On the Learning Curve

The Real-World Fellowship

A resident and I were talking earlier in the week, and she commented that, despite being more than halfway through her residency, she often didn't know the answers to her friends' questions about their children. She felt like she had spent lots of time learning about diseases and hospital management, but didn't know how to answer her friends' "simple" questions.

I wasn't surprised; I remember feeling the same way. I have often thought that my first few years after residency were a fellowship in "real world" pediatrics.

BY LEE SAVIO BEERS, M.D.

As a resident or fellow, you have easy access to seemingly unlimited medical tests, specialist opinions, and cutting-edge technology. It is easy to be "academic"—you have lots of minds and resources at your disposal. On the flip side, however, you are often not in one place for more than a month and are likely in your continuity clinic only once, maybe twice, a week. That makes it hard to achieve long-term continuity with the volume of patients you will have out in the "real world."

One of the most important and surprising things I learned in my real-world fellowship was whether the advice I gave actually worked. My first job after residency was at an overseas U.S. Naval Hospital where I was the only pediatrician (and had no access to pediatricians in the community)! Now, that was an overwhelming transition: To move from the security of residency, where I worked surrounded by more experienced general and specialty pediatricians, to the insecurity of being the senior (and only) pediatrician on staff for a whole hospital. I was providing consultation for staff all over the hospital, when in fact most of the time I felt as if I needed someone to consult myself.

It was a challenging and educational job in many ways, but one of the greatest opportunities it offered me was the chance to really get to know my patients. Not only did I see them in clinic, but I also saw them at the commissary, the community pool, and the movie theater. I was able to develop the relationships and the follow-up with families to learn that some of what I recommended seemed to work really well and some of it was never even tried. I discovered how much I could learn from the families—they told me the things that they had learned along the way, and I was able to use a lot of that advice for other families as well. This may not be information you can find in journals or textbooks (although there is much evidence for the value and effectiveness of family-centered care), but it is extremely valuable nonetheless.

I learned that working in the same clinic and the same hospital every day was a lot different from floating in a half-day a week or for a month at a time. Suddenly, I was much more invested in practice management issues and they seemed to take up a greater proportion of my time. It was challenging in some ways—dealing with lots of administrative things I had little to no training in—but actually interesting in others.

It is rewarding to identify a systems problem in the practice, make a change, and see the result. For many physicians, dealing with billing is the biggest shock. As a resident, I didn't think much about it, even though I was actually trained in it. Once I was in practice, billing became a whole lot more important.

I also learned that it was a lot harder to be a community physician than I ever thought. It's not always so easy to talk to a specialist, get a test done, or spend an hour with a patient sorting out his complex medical issues. I'm also not attending noon conference or morning report every day and so I have to think about new ways to keep up with my education. I developed a new respect for what it is like to be out there on the front lines seeing patients.

I found that it was critically important to get to know the community where I practiced, learn what was available (and what was not available), and develop professional relationships outside of my practice (for example, schools, early intervention, and mental health providers, to name a few).

Even now that I am at an academic center, my role is very different from when I was a resident and has many more varied and competing priorities. I am not just here to learn and work, I also am here to teach, manage patients and staff, work on clinic operations, advocate in the community, and do whatever else lands on my desk—and still have the clinical and financial pressures of helping to make ends meet!

For survival in the "real world" fellowship, it is important to identify resources and professional organizations that can help you through. There are many options, especially if you have easy Internet access, but one that I find very helpful is the American Academy of Pediatrics.

The AAP Section on Young Physicians (www.aap.org/sections/youngphys) is a good resource as you are starting out. With membership in the AAP, you have access to additional resources related to practice management, coding, continuing medical education, and more. PediaLink (www.pedialink.org) is another valuable resource for continuing medical education.

