directors during the upcoming APPD meeting that will occur in conjunction with the PAS/AAP Spring Meeting. The session will take place on Saturday, May 13, 2000 from 2:00-5:00 p.m. The subspecialty workshop will review the newly revised RRC requirements, which are common to all subspecialty training programs (effective July of 2000). It is designed to assist subspecialty program directors to better understand the role of the RRC and to prepare for a successful RRC site visit. The workshop will also be useful for those initiating a new application for accreditation of a subspecialty training program. There will be time for questions and discussion regarding requirements specific to individual subspecialties, but the major focus will be on the issues common to all subspecialties.

In addition to the general requirements for all subspecialties, revisions of the specific requirements for Cardiology, Critical Care, Endocrinology, Hematology-Oncology, Neonatal-Perinatal Medicine, Nephrology, and Pulmonology will go into effect in July of 2000.

Program directors in general pediatrics who have some role in the oversight of the subspecialty fellowship programs in their department may find this session worthwhile. In addition, you may wish to encourage your department chair or the subspecialty program directors at your institution to consider participating in this workshop. Gail McGuinness, the current Chair of the RRC, will conduct the workshop for Pediatrics and Mary Alice Parsons, the Executive Director of the RRC for Pediatrics.

TAKING HEALTHY STEPS FOR CHILD DEVELOPMENT

Steven Parker, MD, Boston University School of Medicine; Joan Seidman Welsh, Toby Levine Communications, Inc.

APPD members who plan to attend the Spring 2000 Annual Meeting in Boston will have an opportunity to examine an innovative approach to primary care for children from birth to three.

"Healthy Steps could be a vital part of your residency program," says APPD President and Healthy Steps Multimedia Advisory Committee member Robert Nolan, M.D. "Its components — enhanced well child visits, home visits, a child development telephone information line, child development and family health checkups, written information for parents, parent groups, and links to community resources — present a way to enhance the behavior and developmental curriculum of residency programs."

The Healthy Steps for Young Children Program has three underlying principles: 1) the first three years of life are critically important for children's healthy growth and development; 2) relationships within families and between families and pediatric clinicians are key to this growth; and 3) effective primary care for children should address not only their physical well-being but also their behavioral, emotional, and cognitive development. Healthy Steps practices add a new professional to the practice team — the Healthy Steps Specialist, who provides child development services for families and focuses on developmental and behavioral aspects of children's growth. A program of The Commonwealth Fund, local funders, and health care providers across the nation, Healthy Steps is co-sponsored by the American Academy of Pediatrics.

The Healthy Steps approach is being implemented and tested in more than 20 sites across the country. The curriculum is now available as the Healthy Steps Interactive Multimedia Training and Resource Kit. Designed for both group and individual training, the kit consists of nine documentary videos that show how Healthy Steps strategies are being used in real medical practices, a CD-ROM that examines the main concepts that each video explores in greater depth and includes more than 100 interactive case studies, and a manual that reviews the Healthy Steps approach, describes how to install and use the CD-ROM, and guides users through each of the video units. The kit was developed by the Independent Production Fund, Toby Levine Communications, Inc., and the Boston University School of Medicine (BUSM) Department of Pediatrics.

"The multimedia interactive training kit is what every residency program director and faculty in charge of behavioral and developmental pediatrics have been asking for," says Barry Zuckerman, M.D., chairman of the BUSM Department of Pediatrics and co-director of the Healthy Steps training team.

On Friday, May 12, Dr. Zuckerman will present a workshop, "Healthy Steps and Pediatric Training." APPD meeting goers are invited to attend the workshop and to stop by the Healthy Steps exhibition, booth 123, at the Advancing Children's Health meeting between May 12 and 14 to chat with Healthy Steps physicians and see demonstrations of the multimedia materials.

For information on ordering the kit, call 800-727-2470 or email healthysteps@tobylevine.com. For information on attending a Boston University Healthy Steps Training Institute, call Healthy Steps at the BUSM Department of Pediatrics (617-414-3826).

