HANDBOOK FOR PEDIATRIC RESIDENCY PROGRAM DIRECTORS

TABLE OF CONTENTS

INTRODUCTION

This handbook was developed with two goals in mind. For the seasoned program director it is intended to provide a readily available, single source of the information that will be most frequently helpful. For the new program director it will serve as a reminder of the details of their responsibilities.

The responsibilities of the program director are not the same in each training program. Some program directors are responsible for intern recruitment, and some are not. Some have an active group of faculty who participate in one-on-one evaluation of residents, while other program directors are the exclusive providers of these periodic evaluations. In addition, policies and procedures vary greatly among residency programs. The loose leaf notebook format of the handbook is an attempt to invite you to add information in a form that is most useful to you. There are "prompting pages" inserted to suggest material that is unique to your program that you might like to insert. These "prompts" include lists of committee membership, resident schedules, maternity and sick leave policies, and other information that only the local program director can provide.

We have also attempted to include information that is more consistently applicable to all program directors. Some of this information, such as the schedule for the National Residency Matching Program, changes yearly. It will be up to the individual program director to update the handbook as needed.

It is impossible to include in this handbook all the pointers and advice that experienced program directors would like to bequeath to those who are new to the position. It is equally impossible to include all the suggestions and ideas that result from successful initiatives in individual programs. We will have to continue to rely upon discussions among ourselves and the interaction provided at the yearly meeting of the Association of Pediatric Program Directors to put flesh on the bones of the information provided in the handbook. We are hopeful, however, that you will find a place for the handbook near your desk, and that you will reach for it often.

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September 14, 1997

A YEAR IN THE LIFE OF A RESIDENCY PROGRAM DIRECTOR

JULY

Applications for the next intern selection have begun arriving. Take this time to review the application and interviewing process.

Sign and return your Program Director's Copy (Exhibit E) of the Institutional Agreement with the National Resident Matching Program. In order to do this you will have to estimate the number of positions you plan to offer through the NRMP for the coming year.

AUGUST
Begin mailing brochures and applications to interested medical students.

SEPTEMBER
Meet with your medical school's fourth year medical students to discuss the process of applying for pediatric residency programs. This is also a good time to put in a plug for your own program. Some program directors choose to have this meeting in May, while the students are still in their third year.

OCTOBER
Meet with faculty interviewers to discuss their responsibilities during the recruitment process.

Meet with resident interviewers and/or tour guides to discuss their responsibilities in the recruitment process.

Complete plans for intern selection: this might mean making sure meeting rooms are reserved, meals or snacks are ordered, developing a filing system, and any other details that must be taken care of before the interviews begin.

Send contract letters to PL1's and PL2's. At this point you should have a pretty good idea which of your current residents will be promoted to the next year of training, who may be planning to leave, and how many interns you plan to recruit for the next year.

You or your chief resident(s) should plan the holiday schedule for December.

NOVEMBER
Interview intern applicants.

DECEMBER
Interview intern applicants.

JANUARY
Interview intern applicants.

Follow up with any current PL1's or PL2's who have not returned their contracts. The final opportunity to adjust your Match quota will be in February, and your PL1 quota for next year may depend upon the number of PL2's and PL3's you will have.

FEBRUARY
Develop rank order list to submit to the National Residency Matching Program.

Send thank you letters to resident interviewers/tour guides and to faculty interviewers.

MARCH
Match Day

Send welcoming letter or mail gram to new interns.

Send contracts and necessary schedule request information to new interns.

APRIL
Determine the schedules for the next year.

Review and revise the residency program brochure.

Establish elective and vacation choices for residents and new interns.

Determine the housestaff budget for the coming year.

Begin planning for intern orientation.

If you plan to meet with the current third year medical students to explain the application process during May, this meeting should be planned during April.

MAY
Plan orientation for new PL1's.

Credential new PL1's for hospital privileges.

JUNE
Last Grand Rounds of the year. This is a good time for public statements from departing residents.

Good-bye celebration (graduation) for PL3's.

PL1 orientation (including welcoming parties, picnic, or whatever is your custom).

ACCREDITATION

IN THE CONTEXT OF GRADUATE MEDICAL EDUCATION, ACCREDITATION IS THE PROCESS FOR DETERMINING WHETHER A TRAINING PROGRAM CONFORMS TO ESTABLISHED EDUCATION STANDARDS. ACCREDITATION REPRESENTS A PROFESSIONAL JUDGEMENT ABOUT THE QUALITY OF AN EDUCATIONAL PROGRAM. DECISIONS ABOUT ACCREDITATION ARE MADE BY THE SPECIALTY-SPECIFIC RESIDENCY REVIEW COMMITTEES OR THE TRANSITIONAL YEAR REVIEW COMMITTEE UNDER THE GENERAL AUTHORITY OF THE ACCREDITATION COUNCIL FOR GRADUATE MEDICAL EDUCATION.

