



APPD NEWSLETTER

Summer 2001

Association of Pediatric Program Directors

EDITOR'S COLUMN

Robert McGregor, MD, Program Director,
St. Christopher's Hospital for Children

Competent to determine competency??

I know many of us would rather not hear the word competency, at least for a while. However as the summer sun begins to shine, I suspect most of you have just completed or are completing the annual ABP tracking forms for promotion or graduation. You will notice that this year there are two areas to sign off for each resident in your program. The first box represents academic/cognitive development while the second represents professionalism/ethical behavior. While I think examining professionalism is important, I must admit I am struggling to define the shades of gray, which would cause me to assign the designation "marginal." I think my struggle is akin to the general discomfort most of us shared when listening to Dr. Leach speak in Baltimore. As we struggle for clearly defined, measurable qualities and continue to seek to fill our "educators toolbox," objectively assessing such a characteristic is daunting.

Perhaps it results from a raised awareness from all the discussions in Baltimore surrounding competences, but I am struggling to separate my personal values and ethics from our profession's values and ethics. Resorting to Webster gives little assistance as the definition of professional is broad and ill defined "(1): characterized by or conforming to the technical or ethical standards of a profession (2): exhibiting a courteous, conscientious and generally businesslike manner in the workplace." The American Board of Pediatrics has put considerable effort into assisting us with defining professionalism, at least the key components.

The following is an excerpt from the ABP's website (www.ABP.org), which I hope you find helpful as you rate the professionalism of your residents. The Program Directors and Ethics Committees of the ABP developed a survey that was shared with the Association of Pediatric Program Directors in May 1999. The survey asked Program Directors to rate suggested components of professionalism that then could be used to create a tool to aid in the evaluation of

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PRESIDENT'S COLUMN

Carol L. Carraccio, MD, Program Director, University of Maryland
Medical System

Our recent meeting in my hometown was a great success! Even the weather cooperated. The skies were blue, the temperature just right and, as always, the seafood delicious. We look forward to hosting our guests again next year and maybe, if we're lucky, the Orioles will be playing a home game.

We had the largest number of registrants ever for this meeting. This is no surprise considering the fact that our speakers were Drs. Lewis First, David Leach and Steven Schroeder. Dr. First inspired us, Dr. Leach gave us a vision, and Dr. Schroeder helped us to put things in perspective and look at the big picture of health care delivery. It doesn't get any better than that.

We also gleaned great information from the organizations that give us an annual update such as the American Academy of Pediatrics, the Resident Section of the Academy, the American Board of Pediatrics, the Med-Peds Programs Directors, and the Residency Review Committee for Pediatrics. The workshops received great reviews and the new poster presentation session was well attended and felt to be a nice addition to the traditional structure of the meeting. We had new leadership elected this year with Lynn Campbell from the University of Kentucky joining the Council and Bud Wiedermann from Children's National Medical Center taking over as Secretary-Treasurer. They are replacing Mike Norman, and Harvey Aiges, respectively. We owe a great deal of gratitude to Mike and Harvey for their contributions to APPD over the years and I hope they continue to remain very involved in APPD. We can't afford to lose their experience and wisdom. The coordinators section also had two new members join their executive committee, Jeri Whitten from West Virginia University, Charleston and June Dailey from Riley Hospital for Children. They said good-bye to Connie Love and Pat Schmidt who provided much work and support to the Coordinator's Section during the initial phase of its' development.

This year, in addition to all that went on visibly at the meeting, there was much behind the scenes work. We had two meetings with the leadership of the Committee on Medical Student Education in Pediatrics (COMSEP) last week. Partnering with this organization is a natural since we should really be addressing the concept of education across the continuum. They share our inter-

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residents in training. The following components of professionalism were selected by [us] Program Directors.

