

The Section on **Med-Peds** Newsletter

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DEDICATED TO THE HEALTH OF ALL CHILDREN™



From the Chair in the Corner

By *Brian Kan MD, FAAP*

Combined Internal Medicine and Pediatrics (Med-Peds) has grown rapidly over the last decade to approximately 4,500 dually trained physicians. In addition, there are approximately 1,400 residents in Med-Peds training programs. Although the Med-Peds Section of the American Academy of Pediatrics (AAP) is just eight years old, it is now the sixth largest section within the AAP. About one-fourth of the membership is residents.

Our Med-Peds Section has begun restructuring its workgroups and committees. Currently, the Section has workgroups focused on mentoring and practice and a few others. The Section's executive committee recently approved creating six new committees which combines some of the activities of the executive committee and some of the activities of the workgroups. There will be at least one executive committee member on each committee and the Section's executive committee will serve as the oversight body for the committees. Figure 1 (see page 16) outlines the new organizational structure for the Section's executive committee and the Section's standing committees. The arrows from an executive committee member to a standing committee denote membership in a committee.

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Versatile Volunteers - Med-Peds Doctors in Action

Editor's Note

This edition of the AAP Section on Med-Peds Newsletter is dedicated to service. With our Med-Peds training, we are able to meet the needs for many diverse clinical tasks. Volunteering is no exception. Recent national events have reminded many of us of the important work volunteers do every day across the country and around the world. There is great need for medical care of people of all ages. In addition, our expertise in the social and psychological well-being of persons from infants to the elderly makes each of us a valuable resource to service and volunteer organizations. As you read these tales of heroism, compassion, and service to others, know that we are saluting all of you who give your time, energy and expertise so that others may have a better life.

From the Chair in the Corner *continued from page 1*

The **Advocacy and Membership Committee** is responsible for all advocacy and membership activities. Current activities include requesting a fee reduction for initial board certification, maintaining a discount for joint AAP/ACP membership and conducting membership drives.

The **Communications and Publications Committee** is responsible for the Section's written materials. These include the newsletter, the website, our email discussion forum and brochures.

The **Academics Committee** focuses on academic career issues for Med-Peds physicians and collaborations with other academic organizations including the Med-Peds Program Director's Association (MPPDA), the Society of General Internal Medicine (SGIM) and the Ambulatory Pediatrics Association (APA). This committee will also be responsible for Section related research activities. If there is interest, this committee may also address issues related to Med-Peds subspecialists.

The **Med-Peds Practice Committee** addresses issues related to the practice of Med-Peds. This includes career paths, practice administration including the financial and legal aspects of practice, group practice and partnering, and managed care. The Executive Committee feels that the activity of this committee needs to be a major focus for the Section.

The **Education and Program Planning Committee** is responsible for planning programs and events at national meetings. This includes planning educational programs, business meetings and social events. While the major focus for the committee is on national meetings, the committee will serve as a resource for regional Med-Peds meetings.

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The **Student, Resident and Young Physicians Committee** is responsible for issues related to students, residents, and young physicians. These include liaisons to similar groups including the AAP, ACP and Med-Peds resident and young physician groups, transitioning from residency to practice issues including maintaining our job search frequently asked questions document (<http://www.aap.org/sections/med-peds/MedPedsJobSearch.pdf>), networking and mentoring, and outreach efforts to medical students.

The **Nominations Committee** is mandated by our bylaws. This committee is responsible for making all nominations. The committee is made up of a Med-Peds Practitioner, a Med-Peds Program Director, and a Med-Peds resident. Each committee member may serve up to two years, and typically, at least one member is a past member of the executive committee.

We are just getting started in organizing these committees. Look for more in depth articles in our newsletters describing these committees. In the future, most of the goals of the Section will be achieved through these committees. If you're interested in getting involved in a committee, we'll be posting each committee chair's name to the Section's web site (<http://www.aap.org/sections/med-peds>); we will also be posting more information to our new Med-Peds email forum/listserver; lastly, many of these committees will be holding meetings at the ACP Annual Session and/or the AAP National Conference and Exhibition.

Over the last decade Med-Peds has grown rapidly. Ten years ago, I recall reading many articles on primary care noting that Med-Peds was omitted from those articles. A recent New England Journal of Medicine commentary on primary care included Med-Peds alongside Family Medicine, Internal Medicine and Pediatrics in defining the primary care workforce(1). Now that Med-Peds is being recognized, we will likely be defining the role of Med-Peds physicians in the nation's healthcare workforce over the next ten years. This newsletter highlights the actions of a number of big-hearted Med-Peds physicians who volunteer their time to help those most in need. Playing an active, visible and helpful role in the health care system makes all Med-Peds physicians look good. A heartfelt "Thank You" goes out to all of you who volunteer or provide charity care locally or in distant locations. Your work makes us all look good.