CERTIFICATION

CERTIFICATION IS THE PROCESS FOR DETERMINING WHETHER AN INDIVIDUAL PHYSICIAN HAS MET ESTABLISHED REQUIREMENTS WITHIN A PARTICULAR SPECIALTY. THIS PROCESS IS CONDUCTED BY THE RESPECTIVE SPECIALTY BOARD THAT IS A MEMBER OF THE AMERICAN BOARD OF MEDICAL SPECIALTIES. IN THE CASE OF PEDIATRICS, THE AMERICAN BOARD OF PEDIATRICS IS THE CERTIFYING BOARD.

The information in this section was provided by the American Board of Pediatrics. Sample forms are included to be used by the Program Director to fulfill his/her responsibility for resident evaluation and tracking. You should already have a notebook distributed by the Board containing these forms, and they will be updated as needed.

American Board of Pediatrics Home Page: http://www.abp.org

THE RESIDENCY REVIEW COMMITTEE (RRC) SPECIAL REQUIREMENTS HOW TO ATTACK AND TAME THE RRC DOCUMENT

The "Residency Review Committee (RRC) Special Requirements for Residency Training in Pediatrics" is the document that lays out the basic necessities that a program must provide a resident in training. The RRC's for each of the recognized

specialties in American medicine operate under the aegis of the Accreditation Council for Graduate Medical Education (ACGME), and they are each responsible for accrediting their specialty's residency programs. The Pediatric RRC is composed of ten members: three appointed by the American Board of Pediatrics, three by the American Academy of Pediatrics, three by the American Medical Association (AMA), and one pediatric resident in training. The "Special Requirements for Residency Training in Pediatrics" are published in the Directory of Graduate Medical Education Programs published by the AMA.

There are 215 pediatric residency training programs in the United States. The ACGME delegates the responsibility for evaluating these programs to the RRC for Pediatrics. Depending on how well or how poorly the last evaluation went, the RRC will re-evaluate each program every one to five years.

The Special Requirements set standards for residency training and, in some cases, advocate for the rights of residents. They are sometimes regarded as oppressive and unrealistic by program directors and department chairs, but the specifics of the Requirements provide a basis for negotiation with your hospital administration when they are reluctant to make changes that are in the best interests of the residents and their education.

While the document is well written, there are times when it will need clarification. For example, one section reads: "a first year resident should be responsible for approximately 6-10 patients. . . . Second and third year residents may be involved in the care of substantially more patients than a first year resident." What is not made clear is that it is acceptable to count the same patients twice - a third year resident who is supervising two first year residents, each of whom is carrying ten patients, is considered to be involved in the care of twenty patients. If you're having trouble with a certain passage, call a fellow program director and ask him or her for an opinion or interpretation. Be aware, though, that occasionally other program directors may bend the interpretation of a passage in order to convince themselves that something borderline in their program is in compliance with the Special Requirements.

If you feel you would like a formal explanation of the Special Requirements, the ACGME has at least one major meeting each year to review to review them. In addition there are sessions devoted to the interpretation of the RRC Special Requirements at the annual meeting of the Association of Pediatric Program Directors held each spring. Finally, don't be reluctant to call the RRC itself.

How do you begin to prepare for the periodic site visit from the RRC? While it is possible to prepare the necessary document with just several months of lead time (especially if you've done it before and your program was in complete compliance at the last visit) I would urge you to begin early - very early. If you wait until the letter from the RRC arrives informing you of the date of your site visit and enclosing the Program Information Forms, you're going to find yourself in a time crunch. Feel free to call the RRC when you start your job, and at any intervals you wish, to get an approximate date. Ask them to send you several copies of the newest Program Information Forms. I feel fortunate that I began dealing with this document some two years before it was due. I found my program to be in disarray in certain areas. We needed faculty members we did not have. We needed curricula for every aspect of our training program. We had residents working excessive months in some areas and insufficient months in others. There were some areas of the program that might have been interpreted as being in compliance, but I, frankly, did not want to live with the anxiety of something being subject to interpretation. Having a positive attitude about the Special Requirements and, thus, being unambivalent in my desire to comply with them, made my job easier. I felt I was fighting a righteous battle and not performing pure drudgery.