1. **Honesty/integrity** is the consistent regard for the highest standards of behavior and the refusal to violate one's personal and professional codes. Honesty and integrity imply being fair, being truthful, keeping one's word, meeting commitments, and being forthright in interactions with patients, peers, and in all professional work, whether through documentation, personal communication, presentations, research, or other aspects of interaction. They require awareness of situations that may result in conflict of interest or that result in personal gain at the expense of the best interest of the patient.
2. **Reliability/responsibility** means being responsible for and accountable to others, and this must occur at a number of levels. First there must be accountability to one's patients, not only to children but also to their families. There must also be accountability to society to ensure that the public's needs are addressed. One must also be accountable to the profession to ensure that the ethical precepts of practice are upheld. Inherent in responsibility is reliability in completing assigned duties or fulfilling commitments. There must also be a willingness to accept responsibility for errors.
3. **Respect for others** is the essence of humanism, and humanism is central to professionalism. This respect extends to all spheres of contact, including but not limited to patients, families, other physicians, and professional colleagues, including nurses, residents, fellows, and medical students. One must treat all persons with respect and regard for their individual worth and dignity. One must be fair and nondiscriminatory and be aware of emotional, personal, family, and cultural influences on patient well-being and patients' rights and choices of medical care. It is also a professional obligation to respect appropriate patient confidentiality.
4. **Compassion/empathy** is a crucial component of the practice of pediatrics. One must listen attentively and respond humanely to the concerns of patients and family members. Appropriate empathy for and relief of pain, discomfort, and anxiety should be part of the daily practice of medicine.
5. **Self-improvement** is the pursuit of and commitment to providing the highest quality of health care through lifelong learning and education. One must seek to learn from errors and aspire to excellence through self-evaluation and acceptance of the critiques of others.
6. **Self-awareness/knowledge** of limits includes recognition of the need for guidance and supervision when faced with new or complex responsibilities. One must also be insightful regarding the impact of one's behavior on others and cognizant of appropriate professional boundaries.
7. **Communication/collaboration** is critical to providing the best care for patients. One must work cooperatively and communicate effectively with patients and their

families and with all health care providers involved.

8. **Altruism/advocacy** refers to unselfish regard for and devotion to the welfare of others and is a key element of professionalism. Self-interest or the interests of other parties should not interfere with the care of one's patients and their families.

Next, we need evidence, or at least consensus, to support the rating of marginal or unsatisfactory. Concretely, I am still struggling with a few of these ratings (fortunately very few.) Does the resident who opts to return to sleep, not responding to the nursing call requesting his presence at the demise of a patient qualify as unprofessional and warrant a less than satisfactory rating? Does such behavior have to be documented repetitively or persist despite documented counseling? Would the fact that the patient who has no parents present and is already designated "do not resuscitate" suitably mitigate the offensiveness of such behavior to erase a marginal or unsatisfactory rating? One thing I do know, is that I document a whole lot more on a case by case basis regarding such scenarios and find my biannual evaluation sessions are fuller and more "evidenced based."

Good luck with your tracking, have a great summer and . . . don't forget your sunscreen!

PS - Would there be any grass roots interest to make our future meetings more of a "working meeting" by having some of the special interest discussions at the beginning of the APPD, break into small work groups during the next few days then report back to the masses at the traditional SIG?

Introducing First Aid for Feelings: A tool for pediatricians to help pediatric patients manage their emotions for optimal health outcomes

As part of Pfizer Pediatric Health's commitment to the health of children, the First Aid for Feelings program was developed with Denise Daniels, BSN, RN, MA, director and founder of the National Childhood Grief Institute. This program was created to facilitate physician-patient interactions and to help young patients manage difficult emotions associated with hospitalization or medical procedures. First Aid for Feelings draws on the field of psychoneuroimmunology, which takes an integrated approach to emotion management as a way of promoting optimal health outcomes. By using First Aid for Feelings tools to interact with children, you help them to feel in control and to contribute to their own healing.



The Feelings Thermometer features images and words describing emotions such as happy, scared, lonely, or sad. Patients can move the "mercury" line to express their feelings and emotions. The accompanying physician reference card describes the program and offers suggestions for discussing emotions.

To receive more information on this program, or for a lunch 'n' learn presentation of First Aid for Feelings, contact your Pfizer representative.

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est in a partnership and we will be developing some joint activities in the very near future. They have a wonderful model for getting the membership involved in special projects and I think the APPD would benefit greatly if we adopted this model. I would like to establish five task forces that will parallel the five task forces of COMSEP. These task forces are: 1) curriculum, 2) evaluation, 3) faculty development, 4) learning technology, and 5) research. My hope is to get enthusiastic members of APPD to volunteer for these task forces. Each task force will have a leader who will then act as the liaison to the leader of the similar COMSEP task force. Since there is so much overlap between goals of APPD and COMSEP it makes sense that we share the resources and the workload. There's much to be done in medical education and it certainly is more fun doing it when you can share collegial relationships with others.