(1) Whitcomb ME, Cohen JJ. The future of primary care medicine. New England Journal of Medicine 2004; 351(7):710-712.

Did You Forget Something?

If you received an orange **Last Issue** sticker on your December Pediatrics and AAP News publications, your membership dues were not received prior to the November 1, 2005, deadline. In addition, your online access to the Member Center, PediaLink®, Pediatrics, and AAP News has been discontinued.

It's easy to reactivate your membership by paying your past-due balance at the [AAP Web Site](#) Once payment is received, all member benefits and privileges will be reinstated. Call the AAP Customer Service Center at 866-THE-AAP1 (843-2271) for membership status and information.

Disaster Preparedness - Med-Peds Style

By Tracy L. Conrad, DO

“Activate Code Grey.” The message came Sunday morning, August 28th, 2005 to put in place the emergency plan for inclement weather. As the Med-Peds program director at Tulane, I had already met with the chief residents and formulated the disaster teams for the 4 hospitals we rotate through. Residents that were deemed ‘non-essential’ were encouraged to evacuate, others were assigned to a hospital team. We all packed the essential: 3 days of food and water, vital records, and a suitcase of personal items. Many of us brought our children and pets to the call rooms and medical school offices where we would await the arrival of Hurricane Katrina.

By Sunday evening, it was apparent that, unlike past Code Grey drills, (near misses from previous years) this storm was going to make landfall in the New Orleans area. My mind raced with the data from years gone by. A doomsday scenario was a category 4 or 5 hurricane having a direct hit on New Orleans. It was projected to leave up to 40 feet of water in the streets for months. Could this be it?

The full force of Katrina was upon us by Monday morning. I recall the howling wind, driving rain, but most of all, the great attitude of the residents and faculty while continuing to care for the patients. The power went off, but we had generators and plenty of fuel. The hot meals were wonderful: beef stew, mixed vegetables and hot rolls Sunday night and full breakfast on Monday morning. The A/C was out, but spirits remained high. Everyone was helping anyone who needed help.

When the wind died down on Monday afternoon, I went for a walk around the hospital. I had heard about the damage in the Superdome, a mere 2 blocks from Tulane, and walked to Poydras Street to see for myself. The city was surreal. They say that the day after a hurricane is one of the nicest days you ever see. This was no exception. The sky was clear by early afternoon. There was a cool breeze and no traffic. Most of the city was still silent. We were asked not to drive out into the city yet because of downed power lines and other hazards. When I returned from my brief walk around the campus, I did notice that there was standing water in an area that was not there when I started my walk. The campus police officer informed me that I needed to stay put. “A levee just gave way.”

Over the next 4 hours, I watched as the dry streets surrounding Tulane University Hospital became an extension of Lake Ponchartrain. The water would eventually encroach into the medical school and the first floor of the hospital to a level of 4-5 feet. The residents and staff sprang into action to move the ER up to the third floor to begin operation out of the endoscopy suites. Morale remained upbeat, and the leadership was phenomenal. The medical staff met twice a day to receive updates to take to the rest of the hospital and medical school. Information was the most important asset during these trying times, and the ability to keep all the patients and visitors calm was important.

Plans for evacuating patients were constantly evolving. Small helicopter ambulances began to land on the roof of the parking garage. The NICU, infants, and critical patients were evacuated one at a time. Light standards had to be removed from the rooftop in order for larger capacity helicopters to begin to land. All day Tuesday and Wednesday, we danced the Texas Two Step with patient evacuation. While we sent patients out to the roof, we received 70 ‘special needs patients’ and their families from the Superdome, and we were bringing over the ICU patients from Charity Hospital on flat bottomed boats. The residents were essential in the long process. There really needs to be a medal for someone who carries a 700 pound person down 5 flights of stairs.

Disaster Preparedness... continued from page 4

Many of the critical patients had to be manually ventilated for hours in the parking garage while awaiting evacuation. Happily, not a single patient died in the hospital or during the evacuation.

This scene was repeated at Charity, University Hospital, and the VA Hospital. We would send a resident or staff member out with some of the transports of critical patients if there were not medical personnel already on board. Meals during this time gradually faded to potted meat and crackers, snack bars, and dry cereal. Toilets were handled by giving a person a small hazardous waste bag with 2 scoops of cat litter in it.

Finally, on Thursday, September 1, all patients and their families had been evacuated from Tulane. We began to evacuate the 1200 medical personnel and their families. I was on one of the last transports out on Friday, September 2, 2005.

