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# APPD NEWSLETTER

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Winter

Association of Pediatric Program Directors

1997-98

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## EDITOR'S COLUMN

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

This mid-year edition of our *APPD Newsletter* contains many of the usual features that will bring you up to date on APPD activities and issues since our annual meeting this past Spring. It includes a summary of our Fall Meeting, and an announcement of our plans for the coming Annual Spring meeting in New Orleans from April 29 through May 1, 1998. I hope it will also elicit responses from a broader representation of our membership on issues surrounding our new listserv, an APPD web site, and the use of procedure logs.

The APPD activity update includes: the President's Column from Dr. Carol Berkowitz, a report from Dr. Berkowitz on the RRC activities, an update from the meeting of the Primary Care Organizations Consortium (PCOC) by Dr. Robert Nolan, regional group activity reports from Drs. Bob Nolan and Bob Kamei, and a question to Dr. Walter Tunnessen on the workings of the American Board of Pediatrics.

Thanks to Drs. Glenda Lindsey and Bob Kamei, the APPD now has a functional listserv. Dr. Lindsey has provided an announcement of the listserv in this issue of the newsletter, and indicates the way in which you may access the listserv. For now, Drs. Lindsey and Kamei have agreed to monitor and edit submissions, with all messages from program directors being placed on the listserv. This method has been selected as the initial mode of operation avoid use of the listserv by outsiders (e.g. advertisers), and having a deluge of multiple messages in your e-mailboxes. Dr. Charles Medani, director of the program at Mt. Sinai Hospital in Baltimore, and some members of the Board of  
*(continued on page 3)*

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## PRESIDENT'S COLUMN

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*Carol D. Berkowitz, MD, Program Director, Harbor-UCLA Medical Center*

The APPD continues to expand the educational services and opportunities it provides to its membership. This past fall, we held what can only be described as an overwhelmingly successful first time meeting to assist new program directors as well as established program directors develop and refine their skills. Many programs took advantage of the opportunity to review the new Program Requirements in Pediatrics, and step by step go through the program information forms. The meeting was also attended by some of the program coordinators who participated in the sessions, and met separately to plan their portion of the spring meeting.

There are a number of additional new activities that the APPD is exploring. We are interested in assisting our colleague program directors in the pediatric subspecialties with providing educationally defined experiences for their trainees and for meeting the program requirements for training in each of the subspecialties. Often these individuals are unfamiliar with the accreditation process, with the need for written evaluations and feedback (understandably problematic if there is a single trainee in the program), and the use of written goals and objectives. In the past, the APPD has provided workshops during the APPD meeting to address some of these issues, but communicating the availability of these workshops to the appropriate subspecialty director was difficult. We are now in the process of compiling a list of identified leaders among the program directors in each of the accreditable training programs, and hope to contact these individuals about our program in the Spring.

Similarly, we are compiling a list of the leadership of the 25 other specialties for which these are RRC's to determine if there are needs or opportunities to collaborate on generic training issues common to all of us.

Other items: We are revising the by-laws; AMSPDC is looking at our ethics statements; the Program Coordinators will be joining us in force this spring.

## NEW APPD LOGO

**INSIDE:**

~ ABP Questions/Answers Column ~ What Should We Be Documenting  
~ Coordinators' Forum ~ Residency Review Committee ~ Clinical Training &  
Experience in Pediatric Allergy/Immunology ~ Program Director's Handbook Revised  
~ Neonatal Services ~ APPD Listserv ~ APPD Holds Successful Fall Meeting  
~ PCOC Update ~ Visiting Professor Program ~ Positions Available

## **ABP QUESTIONS/ANSWERS COLUMN**

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

**Question:** Programs are accredited by the Residency Review Committee and individual resident graduates of accredited programs are certified as qualified by the American Board of Pediatrics. Program directors have associated approval of programs with the RRC. However, now the ABP has a process by which joint programs such as combined medicine and pediatrics, are approved by the ABP. Could you explain how this ABP approval differs from RRC accreditation?

**Answer:** Combined programs are not accredited by the RRCs for the involved specialties. The RRCs will only accredit the categorical specialty programs involved. Since training is truncated in combined programs, it is of great importance to the respective boards to assure that the trainees are meeting the training requirements for each of the specialties involved. The boards do not accredit combined programs, rather they review the training individuals receive to assure that the requirements for the specialty have been met. Each of the specialty training programs must be accredited by the RRC for an individual's training to be approved. The boards approve the individual; the RRC accredits programs.