In this newsletter is a sign-up sheet for the task forces. If you are interested in becoming a member, please fill out the form and fax it back to Laura Degnon. We are also interested in knowing who may be willing to take on a leadership role for the task force. These will be working groups so there will be some expected time commitment, although at this point I'm unclear about how much time that will mean.

Another way of getting our membership more involved is to have abstract submissions for the fall meeting. Although the workshops are valuable, and we will maintain a certain number of those, because of their length we can't get as many people involved in presenting as we would like. So for the fall meeting, start thinking about submitting an abstract on some innovative feature of your training program. We will choose four abstracts for presentation. The format will be the same as for other national meetings with ten minutes for presentation and five minutes for questions. This also serves another purpose - professional development. This is a great line item for your CV! There will be a formal call for the abstracts in the near future.

I'm very excited about these prospects. We learn so much from our colleagues at the meetings and I'm hoping that these additional venues for interaction will continue to foster a significant rise in our learning curves as well as enhance the outcomes of our training programs.

Thanks to everyone for making the recent meeting such a success. What I hope to do now is to keep everyone energized about where APPD is headed over the next year and elicit your help in taking it there. I look forward to seeing many of you in the fall.

***A GREAT RESOURCE FOR
PROGRAM DIRECTORS***

On the ACGME website,

*www.acgme.org, there will soon be a section called
RRC Update.*

*Expected to be available by June 15, this section
will be used to post announcements and updates.*

ASK THE ABP

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

Since questions were not asked, this column will be used to share some information that might be of interest to many program directors. As mentioned at the SIG meeting of the APPD in Baltimore on Saturday April 28, a few program directors have been concerned whether there has been an increasing number of pediatric residents dropping out of training. The ABP was asked if our tracking records would be able to document if such changes were occurring.

Tracking rosters for all United States and Canadian programs were reviewed for the 3 years 1997-1998 to 1999-2000. All residents who discontinued training in programs were tallied by year of training and reason for discontinuation, if provided by the program director.

If one simply looked at the number of residents tracked as PL-1's and the number tracked the following year as PL-2's, the apparent drop-out rates are relatively low. For PL-1 positions in 1997-1998 vs PL-2 positions in 1998-1999, there were 73 fewer PL-2's (2.8%). According to our tracking records for 1998-1999 PL-1s, there were 32 more PL-2's than expected in 1999-2000, or a 1% increase. For 1999-2000 PL-1's there were 76 fewer PL-2s, or a 2.8% decrease. PL-2 decreases for those three years were -2%, + 1.9%, and - 1.2% respectively.

When information provided by program rosters, looking at individuals, was reviewed, there were more drop-outs, 122 (4.7%) of PL-1s from 1997-1998 to 1998-1999, 94 (3.6%) from 1998-1999 to 1999-2000, and 131 (4.8%) from 1999-2000 to 2000-2001. The corresponding numbers for PL-2s for those years were 48 (1.9%), 57 (2.2%), and 59 (2.2%). The differences in tracking numbers versus individual tracking reflects the recruitment of new trainees, most commonly International Medical School graduates who are able to waive one year of training. The PL-2 changes for the respective years were 48 (1.9%), 57 (2.2%) and 59 (2.2%).

Why do trainees drop out? Close to half of PL-1s and PL-2s leave to enter other specialty training. Of those who leave after the PL-2 year, over 75% enter neurology training. The actual numbers who enter neurology are small, however, about 20 per year. PL-1s transfer to many different specialties, psychiatry, radiology, anesthesiology, and dermatology as examples, after fulfilling a required preliminary year.

On average, it appears that 9 residents are terminated from their positions each year, both in the PL-1 and PL-2 years. A few, 2 to 3 PL-1's, leave medicine entirely. A surprising number, as high as 27 in 1997-1998, left training to fulfill military obligations.

The drop-out rate for Canadian programs, of which there are 16, averages about 3% of PL-1s and essentially no PL-2s.

