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# GME ON-CALL

## Inside This Issue



## A Message from the Co-Chairs

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We are in the midst of the COVID-19 pandemic of 2020 that has brought sweeping changes to everyday life in the U.S. almost overnight. Like other hospitals around the country, Boston Children's Hospital is facing enormous challenges in preparing to care for sick patients infected by the virus and needing medical care, sometimes needing intensive care. The logistics of mobilizing equipment, trained staff, and space to meet the anticipated diagnostic and treatment demands are daunting; the situation is fluid, changing day by day. The uncertainty of what the future holds is disquieting; the fear and anxiety of people are palpable.

We are producing this special issue of the GME On-Call newsletter to remind everyone that we at BCH are still fully engaged in teaching our trainees and providing for their safety and well-being, while ramping up the Hospital's preparations for the inevitable increased volume of patients needing our care. Our house-staff are on the front lines of providing essential patient care services. Along with our nurses, pharmacists, respiratory and physical therapists, physicians' assistants, nurse practitioners, and the many other types of health professionals, our residents and fellows are rising to this singular occasion. We are so very grateful for their service and proud of their selfless dedication to their patients.

In this issue of GME On-Call, we review aspects of teaming in patient care and inter-professional education, two of the newest ACGME-designated hallmarks of a high-functioning clinical learning environment. Read the special article by Dr. Alisha Khan on the advances envisioned in the I-PASS program and how these researchers aim to improve even more the efficiencies of patient care. Also in light of the pandemic, the ACGME has modified its activities and requirements regarding physician training. Read about these immediate changes in GME requirements elsewhere in this newsletter.

Unfortunately, we had to cancel our annual 'GME Day' which had been set for April 29th this year. But we will continue to find new ways to honor and celebrate the outstanding service of our residents and clinical fellows, especially in this challenging moment in time. This emergency has prompted those of us involved in medical education to explore new ways of distance learning and virtual webinars and educational modules to enhance the knowledge and skills of trainees. Using BCH resources such as the OpenPediatrics and SimPeds platforms, training programs are developing curricular content and launching innovative e-learning opportunities. Telemedicine, which has adapted to include trainees as an integral part of their patient experience, has expanded the idea of 'virtual clinic visits'. Virtual visits are now a flourishing aspect of out-patient care.

For daily updates on the COVID-19 situation, please go to the BCH website.


## ACGME COVID-19 Related Directive

In light of the COVID-19 pandemic and the increasing patient care demands on hospitals, emergency departments, critical care units, and clinics in the U.S., the ACGME has relaxed certain requirements, postponed site visits, cancelled some activities, and modified its guidance regarding physician training programs across the country. Here is a brief summary of some of these changes:

- **Accelerated implementation of telemedicine requirements:**

-Effective immediately, the ACGME permits residents/fellows, with direct supervision, to participate in the use of telemedicine to care for patients.
-Definition of 'direct supervision' in telemedicine: "the supervising physician and/or patient is not physically present with the resident. The supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology."
-Those residents and fellows who are capable of providing telemedicine with indirect supervision immediately available are covered under the indirect supervision requirements.

- **Clinical Volume**

-The ACGME recognizes that institutions have reduced the volume of their elective visits and procedures and may redeploy trainees to support the critical services of the hospital.
-Residents/fellows may not be able to achieve the minimum number of visits/ cases as specified in specialty-specific requirements. It is up to the program director, with recommendations from the Clinical Competence Committee, to assess the competence of a trainee as one part of the determination of whether that individual is prepared to enter the unsupervised practice of medicine.
-The visits/case logs of graduates who were on duty during this pandemic (particularly those in their ultimate or penultimate years) will be judiciously evaluated in light of the impact of the pandemic on that program. The program can delineate for the Review Committee how it was affected by the pandemic in the "major changes" section of the annual update.

- **Suspended some accreditation-related activities:**

-Self-Study activities, including the submission of self-study summaries
-All accreditation site visits
-All clinical learning environment review (CLER) site visits
-Resident/Fellow and Faculty Surveys

Ongoing Priorities Programs remain responsible for upholding ACGME requirements to ensure patient safety and resident/fellow safety and well-being. Areas of particular importance:

**1. Work Hour Requirements**
The ACGME Common Program Requirements Section VI Work Hour Requirements remain unchanged.

## ACGME COVID-19 Related Directive continued

**2. Adequate Resources and Training**
Any resident, fellow, and faculty member providing care to patients potentially infected with COVID-19 must be fully trained in treatment and infection control protocols and procedures adopted by their local health care setting (e.g., PPE). Clinical learning environments must provide adequate resources, facilities, and training to properly recognize and care for these patients, including the need to take a complete travel and exposure history in patients presenting with signs and symptoms of COVID-19.