ASK THE ECFMG

Eleanor Fitzpatrick, Manager, Exchange Visitor Sponsorship, ECFMG

1. *Question:* Our international office indicates that the spouse of a resident training on a J-1 visa, having a J-2 visa, can work with a federal work permit. When these spouses are physicians, may they use their J-2 visas and federal work permits to train in residency programs (as long as their spouse has an active J-I visa)? If so, should we presume that they must have met ECFMG requirements to begin training? Will the two-year home rule apply to them?

Answer: The foreign national physician who is a dependent of a J-1 visa holder may seek work authorization through the Immigration and Naturalization Service (INS) in order to participate in a residency program.

The J-2's eligibility is limited to the duration of approved sponsorship of the J-1 principle. If the two-year home rule applies for the J-1 principle, the J-2 spouse is tied by association.

The J-2 medical trainee who is an international medical graduate (IMG) must meet all requirements for an IMG enrolled in graduate medical education including a valid ECFMG certificate at the time of program start date.

2. *Question:* I understand that those training on a J-I visa cannot be paid beyond the regular stipend provided for residents in their program to meet the requirements for completing board eligibility. If they chose to do extra work beyond that required, can they be compensated in ways other than additional salary, such as support for meetings, travel to interviews or books?

Answer: J-1 physicians may not participate in any activities outside the scope of the residency/fellowship program for which they are sponsored, regardless of compensation.

The code of federal regulations states that: "The 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." (22CFR § 514.16)

Compensation of any kind is permitted only for approved activities.

3. *Question:* Will there be changes in the CSA (Clinical Skills Assessment) examination this Year? Will it be offered on more sites this year?

Answer: CSA is offered in Philadelphia, but the need for additional centers is under active study. We have made changes to internal elements of the CSA scoring methodology and equating design, including implementation of a revised set of standards.

ASK THE ABP

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

1. *Question:* We have been provided defined expectations for the pediatric portion of combined programs such as Medicine-Pediatrics. Does the Board have similar requirements for residents pursuing a two-year pediatric experience prior to entering the neurology portion of child neurology training?

Answer: At the present time the Board does not have prescribed training requirements for individuals who complete two years of general pediatrics and then enter the three year child neurology pathway. The ABP Credentials Committee discussed this issue last June. Although the Credentials Committee would prefer that these individuals complete a training experience similar to that required of med/peds or triple board residents, they recognized that a significant number of individuals who opt for child neurology may decide on that route after entering general pediatric residency training, sometimes as late as the second year. This would, in most cases, preclude these individuals from fulfilling prescribed requirements. If a program director knows that a resident is planning to complete only two years of general pediatric residency, the Board would prefer a tailored program of experiences to assure broad exposure to general pediatrics.

2. *Questions:* Does the Board recommend that programs establish study programs, beyond the regular curriculum, by which residents prepare to take the qualifying examination? If so, what is recommended? Does the Board recommend any special study program, beyond the regular curriculum, to prepare resident with low in-training examination scores to take the qualifying examination? If so, what is recommended?

Answers: The ABP does not recommend that programs establish study programs specifically designed to prepare for certifying examinations. The performance of individual residents on the In-Training Examination (ITE) may be used to identify specific areas of cognitive weakness, or, in some cases, may help in identifying residents who experience specific difficulties taking standardized tests. Some residents may benefit from additional clinical experiences to shore up their understanding of particular content areas. Others may be directed to additional reading, either in standard texts or specific journal articles, depending on the area. As a former program director I found reviewing AAP PREP Self Assessment examination questions with certain residents was helpful in determining their level of understanding as well as observing how they approached multiple choice questions.

The important question is how do we encourage, educate, and excite our trainees to read both during and following completion of residency training to maintain/improve their competence in pediatrics?

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COORDINATORS' CORNER

Therese D'Agostino, Pediatric Residency Coordinator, Mass General Hospital for Children

The Boston area hospitals are pleased to announce that this year's APPD Spring Meeting will be held May 11-May 13, 2000. The meeting will take place at the Marriott Copley Place Hotel in Boston. We welcome all members and non-members to this annual meeting. We are confident that it will be a rewarding experience.

This year's program coordinators' session guarantees to be educational as well as enjoyable. The forum on Thursday, May 11 includes *ERAS – Questions & Answers*, *GME Tracking at the AAMC*, and *Gathering Ideas and Networking: An Open Forum*. There will be a workshop entitled *Pediatric Residency Program Coordinators Handbook Putting it into Action* on Friday, May 12. On Saturday, May 13, there will be a forum for coordinators entitled *Conflict Resolutions/Stress Management*. We are positive that these conferences, as well as others, will certainly enhance your fund of knowledge.

