The Association of Pediatric Program Directors: The First 25 Years

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Received for publication December 27, 2011; accepted March 2, 2012.
ACADEMIC PEDIATRICS 2012;12:166–170

IN THE EARLY 1970s, the American Board of Pediatrics (ABP) had no mechanism for communicating with directors of the more than 200 residency programs. Communication existed between the ABP and the medical school department chairs through the Association of Medical School Pediatric Department Chairs (AMSPDC), but this mechanism did not extend to the numerous nonuniversity programs. Between 1974 and 1982, the ABP sponsored 4 conferences for program directors. At the meeting in 1978, the feasibility of forming an association of program directors was raised, with particular interest expressed by individuals in nonuniversity programs, and, in 1983, the ABP Program Directors Liaison Committee recommended to the ABP leadership that a program directors' association be formed. ABP leaders presented the idea to their counterparts in AMSPDC and the American Academy of Pediatrics (AAP). Two individuals who deserve special mention are Robert Brownlee and Robert Holm. Dr. Brownlee was the Executive Secretary of the ABP (a position later renamed President and Chief Executive Officer). Before coming to the ABP in 1975, he had been in practice in Greenville, South Carolina, and, in 1971, had started a residency program there, which he directed. Dr. Holm also had been in practice before directing a nonuniversity residency program. He was the Michigan chapter chair for the AAP and solicited AAP support to represent nonuniversity programs.

With the agreement of AMSPDC and AAP, the ABP organized an ad hoc committee, which met at the spring research meetings of the American Pediatric Society, Society for Pediatric Research, and Ambulatory Pediatric Association (APA, later renamed the Academic Pediatric Association) on May 2, 1984. Each of the 3 organizations had 2 representatives: Donal Dunphy and Melvin Jenkins from the ABP; Edmund Burke and Robert Haggerty for the AAP; and Thomas Oliver and Joseph St. Geme, Jr., for AMSPDC. In addition, there were 2 representatives of nonuniversity programs: Evan Charney and Henry Shinefield. Harold Meyer, Associate Executive Secretary of the ABP, served as secretary.

Support for forming an association of pediatric program directors was unanimous. The group established a steering committee of 6 members, 3 from university programs (Oliver, Jenkins, St. Geme) and 3 from nonuniversity programs (Shinefield, Charney, and Holm). Drs. Oliver and Shinefield were designated co-chairs. In December, Dr. Shinefield chaired a conference call of the steering committee, during which bylaws, a slate of officers and councilors, and dues were decided. All ACGME-approved residency programs were to be considered members, categorized as university, nonuniversity, or military; these designations were to be considered in constituting a slate of officers and councilors. Dues were set at $50 per program.

During the evening of Thursday, May 9, 1985, at the spring research meetings, program directors met and approved the proposed bylaws and slate of officers, establishing Henry Shinefield as the first president of the new Association of Pediatric Program Directors (APPD; Fig. 1). Thomas Oliver was elected vice-president (president-elect), Robert Holm secretary, and Evan Charney, Melvin Jenkins, and Gerald Merenstein councilors. Drs. Shinefield, Holm, and Charney directed nonuniversity programs; Oliver and Jenkins university programs; and Merenstein a military program. By design, the structure of the new organization represented all 248 accredited residency programs and was on its way.

1985–1990

In addition to approving the bylaws and slate of officers at the 1985 meeting, the audience heard from 3 members of the pediatrics Residency Review Committee (RRC): Donal Dunphy (chair), Edwin Kendig, and John Griffith. Changes about to go into effect on July 1, 1985, were presented; there was a request from program directors to delay the implementation of the changes in light of the formation of the new organization, but the request was denied. The program closed with a report from the RRC about the accreditation of subspecialties. Notably, only approximately 50% of the programs

Figure 1. *Presidents and executive directors of the APPD.*

(neonatology, hematology-oncology, nephrology, and endocrinology) received approval initially.

The second meeting of the APPD was also a 3-hour evening affair, from 7 to 10 PM on May 6, 1986. Dr. Shinefield reported that 236 of the 248 programs in the United States and Canada had joined the APPD. His presidential address focused on "Pediatric Manpower Issues". Thomas Oliver reported on ABP certification becoming time-limited as of 1988. Wilbur Cohen made a presentation regarding training in disabilities. The program ended with reports from the ABP (by William Cleveland) and RRC (Donal Dunphy). Dr. Dunphy reported that of the 94 programs reviewed, 59 were approved; he made specific mention that 15 of the 26 programs receiving adverse action were university programs. Common problems, he noted, were as follows: the program was too small; had too few patients; had too few patients with complications; had insufficient number of faculty; and had insufficient breadth of subspecialists—a list that did not change much during subsequent decades. On the evening following this meeting, a separate business meeting was convened for all of 35 minutes, with adjournment to permit participants to attend the APA debate about the merit of the new RRC requirements.