The RRC for Pediatrics has the task of accrediting pediatric training programs, both in general pediatrics and in the pediatric subspecialties, which includes a paper review and a site visit by an experienced representative of the RRC. The RRC must assure that the program(s) meets the requirements for residency education in pediatrics or its subspecialties, as developed by the Accreditation Council for Graduate Medical Education. The ABP certifies individuals in the specialty of Pediatrics. One part of the certification process is the approval of the individual trainee based on the satisfactory completion of residency training in an accredited program. The ABP relies on Program Directors to assure that a candidate has met the training requirements and to verify that they are clinically competent to care for children.

**APPD is managed by Degnon Associates:**

**Laura Degnon, Executive Director**

**George K. Degnon, CAE, Associate**

**6728 Old McLean Village Drive**

**McLean, VA 22101-3906**

**703-556-9222**

**FAX: 703-556-8729**

**Degnon@aol.com**

## **WHAT SHOULD WE BE DOCUMENTING?**

*Julia McMillan, MD, Program Director, Johns Hopkins Hospital School of Medicine*

In the revised Program Requirements for Education in Pediatrics that took effect February 11, 1997, the Residency Review Committee for Pediatrics mandated that, "Each program must provide sufficient training in and monitor resident development of" a list of 14 procedural skills. That requirement has led to a great deal of discussion: Why these particular skills? How will residents gain experience with the procedures on the list that are now performed only very rarely by pediatricians, such as chest tube placement?

More worrisome, perhaps, than these questions has been the reaction by many program directors who seem to feel they are now being required to count procedures by residents. I have even heard of residency programs in which competition is being encouraged between residents for the number of procedures performed. Computer programs are being developed, and reports are being issued. The problem with this approach is that once we begin to count, then we report numbers, and pretty soon someone begins to think we know what these numbers mean. Is 20 lumbar punctures enough? Perhaps 25 is better. How many venipunctures in what age infants or children renders a resident "skilled." Surely skill is something that should be judged by a faculty member, fellow, or senior resident who is, him/herself already skilled in the procedure, not by a number.

Insurance companies and hospital credentialing committees can only judge competence by what we tell them. They may be asking for numbers, because that is what they are provided by other specialties. But if, instead, we tell them that we individualize—we actually observe residents doing procedures and document their competence, whether achievement of competence takes 2 tries or 20—then surely we are providing more useful information than any number can convey.

The RRC isn't asking for numbers, it's asking for training and monitoring of skill development. Hopefully we've all been doing that for years. The only thing that's new is that we're now being asked to document what we observe. We'll only get ourselves and our residents into trouble if we pretend that there is a number that correlates with the development of a skill.

## **COORDINATORS' FORUM**

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*Pat Schmidt, Program Coordinator, University of Maryland*

When I was asked to write this article for the news letter I was not sure I was the right person. I always have a lot to say and that has, on occasion, gotten me into trouble.

I have been a Housestaff Coordinator for the past 11 years. When you say it fast, it does not sound like it has been that long. I am sure there are a few of you out there who have been doing the job longer than that. The two things that keep me in my job are that I love the job and I am fortunate to work for a wonderful Program Director. We both started out brand new in the job, the Program Director starting a year and a half before I came. Over the years, we have developed and maintained strong lines of communication. The reason our office runs as smoothly as it does is because we communicate and the Program Director has trust in my abilities. It is not to say we do not have problems.

I am sure the number one problem everyone faces at this time of the year is enlisting faculty to do applicant interviews. Both the Chairman and the Program Director have made it known that I act on their behalf which has helped me win the respect and cooperation of the faculty. We feel it is also important that the coordinators interact with the applicants. I am the first one to greet the applicants and I also give a 15 minute presentation to them about the hand-outs we give them. I answer any questions I can and if there is one I can not, I do what I can to get it answered. We both believe this introduction sets the applicants at ease and lets them know we are a friendly and cooperative office.

I could go on and on but space is limited. The issue I want to get across to both the Program Directors and Coordinators is the need for communication. We both feel that without communication, trust and respect for each other, we would not be able to work as well together as we do. But remember, the way to start is to communicate. However, if you are new to the job and need help getting started or even if you have been in the job for awhile and would like some new ideas, an excellent source of help and information is the Pediatric Coordinators Group. Everyone is always very friendly and eager to help in any way they can.

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

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the APPD, have indicated that they might prefer the spontaneity of an open and unedited exchange through the listserv. It was felt that the latter method of operation would improve communication among program directors. *How do you prefer to use the listserv, monitored or unmonitored?* By the Spring meeting, we will summarize your replies, and

will have had some experience with the monitored method of communication. This will allow us to address the issue further.

