

# pulse

THE QUARTERLY PUBLICATION OF THE AMERICAN COLLEGE OF OSTEOPATHIC PEDIATRICIANS

## inside...

- Business Aspects of Pediatric Medicine
- Compensated Hypothyroidism
- Sites for Sore Eyes



## What's The Good News? President's Message

Steven M. Snyder, DO, FACOP

The ACOP is working hard to bring value to you, the members. At the AOA Board of Trustees meeting, Dr. Minassale continued to reiterate the core values of the AOA: integrity, competency, vision, teaching, commitment and trust. The values were eloquently discussed by John Crosby, J.D., in his report to the AOA Board. I would like to extend them to you, our members.

**Integrity** – we've continued our dialogue with the AOA and the AAP. They see us as physicians of good character. I was asked by the AOA to represent the ACOP in a delegation traveling to Scranton, PA, to be present when President Bush held his national press conference on PLI. I have offered the ACOP's help to the AAP president, J. Edward Stevens, in his effort to improve access for children to health-care. The ACOP was represented at the AOA's Federal Health Council to plan its legislative

agenda. When your officers and staff get called on to work on behalf of our membership or kids, we produce – that's integrity!

**Competency** – our hard-working staff, under the direction of Elizabeth Harano, our Interim Executive Director, has been exceptional. We are in the second year of the AOA's Marshall Grant for membership. The GME committee, with the ACOP staff, recently completed a marathon session for the purpose of upgrading the residency standards for our training programs. Our convention success (educationally and fiscally) reminds us of the long hours and hard work put in by the staff.

**Vision** – the Board of Trustees has embarked on a strategic plan under the direction of ACOP Vice President Lee Herskowitz. Over the next two years, he will guide us through the planning and implementation stages of this plan. This vision of the Board

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## Recap 2003 Spring Conference

More than 100 pediatricians and students were in attendance for the Spring CME meeting in Bethesda, Md., which was held in conjunction with AOA's D.O. Day on the Hill. The meeting started Friday, April 11, at noon and was completed Sunday at noon. The Friday schedule discussed topics including fetal alcohol syndrome, breastfeeding, and pediatric strokes. That evening, spouses and speakers joined us for a wonderful dinner with a presentation on dermatology. Saturday focused on adolescent issues. The morning started with a discussion on adolescent depression and continued with hyperlipidemia and then autism. An excellent lecture was given on OMT on children with respi-



A view of activities at the Spring Conference.



Dr. Goldman's presentation titled "Magic of Diagnosing and Treating ADHD" at the ACOP Saturday dinner.

ratory conditions and on smallpox. Other lectures given over the day were the Yellow Ribbon Program on teen suicide, sexually transmitted diseases, HIPPA compliance, and growth hormone use in pediatrics. Saturday night's dinner program covered ADHD issues with a little magic thrown in that made for an enjoyable evening. Sunday wrapped up the educational blitz with programs covering coding issues in the pediatric practice, Group B streptococcal disease update, perinatal hot topics, weight management, and legal issues in prescribing medications. Overall the

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**MELNICK  
at large**

Every pediatrician knows it. Whether you call it “Kids Say the Darndest Things” or “Out of the Mouths of Babes...” it’s the same: Unexpected humor and wisdom given to us by our little ones.

Some questions about love were given to a group of children between the ages of five and 10. Results: some hilarious, some more sophisticated than we expect. And all full of fun.

**WHAT IS THE PROPER AGE TO MARRY?**

“Eighty-four, because at that age, you don’t have to work, and you can spend all your time loving each other in your bedroom.”

*Judy, 8*

“Once I’m done with kindergarten, I’m going to find me a wife. Not before.”

*Tommy, 5*

**WHEN IS IT OK TO KISS SOMEONE?**

“You should never kiss a girl unless you have enough bucks to buy her a big ring and a VCR because she’ll probably want videos of the wedding.”

*Jim, 10*

“Never kiss in front of other people; it’s embarrassing if anyone sees you. But if nobody’s looking, I might try it with a handsome boy, but for just a few hours.”

*Kelly, 9*

**IS IT BETTER TO BE SINGLE OR MARRIED?**

“It’s better for girls to be single,



but not for boys. Boys need someone to clean up after them.”

*Lynette, 9*

“It gives me a headache just to think about it. I’m just a kid; I don’t need that kind of trouble.”

*Kenny, 7*

**WHAT IS IT LIKE TO FALL IN LOVE?**

“Like an avalanche where you have to run for your life.”

