

From Private Practice to Academia: The Experience of a General Academic Pediatrician

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ABSTRACT: After pediatric residency, the author worked in a rural community where he was able to immediately practice skills acquired during training such as intubations, bag-mask ventilation, IV placement, ear irrigation, foreign body removal from eyes and ears, abscess incision and drainage, intraosseous placement for rapid hydration of a severely dehydrated infant, EKG, X-ray readings, and ear-irrigations to cite but a few examples. Furthermore, the writer acquired other high-valued procedural skills such as neonatal male circumcision, frenotomy, ligation of supernumerary digits, and manual separation of labial adhesions. The author feels that he could only have acquired and maintained these skills by working in a busy rural pediatric practice. When the writer later became a faculty member, he was able to effectively train medical students and pediatric residents to acquire these same skills. Even though there is a paucity of research information on procedural skills acquisition among general pediatric residents, the writer proposes that the recruitment of full-time general academic pediatricians with real-world experience may be potentially beneficial for the training of medical students and pediatric residents.

KEYWORDS: Procedural skills, private practice, academic practice, community practice, residency training

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Introduction

Almost 3 decades ago I graduated from an excellent pediatric residency training program, and I was anxious to go into private practice and serve. During pediatric residency training, we had 3 or 4 months of neonatal intensive care unit (NICU), none in the newborn nursery, a month of cardiology, several months in the wards and emergency department (ED), allergy and immunology, gastrointestinal, infectious disease, and many other subspecialties of my choice to prepare me for general pediatric practice.

The program trained residents in more than 50 procedural skills, but I was not sure which one would be useful in general practice. I knew there would be challenges but I was confident that I was well prepared. The next stage of my life was about to begin, and what follows is a brief account of my experience in procedural skills in private practice and how this experience was later useful in teaching procedural skills to medical students and pediatric residents in a large academic institution.

What I learned in private practice

I joined a busy but excellent rural pediatric practice. This private practice is in MS, USA, and at that time served a population of almost 50,000 with only 3 board-certified attending pediatricians. There was one regional hospital covering this service area. Ours was the only pediatric practice and we all took shared calls in the hospital where the pediatricians regularly admitted and cared for extremely sick children. The pediatrician on call attended all cesarean section (C/S) deliveries. The hospital had over 700 annual deliveries. We have previously published more information on this practice elsewhere.¹ The on-call pediatrician

was also consulted by the other services such as the family medicine and emergency medicine departments.

In the first week, the ward nurse called to insert an IV infusion in a dehydrated patient with collapsed veins. Three nurses had tried and failed, and the patient was becoming lethargic. There is no pediatric ICU here. The nearest Children's hospital was 70 miles away! Oh yes, we were trained in residency that an intraosseous (IO) route was an alternative. I had inserted just one in residency, but this patient was getting increasingly lethargic. Quickly I successfully inserted an IO using a trocar and I rapidly gave bolus IV fluids. Once the patient improved the nurse was now able to obtain a vein for IV fluid maintenance. The next time, it was easier, and I was more comfortable doing the procedure.

I can say that my NICU experience in residency was especially useful in this rural environment where I could practice what the program trained me to do. I was extremely comfortable with intubation and the use of bag-valve ventilation upon graduation. Several times my colleagues and I were called to resuscitate 400–500-g neonates whose parents had life-prolonging goals. These patients were often “Pedi flighted” to a Level 4 NICU for further evaluation and treatment. I intubated and inserted umbilical catheters into other extremely low birth weight preterm neonates and transferred them out to a Level 4 NICU. I had learned these procedures during residency but now was doing the procedure in private practice in this medically hard-to-reach rural community. Rapid intubation and placing umbilical catheters in extremely low birth weight babies became routine to me after 6 months.

In the clinic I often had to do sepsis workup (SWU) which included drawing blood and doing lumbar punctures (LP) for



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culture and sensitivity, incision and drainage of abscesses, ear irrigations, foreign body removal from ears nose eyes, sutures of lacerations, and setting of minor fractures, bladder catheterization, vaccination, to name but a few. The neonatal delivery rooms and ED did not always have trained pediatric specialists, so the ED staff would often consult the pediatricians to do resuscitations, and endotracheal tube placements for extremely sick children.

