

**Minutes of the  
Pediatric Section Fellowship Director's Committee Meeting  
Society of Critical Care Medicine Annual Meeting  
Sunday, February 3, 2008**

**I. Synopsis**

Forty-three Pediatric Critical Care Fellowship Directors (FD), or their representative, attended the two hour meeting on February 3, 2008 at the Annual Meeting of the Society of Critical Care Medicine in Hawaii. The significant news from the meeting:

1. **New Chair of the Pediatric Critical Care Fellowship Director's Committee.** Bob Clark, Pittsburgh, was elected in the Business Meeting to be Chair of the Fellowship Director's Committee for the next two years.
2. **Should we adopt a common application and move the MATCH date?** We need to hold a formal vote, by any mechanism Bob selects, to resolve the issue of whether we adopt a single fellowship match date, and a common application utilizing Electronic Residency Application Service (ERAS), as recommended by the Council of Pediatric Subspecialists (COPS). These two issues, while separate in concept, are in effect linked for procedural reasons as the electronic application can not become available to programs until July, leaving only a narrow window between getting the application and the rank order due day if we do not move the MATCH to December. This entire issue is spelled out in greater detail in the minutes below. This issue is somewhat complicated and will require a careful reading of the material that was very well presented by Rich Mink.
3. **How should we move forward, as we have been in isolation, or work together to develop and share best practices?** There are several projects underway within the committee that hold the promise of fusing us more cohesively around forward thinking initiatives that develop and link best practices on education and evaluation. If we as fellowship program directors, through either inertia or lack of imagination, simply continue on in an ad hoc manner, each individual fellowship program will be left to themselves to react to ACGME and RRC mandates that we may, or may not, see as rationale, necessary and appropriate for pediatric critical care. If I have accomplished anything in 4 years as Chair of this Committee, I hope it is to persuade you that we can and should move toward thinking of ourselves as a dynamic group determined to evolve shared best practices that will help to ensure the best training possible for all practitioners entering our subspecialty. As part of this "cohesive" conceptual framework, we discussed at the Hawaii meeting common initiatives to evolve best practices such as a 360 evaluation tool, and an update on the initiative to develop a web-based video curriculum of master teachers.
4. **New Pediatric SCCM Executive Committee Representative: A Fellow.** At the Executive Committee meeting of the Pediatric Section in Hawaii this year Ed Conway proposed that we amend the bylaws of the section to allow for the representation of a fellow for their non-voting input on decisions before the executive committee. This concept was approved and Ed also presented this to the FD committee where there was also general agreement with the concept. In brief, as it presently stands, a first year fellow will be nominated in the Spring of the first year to sit on the Executive Committee at the annual SCCM the following two winters (ie, in their 2<sup>nd</sup> and 3<sup>rd</sup> year of fellowship). This will give the fellow two years of service to develop an understanding of processes and issues and leave time for their effective participation as a voice of fellows in-training. The plan is to develop an email distribution list for this fellow representative to contact all pediatric critical care fellows in-training on issues before the Executive Committee of the

SCCM. Ed Conway is going to shepherd the implementation of this proposal going forward.

5. **NRMP and ABP data gap for fellows in-training: is the MATCH working fairly or are up to one fifth of all known pediatric critical care fellows in ACGME approved training programs there in violation of MATCH rules?** This year I received fewer reports of concerns about MATCH violations and one more program has entered that MATCH with no programs withdrawing from the MATCH in the past 4 years. Yet, as this is potentially the most divisive issue confronting us as a group, I have always felt it prudent and necessary to present MATCH data at each FD meeting. In Hawaii we reviewed our now 8 years of NRMP MATCH data. I also presented workforce data on the number of fellows in-training according to the ACGME and ABP. In brief, there is a discrepancy between the number of fellows entering training through the NRMP, and the number of fellows in-training according to the ABP, whereby it is not clear how up to 20-30 were enrolled in ACGME approved training programs. Did they all enter outside the MATCH, or in violation of the MATCH among programs that state they are adhering to the MATCH, or are they enrolled by reasons that can be explained sufficiently that the MATCH integrity is being upheld? A long discussion ensued and that the vast majority of these 20-30 fellows can most likely be accounted for reasons that are legitimate exemptions from the MATCH. However, there was agreement that we need to more objectively demonstrate that these 20-30 fellows are legitimately in training programs without violating the MATCH rules in order to assure the integrity of the MATCH. Thus, I or Bob Clark will individually contact all ACGME training programs this June to determine precisely how all fellows in-training were enrolled and present these data by email this summer.

## **II Minutes in Detail**

### **A. New Chair of the Pediatric Critical Care Fellowship Director's Committee.**

By the Pediatric Section bylaws, the Chair of the Fellowship Director's Committee serves a two year term, with the opportunity for one additional two year term. I have now concluded four years as Chair and thus a new Chair was to be selected at this meeting.