The helicopter lifted off of the roof of the parking garage that day and the emotional outpouring I had surprised me. The sight of the city of New Orleans from the helicopter drove home the experience I had been through over the last 6 days, and I was relieved to be getting out finally. I was evacuated to New Orleans International Airport. From there, I was sent by tour bus to Lafayette and went through the HazMat decontamination process. Clothes taken for incineration, shower with chemicals that I am sure I don't want to know the names of, tetanus booster, scrubs and flip-flops provided, then off to the shelter.

The wedding hall that was set up to house the evacuees was booked for a wedding, but the party gladly gave up their wedding reception to allow the space be used for us. The incredible outpouring of assistance and compassion was heartwarming. Now, my duty as a program director required my full attention.

I spent the next 48 hours trying to locate the 24 residents of the Tulane Med-Peds program. They were scattered over 10 states. The month of September was spent arranging to keep the program intact. For this, I am forever in debt to Baylor, UT-Houston, and the University of Mississippi-Jackson for allowing some of my residents to rotate with them for a few months. The story of how Tulane was able to arrange for the students and all the residents and fellows to continue their training without losing any time is ingenious.

Did you know...?

Waivers are part of a well-designed financial policy for pediatric practices. A waiver is a statement that the responsible party (patient/parent/guardian) signs accepting financial responsibility for a requested medical service which may or may not be covered by health insurance. To assist pediatric practices, the AAP Department of Practice has gathered information on waivers. An article on waivers for pediatric offices is available in January's AAP News. Questions and answers on waivers can be accessed on the [AAP Member Center](#), private sector advocacy page.

Attend ACP's Annual Session 2006

The American College of Physicians will hold its **Annual Session from April 6-8, 2006** in Philadelphia, PA at the Pennsylvania Convention Center. Pre-Session courses will be held on April 4-5. Early registration closes on January 31.

There are three activities of special interest to Med-Peds physicians:

Med-Peds Careers and Practice Panel

Friday, April 7, 2:15pm-3:45pm

Med-Peds Reception

Friday, April 7, 5:30pm - 7:30pm

Philadelphia Marriott (Headquarters Hotel)

Catch 'em Before Its Too Late! Obesity: Risk Factors and Interventions in Young Adults

Saturday, April 8, 4:00pm-5:00pm

There will be more than **260 courses** in different learning formats, from “Meet the Professor” courses, with distinguished faculty giving lectures in their specialty, to panels and workshops. One favorite format is the 90-minute **Clinical Pearls** course held each day. It tests clinical acumen in highly interactive case-based sessions, using audience response keypads to answer challenging patient management questions faced in practice. Another not-to-be-missed event is a **Multiple Small Feedings of the Mind** session where physicians can hear answers to some of the most common, yet difficult, patient-management issues. Topics are selected for timeliness and relevance to practice. Faculty provide solutions linked to evidence-based medicine.

In addition to scientific sessions, there will be a variety of **networking and social opportunities** such as the Attendee Welcome Reception, the new Leadership Development Breakfast for ACP Fellows, the Young Physicians Mentoring Breakfast, the new Networking Luncheon for Women Physicians, and the new Volunteerism Networking Brunch.

ACP has also designed courses and events specifically for **Associates, Residents, and Fellows-in-Training**. Courses include The Art of Presentation, EKGs Every Resident Should Know, Medical Mistakes, and Preparing for the ABIM Exam. There will also be Associates Abstract Competition Presentations and Poster Area, an Associates Luncheon Forum, and a series of Doctor's Dilemma competitions.

Courses especially for **Medical Students** include Getting Through the Match, Step Up for Step Two, Stump the Professor, and Surviving Your Internship. Special events for Medical Student Members include the Abstract Poster Area, the Second Annual Internal Medicine Residency Fair, a Medical Student Mentoring Breakfast, and a Medical Student Abstract Luncheon. In addition, there will be an Associate-Medical Student Hospitality Area and an Associate and Medical Student Recognition Reception.

Please register for the Annual Session by calling ACP at 800-523-1546, ext. 2600, (M-F, 9:00 am – 5:00 pm ET) or register online at www.acponline.org.

Returning “Home” After a Disaster: One Doctor’s Story

By J. Thomas Cross, Jr., M.D., M.P.H.

I grew up in South Louisiana from age 3 until finishing medical school. I met my wife in the State; I’ve buried friends and relatives there. When I think “home,” it still resonates as “the one.” I haven’t lived in Baton Rouge or New Orleans in 17 years, but the area still has a special place in my heart. Unfortunately for my wife’s side of the family, we broke the tradition of 8 or 9 generations of having children born on Louisiana soil. Sixteen years after the birth of my daughter I’m still chided for having children born on “foreign” soil (you would think Arkansas would be close enough, but it actually makes it worse). Such is the culture of Louisiana.