*Jean, 9*

“If falling in love is anything like learning to spell, I don’t want to do it. It takes too long to learn, and I don’t have much time.”

*Leo, 7*

**ANY OPINIONS ON BEING IN LOVE?**

“I’m in favor of love as long as it doesn’t happen while The Simpsons are on TV.”

*Anita, 6*

“I’m not rushing into being in love. I’m finding fourth grade hard enough.”

*Regina, 10*

**HOW DO YOU MAKE LOVE LAST?**

“Don’t forget your wife’s name; she hates that.” *Roger, 8*

“Be a good kisser. It will make your wife forget that you never take out the trash.” *Randy, 7*

*Reprinted from AAA Going Places, with deep appreciation to Phyllis W. Zeno, Editor-in-Chief*

**Upcoming Events**

**AOA Annual Business Meeting**

Board of Trustees, July 15-17, 2003

House of Delegates, July 18-20, 2003

The Fairmont Hotel  
Chicago, Illinois

**2003 ACOP Annual Meeting & Fall Convention**

October 12-15, 2003

New Orleans Convention Center • New Orleans, LA

## BOOK REVIEW

# Medical Evaluation of Child Sexual Abuse: A Practical Guide

Reviewed By Arnold Melnick, DO

Past president of the American College of Osteopathic Pediatricians Martin A. Finkel, DO, and coauthor Angelo P. Giardino, MD, have collected and edited a compendium so powerful that it ultimately may become the definitive text on child sexual abuse.

Dr. Finkel, director of the Center for Children's Support at the University of Medicine and Dentistry of New Jersey, is one of those rarities: an osteopathic physician whose book is going into a second printing. Quite a recommendation.

Although comprehensive and minutely detailed, the book never becomes pedantic, and although all aspects of evaluating child sexual abuse

are thoroughly covered – medical, legal, forensics, sexually transmitted diseases, nursing, psychological – the book never loses sight of its primary goal: concern for the care and treatment of children. The authors stress that goal by using repeated and varied emphases throughout the book.

Although chapters are written by several authorities, each preserves the continuity and easy reading of the text, and all are outstanding. Scattered throughout the volume are illustrations, figures, and sidebars with detailed explanations, which aptly expand the text. However, the chapter "Medical Evaluation and Physical Examination" is a masterpiece of information, with

specifics that are most educational. The text's approach to taking a medical history and talking with and examining a child could be a freestanding basic text in pediatrics.

In addition to cohesive chapters, Finkel and Giardino include 19 line drawings, 13 pages of colpophotographic case studies in full color, and an appendix of the most important questions parents ask, with appropriate answers that are exactly worded.

As I have known Dr. Finkel since he was a child (which could conceivably influence my view of this book) and out of respect for him as a colleague, I sneaked a look at several other reviews to test my

views. Unsurprisingly, those articles were at least as enthusiastic, laudatory, and commendatory as mine, and all of them strongly recommended use of the book.

This volume should be placed in every medical library and emergency room. It easily serves as a great backup reference for every primary care physician who sees children. It is also great leisure reading for anyone interested in this field. All uses of this book would greatly benefit children, which is the authors' goal.

*Medical Evaluation of Child Sexual Abuse: A Practical Guide*  
Edited by Martin A. Finkel, DO,  
and Angelo P. Giardino, MD. 298  
pps. 2nd ed. Sage Publications Inc,  
2455 Teller Rd, Thousand Oaks,  
CA 91320 2002. \$79.95.

## PRESIDENT'S MESSAGE

*continued from Page 1*

will help chart our course as a professional association over the next several years. Various board members will serve as the cornerstones of the plan.

**Leadership** – your board has continued to advance the mission of the ACOP, to be the preferred professional association for osteopathic pediatricians. We have communicated with the AOA, the state associations and especially colleges. The ACOP provides leadership to the profession in pediatric issues. J. Johnson represented the ACOP on the AOA's Bioterrorism Task Force – that's leadership. Peg Orcutt-Tuddenham and Paul Smith will represent us at the End-of-Life training program – that's leadership. Your board has supported OPAC, the osteopathic political action committee, to help elect osteopathic-friendly candidates – that's leadership.

**Commitment** – we're committed to our members. At our

last CME meeting, ACOP members who were not AOA members were being charged a non-member registration fee. No more! The ACOP board unanimously supported our members. The AOA listened. We will move to a new level of commitment as we introduce the Osteopathic Pledge of Commitment recently adopted by the AOA Board. The ACOP is committed to protecting, promoting and supporting osteopathic medicine.