For some time now, a web page for the APPD has been under consideration. The cost of establishing and maintaining a web page becomes greater with increasing complexity. Drs. Bud Wiedermann of the Children's National Medical Center in Washington, D.C. Alfonso Vargas of the Louisiana State University Medical Center and Bradley Bradford of Mercy Hospital of Pittsburgh have participated actively in investigating possibilities for establishing an APPD web page. At the Fall Board Meeting, it was suggested that we investigate a less costly alternative of having a simple bulletin board site. This would require members or the national office to set up and maintain the site, and would require the purchase of the host computer system. The question was then raised as to what a simple bulletin board would add to our listserv. *Should the APPD establish a full web page, have a simple bulletin board web site, or utilize the listserv alone for our communications?* Consider the cost-benefit of the various alternatives in responding.

At this year's Annual Spring Meeting, Drs. John Mahan and Leslie Mihalov led a workshop on a computerized procedure log for tracking pediatric residents. In their summary article in the last issue of the newsletter, they cited a number of important uses for such a tracking mechanism: in documenting competence for board certification, establishing qualifications for staff or managed care group privileges, and for reaccreditation documentation for the RRC. Dr. Bob Nolan reviewed a paper version of a procedure log book at the Fall Board Meeting as well. At both meetings, there was a great deal of thoughtful discussion about the usefulness and application of such tracking systems in our programs. In this issue of the newsletter, Dr. Julia McMillan of the Johns Hopkins program has presented her concerns about collecting this data as part of documenting resident competence. I share her concerns, and believe we need to be careful about how we agree to document resident competence. *What is your opinion about how program directors should document and certify resident competence? Will improved collection of procedure data serve our residents best?* We can address this again at the Spring Meeting if it appears warranted.

Thank you all for your responses to these questions. They can be sent to me by e-mail, listserv, fax or snail mail. Best wishes for a successful recruitment effort, and I look forward to reporting back to you in the March issue of the newsletter and seeing as many of you as possible in New Orleans.

## RESIDENCY REVIEW COMMITTEE

*Carol D. Berkowitz, MD, Chair, RRC for Pediatrics*

The Residency Review Committee spent the October, 1997 meeting reviewing 110 training programs. This was the first opportunity for the committee members, as well as for the core program directors, to work with the new program information forms. The forms were developed in part to help convey more objective data that would assist the RRC in its assessment. The Committee has identified some problems with the forms, such as missing data (there's no place to record continuity clinic panel sizes) as well as redundancy. It would be helpful to get input from program directors who have had the opportunity to use the forms. Suggestions and observations should be sent to Mary Alice Parsons directly. Her FAX is 312-464-4098 and her email is [map@acgme.org](mailto:map@acgme.org). We will review all the comments and suggestions at the April, 1998 meeting, and the newly revised forms will be in place by July, 1998.

The Committee is also reviewing proposed revisions for the generic requirements for training in subspecialties as well as for some of the individual pediatric subspecialties, including pediatric critical care, endocrinology, cardiology, perinatal-neonatal, nephrology and gastroenterology. The first step in the process involved reviewing the revisions that were proposed by the subspecialty organizations such as the subspecialty boards of the American Board of Pediatrics and some of the subspecialty program directors. The committee had substantial discussions about the use of numerical guidelines (e.g., the numbers of patients with certain disease entities) that the subspecialty residents should be responsible for seeing. Changes were made in the proposals and these revised revisions will be returned to the ABP, AAP and AMA for review and comment.

The newest pediatric subspecialty to have its requirements complete the approval process was adolescent medicine. It is expected that approximately 45 programs will submit applications for accreditation, and the RRC will have a separate meeting in the Fall of 1998 to review these programs.

Pediatric Emergency Medicine is still in the process of establishing the requirements for training in this area. The process of developing these requirements is more complicated because it involves the input and approval of two different communities, pediatrics and emergency medicine. At the most recent meeting of the RRC for Pediatrics, a number of revisions were proposed to assure that trainees in emergency medicine who are seeking additional training in pediatric emergency medicine have sufficient opportunities to

learn about non-emergent pediatric health care issues.