Program directors may be interested in transfer data. After completing the 1997-1998 training year, 45 PL-1s and 19 PL-2s

transferred to other pediatric programs. For the subsequent two tracked years the numbers are 55 PL-1s and 22 PL-2s and 58 PL-1s and 17 PL-2s.

Some may be interested in tracking data for medicine/pediatrics residents. The actual drop-out rate after the first year (R-1) in 1997-1998 was 29 (6.3%), with half transferring to either categorical pediatrics or categorical internal medicine. Only 9 (2.3%) discontinued training after the R-2 year. Small numbers switched to other specialties. For 1998-1999 tracking, 2.9% of R-1s and 2.8% of R-2s left the program and for 1999-2000, 7.2% and 6.2% did so.

Accurate tracking is hampered by the relatively large number of residents who take leaves and extend training into the following year. The information provided above cannot possibly reflect all changes, but to answer the question initially asked, in the last three years it does not appear that there has been an increase in drop-outs from pediatric residency or medicine/pediatric programs.

The ABP will continue to follow this information over the next few years looking for trends. Your help as program directors will be appreciated in indicating why residents leave and what their plans are for the future.

AAP SECTION ON RESIDENTS

Adam Vella, MD, Chair, Resident Section, Children's Hospital of Los Angeles

As a resident in Pediatrics I often found myself under a seemingly endless workload with little relief in sight. However, as I progressed through the three years of my program, I slowly realized that with effort and determination I was able to see the world beyond my small microcosm of children. I found this experience to be so fulfilling and invigorating that I decided that this would be the topic of this year's Resident Section educational program in San Francisco on October 20th. It is appropriately titled "Residents Reaching Out," and it will deal with the many ways in which we, as Pediatrics Residents, can influence people out of our immediate reach.

The day will begin with three exciting keynote speakers all discussing subjects of great interest to any resident wanting to reach out. Donna Staton, MD, FAAP of the International Medical Volunteers Association will discuss the ways to become involved in international child health opportunities. The month that I spent in Cuba during my third year of residency was by far the most memorable of my entire three years. Dr. Staton will give practical tips on how to either create, or participate in an international child health elective.

You do not want to miss this! She will be followed by Graham Newson, the current director of the department of Federal Affairs at the Academy. Pediatricians are accustomed to taking care of children one at a time. How much more effective might we be if we decided to advance the legislative rights of the chil-

dren for which we care? To be a legislative advocate is a skill that would benefit children out of the scope of our immediate practice and community. **You do not want to miss this!**

Next up is Neal Baer, MD, FAAP who is currently a resident of pediatrics at the Childrens Hospital Los Angeles. Neal is the former executive producer/writer for "ER," the highly acclaimed television series. His topic of discussion as a keynote will be how we as pediatricians can effectively use the media to promote the interests of children. We all watch television. What if we actually started to use the power of the media to serve the children we treat every day? **You do not want to miss this!**

Following a question and answer session for the Keynote speakers, we will present the 2nd annual Resident Section Child Advocacy Award. The district lunches will follow where you will all be given the opportunity to run for positions within the section. This is your first step towards getting involved at the next level!

In the afternoon you will choose between three concurrent educational sessions. The first will be a media work-group with Michael Rich, MD, MPH, FAAP, a member of the AAP committee on Public Education, and Paul Horowitz, MD, FAAP, chair of the AAP Media Resource Team. Both are involved in the Media Matters program and will speak on using the Media as a tool for advocacy. The second group will discuss the complex and very interesting field of International Adoption with Lisa Albers, MD, MPH, FAAP.

The third group will focus on reaching out to the community. The first speaker in this group will be Dawn Haut, MD, MPH, FAAP who will discuss how to advocate for children through the Community Access to Child Health (CATCH) program. Dr. Haut is a community pediatrician who is involved with the Infant Welfare Society. She will be joined by Diana Hu, MD, FAAP who was this year's past winner of the CATCH award for her work in the Indian Health service. She will relay her experiences as the Chief Clinician Consultant for the Navajo Area IHS and give advice to those who are interested in becoming involved.

We wrap up the day with a report from the Washington and State Government offices followed by voting on Policy Resolutions.

To sum it up, **you don't want to miss this!** Come to the AAP National Conference & Exhibition in San Francisco (October 20-24, 2001)!