**Trust** – something that must be earned everyday. Darryl Beehler, the AOA President Elect, looks forward to a day when all osteopathic physicians can say they "trust the AOA." I look forward to the day when all osteopathic pediatricians feel the same way about the ACOP. The ACOP Board and our staff continue to work diligently to earn your trust day by day, week by week and year by year.

As spring brings a renewal of life, so does it renew our commitment to our membership.

**VIEWPOINT**

# Compensated hypothyroidism: to treat or not?

Facilitator: Malcolm S. Schwartz, DO

A 15-year-old female patient with no significant past medical history presents with a 1-year history of dysmenorrhea. Menarche started at age 12, with regular periods since. No symptoms of fever, rash, sore throat, abdominal pain (except during her period), difficulty swallowing, galactorrhea, heat or cold intolerance. No change in her skin or hair texture, and no constipation or diarrhea. Family history is negative for thyroid or other endocrine disease. No surgery or hospitalizations. Physical exam is

notable for no abdominal masses but there is a small palpable goiter.

Laboratory testing reveals normal evaluation of the hypothalamic-pituitary-ovarian axis. Thyroid testing revealed normal T4 but mildly elevated TSH (5.2, normal being .5-4.5). Anti-microsomal and anti-thyroglobulin antibodies are mildly positive. Diagnosis: compensated hypothyroidism. Should the physician treat or not?

**IN FAVOR OF TREATING...**



**Respondent HENRY ANHALT, DO**  
*Director, Division of Pediatric Endocrinology and Diabetes, Maimonides Medical Center, Brooklyn*

Overt hypothyroidism must be treated. This would certainly be the case should a patient have symptoms and biochemical tests consistent with hypothyroidism. It becomes tricky, however, in a state of mild or asymptomatic hypothyroidism. Hypothyroidism is defined by an abnormal rise in TSH. If a repeat TSH is even minimally elevated, the patient should receive treatment. Cholesterol clearance and formation of soluble forms of LDL cholesterol can only happen efficiently when thyroid hormone levels are normal as manifested by a normal TSH. Bone

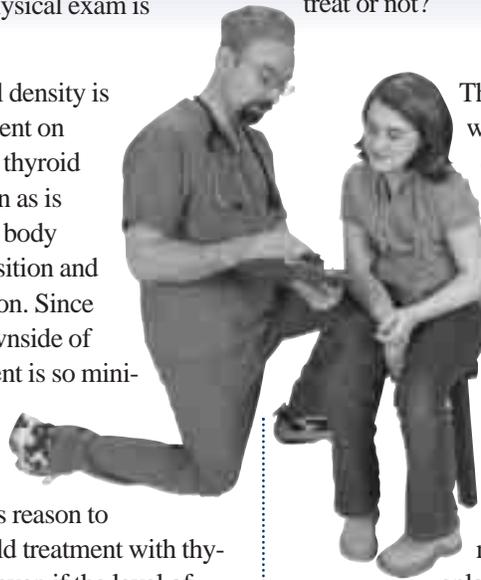
mineral density is dependent on normal thyroid function as is normal body composition and cognition. Since the downside of treatment is so minimal, there is no obvious reason to withhold treatment with thyroxine even if the level of inadequacy is minor. I do not believe that the dysmenorrhea is connected to the mild compensated hypothyroidism but rather represents a red herring.

**IN FAVOR OF NOT TREATING...**



**Respondent MALCOLM S. SCHWARTZ, DO**  
*Chief, Division of Pediatric Endocrinology and Diabetes, Monmouth Medical Center, Long Branch, NJ*

mineral density is dependent on normal thyroid function as is normal body composition and cognition. Since the downside of treatment is so minimal, there is no obvious reason to withhold treatment with thyroxine even if the level of inadequacy is minor. I do not believe that the dysmenorrhea is connected to the mild compensated hypothyroidism but rather represents a red herring.



This young woman demonstrates borderline subclinical hypothyroidism. If the gland is only firm and gritty and minimally enlarged, I

would not hesitate to observe the patient and not to treat until serial TSH determinations reveal an increasing

level. I would also follow serial Free T4 levels to see if thyroid function is impaired. Twenty percent of patients with autoimmune goitrous hypothyroidism may revert to the euthyroid state. In addition, L-thyroxine therapy probably does not influence the long-term progression and outcome of Hashimoto's thyroiditis. Finally, if treatment with L-thyroxine leads to hyperthyroidism, bone mineral density may decrease. Treatment of this young woman can wait until there is further evidence of increasing hypothyroidism.