The RRC continues to plan to assist program directors with the accreditation process by holding workshops at the Fall and Spring meetings. One suggestion that was articulated at the October RRC meeting was that program directors should start gathering necessary data a year ahead of time. The ACGME is happy to supply programs with the Program Information Forms and the program directors could then delegate portions of the forms to colleagues to assist in acquiring the necessary data. This was a suggestion from RRC members who themselves had recently completed the revised Program Information Forms, under the new requirements



*Program Coordinators during the First Annual APPD Fall Meeting -- seated left to right: Pam Occhipinti, Mary Brady, June Dailey, Shirley Hazlewood, Kathy Rose; middle row left to right: Lisa Skoug, Kathy Root, Jeri Whitten; back row left to right, Rosemary Munson, Peggy McFarlane, Melodie Parker, Cindy Liberi, Iris Mau, Linda McNelis, and Valarie Collins.*

The APPD, in association with the Resident Section of the AAP, has developed a procedure documentation log book for residents. This project has been financially supported by Ross Laboratories. Your Ross Laboratories representative will have information regarding the distribution of the log books in the near future.

## **GREAT OPPORTUNITY FOR PEDIATRIC RESIDENTS TO OBTAIN CLINICAL TRAINING AND EXPERIENCE IN PEDIATRIC ALLERGY/ IMMUNOLOGY**

*Michael J. Welch, MD, Executive Committee Member, Section on Allergy and Immunology, AAP*

**DETAILS:** An increasing number of graduates of pediatric training programs are electing to stay in primary care, and we anticipate that even more will do so in the future. Of the patients encountered in the pediatrician's office, it has been estimated that 20 to 30% have problems related to allergy including allergic rhinitis, asthma, sinusitis, eczema, food allergy, antibiotic sensitivity, and insect sting allergy. However, many pediatric training programs lack a board-certified allergist-immunologist on their faculty to provide residents the clinical teaching to help prepare them in properly diagnosing and managing the patient with these various common outpatient allergic (or allergy-related) conditions.

To address this problem, the American Academy of Allergy, Asthma, and Immunology along with the American College of Allergy, Asthma, and Immunology have joined forces to create a program that facilitates residents in primary care training programs to establish a rotation with a board-certified allergist-immunologist in their community. This program is being implemented under the direction of the Joint Committee on Primary Care Rotations in Allergy. The goal of the Committee is to have primary care training programs without an allergist-immunologist on faculty be connected with a specifically selected, qualified, and well-trained clinical allergist who has an interest in educating residents. It is believed that an elective rotation by a pediatric resident thru a local allergist-immunologist's office will provide an invaluable opportunity to enhance the skills of future pediatricians in the field of outpatient allergy and immunology, an area of practical pediatrics sometimes overlooked in certain highly inpatient- focused and/or academic training programs.

A survey of the members of the Section on Allergy and Immunology of the American Academy of Pediatrics has generated a lengthy list of qualified board-certified allergist-immunologists who are willing and eager to accept residents for an office rotation. The Joint Committee on Primary Care Rotations in Allergy is ready now to place pediatric residents in the offices of these interested allergists. Realize that goals and objectives for the resident as well as curriculum material for this program have been created and will all be part of the placement. If you are a training program director and would like further information about this

worthwhile project, please contact any of the people listed below.

Michael J. Welch, MD, 9610 Granite Ridge Drive, San Diego, CA 92123; Phone: 619-292-1144; Fax: 619-268-5145; Email: mwelch@pol.net

Alan Goldsobel, MD, 4155 Moorpark #3, San Jose, CA 95117; Phone: 408-243-2700; Fax: 408-984-1594; Email: abgmd@asthmacare.com

Jay Portnoy, MD, The Children's Mercy Hospital, 24th at Gillham Road, Kansas City, MO; Phone: 816-234-3097; Fax: 816-346-1301; Email: jportnoy@cmh.edu

### **PROGRAM DIRECTOR'S HANDBOOK**

The APPD Handbook, designed for Pediatric Residency Program Directors, was recently revised and distributed to the new program directors at the APPD Fall Annual Meeting in September.

This handbook was first circulated to each program in April, 1994. Those of you who would like to receive the revised page inserts, or cannot locate the original one distributed in '94, please send your request either by email or regular mail to Laura Degnon at the APPD National Office: 6728 Old McLean Village Drive, McLean, VA 22101-3906 OR degnon@aol.com

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

**President:** Carol D. Berkowitz, MD

**President-Elect:** Robert J. Nolan, MD

**Secretary-Treasurer:** Julia A. McMillan, MD

**Past-President:** Kenneth B. Roberts, MD

**Newsletter Editor:** Edwin Zalneraitis, MD

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

## **PEDIATRIC RESIDENT EDUCATION ON NEONATAL SERVICES**

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*Isabella Knox, MD, EdM, Associate Professor of Pediatrics, Associate Dean for Faculty Development, University of Connecticut School of Medicine*

*Presented in New Orleans at the October 31, 1997 Fall Meeting of the Organization of Neonatology Training Program Directors*

I loved my neonatology rotations when I was a resident. I felt that what I learned there was so important. I don't think that it's only my hindsight perspective as a neonatologist that makes me think this either. I'd like to discuss, wearing both my neonatologist hat and my educator hat, what I think neonatologists can offer to residency education in pediatrics.