The third annual meeting, April 27, 1989, was notable for four features that set the stage for all future meetings: It was no longer a brief evening gathering but a full day-long event (8:30 AM to 5 PM); it included multiple presentations on topics of great interest to program directors; workshops were introduced; and the business meeting and reports from organizations were incorporated into the meeting. The topics discussed at that meeting remain as relevant today as in 1987 (Table 1).

The 1985 report on the accreditation of fellowship programs reflected the era of rapidly increasing subspecialization in pediatrics. As noted in the RRC report the following year, subspecialty faculty were being counted in the accreditation process, and in the 1989 revision, general pediatric residency programs were required to have subspecialists in at least 4 areas. The impact of this requirement was felt particularly in small, nonuniversity programs. APPD President Evan Charney prepared and sent to the RRC a 6-page summary of comments on the new requirements; the comments were unsolicited, however, and did not result in any changes. Program directors during this period had 2 additional major concerns: recruitment and reduced work hours. Between 1985 and 1989, the number of positions filled by U.S. seniors declined, whereas the number of

Table 1. Agenda for Third Annual Meeting, April 27, 1987

Meeting Component	Title of Presentation
Mini-symposium on evaluation	Role of evaluation in curriculum planning
	Evaluating the selection process
	Development of a systems approach in evaluating residents
	Evaluation of clinical skills
	Dealing with stress in a training program
Workshops	The selection process
	Health policy issues in GME*
	Evaluating clinical skills
	Effective evaluation of electives
	Interpersonal skill evaluation
	How to decide what to evaluate vis-à-vis the competence of residents
Afternoon presentations	The legal liability of program directors
	Responsibility for ABP "pink sheets" (ie, final evaluation reports)
	Alternative coverage for inpatient service needs
	Funding issues in residency training
	Overview of future educational issues facing residency training

*GME = graduate medical education.

positions offered increased; the result was a 98% increase in unfilled positions. The period of recruitment, which had largely been late summer and autumn, was suddenly changed in 1988, when Robert Petersdorf, president of the Association of American Medical Colleges (AAMC), issued a memorandum to deans to withhold their letters until November 1. Also that year, the commission headed by Bertrand Bell in New York began its deliberations resulting in the "405 rules" that limited resident shifts to no longer than 24 hours (plus a 4-hour period for handovers and education).

It was, indeed, a challenging period for residency program directors, and the importance of the new organization was clearly recognized. As noted, all but 12 of the 248 programs joined the organization. In 1988, the organization was recognized by the AAP (invited to participate in the Committee on Pediatric Education), the AAMC (with membership on the Council of Academic Societies), and as a charter member of the new Federation of Pediatric Organizations. In 1989, the ABP established a program directors committee, and the Kroc Foundation established visiting professorships to enhance residency education, with leaders of APPD serving as the grant reviewers. Perhaps the organization's greatest achievement during this initial period was survival. With the APPD presidency turning over each year and relationships with the other pediatric organizations just forming, changes in structure were needed to make the organization more effective. And they were about to occur.

1990–1994

The major change in 1990 was the extension of the presidency from 1 year to 2. Dues were increased from $50 to $60. The following year, the position of executive secretary was created. Dr. Holm had served as secretary-treasurer from the inception of the organization. The original bylaws limited his term to 3 years, but a bylaws change had been enacted in 1988 to permit him a second term. The leadership in 1991 recognized that the institutional memory of the organization was vested in Dr. Holm and created the executive secretary position for him, opening the secretary-treasurer position for election by the membership. Also in 1991, a liaison from the recently formed AAP Resident Section (established in 1989) was invited to the APPD directors meeting; with approval of the membership, the bylaws were changed in 1992 to create a 2-year leadership position for a resident.

Also in 1990, the annual meetings were expanded: APPD sponsored the first of several Executive Management Training Seminars the day before the annual meeting, and the meeting of the APA Residency Program Directors Special Interest Group, which was established in 1989, was scheduled for the day following the annual meeting. The APA Special Interest Group provided an open forum for program directors and others interested in education, regardless of whether they were members of the APA (or the APPD, for that matter). In 1991, a dinner meeting was held for new program directors the evening before the annual meeting. The meeting became an annual event to welcome new directors, introduce them to the leaders of relevant organizations, and provide some wit and wisdom from three experienced program directors. In 1992, the first forum for directors of small programs was conducted, and in 1993 a separate session was held for directors of combined internal medicine-pediatrics programs.