In keeping with the Pediatric Section Bylaws, names were solicited for nomination in an email I distributed to you all last year, four names were submitted to me by this process and passed on to the Pediatric Section Nomination Sub-committee of the Section Executive Committee. The Nomination Committee then advanced the name of one candidate for the ballot distributed at the Pediatric Section Business Meeting. In addition to Nomination's Committee candidate for Chair of the Fellowship Director's Committee, nominations from the floor for a write-in on the ballot were allowed.

#### **Going Forward on this issue:**

Bob Clark from Pittsburgh was nominated by day Nominations Committee for the ballot and was subsequently elected among those in attendance at the Pediatric Section Business meeting and will now serve as Chair of the Fellowship Director's Committee for the next two years. Congratulations to Bob, you may reach him at [clarkrs@ccm.upmc.edu](mailto:clarkrs@ccm.upmc.edu).

### **B. Should we adopt a common application and move the MATCH date?**

Editorial note: for this complex issue, I am very directly taking the information presented by Rich Mink in an email to us all last Fall, and have reformatted the information he sent then, and presented in Hawaii, to try to make these issues as clear as possible. Up front, I thank Rich for allowing me to use his email in these minutes and for his hard work as one of our two Pediatric Critical Care representatives to COPS, Don Vernon is the other representative.

**1. What is COPS?**

COPS stands for the Council of Pediatric Subspecialists, was created by FOPO and the APPD. FOPO, the Federation of Pediatric Organizations, an umbrella organization composed of the American Academy of Pediatrics (AAP), American Board of Pediatrics (ABP), American Pediatric Society (APS), Society for Pediatric Research (SPR), Ambulatory Pediatric Association (APA) Association of Pediatric Program Directors (APPD) and the Association of Medical School Pediatric Department Chairs (AMSPDC). Although the early focus has been on fellowships, COPS mission is much more broad. See their website for additional information: <http://www.pedsubs.org>. CoPS appointed a Fellowship Application Task force to examine two issues: a single fellowship match date and a common application utilizing ERAS.

**2. COPS Fellowship Task Force Recommends Two Common Match dates.**

Rich Mink wrote, “For the match, the Task force is recommending two match dates, one in May and the other in November. The later date would likely include fellowships in neonatology, emergency medicine and critical care. The other subspecialties thought that this was too late and wanted an earlier match date. Perhaps in the future there will be one date.”

**3. COPS Fellowship Task Force Recommends adopting the ERAS**

Again, Rich explained, “The Task force is advocating the use of ERAS for all fellowship applications. ERAS (Electronic Residency Application Service) is an organization independent of the NRMP, although the two work closely together. ERAS is used for most residency programs and there are some fellowships, including pediatric emergency medicine and GI, that use it now. Fellow applicants complete their application through ERAS which then sends it to the programs to which the individual wishes to apply. There are two cycles for ERAS: December through the following May (December cycle) and July through December (July cycle). See also the ERAS fellow website at <http://www.aamc.org/students/erasfellow/start.htm>.

**4. Why is the decision to adopt a Common Match Date in December linked to adopting the ERAS?**

For a November match, critical care would likely use the July cycle. However, for procedural and technical reasons the ERAS mandates that applications to their system are not accepted until July, i.e. the beginning of the third year of residency. If we keep our MATCH day for critical care around November 10, and therefore by extension our Rank Order due date around October 10, that is a very narrow window for programs and applicants to assess each other, interview, and submit their preferences via the MATCH. Thus, to accept the ERAS we would likely need to move our MATCH date to December. Eighty percent of programs are needed for the subspecialty to enroll. The earliest that pediatric critical care could utilize ERAS would be for the 2010 MATCH, if we agree on it. To get a better picture on how this works, the ERAS 2009 Fellowships Timeline is:

**July Application Cycle Specialties with applicants beginning positions July 2009**

Date	Activity
May 2008	ERAS 2009 fellowship Applicant Manuals will be available for PDF download by chapters or in its entirety on our Web site. <a href="#">EFDO</a> begins to generate and distribute MyERAS tokens.
July 1, 2008	<a href="#">MyERAS</a> Web site opens to applicants to begin working on their applications. Fellowship applicants may apply to July application cycle specialties <b>only</b> .

<b>July 15, 2008</b>	ERAS PostOffice opens to July application cycle programs for downloading.
<b>December 2008</b>	Match Results available for July application cycle programs.
<b>May 31, 2009</b>	ERAS PostOffice will close to prepare for the 2010 season.
<b>July 1, 2009</b>	Fellows begin their training.