The weekend of August 27th we watched television continuously from our home in Colorado, searching for the latest “news” and updates on Hurricane Katrina, flipping between the channels, and watching weather geeks be blown down by the winds. As the storm hit, we knew that the 1st house we lived in as a couple was likely underwater. We thought of our landlords and friends in the city. We attempted to call those we knew, but usually got no answer or “all circuits are busy.” News trickled in that all of our relatives were safe, but one brother had lost his home to the hurricane’s winds. We thought of the possessions they had lost and how we would cope if we had lost ours. It was all rather numbing. The devastation on television was overwhelming—to see towns you new and loved completely underwater or destroyed.

Being from there, I knew I wanted to do something. I applied online *ad nauseam* to every website I could find at the Federal and State level. I waited. A week went by. I continued to get polite E-mails from the Department of Health and Human Services of the U.S. Government thanking me for applying but that they didn’t need my services at this time. Another week went by. I watched television and saw the lack of coordination between private and public agencies. My angst grew worse.

Luckily I was able to find a private community organization in need of a physician. They called me the day I applied on-line and I flew down the next day. The next morning I drove down to Algiers, which is right across the Mississippi River from the downtown New Orleans area. If you’ve been to the Riverwalk or the Aquarium area and gazed across the river you’ve seen Algiers, located on the west bank of the Mississippi. The clinic was set up inside a Mosque—yes, a Mosque. A former Black Panther, now a community leader in the area, realized that there was not adequate health care for the people of his community. He had pulled together a rag-tag group of individuals and had been able to recruit nurses and a fairly well stocked pharmacy. I was the physician for the week. Most of the nurses were from Wisconsin and Michigan. We saw between 50-100 patients/day mostly for routine care, and many were in need of medications, because only a few pharmacies had reopened in the area since August 27th (it was now Sept. 21st). Most of the people we saw were over 65 and few had transportation; they had relied on the city bus system, which at this point was nonexistent. Algiers is at a relatively high elevation and protected by a very good levee system, so the flooding that occurred in other areas had not been a problem. The biggest obstacle for people living in the area was lack of supplies and goods. Few delivery trucks had made it into the area and nearly 3 weeks after the storm, grocery stores were just becoming restocked. Now 3 weeks out, many people were allowed to return to the area. While they could return to their homes, they had no jobs or way to produce income. Postal service had not occurred in 3 weeks and many banks were still not functioning to capacity. Those on fixed incomes that relied on mail to receive their Social Security checks were out of luck.

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Things went fairly well in the clinic until Hurricane Rita entered the picture. Initially it appeared that Rita would head toward Houston and westward but then it made a dangerous turn back towards the Louisiana coast. Once again those in the New Orleans area were told to evacuate and so we left the clinic and headed north. Most of the nursing staff was due to fly back home out of Baton Rouge so we returned there and I contacted the State to see where they could use a physician. Over the next few days, I would essentially call in and find out where I was needed. Most were routine clinics set up to serve those without access to care or those who were “first responders” (from other localities brought in to help and without local medical care). Eventually I landed at the River Center Complex in Baton Rouge, which is a convention hall on one side and a hockey arena on the other. The complex had become home to nearly 6,000 displaced persons (the word “evacuees” you quickly learned was not a politically correct term to use!) from Hurricanes Katrina and eventually Rita. For me, walking into the former convention center and arena was the most disturbing visual image of the journey. Imagine your last convention or hockey/basketball game in a large venue; now, cover the floor/arena with wall-to-wall cots. There were literally thousands of people living on cots in a convention center or hockey arena! Families of 5, 6, and more lived in the arena. They were provided food, clothing, and shelter. Two clinics were set up in the complex – one for the convention center side and one for the “arena” side. I was assigned to the arena side and had 2 nurses and a nurse assistant. Most of what we saw could be divided into 5 categories: 1) “Katrina crud” as we came to call it, which was a persistent runny nose, cough syndrome; 2) situational depression and despair; 3) significant mental illness 4) recently released prisoners and 5) the drug seeker.

To my shock, I learned as I talked to these people that many had been there for 30 days now! I could not imagine living on a cot with thousands of other people for a month or more. Many said that they would not leave until they could return to their homes. I wondered to myself how many actually had a home to return to. I wondered why some family member hadn’t found them or offered to take them in. I wondered how people could cope with this for such a long time.