**3. Adequate Supervision**
Any resident or fellow who provides care to patients will do so under the appropriate supervision for the clinical circumstance and the level of education of the resident/fellow. Faculty members are expected to have been trained in the treatment and infection control protocols and procedures adopted by their local health care settings.

*Due to the continuously changing information regarding COVID-19 and relevant requirements and guidelines, please go to www.ACGME.org for the most up-to-date information.*

## 2020 Match: Largest in NRMP History

*A* record-high 40,084 applicants submitted program choices for 37,256 positions in the 2020 U.S. National Resident Matching Program (NRMP). It's the most ever offered in the Match. Highlights of the data include:

- 6,581 U.S. DO seniors submitted program choices - an increase of 1,103 over 2019.
  -Of those, 5,968 (90.7%) matched to PGY-1 positions, pushing the U.S. DO seniors match rate up 2.6% from 2019.

- A record-high 19,326 U.S. MD seniors who submitted program choices, up 401 over 2019.
  -Of those, 18,108 (93.7%) matched to PGY-1 positions, the highest number ever.

- 6,907 IMGs submitted program choices, up 38 from 2019. That's the first increase in three years.
  -Furthermore, 61.1% of IMGs matched to PGY-1 positions, which is 2.5% higher than 2019 and the highest match rate in 30 years

- Of 34,266 PGY-1 positions offered, 17,135 were in the primary care specialties (Family Medicine, Internal Medicine, Internal Medicine - Pediatrics, Internal Medicine - Primary, Pediatrics, and Pediatrics – Primary)
  -This is a 7.4% increase over the number of positions offered in 2019.
  -Of those, 95.4% were filled and 45.1% were filled by U.S. MD seniors.


# Inter-Professional Education (IPE) & Teaming

IPE involves the placement of learners from different health disciplines into an environment where they pursue shared educational goals, learning with, from and about one another. IPE in residency programs is highlighted in the ACGME common program requirements as a core competency in 'systems-based practice'.

"Teaming" recognizes the dynamic and fluid nature of the many individuals of the clinical care team who come together in the course of providing patient care. It aims to foster collaboration among health care professionals from different disciplines so that together, they can provide effective patient care. Teaming capitalizes on their various professional strengths – coordinating care that is both safe and efficient.

**Inter-professional Learning & Development**

The CLE at BCH promotes teaming as an essential part of inter-professional learning. Mock codes, SimPeds, educational presentations, and the BCH-affiliated Institute for Professionalism & Ethical Practice (IPEP) offerings are examples of learning venues that are multidisciplinary in their formats. On-line continuing education and trainee-targeted modules in OpenPediatrics are examples of inter-professional based, 'just in time' learning tools.

In addition, Grand Rounds and other recurring professional educational events at BCH are frequently held in conjunction with input from nursing, social work, or other types of professionals. Inter-disciplinary mortality and morbidity conferences are quality improvement events in which IPE often takes place. Monthly inter-professional workshops offered by the BCH Teaching Academy are examples of professional programming on learning, which share nursing, physician, and other professional perspectives on common clinical issues.

**High-Performance Teaming**

Patients and their parents are engaged in clinical care decisions through family-centered work rounds at the bedside. Family-centered I-PASS based transitions of care are another way that patients and their families can provide input to the care team. BCH also involves parent volunteers who sit on its committees charged with the maintenance of high quality of care and clinical communications.

Daily safety 'huddles' are held on the wards and are multi-disciplinary and inter-professional. Discharge planning is another routine activity where inter-disciplinary communication is a priority to insure clear, consistent messaging to families and patients. Physician orders, nursing care instructions, follow-up appointments in specialty clinics, community supports, the provision of medications and other out-patient management plans must all be aligned to meet patient needs and family expectations.

BCH as an institution includes multi-disciplinary approaches to planning and problem-solving, with inclusion of trainees on many key hospital-wide committees. Our Teaching Academy at BCH is also multidisciplinary in its membership, which includes trainees, psychologists, nurses, physicians and others with an abiding interest in medical education.