Welcome New Program Directors

Erica Liebelt, MD
Geisinger Medical Center

Irene Sills, MD
Albany Medical Center

COORDINATORS' CORNER

Jan K. Minges, Kalamazoo Center for Medical Studies/Michigan State University

Dear Friends,

We made it through recruiting and winter and we were ready for the beautiful, warm sunshine we were greeted with in Baltimore. The strong camaraderie and supportiveness among the coordinators is always gratifying.

One coordinator, attending on a scholarship, said, "Opportunities abounded. And I absorbed ideas like a sponge . . . Putting faces to all the names makes me feel more like part of a large family and less like an island surrounded by seas."

Being a coordinator means you must enjoy meeting people and possess good people skills and that is part of the reason we always have such a good time at our conferences. No one in the coordinators' section goes home a stranger. Since first attending these conferences, the friendship and support I have received from the other coordinators has been phenomenal. It is hard to believe that so many miles lie between us.

From the feedback received, the new Mentoring Program is a great success. A new mentee commented, "We clicked from the moment we met and I like her very much . . . I really feel that there's a person out there who's a good resource for me." Another coordinator said she feels more connected with the other coordinators now that she has a mentor.

I think everyone agrees that this year's APPD Coordinators Section Conference was outstanding. Our thanks go to Moira Edwards, ERAS Director for the Association of American Medical Colleges. Her informative comments and great sense of humor were appreciated. Several coordinators commented that they felt Ms. Edwards understood and sympathized with the problems we had while the bugs were worked out of the new ERAS program. She assured the coordinators that the personnel manning the Help Desk in the future will be more knowledgeable and more responsive to our inquiries.

Thanks to Jennifer Grosky, GME Track Director, Association of American Medical Colleges, for sharing her time with us to review the enhancements to the GME track, some shortcuts, and common mistakes.

We all want to express a special thank you to Dr. Jimmy Simon, from the ACGME, for taking time to meet with us and explaining what our role is in preparing for a RRC site visit. Jeri Whitten's (West Virginia University) tips on getting ready for the visit, especially her comments on time elements, should be very helpful.

Saturday morning's presentations were very beneficial and well done. Thank you Aida and Dr. Zalneraitis (both from the University of Connecticut) for your presentation on "Ways Coordinators Can Enhance Their Duties and Experiences." And, thanks to Melodie Parker (Baylor College of Medicine) and Cathy Root (St. Christopher's Hospital for Children). Their presentation

"Communication – A Coordinator's Master Key" was fun and informative.

My personal favorite was the "Survivor" segment. What great imaginations to come up with this presentation – complete with props and music (even if it was a little loud!). And, at next year's conference, I want my name tag to reflect my new "survivor" name - "Molly Make It Better."

I would like to offer a personal thank you to everyone who presented at this year's conference, to the Executive Committee for their hard work, to Laura and Cyndy for their guidance, and to everyone who attended. No matter how I feel when I arrive, because of all of you, I always leave with renewed energy (you all recharge my batteries!), new ideas, and the support of my coordinator friends. Thanks again and see you next year - there's still a lot more of Baltimore to see!

With warmest regards,
Jan

CALLING ALL COORDINATORS

Jeri Whitten, West Virginia University (Charleston Division); June Dailey, Indiana University School of Medicine 2002 Program Committee Chairs

Our 2001 Coordinators Section Conference brought more than 90 of our peers to Baltimore. This is the largest group ever and we want to have an even bigger attendance in 2002.

The 2002 Program Committee is already busy putting together what we hope will be an excellent and informative program, BUT WE NEED YOUR HELP! Next year we will have spaces for three 20-minute presentations, three 45-minute presentations, and we are adding a poster session just for coordinators. The APPD office will be mailing the call for abstracts and posters in July. We want to encourage all of you to get involved by submitting an idea (abstract) for a presentation, or if you don't feel quite ready to present in front of the group, do a poster. If you are not ready for a formal presentation of any kind yet, but have a great idea, let us hear from you.

This is your section and we want to assure that we are meeting your needs. Get connected and get involved. We look forward to hearing from you and seeing you in Baltimore May 2 - 4, 2002. Contact Jeri Whitten, jwhitten@hsc.wvu.edu, or June Dailey, sjdailey@iupui.edu.