I was able to spend my last week volunteering at this clinic. I realized the true value of continuity of care in this type of “disaster” setting—it works so much better if you can have the same nurse, doctor, etc. It speeds up the whole triage process immediately and you end up saving a lot of time and energy already knowing the patient; plus bond and trust between patient and health care provider is immediate. “Triage” is probably not a good word. It worked more like “Hey Mr. Jones, back again today? OK, come on back to this table and let’s have a chat.” The “clinic” was 2 folding tables and 4 plastic chairs.

The 3-month-old with “Katrina crud” I saw yesterday came back for followup. The 20-year-old schizophrenic woman came in to receive her medications. The 80-year-old man came in just to chat. They had no where else to go; I was a face from the outside, a face that was there to provide comfort and care. I spent a lot of my time just “talking” to people. I listened to their stories; I heard about their grandchildren; I held their hand while they cried and talked of the home they hoped was still there. I spent some time making “house calls” to the cots – just seeing how people were doing and surviving. The most difficult issue for me was dealing with the palpable anxiety and depression—I’ve always been very conservative about giving out anti-anxiety agents or antidepressant drugs. We’re taught in medical school and residency to be careful—“you don’t want to get someone addicted” or “most are just seeking the drugs to sell on the street.”

In the past, I would get this internal “gut punch” when a patient would come in asking for Soma or Lortab. However, think of this: If you had lived on a cot for 30 days, had lost your home, had no idea where you would work or live, and had no family willing to take you in—would you have back pain, anxiety, and/or depression? I became fairly liberal about dispensing these agents.

We had rudimentary records. Our “records department” was even pre-Dr. Welby days, a large cardboard box that we alphabetized by last name. I did have the joy (glee!) of not worrying about making sure I met all of the ****#%# Medicare bullet points for billing. The center had a full pharmacy run by volunteers as well. We joked about how much “street value” we had given out over the week, and we knew that a few had sold it on the streets; but we also knew that a majority of those who we had given these drugs needed them. Unfortunately for the true drug seeker, I was there consistently as the physician for the week so if they tried to say “I lost it” or “I didn’t get a prescription, last time” we could quickly send them off to try somewhere else. Social workers were available as well, but were completely overwhelmed by the amount of assistance needed. A psychiatrist was available once a week for 3 hours.

One of my most vivid anecdotes is of a 60-year-old woman displaced from Lake Charles due to Hurricane Rita. She presented with a chief complaint of “I need my last chemo for my breast cancer.” I looked at the bald, thin woman and my heart ached for her. She had a slight quiver to her voice and I could only imagine what she had been through in the last few months dealing with her cancer and treatment and now she had the misfortune of having to deal with sleeping on a cot and not having her own room or the comforts of her home. She asked if we had the chemotherapy in the clinic and could she get it today, because today was the day she was due for it. After a few phone calls to the local cancer treatment center we were able to arrange transportation and get her evaluated for chemotherapy that day—it amazed me how bureaucracy and red tape could disappear when you uttered the words “I have a displaced person (whisper, “evacuee”) who needs “X” and the answer would always be—send them over or we’ll get on it right away.

It’s nearly Thanksgiving when I write this and it has taken some time to digest all I have experienced and observed. I still cannot truly express all that I witnessed and brought back to Colorado with me. I know that the River Center was able to finally relocate those displaced by the storms by the middle of October. I’m hopeful that the patients I saw in Louisiana are all living in better conditions and have at least found some semblance of normalcy. I look forward to my next social visit back, but know that my feelings about Louisiana will never be the same. However, in the end, Louisiana will always be “home.”

Online Resource:

The National Immunization Program at the Centers for Disease Control and Prevention has created a Web page noting new and pending Vaccine Information Statements (VIS) for several vaccines. Under federal law, all vaccine providers must give patients, or their parents or legal representatives, the appropriate Vaccine Information Statement (VIS) whenever a vaccination is given. Details are available at the [Centers for Disease Control and Prevention Web site](#).

In the Event of an Emergency: What Can You Do?

By Ellen Singer, M.D.

In the weeks of the Hurricane Katrina crisis I received five emails from the Department of Health and Human Services in three days requesting my help as a medical volunteer for the Katrina evacuees. As my colleagues and I watched the news we all talked about how we might be able to juggle our schedules to go to Louisiana or Texas to help. Some of our colleagues were able to travel with multi-agency emergency teams. The rest of us felt overwhelmed. We recognized that we had the medical skills that the hurricane evacuees desperately needed; however, we also had assigned shifts and families of our own to care for. We could write checks to relief agencies but we could not help out in any hands-on, tangible way.