On Saturday, May 13, there will be a coordinators' get together. The APPD has organized a *Boston Duck Tour*. All are welcome. This tour, in an authentic, renovated WWII amphibious landing vehicle, will travel from the State House to the Boston Common, from the Old North Church to Newbury Street, and then enter the Charles River for a magnificent view of Boston. This gathering was designed for APPD coordinators, but is open for everyone to enjoy (an additional fee applies). Please remember when registering to include this on your form.

As you will soon learn upon your arrival, Boston is a vigorous place to visit. Bostonians welcome more than 10 million visitors each year from all over the world. Tourism is one of Boston and New England's largest industries, and, therefore, you will find a city willing to accommodate and entertain you as few other cities can. Although the "Big Dig" may slow you down a bit, we guarantee that everyone will find something for their enjoyment. We are very proud to show you historic as well as contemporary Boston.

We look forward to welcoming you to Boston.

WELCOME NEW PROGRAM DIRECTORS!

Susan Bostwick, MD
Cornell University - New York Presbyterian Hospital
Matilda Garcia, MD
St. Joseph's Hospital & Medical Center
William Graessle, MD
Cooper Hospital (Robert J. Wood - Camden)
Suzanne Lavoie, MD
Medical College of Virginia
Mark Richard, MD
MetroHealth Medical Center

REMINDER ~

The APPD ballots and surveys are to be returned to the APPD office by March 24. Every program is strongly encouraged to exercise their right to vote! Since the votes are per program, we highly encourage that Program Directors discuss their votes with their program coordinators, department chairs, co-directors and others in the program that may be considered members of APPD.

AAP SECTION ON RESIDENTS

Scott A. Shipman, MD, Past Chair of AAP Section on Residents, 1st Year Fellow, Robert Wood Johnson Clinical Scholars Program, Johns Hopkins School of Medicine, Baltimore, MD

"Sports Medicine: Do we get it?"

Collectively, organized sports for children have become a huge industry in our country. Small fry basketball leagues, Pop Warner football leagues, little league baseball and softball, ballet classes, and gymnastics are just a few of the ever-expanding programs which allow children to learn good techniques, enjoy time with their peers, and, increasingly, win at all costs.

Reports of parents slugging each other over their 8 year olds' playing time, or screaming a litany of profanities at referees, or berating their child for a lackluster performance have become commonplace. Furthermore, kids are often pushed into practicing and playing more hours per week, with overuse injuries as a common consequence.

Paradoxically, childhood obesity has been simultaneously skyrocketing in our society, albeit in a different group of children. Lack of physical education classes in school, the fast-food culture, and hour upon hour of idle time staring at the television all contribute to this epidemic.

What does this have to do with pediatricians in training? Everything! Though RRC recommendations give scant reference to education in sports medicine, we should listen to the graduates of pediatric residencies. Looking back on their residency experience, practitioners have repeatedly stated that sports medicine is among the top two areas in which they needed better training (1,2). Sports medicine is fundamental in both preventive and acute care, and it relates to children from elementary school through college.

Based on the examples above, the preventive components of sports medicine are many. A sampling of the items which should routinely be discussed with parents and children include: a healthy level of participation, in terms of hours; diversity of activities and degree of competition; safety measures, such as appropriate equipment for the sports of interest; and the importance of off-season training to prevent injuries. The pre-participation examination needs to be appropriately addressed in training as well. If residents aren't exposed to such issues of preventive care, they may never incorporate it into their practice.

How about acute care? Too often, residents are exposed to athletic injuries on an infrequent basis, as patients with these injuries filter through general outpatient clinics, emergency rooms, or adolescent clinics in between a myriad of other conditions. In a 1996 national sample of pediatric chief residents, 43% reported that they were exposed to less than 5 hours of clinical training in sports medicine (3). Residents need repetition to learn the appropriate physical exam and to accurately diagnose sports injuries.