**5. What was the discussion of these issues in Hawaii**

Rich Mink presented the information above and pros and cons were discussed, with no clear consensus emerging from the discussion. Several FD expressed concern that moving the MATCH date to December would provide too narrow of a window to complete the increasingly arduous credentialing process by July 1. Others expressed concern that narrowing the “start point” of the application process to July 15, if we accept ERAS, was perhaps more problematic than the benefits of using ERAS and could we not as a committee develop and agree on our own common application?

**6. Going forward on this issue:**

These issues are obviously very important to us all that I felt we must conduct an accurate poll of each ACGME sanctioned FD. Moreover, as was noted above, we must get 80 percent of all programs are needed to enroll in ERAS before this service can be utilized. I will defer to Bob Clark on how and when he would like to conduct a formal poll on these separate, but as we have seen, linked issues.

**C. How should we move forward, in isolation do or work together to share best practices?**

As noted on page one, I believe we can and should move toward thinking of ourselves as a dynamic group determined to evolve shared best practices that will help to ensure the best training possible for all practitioners entering our subspecialty. As part of this “cohesive” conceptual framework, we discussed at the Hawaii meeting common initiatives to evolve best practices such as a 360 evaluation tool, and an update on the initiative to develop a web-based video curriculum of master teachers.

**1. 360 Fellow Evaluation Tool**

Aaron Calhoun, a first year faculty member from Vicki Montgomeroy’s Division in Louisville, and a graduate of my fellowship program, has an academic focus on developing and implementing a 360 evaluation tool. He presented his 360 evaluation tool to the group. Aaron writes, “The PCCF-360 is a 360-degree feedback tool designed to generate comprehensive graphical feedback on pediatric critical care trainee competency in the areas of patient care, teaching, and academic development. The tool is designed to collect data from an interdisciplinary cohort of raters, including attending physicians, resident physicians, and nursing staff. A gap analysis component has also been built in to the tool, allowing for assessment of self-appraisal. The current iteration of the tool has been psychometrically validated and is ready for use, with high measures of internal consistency (average Cronbach’s alpha of 0.84) and inter-rater reliability (Intra-Class Correlation of 0.85). Further development of the tool is planned, and will include a transition to a Dreyfus Scale system, the incorporation of self-generated planning for future growth in the self-surveys, and the development of a family survey tool.” To view the example survey at surveymonkey go this link:

[https://www.surveymonkey.com/s.aspx?sm=sSANLQgSre3VwdPQFhULoQ\\_3d\\_3d](https://www.surveymonkey.com/s.aspx?sm=sSANLQgSre3VwdPQFhULoQ_3d_3d)

In the discussion of this presentation that followed Harris Baden conveyed his recent ACGME site survey in which the surveyor asked to see the fellow evaluation tool as well as the individual fellow evaluations, seeking in particular evidence that the fellows were evaluated by parents and family members. Aaron's tool as presented did a 360 evaluation based on evaluations from nursing staff, residents, fellow peers and faculty but not parents or family members. Going forward Aaron plans to incorporate this as Harris and several others pointed out this is in fact mandated by the ACGME.

#### **Going forward on this issue:**

Mary Lie Lai from Wayne State in Detroit agreed to Chair a subcommittee to work on developing and implementing a common evaluation tool. Contact Mary at [mlielhai@med.wayne.edu](mailto:mlielhai@med.wayne.edu) if you are interested in working on this subcommittee. Any who is interested in using either the current or future iterations of Aaron's tool should contact him at [aaron.calhoun@louisville.edu](mailto:aaron.calhoun@louisville.edu). Aaron thinks he could take on several other sites assuming that 1) you a fellowship coordinator that can be taught by Aaron on how to use/distribute, and potentially summarize results from, the tool and 2) you would be willing to stagger evaluations to some extent (if they all hit at the same time, say the last week of May, it will be more than he can manage at this time). The goal would be a large degree of self-sufficiency at each site, with Aaron functioning as a coordinator and troubleshooter.

## **2. PICU Without Walls & Borders**

I presented an update on the PICU Without Walls & Borders project. The objective of this project is to harness the internet to bring outstanding educators in pediatric intensive care to any fellow in-training -- in any program -- by creating a web-based video library of notable clinicians speaking on essential topics in the care of a critically ill child, I have two pilot videos now ready to view. Please note that I have used two physicians presently or previously affiliated with Children's Hospital Boston out of practical convenience to get the idea launched. To see the initial videos as a "proof-of-concept" see:

[www.childrenshospital.org/criticalcare](http://www.childrenshospital.org/criticalcare) and click on PICU Without Walls link.