I began by reviewing the Special Requirements from the very beginning. I realized that if I were ever going to bring my program into complete compliance with this complicated document I needed a way to break these requirements up into their component parts. I went through the document circling in red each item that I felt was a standard or point by which our residency program could be

judged. This turned out, piece by piece, to be most of the document. Sometimes I found myself dividing a sentence into two or more concepts. For instance, in the sentence "General ambulatory pediatric care of high quality is essential for adequate training and requires the physical presence of qualified supervisors in settings where the patient load is maintained at a level appropriate for adequate learning," there were two concepts for which I felt that my program would be held accountable. One was that my program's ambulatory care component must have the physical presence of qualified supervisors and the other is that the patient load be maintained at a level appropriate for adequate learning.

Since you know your program intimately, you will see and know things about it that no one else does, and you will therefore see the RRC Guidelines differently than another program director might. In your program, for instance, having an adequate number of attendings in your ambulatory setting might be laughable. You may have eight of them there on a full time basis. On the other hand, all eight of them may be incompetent, not board certified, dangerous nincompoops. Teachers in training programs need to be board certified or have suitable equivalent qualifications. Therefore, the two concepts you might see in the same statement are that your ambulatory care component must have the physical presence of qualified supervisors and that the patient load is maintained at a level appropriate for adequate learning. I drew my circles around the two components of the sentence that were relevant to my program. Sometimes I found myself including entire paragraphs in one circle (see Illustration 1). Using the numbers and letters already in place on the Guidelines, I added additional numbers, one for each of the circled areas.

Across the top of a page of paper I wrote four column headings. Going from left to right they were "Requirement," "Current State of Implementation/Monitoring," "Degree of Non-compliance," and "Plan for Amelioration." I then had my secretary enter each circled item, together with its appropriate numerical designation, down the column labelled "Requirement" (see Illustration 2). I was stunned to find that this required approximately 40 pages of paper.

Responding to each "Requirement" meant I had to acquaint myself with the definitions of certain words used in the RRC Special Requirements. The critical words were "must," "shall," "should," "essential," and "desirable." These words appear throughout the document. You may find the RRC's specific definition of these terms in the Directory of Graduate Medical Education Programs. My own simplified definitions are that the first four words mean "it's required" and the last word, "desirable," means "it would be nice if you had it but you won't be out of compliance if you don't."

It is important to be totally and brutally honest about the state of compliance of your program. You probably like your program. You are biased. Someone looking at your program with a checklist of yes's and no's doesn't like or dislike your program. For him or her this is an objective exercise. No one need ever see your confidential worksheets, so make them as complete as possible.

Once the individual items have been enumerated and you have honestly evaluated your program for its degree of compliance, meet with one or two other faculty members who are particularly knowledgeable about the program and close to the residents. You might consider including the Chief Resident(s) and the Academic Coordinator (if you have one) in these meetings as well. Add their additional good ideas to your original draft worksheet.

When your worksheet is completed (no small task), summarize all of the things you'll need to bring your program into compliance. You may find that many of your problems are resolved by adding an extra resident or two at each year level. Be careful, though. Don't add so many resident to cover night call that you dilute the ratio of six to ten patients to one resident on your ward rotation(s). Selecting the number of residents in your program based on every 4th night call is the old standard way of doing things, but given newer limitations spelled out in the Special Requirements, you may find that by using this formula you have too many residents for the number of patients they see.

The neonatal intensive care unit (NICU) is a place where the service requirement for resident coverage often conflicts with the RRC Special Requirements. The RRC has stipulated that residents shouldn't spend more than 6 months of their three years of training in the NICU and that night call taken in the NICU while the resident is rotating on another service counts as one half month of NICU time. Thus, if you bring enough residents into the program to cover all NICU night call and remain within the maximum number of NICU months per resident, you may swamp the patient-to-resident ratio throughout the program. There are other individuals who can provide NICU night coverage, including moonlighters, nurse practitioners, residents from other services, such as family practice and emergency medicine. It is not your problem, though, to solve the NICU's night call shortfall. That is the responsibility of the Chair, the head of neonatology, and the hospital administrator. It only becomes your problem if the Chair asks you to fudge the numbers or cut corners and you go along. Remember, the buck for RRC compliance stops with you. If you would be out of compliance by providing more NICU coverage, don't do it.