Two weeks before Hurricane Katrina struck the Gulf Coast I participated in the first regional training for the Multnomah County Medical Reserve corps. The Medical Reserve Corps was a new and small voluntary program funded by the Homeland Security Administration. I met with the medical director of the county health department and our regional emergency preparedness officer in a group of twenty other physicians and a few nurses in the basement of our county health department. We learned about the goals of the corps, the planning that our county officials had done for potential catastrophes and what our role would be if called to assist. We also discussed our own home emergency preparedness and how to secure our families' safety in the event that we were mobilized to work. We reviewed the types of emergencies that might come to Portland, OR – earthquake, pandemic flu, bioterrorism – all of which seemed remote in late August. We learned about the county's preparedness training for mass vaccination clinics and the hospital staffing for the "worst case scenario" influenza season.

And then Hurricane Katrina struck and suddenly there was work for us, right here in Portland. Portland was to be a secondary evacuation point for those left homeless by the hurricanes. The Red Cross prepared an empty high school building as a shelter for 1000 people, all of whom would need intake medical screening and evaluation. We waited for several days to hear that this mass evacuation was not going to happen. However we still had several hundred people who had self-evacuated to Portland who needed medical care. Thus the county health department set up a mobile screening clinic for 2-3 weeks, staffed primarily by those of us who had already volunteered with the Medical Reserve Corps. Most of the patients who came to the clinic had chronic medical conditions and needed help with prescription refills. However several patients had acute infections requiring immediate care. As I scheduled and did my volunteer work at the clinic, I found that my sense of anger, horror and helplessness at the Katrina tragedy was less intense.

No one wants or expects a disaster – natural or man-made — to strike. But when it does, our instinct is to help. As Med-Peds physicians we are uniquely trained to serve the frailest members of our local, national or international community. Our skills are highly valued and appreciated. If you want to help you can. To learn more consider joining or starting a Medical Reserve Corps in your community. You can investigate this by reviewing the website: www.medicalreservecorps.gov . Both you and your local community will benefit!

Practitioner Spotlight Wendy Badgwell, MD

By Scott Holliday, MD

Dr. Wendy Badgwell helped to provide care for people displaced by Hurricane Katrina to Houston. Dr. Badgwell received her Med-Peds training at The Ohio State University. She currently works as a hospitalist for IPC at St. Luke's Hospital in Houston, Texas.



Q: Dr. Badgwell, can you tell me how you got involved with the health care of Hurricane Katrina evacuees in Houston?

A: I had just moved to Houston. I knew that there was urgency for doctors to help with the health care needs of the evacuees from New Orleans who were being housed in the Astrodome, so I went to the make-shift facility and said ‘I’m a doctor, can I help?’ Being a Med-Peds physician, I was able to offer services that could meet the clinic’s needs. I went for several sessions to the area around the Astrodome. Evacuees were brought to the Reliant Center which had been transformed into a large medical city. Multiple volunteer organizations came together to provide health care services for those in need. Patients were first triaged based on their needs. After triage, the patients went to the appropriate health care provider – pediatric, obstetric or adult care provider. During the time I was able to help, there were enough Pediatric care providers – so the organization utilized my Internal Medicine skills.

Q: What were the health care needs of the evacuees and what help was provided?

A: There was a wide variety of patient needs – some of which were expected, others surprising. Of course, it was very common to see patients with varying degrees of trauma from the storm and evacuation process. However, management of chronic health problems was also a big need since many people were without the medications they needed to control their chronic conditions. While much of what we did was not the ‘glamorous’ work portrayed on “ER”, the need for these services was great. There were about 30 doctors there each day helping out – from residents to retired doctors. Many of the resources for the facilities were donated. We would find out what their medical conditions were and determine what medications they needed. CVS had set up a pharmacy on site, and the patients were able to take the prescriptions to this pharmacy and get the needed medicine – private physician offices had also donated sample medications for patient use. Patients with conditions such as diabetes, asthma, COPD, renal failure and hypertension had varying degrees of exacerbation, with some needing urgent therapy or hospitalization. We needed to decide who could be treated in our clinic and who needed to be admitted to the hospital. We had the ability to do basic lab work as well. Dell had donated computers to track and document the patient care. There were also social workers on hand to help people find medical homes with the local physicians. Our make-shift clinic was a temporary one. The patients needed places to get continuing medical care.

With evacuees in close quarters, there was also a problem with the spread of infectious disease within the Astrodome. When Norwalk virus began to spread through the arena, isolation areas had to be created to halt the spread of the illness.

Q: What about your Med-Peds training made you prepared for this experience?

A: My training gave me a general fund of knowledge and breadth of knowledge which allowed me to be prepared to see most any person who needed care. I've found this to be the case with other volunteer work I've done as well.