The past decade has brought major changes in pediatric residency education, most of which are for the better. In the old days neonatal services saw residents for 6 or more months over their three years of residency. Also, since there was little direction about what residents needed to learn during their residency education, we let the context drive the content. Residents learned about whatever conditions came through the door. Teaching rounds were case-based, and the more bizarrely striped the zebra, the more desirable it was as a case to present.

Then it entered the consciousness of the RRC and of pediatric residency directors that a residency was an educational program that could be planned, could have a "curriculum." Some principles of education were brought into residency training, most notable the whole idea of "objectives:" that you can and should have specific objectives that you want your learners to attain by the end of the program you're developing. Objectives can be for a near-term experience, such as a teaching session, or for a long-term experience, such as a three year residency. Hopefully, the former work towards the latter and the latter correctly prepares the learner for what he or she is planning to do when the educational program is over.

With this in mind, residency directors examined the amount of time residents spent on neonatal services and cut it back. The reasoning was that since general pediatricians don't take care of NICU patients, students who are working to become general pediatricians should not spend too much time learning from NICU patients. There are some good reasons for this conclusion, supported by educational theory. First is the theory of "situated cognition,"—you are more likely to remember something if you learned it in a context similar to the one in which you need to recall it. This would

argue that general pediatric education should take place in the context where most general pediatricians work—the outpatient clinic or office. The second underpinning of the decision to take residents off of neonatal services comes from the tenet of adult learning theory that says that adults are motivated to learn what they think will be useful to them. There were other considerations, more practical in nature, that took residents out of the NICU—a big one was time. Residents clearly spent a lot of time in NICU's because NICU's need a lot of staffing. That left less time for residents to learn other areas of pediatrics.

But I think neonatal services and neonatologists still have a lot to offer residents. I believe that residents benefit from learning opportunities on neonatal services in many ways, and that we should work to preserve and perhaps even augment those benefits, while continuing to cooperate with the benefits to residency education that come from decreasing time on neonatal services.

To understand this better, I did a case study of how neonatal topics are taught at my institution. I got information on the curricula used in our two NICU rotations and in the well-baby rotation, which is taught by a general pediatrician. The results are interesting. Looking at the written curriculum for the well-baby rotation, I would say that every topic listed is definitely something that a general pediatrician should know about; every skill is something that a general pediatrician should know how to do. Examination of the curricula for the two NICU rotations shows a little different picture. The topics break up into three categories: First, there are topics that are, again, relevant for budding general pediatricians, such as resuscitation, hyperbilirubinemia, and meconium. Second, there are topics that are in the arena of subspecialty knowledge, but knowledge that it is necessary if you are going to work safely in a NICU for any period of time. These include, ventilator management, high frequency ventilation, parenteral nutrition, IVH, BPD. Third, there are topics that relate to conditions that would probably be taken care of by neonatologists, not general pediatricians, but that contain information and principles that are useful to pediatricians caring children of any age: For example, topics like renal failure, anemia, blood gas interpretation and coagulopathy.

With this analysis in mind, I tried to articulate what I think is special about what we neonatologists offer. It's a lot more than a few essential topics. Here is my list of what neonatologists as teachers and neonatal-perinatal medicine as a field offer that is important for general pediatric residents to learn:

1. Neonatal-Perinatal Medicine includes knowledge, skills and attitudes that make up a vital segment of routine pediatric care. Especially neonatal services that include normal newborns have a whole content area that is unequivocally necessary for residents to learn.

2. Neonatal-Perinatal Medicine is primary care, for a selected population. We are generalists and can teach generalist principles. No one but a neonatologist will be the primary care physician for a 26 weeker. Taking responsibility for coordinating all treatments in a complex multi-system involved patient is a generalist principle.

3. Neonatal-Perinatal Medicine is physiology in action. Residents need to review physiology and apply it to the clinical learning they do in all their rotations.

4. The practice of even routine Neonatal-Perinatal Medicine requires a high degree of critical thinking and problem-solving. There's very interesting data about how expert clinicians make diagnoses and how that's different from how novices do it (Schmidt et al, 1990). Experts tend to use pattern recognition for most of their work, whereas novices have to use a problem-solving approach to build their patterns. I think the complexity of neonatal patients and the pressure of the rapid pace of their illnesses causes neonatologists to rely less on pattern recognition and more on explicit problem analysis. Residents benefit from participating in this process.