**Technology Supports of IPE**

BCH employs updated software in documenting medical encounters, reporting laboratory and other diagnostic testing and monitoring results, prescribing and test ordering systems, etc. IT staff in the Hospital are engaged in continuous improvement with input from the Hospital's health professionals in supporting teaming activities and inter-professional care. Decision support systems, artificial intelligence, and data aggregating techniques employing the 'Patient 360' database also assist the team in rendering the best possible care.

**Teaming & Patient Safety**

Patient safety and quality improvement initiatives can be either 'champion-based' from clinical leaders in a top-down approach or from organic, 'front level team based' origins. Triads of safety teams across hospital wards and units include a variety of health professionals and trainees. IPE and teaming are integrated into the BCH culture of safety. Teams work together to deliver the highest quality of patient care, with trainees participating in continuous quality improvement.

# GME Trainee Spotlight

## DUNCAN MORHARDT, MD, PHD
## PEDIATRIC UROLOGY FELLOW

*Editor's Note: Dr. Duncan Morhardt is a second-year fellow in Pediatric Urology. We asked him in this interview to describe what events led him to his chosen field of study and what his life is like here at BCH.*

**Tell us about where you grew up?**
I grew up in Alexandria, Virginia, outside of Washington, DC. All in all, it was a great town that valued its whole community. I went to the public high school, T.C Williams of "Remember the Titans" fame, where I interacted with people from many backgrounds.

**When did you know that you wanted to become a doctor?**
I took a less traditional route to medicine. I studied molecular biology and rowed at Cal. I liked teaching, navigating, personal interactions and physical work, and so I gravitated toward coaching as my job. At around the time I was to solidify that career fate a year after college, my stepfather was diagnosed with advanced prostate cancer. I found myself looking into the molecular biology papers and research he was sending me about his condition. I would talk to him about what I understood about his disease: how diet or supplements or activity may slow it. Sadly, it was only a couple of months after that he succumbed to his disease. This experience changed my priorities about my career goals and I took a serious look at medicine.

**What has been a big motivating force in your career?**
I have two central motivations: discovery and patients. Research is the best focus for my curiosity and the best outcome of curiosity is discovery. People talk about the "research bug" and that's a feeling of being right on the edge of discovery or making some connection for the first time. Like the pursuit of happiness, the joy of discovery is at is not the end but the journey. It keeps me in the lab and it keeps me asking questions. But there is another bug, if you will: the "patient bug". It is similar to the research bug because it is motivated by genuine curiosity. Those conversations with a patient are such a strong review of any knowledge in its most accessible form. Communicating like that is so satisfying and helps me to see the holes in my knowledge. As a urologist, to fix a problem is the ultimate application of that knowledge. In academics, lab discovery meets definitive patient treatment. While I'm lucky, I feel it is only natural that I would arrive at my purpose here.

**At what point did you know that you wanted to work in Urology?**
In medical school, no one dealt with more intimate and hidden problems than the urologists. The urologists I met were accessible, thoughtful, and tactful. They were funny, too, which helps.

**Can you tell us a little about your (medical) experiences before you landed at Boston Children's Hospital?**
I was a resident at the University of Michigan. It was excellent training in a fabulous environment. For urology, one has adult and pediatric services and many opportunities to talk to patients. One patient, or family more like, made a huge impression on me and probably solidified my direction to work in pediatrics. The boy was about 4 years old with a severe seizure disorder, urinary tract infections, and kidney stones from his diet and medications. He was in the hospital a lot during my rotations. His mother was always with him even though she had four other children. I was impressed with her. She brought a determination to each conversation and made every effort to understand everything that was wrong with her son. Unfortunately, as it true with many complicated and sick children, there were real limits to his treatment options. We would have long conversations (a luxury of residency) trying to reconcile these issues and the management strategy. We often would arrive at the bitter truth-there was little we could do to really improve his status, but we could improve his quality of life. Sadly, her son eventually died at home after a massive seizure. I ran into her in an ER one night because another child of hers had a painful testicle. She mentioned I should stay working with kids. That comment stayed with me.