Q: What surprised you most during your experience?

A: It surprised me how well the evacuees were doing. People told stories of being stranded on their rooftops and of being washed away in the flood water. I expected to see a lot more severe trauma given the experience they had been through. I was amazed by the resilience of these people from New Orleans – many of whom had adopted the attitude of ‘this has happened, but we’re moving on.’ I was also surprised to find that many of the doctors who were working along side of me were in fact evacuees themselves. Many were residents who had also lost their homes and had no assurances of what the future brought for them – yet they jumped right in and continued to be doctors and continued to provide care for their neighbors.

**AMERICAN ACADEMY OF PEDIATRICS
SECTION ON MED-PEDS EXECUTIVE COMMITTEE MEETING**

Executive Summary

**Monday, October 10, 2005 8:00 AM – 12:00 PM
Washington, DC**

Dr. Kan called the meeting to order at 8:00 AM on Sunday, October 10, 2005. Dr. Kan welcomed those present.

The minutes and action items from the April 15, 2005 meeting were reviewed and approved.

Workgroup Restructuring

The Executive Committee reviewed a draft document concerning the restructuring of the Section's workgroups (committees). These include: academics, communications/publications, education/program planning, advocacy and membership. resident, young physicians and medical students, and Med-Peds practice.

R-4 Survey

The Executive Committee reviewed the R-4 survey. It was noted that the Section should continue to pursue research but whether the focus should remain on residents was examined. It was noted that the Section needs a survey of Med-Peds doctors 10 years out of training.

It was suggested that a Med-Peds community develop a research council to create a research agenda.

Executive Committee Meeting Minutes continued from page 12

Med-Peds Brochures

Staff noted that the AAP has approved the use of the AAP logo for both brochures if the AAP can copy-edit the brochures, if they are given free only to Section members, and if the final brochure has been approved by an AAP Board member.

ACTION: Staff will e-mail the brochure copy to Ms. Swiacki so that she can obtain approval from ACP to use the ACP logo on both brochures.

Listserv

Dr. Kan noted that the Yahoo Med-Peds list serv and the AAP list serv have been successfully merged.

Recruitment

Dr. Kan noted that the Section, in conjunction with the ACP, has a plan for several membership drives over the next several months.

Educational Programming

Dr. Cross noted that the Section will execute “The Med-Peds Physician: Being a Super Hero in the 21st Century” educational program as part of the 2006 AAP NCE and the 2007 ACP Annual Session although faculty names will change slightly.

Medical Student Outreach

It was noted that since NMPRA, the Section and the MPPDA are all involved in the recruitment of medical students; it would be advantageous to have a cross-organization workgroup. Ms. Swiacki noted that the ACP will again host a medical student career fair at the ACP Annual Session.

MPPDA Update

Drs. Friedland & Holiday gave an update from MPPDA.

Resident Section Update

It was noted that the AAP funds resident travel grants to the NCE although the grants are limited to 1 per training program and in many instances, categorical peds must compete with combined –training residents for the grant. It was suggested that the Med-Peds Section could offer their own travel grants to the NCE. It was agreed that the Section would offer two (2) travel grants to the AAP NCE specifically for Med-Peds residents. The recipients would be randomly drawn from the pool of interested residents.

ACTION: Staff will work with Drs. Kan and Kaelber on the newly proposed Med-Peds resident travel grant program.

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Med-Peds Database

The Section has a list of Med-Peds physicians containing over 4,000 names. It includes the entire “universe” of Med-Peds trained physicians. This list can serve many useful purposes including recruitment, physician referral, research if approved.

Section Elections

Dr. Chamberlain will chair the Med-Peds Section election nominations process for 2006.

Questions about this summary should be directed to Jackie Burke at the national office at jburke@aap.org or call her at (800) 433-9016 ext 4759.

Med-Peds Job Postings

Upper Midwest:

Park Nicollet Clinic is a multi-specialty clinic in Minneapolis that is community owned and physician run. We currently have 6 Med-Peds physicians in a single office and we are looking to add additional Med-Peds physicians. Some of the features of the group include equal adult and pediatric patient populations and the opportunity to teach medical students and residents. Please contact Bernt Helgaas, MD at (952)993-1403 or Bernt.Helgaas@ParkNicollet.com

Nevada

Tired of working for others?? Be your own boss. Busy multi-specialty private primary care practice (1 Med-Ped, 1 Ped, 4 IM, 1 NP) in Carson City, NV is seeking an additional Med-Peds physician. Enjoy all the Sierras and Lake Tahoe have to offer. Work in a brand new, state of the art office and hospital. Excellent lifestyle with light shared call (with coverage of both specialties) - averages 1 in 7. Salary negotiable. Possible partnership after 1 year. Relocation benefits available. Contact Mike at (775) 283-3238

Midwest Med-Peds Practice Opportunity:

Private practice in Columbus, Ohio is looking for full-time or part-time physician who is either Med-Peds or IM trained. Our practice group consists of 7 Internists, 2 Med-Peds Physicians and 2 Nurse Practitioners. We provide both office and inpatient care of our patients. If interested, please contact Steve Canowitz, MD at 614-496-4823.