Every year I am out of training reminds me that learning doesn't stop with residency—and in many ways, learning is just beginning. ■

DR. BEERS *is an assistant professor of pediatrics at Children's National Medical Center in Washington. She also is a member of the Pediatric News editorial advisory board and the American Academy of Pediatrics Committee on Residency Scholarships.*

IRBs Lambasted for Excessive Red Tape; 'Pediatric Research Courts' Proposed

BY TODD ZWILLICH
Contributing Writer

WASHINGTON — Frustrated researchers are calling for the gutting of what they see as faltering institutional review boards now charged with the monitoring of medical research on children.

At a meeting of the President's Council on Bioethics, scientists told council members that institutional review boards (IRBs) are overburdened with bureaucratic red tape and are increasingly hamstrung in their efforts to scrutinize pediatric research.

The bureaucracy, they said, comes from federal laws laid down in the 1970s exerting tight IRB control over research protocols. The rules were enacted to prevent lapses in the wake of several well-publicized child research ethics scandals. Instead of protecting children, the rules have weighed down IRBs and made their deliberations arbitrary, experts charged.

Dr. Robert J. Levine, professor of internal medicine at Yale University, New Haven, Conn., and others warned that IRBs now spend much of their time exercising perfunctory annual reviews of ongoing research protocols. The reviews include scrutiny of each adverse event occurring during a trial. "What I see now is a turn toward excessive bureaucracy, excessive attention to pointless detail" with IRBs, Dr. Levine said.

Dr. John Lantos, a professor of pediatrics at the University of Chicago, said that IRBs routinely struggle to enforce federal rules requiring guardians of minor subjects to give informed consent for trials posing more than a "minimal" risk to patients. Whereas the rules were meant to protect child subjects, IRB decisions on what constitutes a minimal risk have become "amateurish" and "idiosyncratic," he said.

As a fix, Dr. Lantos urged the council to recommend a new system of what he dubbed "pediatric research courts." The courts would operate with regional or national jurisdiction and would render decisions on whether trials meet federal standards for ethical science.

"It would do this by hearing cases, publishing rulings, establishing precedents, [and] generalizing interpretations in a way that was truly public, meaningfully accountable, and transparent," said Dr. Lantos, adding that such a court should have "regulatory teeth."

"It should come up with an answer the way the Supreme Court comes up with an answer," he said.

The council is scheduled to issue recommendations on the monitoring of child research ethics, although those recommendations won't have the force of law. It will be up to Congress to enact any changes, and it is unclear whether lawmakers will back drastic changes to the IRB system.

Regardless, others who spoke before the council agreed that IRBs have lost the ability to effectively monitor pediatric research.

"We've just got ourselves stuck into a situation that is going to get worse and worse and worse," said Dr. Paul R. McHugh, a professor of psychiatry at Johns Hopkins University, Baltimore. ■

Morphine Delivery Only 37% of Prescribed Dose In Sickle Cell Patients

BETHESDA, MD. — Children with sickle cell disease who were hospitalized for frequent recurrent painful episodes were given significantly less than the prescribed amount of morphine, Eufemia Jacob, Ph.D., reported in a poster presented at a meeting sponsored by the National Institutes of Health's Pain Consortium.

The mean dosages delivered during prolonged hospitalizations were 0.5-1.5 mg/kg per day, which represented, on average, only 37% of the prescribed amount of morphine. The prescribed amount consisted of a lower-than-recommended "background" infusion and additional higher doses the patients could get by pressing a button. Dr. Jacob and her colleagues concluded that the children were given "suboptimal" regimens, but she cautioned that "suboptimal" does not necessarily mean "undertreatment."

Dr. Jacob of the department of pediatrics at Baylor College of Medicine, Houston, offered several possible reasons for the observed dosage difference: Children might not have pushed the button because they were asleep or too exhausted from the pain, did not like the side effects, or might not have understood the self-delivery system. The inherent processes involved in the biology of sickle cell disease may not be responsive to morphine. She is currently conducting a study to compare different methods of programming the morphine delivery system and to assess the contributions of genes and other biology markers. She hopes to customize regimens to shorten hospital stays for acute, painful episodes in patients with sickle cell disease.

—John R. Bell