In addition to repeated clinical exposure and expert preceptors to teach them the finer points of sports medicine, residents need a didactic education in issues pertinent to sports medicine in children. They need to have a sense for the culture of children's sports, so that they can foster a healthy respect for activity and sportsmanship in their patients and their families.

Residency graduates are asking for more training in sports medicine. Cultural trends, which range from too little to too much emphasis on physical activity and organized sports, underscore its importance. Make an effort to evaluate and improve the sports medicine component of your residency, so that your residents and graduates can rightfully claim, "We get it!"

1. Camp BW, Gitterman B, Headley R, Ball V. Pediatric residency as preparation for primary care practice [see comments]. Arch Pediatr Adolesc Med. 1997;151(1):78-83.

2. Taras HL, Nader PR. Ten years of graduates evaluate a pediatric residency program. Am J Dis Child. 1990;144(10):1102-5.

3. Stirling JM, Landry GL. Sports medicine training during pediatric residency [see comments]. Arch Pediatr Adolesc Med. 1996;150(2):211-5.

ASK THE RRC

Gail A. McGuinness, MD, Chair, RRC for Pediatrics, University of Iowa Hospitals and Clinics

1. *Question:* It has been suggested that for optimum continuity of paticipation in care on intensive care rotations, the ambulatory continuity experience might best be accomplished by a full day every other week, rather than a half-day each week. Would this be an acceptable approach to continuity experience for the five to six intensive care blocks?

Answer: The program requirements state that residents must devote at least one-half day per week to their continuity experience throughout the three years and an additional half-day session per week is suggested. The goal of the experience is to allow residents the chance to develop an understanding of and appreciation for the longitudinal nature of general pediatric care. The continuity experience must receive priority over other responsibilities and cannot be interrupted even during intensive care rotations. When the experience occurs every week, residents are more readily available to the patients for whom they are responsible on a regular and continuing basis.

The RRC would have some concerns about restructuring this experience in the way described since residents would be less available to their patients for up to six months of ICU rotations in which it is already difficult, if not impossible, to participate in the care of their patients through hospitalizations, assess them during acute illnesses, and be available to facilitate other services.

That said, the RRC reviews each program on an individual basis to determine if the program is in substantial compliance with the requirements. If a program director chooses to deviate from a specific requirement in order to provide what is deemed to be a better educational experience, then the onus is on the program to provide convincing evidence to the RRC that such is the case. In this particular circumstance, although the intensive care experience might be improved by such a structure, the program would have to demonstrate to the RRC that the continuity clinic experience meets the clear intent of the requirements and is not impacted negatively by the design of the experience.

2. *Question:* Within a single residency program, some participating hospitals or institutions may qualify as integrated while others are merely affiliated. Can you clarify the differences between the two? What is the RRC's intent regarding the role of the program director, the geographic proximity to the primary teaching site and the duration of rotations to institutions that are integrated?

Answer: The RRC has recognized that there has been confusion in

(RRC continued from page 5)

the understanding of this terminology. Some programs have proposed sending residents to multiple hospitals which are designated as integrated, many located miles away from the primary site, for rotations of only one to two months duration in order to put together a program. This violates the intent of the requirements and has recently been clarified by revised wording in the program requirements.

Affiliated institutions develop formal agreements and conjoint responsibilities to provide complementary facilities, teaching staff, and teaching sessions. When these affiliated institutions have a single program director assuming responsibility for the entire residency, including the appointment of residents, determination of all rotations, and the assignment of both residents and members of the teaching staff, the affiliated institution may be proposed as integrated. The clear intent of the RRC is that when a hospital is designated as integrated, this entails significant ongoing interaction of the participating personnel with faculty and residents at the primary site. The RRC must approve the designation of the participating hospital as integrated. In doing so, the committee will consider the proximity of the hospital to the primary teaching site and the duration of rotations planned. Normally, at least three months of required experience should occur at a hospital that is designated as integrated. No upper limit is placed on the duration of rotations to integrated institutions, although the duration must have RRC approval.

The ACGME at its most recent meeting in February of 2000 approved minor changes in the language of the Program Requirements for Residency Education in Pediatrics to clarify this issue. The exact language of the revision is available on the ACGME website (www.acgme.org).