#### **Going forward on this issue:**

I have received a \$100,000 grant to further develop this idea. Please contact me if you know of an outstanding educator at your institution who has a renowned talk on some aspect of pathophysiology or other essential component of the art and science of pediatric critical care medicine. My plan is to have further talks developed locally with me reimbursing that site for expenses in creating a high quality video, as opposed to me trying to bring a video production team to your location. Also, as the site becomes populated with more information I will move the link to PCCM and/or the World Federation website while the server will remain with my Division in Boston for now. Also, I would appreciate your feedback on what worked with these pilot videos and what could be better going forward.

## **D. What explains the gap between the NRMP and ABP data for number of fellows in-training?**

I can not yet give you a precise answer to my question above. As noted the first page of the minutes, the MATCH remains one of the most potentially divisive issues confronting us as a group. I have always felt it prudent and necessary to present MATCH data at each FD meeting.

Here is what we do know. Over the course of the MATCH we have only added ACGME programs to the MATCH, there has been no attrition. The ACGME states that there are 62 approved fellowship training programs in pediatric critical care medicine. In November 2007, 49 programs of 62 programs, the highest number in all the years we joined the MATCH in 2000, participated in the NRMP sponsored MATCH. These 49 programs offered 116 positions to the 92 fellow applicants who also entered the MATCH. Of these 92 fellow applicants, 93% matched and 7% did not. Moreover, 53% of programs filled in the MATCH, while 47% did not.

Here is where it gets confusing. In the Summer of 2005, 119 fellow applicants contacted the NRMP to participate in the MATCH. Of these, 11 withdrew and 4 did not return rank order lists, leaving 104 fellow applicants who submitted a rank order list for the MATCH that occurred in November 2005. Yet, according to ABP data, in July 2006 there were a total of 164 first year fellows in all accredited programs. This is most peculiar, as it exceeds not only the number in the MATCH the previous November, but the number of approved ACGME positions as well. Recall that the MATCH is voluntary, so perhaps the 13 programs not in the MATCH in November 2005 explain that 13 program took 60 first year fellows outside the MATCH. But of course this seems highly unlikely, for this would be almost 5 first year fellows per program and there are only 3 or 4 programs of that size in the US, and they all filled that year. Moreover, I have personally contacted the 13 or so programs not in the MATCH and asked them for the number of positions they offer outside the MATCH and cross checked this with the number of positions the ACGME approves for these programs, and the numbers coincide at around a dozen or so first year fellow positions that are outside of the MATCH. That is, while the ACGME has approved 1 or 2 first year fellow positions at each of these 13 programs, by the choice of the program they are not always active each year, so that some years 4 or 5 of the programs not in the MATCH are also not accepting any fellows into the first year (most cited financial reasons when I spoke with them, that is they did not have reliable funding to support the fellow). I have attached the ABP data below. Note also that there is a consistent but growing discrepancy between the number of fellows reported to the ABP training in the first year compared with the number of fellows who make it to the third year of training.

American Board of Pediatrics Data: Pediatric Critical Care Fellows In-Training

	Training Level 1	Training Level 2	Training Level 3	Total Number of Trainees
<b>2000-2001</b>	99	88	75	262
<b>2001-2002</b>	99	88	84	271
<b>2002-2003</b>	112	82	83	277
<b>2003-2004</b>	116	99	85	300
<b>2004-2005</b>	135	107	74	316
<b>2005-2006</b>	127	122	96	345
<b>2006-2007</b>	164	113	105	382

I suspect that programs are reporting to the ABP fellows who really are not physicians seeking a formal three year training program to lead to board eligibility, but a host of other physicians from various subspecialties who are working as “fellows” for manpower reasons. I sincerely and firmly do not believe that 60 fellows entered ACGME programs by violation of MATCH rules. This opinion is based on everything I know about the data, from my interviews with various program directors, and based on any concerns reported to me by you over the years.

**Going forward on this issue:**

Despite my assessment of the data outlined above, I obviously can not objectively explain the gap between the NRMP data and the ABP data and it must be explained to maintain the integrity of the MATCH. So, I will personally contact each of the 62 ACGME approved program directors in June to ascertain from them, promisingly anonymity to engender confidence, this June to determine how many fellows will enter every program in July of 2008. We will then compare this against the number

of first year fellows who get reported to the ABP as having entered training as of July 2008. I will be sure to define the term “fellow” broadly at first, and then more precisely, with each FD to determine if programs are reporting physicians providing manpower as first year fellows as distinct from a first year fellow accepted with the intention of completing a three year program in pediatric critical care medicine with the goal of board eligibility in pediatric critical care medicine by the American Board of Pediatrics. Of course, if Bob Clark would like to conduct this survey I will defer to him!

Last, thank you for your support of me as Chair of the Committee over the past 4 years, I look forward to Bob's new ideas.