After your chosen fellow faculty members have reviewed your hard work and you have made appropriate modifications, it is time to run it by the Chair. Expect that the Chair will have some good solutions to suggest as well. I spent a total of eight hours going over the material with my department Chairman. When your review is done, summarize your plan and run it by your Residency Committee as a whole. Ask that your recommendations be approved and that the actions suggested be instituted. Have the committee address a memo stating these recommendations to your department Chair. He or she will then deal with the hospital administration as needed, with your plan as the basis for any negotiations.

It is important that you keep a file of all the work you have done to justify needed changes. Written information may include memos, written justifications, and collections of data. You may need to refer to some of these in the future, either as you try to justify your requests to the hospital administration or in response to the RRC's Program Information Forms or site visit.

Finally, you will need to fill out the Program Information Forms. I've got one tip for you here. Don't describe everything about your program. **Answer the questions that you are asked!** You will know the Special Requirements well enough by the time you fill out these forms to know what the RRC is looking for. Give them what they want, but remember that less is more.

It is possible that other faculty members can help complete the Program Information Forms, but be sure to scrutinize their responses. One person should edit the whole document so that it is even and not repetitious. The Forms must be completed and sent to the Site Evaluator about ten days before the visit. Additional copies should be available to him or her on arrival.

I suspect that very few of the programs the RRC evaluates are perfect. The Guidelines have been developed with the best interests of the residents-in-training and the American public at heart. The RRC wants to be taken seriously.

Some of the same deficiencies show up over and over again (see Table 1). Our program was lacking an Ambulatory attending for half the week. We assigned other attending to those clinics to provide interim supervision until we could find the right person. When the RRC's site surveyor arrived he wanted to talk to the hospital's administrator to be sure that a position for an Ambulatory attending had been approved. (It had been.) If he had asked me to show him advertisements in journals I could have.

In short there are very few wasted words in the RRC Special Requirements. Break them down, requirement by requirement. Be brutally honest with your internal and confidential evaluation of your state of compliance. Work to resolve your deficiencies. Maintain copies of everything you do in the process of resolving your shortcomings. Even if things are not perfect when the RRC site surveyor arrives, your ability to document your efforts will stand the program in good stead.

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INTERN SELECTION AND THE MATCH

Insert the following:

1. The interview day schedule for your intern applicants
2. Sample letters to applicants, including
    a. Letter accompanying the application, brochure, and other information you normally send on first contact
    b. Letter inviting or scheduling the applicant for an interview
    c. Letter of regret for applicants you choose not to interview
    d. Other letter(s) appropriate for your program
3. Copy of your application form
4. Electronic Match
5. National Residency Matching Program Schedule of Dates (mailed to you each summer by the NRMP)
6. Program Director's Copy of the yearly Institutional Agreement between your institution (hospital) and the NRMP
7. List of the members of your Intern Selection Committee, if appropriate
8. Other information useful to you and used on a yearly basis regarding intern recruitment and the NRMP

ACCREDITATION

Insert the following:

1. Your most recent letter of accreditation from the Accreditation Council for Graduate Medical Education
2. A copy of your most recent accreditation survey submitted to the Accreditation Council for Graduate Medical Education
3. Add "Internal Review Document"
4. Add "Correspondence with ACGME"
5. RRC Special Requirements
6. RRC Institutional Requirements
7. Add "RRC Special Requirements for subspecialty programs in your department"

PROBLEM AREAS NOTED IN 45 PEDIATRIC PROGRAMS EVALUATED AGAINST EXISTING RRC REQUIREMENTS, 1990-1991

Problem Areas	# Citations
Patient population (adequate # and mix)	15
Too much intensive care nursery	10
Faculty scholarly activity	9
Continuity clinic	9
Board scores	9
Subspecialty experiences	8
ER/acute care clinic (< 1 month)	6
Evaluations (residents/attending/program)	6
Call/day off each week	6
Adolescent medicine	5

Pediatric surgery	5
Normal newborn	4
Conferences, education	4
Service orientation	4
Child development, handicapped children	2
Library/labs	2

THE AMERICAN ACADEMY OF PEDIATRICS

The American Academy of Pediatrics was initially organized by pediatricians to create "a united front to influence pediatrics in its various phases: sociologic, hygienic, educational, investigative, and clinical."* The Academy was founded in 1930, and it continues to work on the national and regional level to support pediatricians, pediatric education, and the social and political causes judged by pediatricians to be in the best interests of children.