The number of unfilled residency positions continued to fuel concern about the integrity of the National Resident Matching Program (NRMP), with additional suspicion fostered by the lack of a reliable source of information regarding the number of pediatric residents. An APPD survey was able to resolve the discrepancies among the various databases (ABP, AAP, NRMP, American Medical Association) and noted that 30% of programs did not list all of their available positions on the match. The confusion was put to rest for good in 1992 when the ABP established its tracking system.

The APPD attempted to create an Ethics in Recruitment statement during the next few years, but the process was halted when the Federal Trade Commission ruled that a similar project in family medicine was considered restraint of trade. Although the Ethics in Recruitment statement did not reach fruition, 2 "products" of the era did: A Program Directors Handbook and a mission statement. The Handbook was designed in a loose-leaf format so that updates could be included easily.

In 1993, the RRC embarked on another revision of its requirements. Evan Charney, the former APPD president who had sent comments about the previous set of requirements on behalf of the APPD, was now chair of the RRC. Once a draft of the revision was completed, he opened the review process to the various pediatrics organizations, including the APPD. Program directors submitted more than 200 pages of comments, which were distilled down

to 8 pages. Many of the changes suggested by the APPD were accepted.

During this period, some thorny issues remained, such as the relationship with AMSPDC. A survey conducted in 1989 identified that 39% of the individuals identified as program director were also chair. In some programs, individuals held both positions, but, in many others, the program director went unrecognized outside the institution. There was clearly enough work for both a chair and a residency program director, and the APPD needed to take additional steps to develop the roles and careers of program directors—and to advance graduate medical education.

1994–2000

The first non-chair residency program director took office as president of the APPD in 1994. As a prelude to the initial meeting of the new officers and councilors, he issued the following challenge to the other officers and councilors: "Think infrastructure." For its first decade, the APPD had literally been a "mom-and-pop" operation, with Carol and Robert Holm keeping the books, arranging the meetings, issuing all of the association correspondence, and securing outside funding to support APPD activities. A discussion with the president of the Association of Program Directors in Internal Medicine confirmed the benefit of a full-time professional executive director, and APPD issued a Request for Proposal for such executive support. Degnon Associates was selected in 1996. In 1996, long-range planning began, with emphasis on initiatives to develop program director careers, recruit subspecialty program directors, and create a Program Directors Consultation Program.

Workshops for the annual meeting had been invited, but in 1995 were, for the first time, competitive. In 1996, a leader of the NRMP was invited to explain the match at the APPD annual meeting. Many program directors, who thought the algorithm was based on student preference, were surprised to learn that the algorithm was, and always had been, based on hospitals' lists first. During the next year, the APPD pressed to change the algorithm, and the NRMP agreed. Recognizing the limitations of a relatively brief dinner meeting to address the needs of new program directors, a fall meeting primarily for new program directors was initiated in 1997. A coordinators section was created that year, and chief residents were included in activities of the association in 1998. By 1999, the APPD was ready for its first competitive election and also assumed responsibility for the APA Special Interest Group, incorporating it as the "grassroots forum," an integral part of the annual meeting. Communication with program directors was facilitated by a newsletter, starting in 1995, a listserve (1998), and a website (1999). Attempts were made to promote regional meetings—an idea that had been introduced a decade earlier.

Activities external to the organization were impacting pediatric graduate medical education (GME). In 1995, the APA released its Educational Guidelines for Residency in General Pediatrics which helped program directors formulate goals and objectives. In 1997, the Health Care Financing Administration issued Interrogatory Letter 372 (IL-372), which required faculty members to provide services beyond supervision of residents in order to bill Medicare. This had a profound effect on the involvement of faculty in clinical day-to-day activities, ripples of which continue to be felt today. By the end of the decade, the pediatrics community had come together to consider the Future of Pediatric Education (FOPE II). Then, another curve ball: The Accreditation Council for Graduate Medical Education (ACGME) initiated a paradigm shift, the Outcome Project. The intent was for a movement away from time served (the "tea-steeping" approach) to assessment of competency. It is fair to summarize the general response as confusion and resistance, although not by everyone.