5. The time frame in which the conditions treated in Neonatal-Perinatal Medicine go through the stages of presentation, diagnosis, treatment and resolution is short. You can see a lot of stages of an illness in four weeks on a neonatal service. Each stage has important biomedical and psychosocial components.

6. Developmental principles play out in neonatal patients right before your eyes. This includes physical and behavioral development and concepts such as, the predictability of developmental stages and the impact of illness on development.

7. Neonatal-Perinatal Medicine uses ethical principles constantly. We don't only deal with death and dying, but also critical subjects like informed consent, what to do when you make a mistake, and allocation of scarce resources.

Neonatologists should be clear about why they are teaching specific topics. It's OK to have a category of things residents need to learn to enable them to work in the NICU without endangering patients, but this should be carefully

assessed and minimized. With some thought, most of the topics in this category can be presented in a way that they meet other goals, such as teaching general principles or physiology. Residents and residency directors all will value a well articulated and well integrated educational program for pediatric residents in the NICU, a program that consciously teaches what we can teach so well.

Schmidt, HG, Norman GR and Boshuizen HPA. Cognitive Perspectives on Medical Expertise: Theory and Implications. *Academic Medicine* (1990), 65: 611-621.

## **APPD LISTSERV**

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*Glenda Lindsey, MD, Program Director, King/Drew Medical Center*

The APPD listserv is up and running thanks to Bob Kamei and UCSF. By now, if you have provided the APPD with an email address you should have received the first mailing. If you have not received the mailing, have a new email address, are no longer the program director and/or do not wish to be included in future mailings please email Glenda or Bob.

The listserv is your vehicle to reaching out and communicating with your fellow program directors on issues/concerns you may want to discuss or share with your fellow APPD members, it is here to serve your needs. In order to avoid use of the listserv by outsiders (with advertisement etc.) or deluge you with multiple messages that fill up your mail box, the listserv will take the following format: Bob will administer the listserv and Glenda will serve as the editor/monitor. Messages to the listserv will return only to Bob or Glenda, not the entire group. Messages will be forwarded as a single mailing with a content list, followed by the messages in the order listed in the content list. In general, everything sent to the listserv will be forwarded to the group, but until we get more experience, we reserve the right to include/exclude/edit any submissions. At this time, the frequency you will get messages from the listserv is uncertain. We will generally accumulate a few things to send out at one time. Simply email us with any announcements, concerns, interesting facts, questions or comments and we will include your note on the listserv. If your message/note is emergent/urgent simply include "urgent"/"emergent" at the beginning of your note. You can reach us by emailing us at: Glenda: galindsey@pol.net Bob: kamei@itsa.ucsf.edu

We hope the listserv will help you keep up to date and hope you will look forward to periodically finding our notes among your stack of email.

## **APPD HOLDS SUCCESSFUL FALL MEETING**

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

The APPD sponsored the 1997 Fall Meeting at the Ritz Carlton Hotel in Tyson's Corner, Virginia, on September 14th & 15th. The meeting was well-attended by 116 registrants, that included a broad cross-section of individuals from residency programs. Coordinators were widely represented, as were new and associate program directors. However, there were also many experienced program directors present for the comprehensive update and to prepare for upcoming RRC reviews. While the program seemed to have been of value for the established program directors, they were also welcome contributors to the program themselves. This certainly added to the value of the Fall program for the others.

The program began with a discussion of the APPD by Dr. Robert Nolan, our President-elect, that addressed the scope of our issues, our meetings and the new handbook. Dr. Errol Alden, Deputy Executive Director of the AAP, reviewed the broad range of support offered by the American Academy of Pediatrics. Title VII funding was discussed by Dr. Carol Bazel from HRSA, and Dr. Robert Beran, Director of the NRMP, reviewed pertinent aspects of the match. Ms. Jeri Whitten, coordinator for the West Virginia University program, presented an overview of the role and ideal job description for residency program coordinators. Dr. Walter Tunnessen, Senior Vice President of the American Board of Pediatrics, presented an update of current interactions between the ABP and program directors. Dr. Carol Berkowitz, the current President of the APPD and Chair of the RRC, provided an overview of the role of the Residency Review Committee. A session on the impending implementation of ERAS was provided by the Director of ERAS, Ms. Gwynn Kostin.