## GME Trainee Spotlight cont..

**Can you tell us about your current work?**
My fellowship gives us two years of clinic-free research. My lab works in tissue engineering to develop alternatives to bowel as a substrate for bladder surgery. We work with large animals, like pigs and sheep, as well as mice. We test silk fibroin scaffolds to replace esophagus, bladder, and urethra. Aside from that work, I maintain several collaborations at BCH and elsewhere trying to understand and develop better biomaterials to be used as tissue replacement.

**How do you manage your time and bring balance to your life?**
I know some people like to go parachuting or travel the world. That's just not going to happen in fellowship. Besides it's not really a concession. My wife and I have kids. They are really the only balance I need. Getting to spend time with them calms me and helps me feel centered. With kids, you can have them do the things you like to do. So, we go for hikes, build forts, ski, make music, go to baseball, basketball, and hockey, and cook together. Kids bring discovery to those times, and that makes the time we spend together so exciting.

## Wellness During COVID-19

While most have shifted to eWork, Housestaff are on the front lines taking care of patients, but also need to take care of themselves. The GME Office has been compiling a list of wellness opportunities for Housestaff to put to use during these unpredictable times. These opportunities include:

The Boston Children's Hospital Office of Clinician Support (OCS) provides a safe space for faculty and housestaff to talk. This program offers support for any issue a clinician may be having – whether it be work-related or personal. The OCS can be reached at (617)355-6705.

The Boston Symphony Orchestra has created "BSO at Home" – an online hub where listeners can stay connected and engaged while they are unable to host any in-person events at Symphony Hall.
For more information, visit www.bso.org/athome

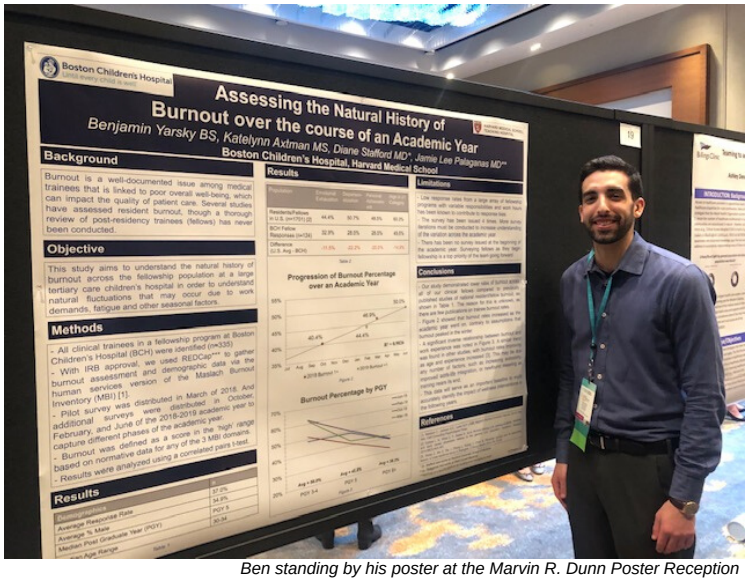
The GME Office created a "Crowd Sourced Virtual Wellness" Google Document which serves as a master list for faculty, housestaff, and administrators alike. Some of these resources include yoga, meditation, and self-care, as well as resources surrounding childcare and education for those who are at home with children.

As always, we are actively soliciting your ideas regarding
wellness at Boston Children's Hospital. Please email GME@childrens.harvard.edu.

# Tracking the Course of Burnout over an Academic Year

**BENJAMIN YARSKY**
**GME DATA ANALYST**

This year's ACGME Conference (in San Diego, California February 27-March 1) featured a Marvin R. Dunn Welcoming Poster Reception, in which we displayed a research poster. Our poster was on the ongoing burnout survey the GME Wellness Committee at Boston Children's Hospital has been running for the past 3 academic years. The survey uses an adaptation of the Maslach Burnout Inventory (MBI) to anonymously determine if a fellow tests positive for burnout, simultaneously collecting basic demographic data such as age range, post-graduate year (PGY), and gender. We surveyed the house-staff about every 4 months, to determine if there was burnout seasonality over the course of an academic year.