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REPORT FROM THE SMALL PROGRAMS FORUM - APPD ANNUAL SPRING MEETING

Ina Stephens, MD, Program Director, Sinai Hospital of Baltimore

The Directors of Small Programs held their meeting in Baltimore on April 26, 2001. Seventy-four physicians attended this meeting. These Program Directors understood that their residency programs face unique challenges. Accordingly, many of us realize that it is productive to share our approaches to these challenges in an open forum. Our 4-½ hour forum cannot be fully summarized but following are the highlights.

Much of the first half of the forum addressed the ACGME Outcome Project and the upcoming changes regarding the General Competencies. Mary Alice Parsons lent her expertise in this area, prompting a lively discussion regarding the phases of expansion, how the RRC plans on defining program compliance with the competencies and how programs can define the general competencies as part of educational objectives. Mary Alice recommended that Program Directors review the ACGME website at least monthly to stay on top of things such as changes in the Program Information Form, changes in Program requirements, information on the Outcome Project, Frequently Asked Questions and other announcements from the ACGME. There is also information about the site visit process as well as a new addition to the site, called "RRC Update." Included on this page will be an opportunity for programs to describe anything they are doing for that phase in the timetable described as "RRC citation without consequence." This will also be a way for the RRC to gather information from programs.

The second half of the meeting focused on issues specific to smaller programs. Among these was faculty development. We discussed how faculty can obtain support for teaching, administration, research and staff while still meeting the financial needs of the department. Faculty development grants were suggested as one potential revenue source. Other resources identified included the Ambulatory Pediatric Association's Special Interest Group, which has developed ongoing workshops, faculty retreats and online education that can be incorporated into any program. One useful suggestion: faculty development does not have to be done alone - partnering with a larger program or other teaching programs, such as Family Medicine, can be very beneficial.

One concerning issue was inpatient/outpatient census, both in terms of insufficient numbers and complexity. As we are seeing, the RRC requirements are changing more toward the FOPE recommendations and the Outcome Project. The requirements will focus more on the quality of training and outcomes than on process. Ms. Parsons suggested that the RRC may be receptive to suggestions on ways the PD's can report experience in such a way that would allow the RRC to evaluate whether the experience is acceptable. High volumes of patients, however, might still be needed for a program to demonstrate that the residents have become competent. It seems that this is a very complex issue for a specialty like pediatrics, which is not comparable to

a surgical specialty in terms of numbers of procedures, etc.

An additional concern was the recent decision regarding the publicizing of resident board passage rates. It was felt by a number of programs that this may not be in the best interest of smaller programs, as this number can change dramatically if only one resident fails the boards. It was also felt that board passage rates do not necessarily reflect how good a training program is or illuminate the strong points of a program. While many smaller programs welcome this information because their residents do well, other programs have concerns that these rates may affect recruitment.

Other issues discussed included resident research, mentoring, curricular issues, meeting RRC requirements, resident/PD relationships, the "problem" resident and Evidence-based Medicine. For feedback on the above or more details, please feel free to email me at istephen@lifebridgehealth.org.

ASK THE RRC

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

1. *In beginning to incorporate the core competencies into our curricula, is the expectation that competencies be measured or evaluated for each element in the curriculum, or is it acceptable to use a "global evaluation" as the means to identify competence?*

In the initial phase of the ACGME Outcome Project (July, 2001 to June, 2002) it is expected that programs will begin planning and/or piloting the integration of the core competencies into the curriculum and begin to implement new and/or improved assessment tools during this time. For many years the program requirements in general pediatrics have included goals and objectives for each required rotation, as well as a process for the global evaluation of residents in the program. Thus, programs that have developed their educational program around specific goals and objectives are already on the way to meeting the requirements for a competency-based curriculum. The next step is to link the evaluation process with specific learning objectives, thus it would not be acceptable to use only a global evaluation to determine the competence of a resident. For example, if one objective of the NICU rotation is to demonstrate effective resuscitation of the newborn in the delivery room, one component of the evaluation of a resident on that rotation should include the assessment and documentation of this particular skill. The program director should determine whether the program is currently completing the assessment step now, or if it will be necessary to develop a more rigorous and dependable process to evaluate the acquisition of this skill.