Dr. Carol Carracio, Program Director for University of Maryland program, teamed up with the Coordinator of that program, Ms. Patricia Schmidt and the Associate Program director Robert Englander, to present a workshop on a very practical approach to planning a yearly schedule for a pediatric residency program. Dr. Ken Roberts, Director of Pediatric Teaching programs at Moses Cone Health System in Greensboro, North Carolina, and I teamed up to put together a workshop on establishing and implementing goals and objectives for curricular components of a program. A workshop on legal issues for program directors was developed through Dr. Sharon Crandall, Program Director for the University of Texas, Houston. Dr. Crandall recruited Attorney Ann Litkhe to provide authoritative opinions for

those in attendance. Dr. Beth-Ellen Davis, from the Uniformed Services University of Health Sciences offered a workshop on giving effective feedback to residents, that complemented nicely Dr. Richard Moriarty's workshop on dealing with problem residents. Dr. Moriarty, Program Director of The National Naval Medical Center and Walter Reed Army Medical Center, presented his workshop in an informative, case-based format. Dr. Carol Berkowitz added to her RRC presentation with a workshop on filling out the Program Information Form for reaccreditation. There was also a luncheon panel discussion on how to survive as a program director, that was facilitated by Drs. Nolan, Berkowitz, Roberts and Julia McMillan of the Johns Hopkins program.

Feedback and comments on the program were generally favorable. Ms. Rosemary Munson, coordinator for the Maine Medical Center program noted: "All the sessions were geared to both program directors and coordinators. Every time you come to an APPD meeting, you pick up at least one gem." Dr. Alan Friedman, a new associate director of the Yale University program felt: "The presentation on planning your year provided a very helpful framework to build a year's organization." Ms. Pamela Occhipinti, coordinator for the Cleveland Clinic Foundation, commented on the University of Maryland workshop as well: "I like the use of a coordinator and director together for that presentation." Dr. Jerry Durbin, new program director for the University of Massachusetts, commented on the workshop on legal issues and noted: "Learning that we shouldn't be afraid of ADA was very helpful." Ms. Jean Criffield, coordinator for the Dayton University program, felt: "The information on the RRC was very helpful, and I also enjoyed hearing the lawyer's point of view in the legal issues workshop." Overall, it appeared that a Fall meeting is both a popular and useful addition to the APPD activities.

### **Welcome - New Program Directors!**

Gary Don Crouch, MD, Keesler Medical Center  
William Jerry Durbin, MD, University of Massachusetts  
Charles Pegelow, MD, University of Miami  
Pam Shaw, University of Kansas Medical Center  
Tribhawan S. Vats, MD, Texas Tech University (Amarillo)

### **Best of Luck to Those Who Have Moved On**

Kenneth B. Roberts, MD, former Program Director at the University of Massachusetts, has moved to North Carolina and is now Director of the Pediatric Training Program at Moses Cone Health Systems...but promises to stay involved in APPD.

## **PRIMARY CARE ORGANIZATIONS CONSORTIUM (PCOC) UPDATE**

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*Robert J. Nolan, MD, Program Director, University of Texas*

The Primary Care Organizations Consortium (PCOC) met in Washington, D.C. on October 7, 1997. PCOC has received funding from the Division of Medicine of the Bureau of Health Professions of HRSA to organize three conferences. The working title for the first conference is "Rethinking Faculty Development in the 21<sup>st</sup> Century: A PCOC Working Conference." The intent of this working conference would be to identify strategies for training teachers and faculty development in the managed care environment of the next decade. The second conference, tentatively titled "Building Primary Care Research Capacity: Strategies for the 21<sup>st</sup> Century," would explore setting priorities for primary care research. The third conference would examine models of collaborative teaching across the primary care disciplines. These conferences would be held in the fall or winter of the 1998-1999 academic year.

PCOC was given an update on the interdisciplinary generalist curriculum project which is now in this fourth year. The IGC collaborative symposium will take place September 24-28, 1998 in Baltimore, Maryland. Dr. Enrique Fernandez presented information regarding Title VII funding and the Balanced Budget Act of 1997. Title VII funding will likely remain level for fiscal year 1998 but remains under a continuing resolution as of late October. The comment period for the implementing rules and regulations for the Balanced Budget Act of 1997 concluded in late October. Dr. Fernandez reminded PCOC that the IME payments to teaching hospitals will be reduced from 7.7% for every 10% increment in a hospital's residents to bed ration in a staged fashion to 5.5% by FY 2001 and subsequently. The rules by which the Secretary of HHS will determine which "qualified non-hospital providers as the Secretary deems appropriate. The PCOC membership was reminded that individual hospital applicants who wish to participate in the voluntary incentive plan for the reduction of house staff positions must reduce their number of residents by at least 20% of the base number of residents if the base number exceeds 750, and at least 25% of the base number if the base number does not exceed 600 residents over a period of time to be determined by the secretary of HHS.