2000–PRESENT

The president of the APPD in 2000 embraced "The Competencies" and both urged others to do so and assisted them by converting the traditional language of goals and objectives to the language of competencies, first in the revision of the APA Education Guidelines, then for the RRC. In 2001, at a strategic planning retreat, a new mission statement was developed that focused on 3 core areas: improving pediatric GME, enhancing career development in pediatric GME community, and promoting leadership and collaboration with related organizations. True to the mission statement, the APPD's role in GME was enhanced greatly, augmented through collaboration, but without sacrificing the momentum in developing organizational infrastructure. In 2001, the APPD established Task Forces that aligned with those of sister organization, the Council on Medical Student Education in Pediatrics (COMSEP). In 2004, the association celebrated its maturity by creating awards: the Robert S. Holm Leadership Award, and the Walter W. Tunnessen, Jr. Award for the Advancement of Resident Education. In 2005, the Carol Berkowitz Award for Lifetime of Advocacy and Leadership in Pediatric Medical Education was established to honor a program coordinator. Directors of subspecialty fellowship programs were included in the APPD in 2005, and associate program directors in 2007. Meeting formats were again adapted to meet specific needs of these newer constituents. Additional strategic planning retreats were conducted in 2006 and 2010, and annual reports were provided to the membership starting in 2005.

Initiatives during the past decade include: the consultation program desired at the 1996 planning committee, brought to fruition in 2001; a Special Projects program (2005); mentoring program (2005); the share warehouse (2006); a Longitudinal Educational Assessment Research Network (APPD LEARN, first conceived in 2006 at a strategic planning meeting and implemented in conjunction with the Initiative for Innovation in Pediatric Education in 2010); and APPD pages in Academic Pediatrics (2009). An initiative that deserves special mention relates to procedure logs, which the ACGME planned to

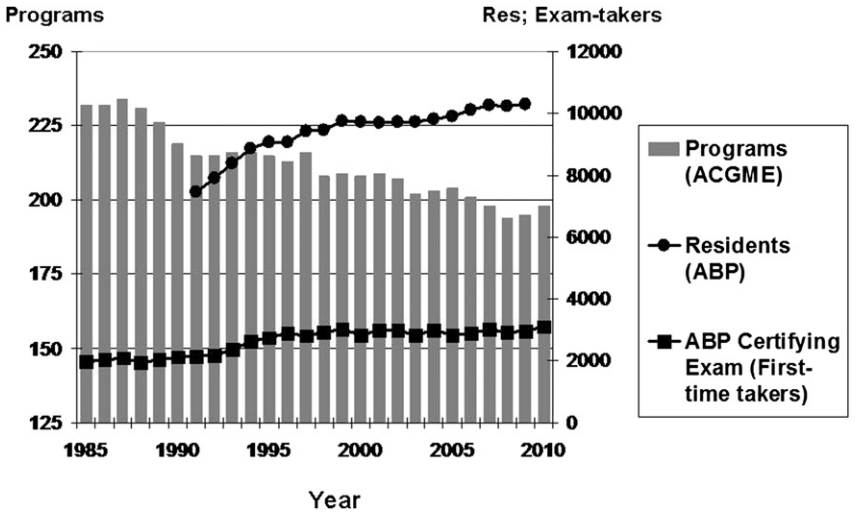

Figure 2. *Number of ACGME-accredited residency programs, residents, and first-time takers of the ABP Certifying Examination, 1985 to present.*

implement in pediatrics in 2006. In response to APPD requests, the implementation date was delayed, and, after ongoing discussion, the restrictive process designed by the ACGME was changed, in accordance with recommendations by the APPD.

Also during the past decade, the APPD collaborated first with the ABP and then partnered with AMSPDC to support the creation of the Council of Pediatric Subspecialties (2006). Collaboration with the ABP also resulted in the production of a Guide to Teaching and Assessing Professionalism (2008) and an Assessment Primer (2011). Collaboration with COMSEP resulted in a subinternship curriculum (2009) and a combined meeting in 2009. APPD has co-sponsored a number of meetings: with COMSEP (2009); with APA, COMSEP, and CoPS (the Pediatric Educational Excellence Across the Continuum meetings in 2009 and 2011); with APA (a leadership conference, 2010); and sessions at the meetings of the Pediatric Academic Societies (forum for fellowship directors, 2010 and 2011, and a session for fellows, 2011). Although the request to be a nominating society for the RRC has been denied repeatedly since initially proposed in the 1980s, the perspective of program directors is currently well represented; in fact, most of the recent RRC chairs and the chair-elect have been program directors. Since 2006, the APPD has been a nominating society for the ABP. Program directors have become Designated Institutional Officials and leaders in medical education.