Other high-valued procedures I learned to do were circumcisions, frenotomies to correct tongue ties in breastfeeding children, ligation of supernumerary digits, reduction of nursemaid's elbows, and manual separation of labial adhesions. Some of these are procedures are often not taught in all residency training programs but are important to know in hard-to-reach communities.

After 6 years in this practice, doing all these procedures had become quite routine to me. Had I stayed in academia following my graduation as a general pediatrician, I would never have perfected what I learned during residency, and neither would have I learned the new procedures cited above.

Return to academia

I became a faculty in a large tertiary care institution. Here things were done differently, very differently! One morning, I was preparing to do an LP in one of the outlying clinics where faculty members usually rotate. Then a more senior colleague, who had never worked in a private practice setup asked me with a smile "Hey, what are you doing?" "Preparing to do an SWU of this febrile 3–4-week-old neonate," I replied. "No, no! Do not try to do too much here in the clinic. Just send the patient to the ED." I was soon to realize that senior attendings frowned upon doing even simple procedures such as incising an abscess in the clinic since you could just easily send the patient to the ED next door. I had perfected the performance of certain procedures I learned during residency and in private practice where I had the freedom to do them. My procedural skills during that time gradually dwindled and I was concerned that I would lose these skills as I rose in the academic rank.

I moved to another academic institution. I am glad to report that I was able to restart doing my favorite procedures once more. These are procedures I have taught medical students and residents over the years. Some of these simple skills are especially important for the training of the general pediatrician without the need to refer them to the subspecialists especially if the pediatrician is working in a remote medically "hard-to-reach" community as noted by Iyer et al.²

Comment

Would the recruitment of private general pediatricians be beneficial to train our general pediatric residents? Private practice pediatricians tend to perform more procedures as compared to academic pediatricians especially those working in medically hard-to-reach areas.² A list of common procedures has been proposed by the Accreditation Council for Graduate Medical Education that a pediatrician should acquire prior to graduation,³ but the need of

acquiring skills of these procedures will vary depending on the locality of the pediatric practice. There are no studies on how general pediatricians acquire new procedural skills after graduation when working in the community, but we can speculate that these skills are acquired from their more senior colleagues in the same practice (like in my case), or they may decide to attend special seminars where courses on these procedures may be offered.

Over the past 2 decades, I have been able to train general pediatricians graduating from our program with these skills. This is important, as they can hit the ground running when they join a private practice or decide to start their own practice. Very often general pediatricians, especially those working in hard-to-reach rural areas, serve as consultants to obstetricians, family practitioners, nurse practitioners, and other paramedical staff on health-care issues concerning children. Specialists are not always easily available at the pediatrician's calling to do these simple procedures. The general pediatric resident would benefit by acquiring these skills during residency training or be prepared to spend time acquiring these skills from his or her more experienced private practice colleagues upon joining the practice.

Studies show that pediatric residents may not believe that they are adequately proficient in many common procedures.^{2,4} More studies are therefore urgently needed to determine which procedural skills are needed by trainees because these skills may not necessarily align with those recommended by the Accreditation Council for Graduate Medical Education³ but it is probably more realistic for each training program to tailor this list according to local realities.⁵⁻⁷ Furthermore, a personal list of the needed skills may be determined a priori by each of the graduating general pediatricians depending upon where they will be practicing. Therefore, depending on their individual needs, medical students and residents should rotate through community clinics but preference should be given to rural or other hard-to-reach pediatric practices and/or EDs where pediatricians are likely to be consulted for various procedures.

Recommendation

Training programs should continue to encourage all medical students and residents to rotate in community clinics and local EDs where they may learn various procedural skills. We need more studies on which procedural skills pediatric residents acquire during training and after graduation. Furthermore, we urgently need more studies on how community general pediatricians can effectively contribute to the acquisition of these skills either as adjunct faculty or subsequently as full-time faculty members in training institutions.

Conclusion

It is my perspective that general pediatric training programs could benefit by directly recruiting, full-time faculty members, and community general pediatricians with real-world experience, especially those with experience from hard-to-reach rural areas if they have certain specific procedural skills tailored to the program's needs.

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