Included in this section are materials that describe the Academy's programs in support of pediatric residents. Those programs include the following:

Resident membership
The Resident Section of the Academy
Pediatric Review Education Program (PREP) for Residents
Pediatric Review Education Program (PREP) materials for the Program Directors
Resident Scholarships
Resident Research Grants

* Hughes, JG: American Academy of Pediatrics: The First 50 Years, American Academy of Pediatrics, Elk Grove Village, Illinois, 1980, p. 2.

ASSOCIATION OF PEDIATRIC PROGRAM DIRECTORS

Insert the following:

1. Annual dues information
2. List of Program Directors
3. Add "APPD Newsletters"

MISSION STATEMENT

In order to ensure the optimal health and well being of children, the Association of Pediatric Program Directors strives for excellence in pediatric graduate training programs by:

1) Providing a voice and venue for defining, promoting, and improving pediatric graduate medical education

2) Enhancing the career development, professional satisfaction, and scholarship of individuals in the pediatric graduate medical education community

3) Promoting leadership and collaboration with related organizations.

RESIDENT EVALUATION

Insert the following:

1. Your Departmental evaluation forms and policies, including

- A description of your evaluation system for residents, faculty, and the program
- Forms for documenting feedback to residents
- Forms for documenting feedback to faculty
- A description of the advisor system
- A description of your system for filing evaluation information

2. Any institutional policies on resident and faculty evaluation

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GUIDELINES FOR DEALING WITH MARGINAL OR DYSFUNCTIONAL RESIDENTS

The marginal or dysfunctional resident must be identified early in the training program. There must be adequate documentation of deficiencies which must come to the program director's attention in a timely manner. At that point the resident must be appraised of deficiencies. I make it a practice to identify strengths and weaknesses and generally give only one or two particular areas to work on for improvement. Those areas of difficulty must then be monitored over the next several months and, continued evaluations need to be done. If areas of difficulty continue, the program director needs to meet with the resident and give additional feedback and the opportunity to improve performance. At this point it is wise to assign one faculty member to work with the resident on specific areas of difficulty. In general, remediation at the resident level is difficult to accomplish.

If similar deficiencies exist for a third time, I usually give them verbal and written notice of what the deficiencies are and stipulate the need for improvement. I also tell them verbally and in writing what the consequences will be if there is no improvement. If no improvement is seen, there is a danger that the resident's training will be altered, either by extending training up to one year, giving them a marginal evaluation or unsatisfactory evaluation, or termination or non-renewal of contract. There must be written documentation of all these meetings. If at any time you consider the possibility of termination, then the chairperson must be appraised of the situation and there must be a written letter to the resident, either delivered by hand or by certified mail, listing the deficiencies, the time frame to improve, and the consequences if improvement does not occur. If there is still no improvement, a decision must be made for non-renewal of contract or for termination.

Each institution must have a written policy for both termination and non-renewal of contracts with an appeals mechanism built in. In general, non-renewal of contract is much easier than termination. Non-renewal of contract doesn't necessarily require an appeal mechanism. However, if you terminate someone during the year, there must be an appeal, and it should be handled internally. One system is to have non-pediatric program directors who are not directly involved review all the information to see if the program director had sufficient reason for terminating a resident's contract. At that point legal representatives could be involved, but they are not necessary until this review is complete.

By far the most important aspect of dealing with the marginal resident is documentation of identified weaknesses and areas to improve. Documentation must be in writing, and the resident must have been notified about it, both verbally and, when considering termination or non-renewal, in writing as well. These actions should be taken only as a last resort. Many residents take time to adapt to the residency and then will improve. Whenever there is a dysfunctional resident, one must always explore the possibility that there are other stressors in the resident's life that account for the less than ideal behavior. Often there is, and the resident may need mental health services or leave of absence to deal with the issues. After intervention, their performance should be closely monitored.

The most common reason that residents do not fulfill expectations is that those expectations have not been specified. It is important to set the expectations clearly, and if there is a problem to reset the expectations first. As always, feedback is best when it's given in a timely manner on an observable behavior that can be changed. Initially feedback should be informal and informative; later it can be formal and summative.

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May 25, 1993

THE RESIDENCY COMMITTEE

Insert the following:

1. The responsibilities of your department's Residency Committee
2. A list of Committee members with their office, telephone, and FAX numbers
3. Residency Committee meeting schedule

DEPARTMENTAL POLICIES

SUGGESTED POLICIES TO INSERT HERE INCLUDE THE FOLLOWING:

--Maternity leave
--Paternity leave
--Sick leave
--Policy regarding out of town electives
--Moonlighting

PEDIATRIC RESIDENCY PROGRAM DIRECTOR--RESPONSIBILITIES

What follows is one version of the job description of the pediatric residency program director. Yours may be very different. If and when you turn your responsibilities over to someone else, such a list of responsibilities might be helpful.