NRMP SEEKS OPINION ON TWO-PHASED MATCH

Robert Beran, MD, NRMP Executive Director, Vice-President, American Association of Medical Colleges

In response to concerns regarding the process of placing National Resident Matching Program (NRMP) applicants who were unmatched after the conduct of the main match – commonly referred to as the "scramble", - the NRMP Board of Directors established an Advisory Committee on the Unmatched Applicant in 1997. This committee was charged with examining the process and procedures associated with placing unmatched applicants and the filling of unfilled positions and to specifically evaluate the advantages and disadvantages of a two-phased match (also known as a "second match").

A number of the advisory committee's early recommendations were implemented in the new delivery schedule for match results implemented for the first time during the 1999 Match. The NRMP Board of Directors and the Advisory Committee are now soliciting the opinion, suggestions, and recommendations concerning the idea of a two-phased match from all participants in the Match. The proposal for a two-phased match was precipitated by several perceived inadequacies that are presently extant during the "scramble:"

- insufficient time to investigate options (applicants and programs)
- pressure to accept the first viable option presented (applicants and programs)
- inability of International Medical Graduates (IMG's)
- to communicate in a timely manner with program directors and
- inefficient/ineffective means of communication (fax and telephone gridlock)

The principal rationale for a one-phase match can be equally applied to a second phase: namely, it would provide a uniform date of appointment for unmatched applicants and unfilled programs, and an impartial venue for both parties to indicate their preferences and be matched in an orderly process.

In the 1999 Match, 8,064 applicants were unmatched to PGY1 positions and 2,055 PGY1 positions were unfilled. The maximum match rate for applicants, if a second phase had been run for the 1999 Match, would have been 25%.

In order to have Match participants discuss and consider the two-phase match proposal, a number of assumptions are necessary as background for your discussions:

- A second match is not a new match, but rather the second phase of the same match, keeping all agreements and contracts in force.
- Results from the Main Match would not be released until the second phase is completed.
- No additional fees would be collected to participate in the second phase.
- Programs with unfilled positions would be required to participate in the second phase, and language to that effect would be added to the agreement signed by each institution. There would not be any Scramble between phases.
- All unmatched applicants and unfilled positions registered at the time of the Main Match would automatically be included in the second phase. Those who do not want to participate in the second phase could choose not to send in a Rank Order List.
- Programs could not require an in-person interview.
- All unfilled, reverted positions would be returned to the original program, and if unfilled again, would follow the original reversion scheme.
- All options in the Main Match would be maintained: couples, joint S/P programs, reversions, PGY, etc.

The NRMP is very interested in the opinions of all participants in the Match – particularly the program director community. The concept of a two-phase match will only work if supported by all the specialty program directors participating in the Match.

The NRMP Board of Directors is seeking reactions and recommendations to this proposal by April 15, 2000. The Board will discuss the reaction from the participants at its Board of Directors Meeting scheduled for May. Participants are asked to identify specific issues/problems and benefits they envision with the concept of a two-phased Match.

You are encouraged to share your views with the leadership of your program director organization or with the NRMP. A full electronic version of the two-phased match proposal can be forwarded to you by contacting Robert Beran, NRMP Executive Director, at rberan@aamc.org.

NOTES FROM THE MED-PEDS PROGRAM DIRECTORS' ASSOCIATION

J. Thomas Cross, Jr., MD, MPH, MPPDA President, LSU Medical Center-Shreveport, LA

Just a few comments from the Medicine/Pediatrics Program Directors Association. We expect Med-Peds to continue to thrive along with general pediatrics early on in this decade. Data from 1999 shows that

- Of the pediatric residents nationally, 17% of them are Med-Peds residents.
- Over half of the institutions with pediatric programs have combined Med-Peds programs.
- The average age of Med-Peds programs nationally is now 11 years.
- After doubling over the previous 5 years, the number of Med-Peds physicians will again double in the next 5 years.
- The Med-Peds Section of the AAP has over 2,200 physicians listed.
- We now have data to confirm what we all have known for a long time: 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.
- In contrast to recent years, most Med-Peds programs now have Med-Peds trained directors and/or Med-Peds trained faculty.