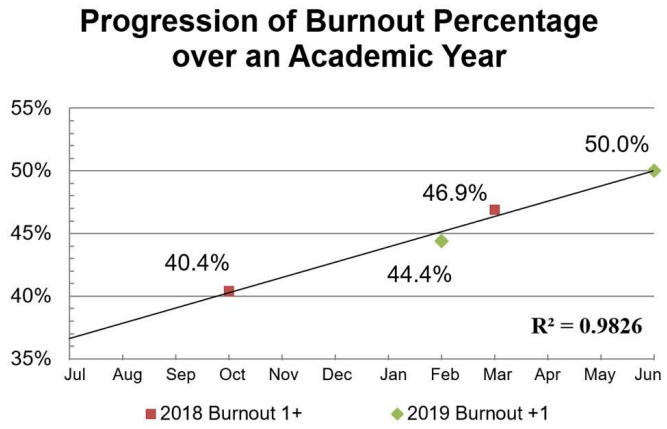

*Ben standing by his poster at the Marvin R. Dunn Poster Reception*

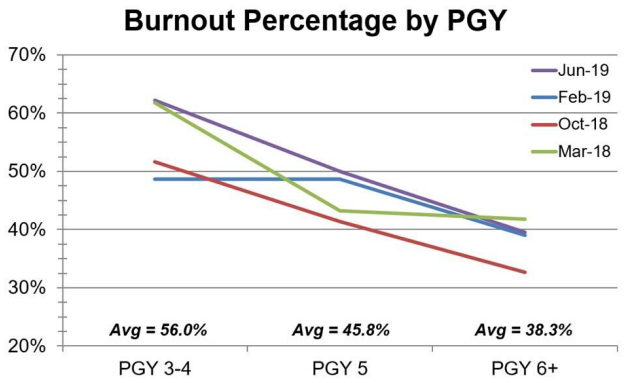
We reported two main findings. The first was that there was a steady increase in burnout percentage as the school year progressed. This was contrary to our initial assumption that burnout peaks in the winter, when the weather is the worst and you're in the middle of the academic year. The other was that as trainees became more experienced (PGY increases), burnout decreased. This seems to be congruous with what others have found in similar studies.

Our poster was very popular at the conference, with many attendees from various institutions from across the country and around the world asking about our methods and findings. We printed out 50 copies of our poster for people to take with them, and by the end of the session they were all gone. Hopefully we will get some outreach from other institutions that are interested in our work.

One poster similar to ours was a poster conducted by an ACGME research team itself. This team included an optional survey at the end of the resident ACGME annual survey that asked about burnout and family life. They also used the MBI, but asked specifically whether the trainee had a partner or children at home. Their findings were that those trainees with children/spouses were less burnt out than those without. This is quite an interesting finding, perhaps pointing to increased fulfillment and work-life balance for those with a family. However, it is important not to take this correlation as causation. It could be that those support systems are lessening burnout, or that those handling the stress well are able to find time to start families. There is also the possibility of selection bias in who takes the time and is motivated to fill out an optional survey.

For any questions or comments on our poster, reach out to Benjamin.Yarsky@childrens.harvard.edu.



# Boston Children's Hospital Well-Represented at the ACGME Annual Educational Conference

**TERY NOSEWORTHY, C-TAGME**
**DIRECTOR, GME**

The ACGME held their annual educational conference from February 27 – March 1 in San Diego, California. More than 4000 DIOs, program directors, coordinators, residents and fellows attended, including thirteen people from Boston Children's Hospital.


The theme of this year's conference was "Meaning in Medicine – Connection and Compassion". With multiple sessions over the course of the three days participants had a chance to learn more about ACGME requirements, best practices and innovations in graduate medical education. All participants gathered together for three keynote presentations. Thomas Nasca, MD, CEO of the ACGME, spoke on the current state of GME. Mona Hanna-Attisha, MD, MPH, author of What the Eyes Don't See, gave a captivating talk about her advocacy work around the Flint Water Crisis, and Eric Topol, MD closed out the conference with a compelling talk on the use of AI in medicine.

# Kaytlyn Darling and Tery Noseworthy Present at the ACGME Annual Educational Conference

Kaytlyn Darling, MHA, C-TAGME, Educational Coordinator in GME and Tery Noseworthy, C-TAGME, Director of GME, were the invited plenary speakers for the Coordinators Forum at the ACGME Annual Educational Conference in San Diego on February 27th. Their talk, "Shifting the Focus: Coordinator-Centered Networks for Personal and Professional Development", was focused on teaching residency/fellowship coordinators how to create a developmental network that can help them achieve their professional goals as well as provide support for them. The presentation combined traditional didactic learning with hands-on and interactive exercises to help participants identify their goals, recognize and improve their individualized developmental networks and learn practical techniques to improve and expand their networks.