A. **Training**
   1. Plan yearly schedule for each resident to meet board eligibility requirements and to consider individual skills and background
   2. Monitor the three-year program for each resident to ensure adequate training in all required areas at all required levels of responsibility
   3. Counsel residents in selecting elective experiences and approve elective requests
   4. Develop, or supervise the development of, a yearly formal conference series to follow a planned curriculum
      a. include a broad range of topics and speakers
      b. monitor attendance, presentation, audience response
      c. identify core lectures for new residents
   5. Advise the chief resident in his/her choices of conference topics, speakers, and cases for the conferences for which he/she is responsible
   6. Advise and assist residents in running a monthly journal club
   7. Coordinate pediatric training for non-pediatric residents in family medicine, obstetrics/gynecology, anesthesiology, psychiatry
   8. Arrange electives for pediatric residents from other programs
   9. Arrange and conduct orientation of all new residents
   10. Develop, review, enhance, revise the curriculum (educational experiences) for pediatric residents

B. **Evaluation**
   1. Arrange and monitor monthly evaluations of all residents by faculty and supervisory residents, including non-pediatric residents
   2. Provide individual feedback to residents as indicated, personally or through chief resident or faculty advisor
   3. Provide feedback to other program directors for non-pediatric residents

4. Chair the Resident Evaluation Committee
    a. arrange quarterly review of all residents
    b. arrange feedback to all residents
    c. arrange and implement special actions, such as extensive counseling about performance, probation, remedial activities, and assignments
5. Arrange and monitor monthly evaluations by residents of attending faculty/services and supervising residents
6. Provide feedback to faculty individually or as a group as indicated from evaluations
7. Review files with individual residents if requested
8. Review evaluation forms periodically and revise as needed
9. Participate on the Chairman's committee to recommend residents for the American Board of Pediatrics certifying examination

C. **Administration**
1. Schedules
    a. Advise and assist chief resident with monthly on-call schedules
    b. Prepare yearly faculty attending schedule
    c. Assist chief resident with yearly vacation assignments
    d. Assign residents to pediatric group practice
    e. Modify pediatric group practice schedule as needed due to other assignments
2. Personnel
    a. Sign forms for examinations, loan approvals, etc.
    b. Prepare letters of recommendation for licensure, fellowships, jobs, hospital privileges, for current and former residents
    c. Supply the hospital Graduate Medical Education office with information about residents as requested
    d. Counsel residents about career development and planning
    e. Advise residents about personal health, well being, finances, and refer as needed for specific services
    f. Assign faculty advisors for all residents
3. Committees
    a. Graduate Medical Education Committee and subcommittees--monthly
    b. Department Quality Assurance Committee--monthly
    c. Department Executive Committee--sporatic
    d. Department Evaluation Committee--quarterly
    e. Resident Selection Committee--yearly
4. Miscellaneous
    a. Serve as mentor and faculty advisor for the chief resident
    b. Supervise pediatric housestaff secretary
    c. Arrange faculty coverage for pediatric residency coordinator

D. **Recruiting**
1. Assist with interviews for new PL-1s
2. Assist with selection of PL-1s
3. Arrange for recruitment as needed for PL-2 and PL-3 positions
4. Select chief resident
5. Review and approve Division requests to recruit fellows

SCHEDULES AND INFORMATION

SUGGESTED ITEMS TO INSERT HERE INCLUDE THE FOLLOWING:

--A list of current residents
--A list of residents with their faculty advisor
--The current year's rotation schedule for residents
--The year's attending schedule
--A list of faculty members with telephone and FAX numbers
--A list of housestaff benefits (health insurance, dental insurance, leave policies, etc.)
--Last year's schedule of orientation activities
--Copy of resident contract

INTERNATIONAL MEDICAL GRADUATES

The information on the following pages was taken from the second edition of the Program Director's Manual published by the Association of Program Directors in Internal Medicine. The information is presented in such a clear and thorough fashion, that we felt it would be useful to reproduce it in its entirety. Please note that the paragraph entitled "Application to Residency Programs" applies only to residency programs in internal medicine.

We are grateful to Dema C. Daley, Executive Director of the Association of Program Directors in Internal Medicine, for allowing us to reproduce this section.

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