Minnesota Practice:

Looking for a Med-Peds trained physician to join our booming practice. Park Nicollet is a multi-specialty PPO in the Twin Cities based out of St. Louis Park with numerous satellite clinics across the immediate metropolitan area. Specifically we are looking to recruit a Med-Peds physician for our Maple Grove Clinic to join 6 other Med-Peds physicians. The area is growing incredibly fast and we are needing to meet the demand by hiring another provider. A full time position would include 32 hours of clinic time per week with on average 2-3 Medicine calls per month and 1-2 Pediatric calls per month. We also do dedicated inpatient rounding (i.e. taking place of clinic time) for a total of 4-6 weeks out of the year. There is opportunity in conjunction with the University of Minnesota to be involved in teaching of medical students and residents, including being a continuity clinic preceptor for residents if desired. Please contact Greta Chen, M.D. at cheng@parknicollet.com or 952-993-1440 if interested.

Family Health Care, P.C. is a growing, physician-owned primary care group located in beautiful Northwest Montana. We are recruiting for a full-time Med-Peds physician to join our current provider staff of five Med-Peds physicians, six Family Practice physicians and five mid-level providers. Our patient base has an approximate mix of 40 percent pediatrics and 60 percent medicine. For anyone interested in the mountain west, this is an excellent opportunity in an attractive and thriving area.

Contact Info:

Mark Davis, Practice Administrator

1287 Burns Way

Kalispell, MT 59901

(406) 752-3762

mdavis@krmc.org

Med/Peds Opportunities in the Midwest

Build Your Practice . . . Where The Future Of Medicine Lives.

Marshfield Clinic is a 725 physician-directed multi-specialty group practice with 41 centers in Wisconsin.

These positions offer:

- A benefit package including a fully funded retirement plan, matching 401K plan, 20 days paid vacation, two weeks CME with up to \$5,500 allowance, generous relocation, and more.
- The resources to effectively care for patients including an efficient network of Electronic Medical Records accessed with personal tablets.
- The advantage of practicing where genetic research and educational opportunities are easily accessible.
- A community that offers affordable housing, top-rated schools, plus excellent indoor and outdoor recreational activities. Two locations are in proximity to the St. Paul/Minneapolis metro area.

To learn about these excellent opportunities, please contact:

Mary Treichel, Physician Recruiter, Marshfield Clinic, 1000 North Oak Avenue, Marshfield WI 54449; Ph: 800-782-8581 ext 19774; Fax: 715-221-9779; E-mail:

treichel.mary@marshfieldclinic.org; Website: www.marshfieldclinic.org/recruit

Family Medicine or Med-Peds Physician Faculty – The Firetower Medical Office of ECU Physicians, the Medical Faculty Practice Plan (MFPP) of The Brody School of Medicine at East Carolina University (ECU), is seeking two (2) full-time, board-certified family physicians or med/peds physicians. Duties include outpatient primary care with some evening/weekend sessions and designated holidays. On-call responsibilities will be assigned on a rotating basis. Familiarity with electronic records system preferred. No significant inpatient responsibilities.

The Brody School of Medicine is known nationally for its commitment to medicine. ECU has approximately 22,000 students and is the third largest university in the 16-member UNC system. The successful candidate will join seven primary care providers in a state-of-the-art medical practice located off-campus that is designed for convenient and comprehensive medical care with a patient focus. In addition to State of North Carolina benefits, faculty receive a comprehensive insurance package from the MFPP. The practice is located near the coast in Greenville, NC, a progressive city of 67,000, which offers cultural activities and many recreational opportunities with easy access to the coast and the Smoky Mountains.

Applicants should submit a letter of interest, current CV and names and addresses of three references to: Michael Coyle, MD, FAAP, FACP, Clinical Professor and Site Director, Firetower Medical Office, 1204 East Fire Tower Road. Greenville NC 27858. Screening will begin on December 3, 2005, and will continue until a candidate is selected. The desired start date is July 1, 2006. East Carolina University is an EEO/AA employer which accommodates individuals with disabilities. All applicants must comply with the Immigration Reform and Control Act.

Figure 1

Med-Peds (M-P) Section Organizational Chart