In the near future, there will be no noticeable change in the accreditation process, but programs will be expected to demonstrate that they are making an effort to use increasingly more dependable methods to evaluate the general competencies. In other words, they must demonstrate progress in implementing evaluations that relate specifically to the curricular objectives

of the training program.

For the most recent information regarding competencies, click on ACGME Outcome Project at www.acgme.org.

2. *Since the RRC frequently cites programs for inadequate continuity clinic experiences, is there a sense on the part of the RRC that the language or numbers pertaining to continuity clinic are too stringent?*

The RRC is eagerly awaiting input from the APPD, AMSPDC, and the APA regarding the current program requirements and hopes that insights from these groups will help the committee address the issue of continuity care experiences. The move towards competency-based evaluation should be very useful in this regard and help the committee in shaping the language of the next revision of the requirements. The RRC needs the advice of the pediatric community regarding the specific outcomes that we wish to achieve in the continuity care clinic, the methods by which residents might document their experiences, and the process by which the program director and the faculty would determine that each resident is having an appropriate experience. Rather than placing the use of numbers at the forefront of the discussion, we must get at the heart of what specific competencies we wish residents to achieve during their continuity experiences and only then consider the significance of patient numbers, the frequency of patient contacts and panel sizes to meeting the requirements for a competency-based curriculum. Before the RRC makes decisions about this issue, input from program directors is critical.

WANTED: INPUT FOR REVISION OF THE APA EDUCATIONAL GUIDELINES FOR RESIDENCY TRAINING IN GENERAL PEDIATRICS

In 1996, the Ambulatory Pediatric Association published the first edition of the *Educational Guidelines for Residency Training in General Pediatrics*. The product of a two-year project under the direction of the APA Education Committee, which was then chaired by Diane Kittredge, the *Guidelines* have provided model goals and objectives for residency training. The *Guidelines* were published in loose-leaf binder format and also distributed electronically on floppy disk, to encourage program directors to make modifications in accordance with local needs and resources. Program directors or other pediatric educators from 80% of residency programs report that they have used the *Guidelines* in their program. It is likely that changes in the accreditation requirements have prompted such great interest in these *Guidelines*. The Accreditation Council for Graduate Medical Education, through the Residency Review Committee for Pediatrics, now requires each program to have written goals and objectives for each component of the residency.

At this time, a revision of the 1996 *Guidelines* is planned for five reasons:

- 1) Suggestions and experience have accumulated since the 1996 edition that will make the revision more complete;
- 2) The widespread use of Internet tools makes it possible to improve access and flexibility of use;
- 3) Several new curricular areas are now receiving emphasis in residency programs;
- 4) The ACGME is moving toward defining required competencies for residents, rather than simply counting the time they serve on various assignments, so a change in the language of goals and objectives is needed;
- 5) It is desirable to involve the entire pediatric community in the formulation of the new *Guidelines*.

The 1996 edition of the *Guidelines* has recently been posted to the APA website (www.ambpeds.org). This can be viewed and printed "as is" but can not be downloaded for modification. The committee is seeking input on the following topics:

- Specific changes in content or new content areas
- Changes in organization
- Changes in the format
- Other modifications

Suggestions and comments should be emailed to Kathryn Kelley (kathryn@ambpeds.org) at the APA office. Your input will help the committee plan the scope and details of the revision.

The APA office can also email the *Guidelines* to anyone interested as a zipped MSWord version of the document. In this format, programs can adapt it for local use. Requests should be emailed to Kathryn at kathryn@ambpeds.org with the following information: a) Name; b) Title; c) Role in Residency and; d) Intended Use of the Guidelines.

Association of Pediatric Program Directors Leadership

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Sara S. Viessman, MD

Coordinators' Executive Committee

June Dailey; Jan Minges; Melodie Parker;
Lucy Thompson; Aida Vélez; Jeri Whitten



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APPD 2001 Fall Meeting

**September 15 - 16, 2001
Hyatt Regency Hotel
Reston, VA**

Plan to attend this meeting IF...

- *You are a New Program Director or Coordinator*
- *You are an Associate Program Director*
- *You are considering becoming a Program Director*
- *You are interested in a comprehensive update*
- *You are preparing for an RRC site visit*
- *You are assisting a Program Director*

Registration materials will be mailed soon! Check the APPD website, www.appd.org, for updates or call the APPD office, 703-556-9222.