A recent review article appeared in August 1999 in Arch Pediatr Adolesc Med, vol. 153 p.823-828 by Carole Lannon as lead author. I recommend it highly for those of you involved with Med/Peds programs or thinking about starting a Med/Peds Program. Carole's group gives convincing data on the success of the Med/Peds Residency. For those of you interested in Med/Peds, we will be having a workshop at the Spring APPD meeting on the "Nuts and Bolts" of Med/Peds programs.

The MPPDA appreciate the support of our colleagues in the APPD and your efforts to improve resident education. The influence of Pediatric and Med-Peds physicians on a local and national level continues to spread. We are excited about continued growth in our discipline. Hope to see you in Boston!

AAP MEDICAL STUDENT OUTREACH AND PEDIATRIC CAREER SUPPORT PROGRAM

Pat Stien, Manager, Division of Chapter and District Relations, American Academy of Pediatrics

Following several years of research and analysis, it was determined by the AAP Board of Directors that a coordinated program for medical students would be beneficial to both the Academy and to medical students. In January 1999, the Academy launched a new program that enhanced communication and interaction with medical students and the medical school community. The Medical Student Outreach and Pediatric Career Support Program establishes and implements several different approaches to connect with medical students and the medical school community, as well as others that inquire about pediatrics as a future profession. The program encompasses six components including: 1) membership opportunities at the national and chapter levels; 2) medical school outreach and networking; 3) chapter outreach and networking; 4) information resources and publications; 5) liaison and representation; and 6) establishment of an administrative home. The following provides a brief overview of these components.

Membership Opportunities at National and Chapter Levels
The Resident Section Executive Committee conducted a bylaws referendum in the summer of 1999. As a result, an affiliate member category for medical students was approved in October 1999. According to the 1998/99 chapter annual reports, 48% of AAP chapters have medical student membership categories or clubs.

Medical School Outreach and Networking
The AAP Department of Education invites, free of charge, area medical students to the AAP Annual Meeting. In addition, the Academy sends a representative to the Council on Medical Student Education in Pediatrics (COMSEP) meetings and COMSEP representation in included on the Committee on Pediatric Education (COPE). The Academy serves as a resource to medical schools to develop pediatric clubs and is developing a partnership with clerkship directors and chapters.

Chapter Outreach and Networking
The Division of Chapter and District Relations promotes medical student membership through the quarterly newsletter, *Chapter Connections*, and by working with chapters as they revise their bylaws. Information regarding successful Pediatric Interest Groups is shared with all chapters. Also, special emphasis has been placed on medical student activities as part of the chapter awards process.

Information Resources and Publications
The following career publications are available from the Academy: fact sheets, common questions brochures, "Your Career in Pediatrics" and "PEDS 101." PREP is also offered to medical students at a discounted price. Additionally, pediatric clerkship directors are provided with complimentary subscriptions to PREP and are asked to make it available to medical students. The AAP Department of Marketing and Publications works closely with book distributors to ensure Academy publications are available in medical bookstores across the country.

Liaison and Representation
The AAP is working to establish new and/or support existing liaisons from the AAP to the American Medical School of Program Director Chairpersons (AMSPDC), COMSEP, and the Association of Pediatric Program Directors (APPD). A sub-committee of the AAP Alternate District Chairpersons Committee will be meeting with Board members of APPD during the Pediatric Academy Societies/American Academy of Pediatrics jointly sponsored meeting in May 2000 in Boston, Massachusetts to discuss strategies.

Administrative Home
Responsibility for the Medical Student Outreach Program has been assigned to Jacqueline Burke, Sections Manager in the Department of Membership. A central information telephone number, as well as an e-mail address was established for all inquiries in regard to a career in pediatrics. Pediatric career inquiries are logged monthly by publication, phone, mail or e-mail. If you have any questions regarding the AAP Medical Student Outreach Program, please feel free to contact Ms. Burke at 800/433-9016, extension 6759, or by e-mail at jburke@aap.org.

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Spring Meeting Registration
May 11-13, 2000
Boston, MA

Preliminary Program and Registration Material was mailed several weeks ago.
If you have not received yours, please contact the APPD office, info@appd.org or 703-556-9222.

Early Registration Deadline is April 10

Special Offering: The fourth (4th) person registering from the same APPD program is free. These must be received prior to the April 10 deadline.