Kaytlyn and Tery each gave individual workshop presentations as well.


# Boston Children's Hospital Well-Represented at the ACGME Annual Educational Conference

TERY NOSEWORTHY, C-TAGME
DIRECTOR, GME

Kaytlyn's talk "Empathy and Emotional Intelligence: Why Coordinators need it, how to develop it, and how to teach it" taught coordinators why empathy and emotional intelligence are essential skills for coordinators to possess. Participants confronted ways that coordinators often lack in these areas and learned the importance of cultivating greater empathy and emotional intelligence and how these skills can help improve communication with trainees and program leadership.

Tery's workshop, "Managing up For the Mission: Developing Successful Relationships Within Your Program Team" focused on defining your role, developing strategies for working with different management styles, identifying ways to improve your relationship with your leadership team as well as techniques for dealing with difficult situations.

# HMS Office for Diversity, Inclusion, and Community Partnership

The Harvard Medical School office for Diversity, Inclusion, and Community Partnership has created two videos that can be used by the training programs at the various teaching hospitals to assist in recruitment. The videos - "Training at a Harvard Hospital" and "1st Generation Journeys" are available both on the Harvard Medical School website and via a link on the external GME website for Boston Children's Hospital at https://dme.childrenshospital.org/graduate-medical-education/diversity-inclusion-and-health-equity/.

While the videos include people from across the wider Harvard Medical School Community, Boston Children's Hospital is well represented in both.

*"There are people here who are keenly aware of needing that kind of diversity and seek it out, and so the reality is that the differences that we have can improve patient care, which is the long term goal."*

Kevin Simon, MD

Kevin Simon, MD
Child and Adolescent Psychiatry Fellow
Boston Children's Hospital

# Engaging Families and Nurses on Rounds: The I-PASS SCORE (Safer Communication on Rounds Every time) Program

ALISA KHAN, MD, MPH; KATIE LITTERER, BA; JAYNE ROGERS, RNC, MSN; ISABELLA LISS, BA; CHRISTOPHER LANDRIGAN; AND THEODORE SECTISH, MD

"*Any questions, Mrs. Suarez?" I was a third-year medical student finishing my presentation at the end of family-centered rounds during my pediatrics rotation. Directing my presentation alternatingly at the parent and my attending, the two people I viewed as my most important audience, I presented in the organized: Subjective, Objective, Assessment, Plan (SOAP) fashion. I asked the mother if she had any questions at the end, and when she did not, I felt satisfied. I was oblivious to the fact that by using medical jargon, a parent might not understand. Also, a perfunctory "do you have any questions?" at the end of the interview wasn't the most effective way to engage a parent. In many ways, my presentation was a one-sided performance in which the patient was a spectacle, the parent and nurse spectators, and the attending my judge. In retrospect, there was little that was "family-centered" about my rounds, other than perhaps the fact that we had arranged ourselves in a semicircle around the family at the bedside.*

**Background:** Although family-centered rounds (FCRs) have been practiced for years at many academic centers, the way they occur and whether they are truly family-centered varies. In one BCH study, parents and physicians disagreed about the reason for hospitalization and plan in nearly half of cases, indicating an opportunity to improve communication with families.1

**Patient and Family Centered I-PASS:** Building upon the work of the I-PASS Study group in structuring resident handoff communications to improve patient safety2, a team of over 100 physicians, nurses, and family members across the US and Canada co-produced and studied "Patient and Family Centered I-PASS". Funded by the Patient Centered Outcomes Research Institute (PCORI), Patient and Family Centered I-PASS includes a bundle of interventions to improve inter-professional communication on FCRs.