The American Association of Colleges of Osteopathic Medicine (AACOM) has been awarded the contract to be the administrator of the UME 21 project (Undergraduate Medical Education in the 21<sup>st</sup> Century: A Demonstration of Curriculum Innovations to Keep pace with a Changing Health

Care Environment). This HRSA initiative will fund up to eight demonstration projects for three years at \$125,000 a year. UME 21 will attempt to build on the success of the IGC and will fund projects which demonstrate curricular innovation in the clinical years of undergraduate medical education (third and fourth years) related to the interdisciplinary preparation of students to work in a changed health care environment in collaboration with non-academic clinical entities such as managed care organizations and other non-traditional clinical entities. The RFP's for the UME 21 demonstration projects will be available in late November or early December with a probable deadline of mid-February, 1988. Please make your undergraduate medical education colleagues aware of this important opportunity. The contact person at AACOM is Douglas L. Wood, DO, PhD (301) 968-4142.

## **VISITING PROFESSOR PROGRAM PEDIATRIC ALLERGY AND IMMUNOLOGY**

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*Michael J. Welch, MD, Executive Committee Member, Section on Allergy and Immunology, AAP*

Could you and your training program benefit from an update on the latest information on pediatric allergy and immunology, straight from the professor's "mouth"? If so, the Section on Allergy and Immunology of the American Academy of Pediatrics has just what you need - the Visiting Professor Program.

This free program sends an allergist/immunologist for two days to pediatric training programs which do not have a pediatric allergist-immunologist on staff. While visiting, the professor provides lectures, discusses clinical problems, reviews complicated cases, and helps out in any other ways the training program desires.

The Visiting Professor Program in Allergy and Immunology began in 1989 and so far has been very successful. Numerous training programs have taken advantage of this great educational experience.

A list of the board-certified allergist/immunologists who have volunteered to participate as visiting professors will be mailed to you upon your request.

Don't hesitate - the visiting professorship grants are limited so act now. Anyone interested should contact: Anne McGhiey, Sections Manager, American Academy of Pediatrics, 141 Northwest Point Boulevard, Elk Grove Village, IL 60009; phone 800-433-9016 ext. 7658 OR Michael J. Welch, MD, Executive Committee Member, Section on Allergy and Immunology, AAP, 9610 Granite Ridge Drive San Diego, CA 92123; phone 619-292-1144

**Association of Pediatric Program Directors  
6728 Old McLean Village Drive  
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If you haven't already made your reservations for the April 29-May 1, 1998 APPD Annual Spring Meeting, be sure to do so today! The APPD meeting will take place at the New Orleans Hilton Riverside Hotel, New Orleans, LA. Tentative schedule:

<u>April 29:</u> 1pm - 5pm Directors of Small Programs 1pm - 5pm Program Coordinators Plenary 5:30pm - 7:30pm APPD Social Reception	<u>April 30</u> <b>8am - 5pm</b> <b>APPD Plenary Session and Workshops (Designed for both Program Directors and Coordinators)</b>	<u>May 1</u> 8am - 10am APPD Committee Meetings 10am - 1pm APPD/APA SIG 8am - 5pm Program Coordinators Plenary
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### **POSITIONS AVAILABLE**

PL-2 position unexpectedly available July, 1998 at St. Joseph's Hospital and Medical Center, a major tertiary pediatric center, in beautiful Phoenix, Arizona. Strong general pediatric focus with excellent subspecialty teaching. ACGME accredited. Satisfactory completion of PL-1 year required. Interested individuals should contact: John Olsson, MD, Director, Pediatric Residency Program, Children's Health Center, 350 West Thomas Road, phoenix, AZ 85013. 602-406-3519. EO/AAE.

The Department of Pediatrics, Children's Hospital of Michigan/Wayne State University is seeking applications and nominations for the full-time position of Director of Resident Education. This individual will be responsible for recruitment, selection, instruction, supervision, counseling, evaluation, and advancement of the 100 pediatric residents in our program. The position will include clinical and teaching responsibilities in general pediatrics or in the individual's area of subspecialty training. Minimum qualifications include board certification in pediatrics and clinical and administrative experience. Previous medical education experience preferred. Children's Hospital of Michigan and Wayne State University are EO/AAE. Please send CV or nomination to: Children's Hospital of Michigan, Attention Howard Schubiner, MD, Search Committee Chair, 4201 St. Antoine, UHN-5C, Detroit, MI 48201.