CONCLUSIONS

Since 1985, the number of pediatrics residents has increased whereas the number of ACGME-accredited residency programs has decreased (Fig. 2). Directing a residency program is more complex than when the association was formed, with greatly increased RRC requirements (from two paragraphs in the initial iteration to 46 pages plus an 8 page companion document). Expanding membership beyond the initial one member per program to the current average of 14 individuals per program (2744 individuals) has expanded the APPD's sphere of influence, impact on programs, and development of individuals. The APPD has grown from its mom-and-pop beginnings into a mature organization with executive support and success in addressing its mission as articulated in 2010: "The Association of Pediatric Program Directors serves pediatric programs and their leadership by advancing the art and science of pediatric education for the purpose of ensuring the health and well-being of children." The APPD's vision is "Exemplary pediatric education across the continuum," valuing innovation, collaboration, communication, and scholarship. In its 25 years, the APPD has served the discipline of pediatrics well but has also advanced the field of medical education. And, with the projects initiated in the past decade, the best is yet to come.

ACKNOWLEDGMENTS

Sources for this article include: files and materials preserved by Robert Holm and the authors (K.B.R., L.E.D.); a previous history by Robert Nolan, MD; and interviews with Robert Brownlee, MD, and past presidents Drs. Henry Shinefield, Edward Reiter, Evan Charney, Richard Lampe, James Stockman, Michael Kappy, and Robert Nolan. The following individuals provided or confirmed facts: Julie Raymond (AAP), Robert Perelman, MD (AAP), Henry Sondheimer, MD (AAMC), Caroline Fischer (ACGME), Jean Bartholomew (ABP), Kathy Haynes Johnson (APPD), Carol Berkowitz, MD, and Julia McMillan, MD.

data sets. Further study is necessary to determine what elements of a community pediatrics curriculum would improve objectively measured community knowledge and whether or not its effect would be stronger in a community-based clinic.

Finally, the size of a clinic's community may affect community knowledge. The hospital-based and PCT clinics served much larger areas than community-based clinics including multiple neighborhoods. This could affect knowledge in several ways. Intimate knowledge of each neighborhood and its schools, resources, and barriers to health could be more difficult to acquire when working in larger clinics. This could be an alternate explanation for our results. It could also describe why community-based practices could be promising. The ability to intimately understand a single community may help residents see first-hand the relationship between community factors and health. However, this was not within the scope of this study.

This study has several limitations. Subjects were all from one institution in one city. This limits generalizability of the study. We also had a small subject pool with a fair response rate from the residents. Therefore, the study may lack power to describe all possible differences between the groups. The study could also be affected by response bias. The survey was entirely anonymous to try to limit this. A future multicenter study would improve power and generalizability.

One subject in this study was developing a community curriculum with 2 clinic attendings. This is a potential source of bias; however, this subject did not score higher than the community resident average; therefore, we did not consider participating in curriculum development to be a factor in the results.

The survey was a test of what the authors thought residents should know about these communities on the basis of the recommendations of our professional organizations. Although it was evaluated by local experts for content validity and clarity, the survey was not a validated tool. It is possible the questions were too difficult or did not represent all views of adequate community knowledge. We have included the questions and their results to provide our readers with context.

CONCLUSIONS

This study lends some support to the AAP recommendations for community-based experiences for pediatric residents. However, at our institution, working solely in the community did not equate to better scores across all content areas. Community-based clinical training demonstrates potential for improving resident knowledge of the community. More study is needed to determine how best to optimize the experience. Without a universal community pediatrics curriculum, most residents got their knowledge of the community from sources within the clinic. Formal community-based curricula which consistently address all 7 content areas and encourage outside sources of learning may be a promising area for exploration. Lastly, more study is needed to determine whether improved knowledge of the community translates into improved skill at working with patients within the community to improve health.

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ERRATUM

IN THE ARTICLE by Roberts KB et al ("The Association of Pediatric Program Directors: The First 25 Years" Vol. 12 No. 3, May/June 2012), there are two errors that require correction. On page 167, The name "Wilbur Cohen" should in fact be "Herbert Cohen."

Also, in Figure 1, Evan Charney is listed as president of the APPD from 1987 to 1988 and Edward Reiter as president from 1988 to 1989. In fact, Dr. Reiter was president from 1987 to 1988 and Dr. Charney was president from 1988 to 1989.