Targeted learners include faculty, residents, nurses, and families. The intervention consists of:

1) A structured communication framework for FCRs based on the I-PASS mnemonic (Illness severity-Patient summary-Action items-Situation awareness and contingency planning-Synthesis by receiver), emphasizing:
   a) Family engagement
   b) Health literacy universal precautions3
   c) Bidirectional communication
   d) Inter-professional and nurse engagement
2) A "Rounds Report":
   a) A daily written summary of rounds for families organized in I-PASS format
   b) Completed in real-time on whiteboard or on paper
3) A training and learning program:
   a) Interactive learner-specific workshops for faculty, residents, and nurses (e.g., simulations and role-plays, computer-based video modules)
   b) Patient and family orientation and family-centered rounds brochure
4) Strategies to support teamwork and implementation:
   a) Mid-shift afternoon and overnight nurse-physician huddles
   b) Structured weekly observations, assessment, and feedback by observers
   c) A sustainability campaign (logo, posters, other promotional materials)

**Findings:** To assess changes in rates of medical errors following implementation, a rigorous methodology that included family safety reporting was used.4 Harmful medical errors decreased by 38% across 7 North American hospitals following implementation of Patient and Family Centered I-PASS.5 Top-ratings for several components of family experience also improved, as did family and nurse engagement on FCRs. Frequency of teaching on rounds and average rounds duration remained unchanged.

# Engaging Families and Nurses on Rounds: The I-PASS SCORE (Safer Communication on Rounds Every time) Program cont...

**SHM I-PASS SCORE:** In 2018, Christopher Landrigan, PI of Patient and Family Centered I-PASS and Chief of the Division of General Pediatrics at BCH was awarded a $1.8 million, 3-year PCORI grant to disseminate and implement Patient and Family Centered I-PASS in pediatric units of 21 pediatric hospitals across the US. The SHM I-PASS SCORE program refines Patient and Family Centered I-PASS by bolstering the role of the nurse on rounds and enhancing elements of the curriculum (e.g. a flipped classroom approach). To ensure effective implementation, the program utilizes the Society of Hospital Medicine's award-winning Mentored Implementation Program.6 Each site is paired with a mentor trio: a physician, nurse, and family mentor. The mentor trio provides individualized expert support tailored to the individual site's needs to ensure effective implementation of I-PASS SCORE. Four strategies bolster the program: 1) a site visit and needs assessment early in implementation; 2) monthly mentor-site calls; 3) a comprehensive implementation guide and campaign materials to support socialization of the program; and 4) quarterly collaborative calls to share successes and barriers across sites. In addition, regular review of run charts of key adherence metrics, based on rounds observations as well as family and staff surveys, track implementation successes and identify opportunities for improvement via plan-do-study-act (PDSA) cycles.

**Progress to Date:** To date, all 21 sites participating in SHM I-PASS SCORE have begun baseline data collection. Sites implement in a staggered fashion in 2 waves. Twenty sites have begun implementing the intervention; the remainder will do so in the coming months. The study will continue through 2021. Preliminary results suggest wide gaps in baseline perceptions of the role of families and nurses by different team members, identifying opportunities for improvement.7 Study outcomes include rates of resident-reported harms, family experience, and safety culture.

SHM I-PASS SCORE is predicated on the principle that families, nurses, and physicians are equal members of the care team, and that effective teaming on rounds leads to safer and higher quality clinical care. The Patient and Family Centered I-PASS Study Group intends to apply lessons learned from this program to inform future adaptations across a wide range of adult and pediatric settings.

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## Article Recommendation: Combined Training

Jonathan P Palma, Jonathan D Hron, Anthony A Luberti, Early experiences with combined fellowship training in clinical informatics, Journal of the American Medical Informatics Association, , ocaa015, https://doi.org/10.1093/jamia/ocaa015

Combined training, in which a resident or fellow completes two training programs simultaneously, is becoming more and more common over time. While previously restricted to Internal Medicine/Pediatrics here at Boston Children's Hospital, it's now expanded to include many different specialties. Some combined programs are recognized as pathways by both the ACGME and the relevant specialty board, like Pediatrics/Anesthesia and Medical Genetics/Maternal Fetal Medicine; the ACGME recognized more than 200 combined programs in the last academic year. Other dual fellowships must be approved by the relevant specialty boards when programs have a candidate who is interested on pursuing both specialties simultaneously. The program directors for both potential programs must develop a combined curriculum and schedule and apply to each specialty board to obtain approval for the individual fellow.

Over the past few years we've had several fellows in combined fellowships, including Neonatal Medicine, Critical Care, Infectious Diseases, Emergency Medicine and Clinical Informatics. Jonathan Hron, MD, Program Director for Clinical Informatics, wrote an article in the Journal of the American Medical Informatics Association in which he, along with two other Clinical Informatics program directors, describes his experience in establishing dual fellowships. It's an interesting read that describes why they felt it was important to increase the flexibility in Clinical Informatics training and how they got that approved.

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