**2003 SPRING CONFERENCE**

*continued from Page 1*

meeting was a huge success and we are looking forward to seeing everyone at the 2003 Fall Convention in New Orleans.

*The ACOP gratefully acknowledges Braintree Laboratories, Inc.; Elsevier*

*Science, IPS Physician Services, LLC, McNeil Pharmaceuticals, Mead Johnson Nutritionals, Nestle Pediatric Nutrition, PBM Products, Inc. for participating in the ACOP Exhibitor Day.*



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CONSULTATION



**Keeping an eye on vision screening**

**Rachel Anastasia Coulter, OD, FFAO**

Diplomate, Pediatric Optometry and Binocular Vision  
 Chair, Department of Optometric Sciences  
 Nova Southeastern University College of Optometry

Vision disorders are the fourth most common disability among children in the United States. Yet, although most children aged birth to 17 years in the U.S. have access to health care, relatively few young children receive vision screening and eye examinations. Only about 31 percent of children between the ages of 6 and 16 are likely to have had an eye examination in the last year. For preschool children, only 21 percent have been screened for vision problems and only about 14 percent are likely to have had an eye

examination. The consequences of undetected vision problems are significant. Children with vision impairment are more likely to have learning difficulties, trouble participating in sports, and difficulties with psychosocial development.

Long-term consequences include limitation in career choice and increased morbidity and mortality due to accidents.

Pediatricians continue to play a central role in the detection of vision problems. According to the most recent survey of pediatrician routine practice, the majority screen children 4 years and older. However, only one out of three tested visual acuity in children 3 years or younger and sensory binocular vision testing such as stereopsis was done only about half the time.

As many as one out of two amblyopes may be missed in children who have had good access to health care. Comprehensive studies of the vision screening process have revealed multiple reasons for non-detection:

- 1) not screening for children 3 and younger due to age
- 2) not screening due to language in Hispanic children
- 3) no binocular screening for latent strabismus
- 4) failing to notify the parents of a failing result on the screening.

Children at additional risk for vision problems include those with exposure during gestation to drugs or alcohol, those with low birth weight, those with a family history of vision and eye problems, those with systemic syndromes and chromosomal abnormalities.

Research to improve detection and management of vision problems in children is a national priority. Currently, large, national multi-center trials to establish treatment regimens for amblyopia (Amblyopia Treatment Studies) and to compare vision screening techniques for preschool children (Vision in Preschoolers Study) are under way. Smaller, more focused studies evaluate photoscreening and screening differences inherent to ethnicity or socioeconomic group.

The pediatrician in cooperation with eye care practitioners can support screening efforts by reviewing practice approaches, training or re-training personnel and attending continuing education courses on the subject.

PEDIATRIC POINTERS

**Acute gastroenteritis**

Stanley E. Grogg, DO, FACOP

The organisms that cause acute gastroenteritis in the U.S. include viruses, bacteria and protozoa. Rotavirus is the most common viral agent. Shigella, Salmonella, Campylobacter and Yersinia are the most common bacteria, and Giardia the most common protozoan.

An appropriate clinical history is the most important diagnostic clue; you can then decide whether further testing is indicated.

Rotavirus is most common in the winter and is associated with fever, vomiting, diarrhea, and usually a runny nose. The most likely patient is a child under three years of age in a day-care setting. Shigella presents with a very foul-smelling diarrhea and

high fever, but no vomiting; it is most common in the summer. Salmonella presents with fever, vomiting and constipation followed in a day or two by diarrhea. A patient with Campylobacter usually develops very mucousy, bloody diarrhea and fever. Yersinia frequently presents as acute appendicitis with vomiting, diarrhea, fever and right lower quadrant pain. Giardia-infected

patients are afebrile with a lot of flatulence, abdominal distention and foul-smelling, greenish-colored diarrhea.

A CBC may give another clue. Rotavirus will show a lymphocytosis, Shigella a leukocytosis with bandemia, and Salmonella with a normal CBC and a bandemia. Stool examination for ova and parasites will frequently not indicate Giardia; an antigen test is necessary.

## BUSINESS ASPECTS OF PEDIATRIC MEDICINE

### To manage a successful practice: Remember the ACOP

Ronald V. Marino, D.O., M.P.H.  
Associate Chairman  
Department of Pediatrics  
Winthrop-University Hospital  
Director of Pediatric Residency Program  
Good Samaritan Medical Center

The first step in successfully managing the business end of a pediatric practice is building the practice. Without a patient base, billing and collections are unnecessary. Retaining patients in your practice and attracting new ones is the key to success. Remember, patients have many health-care options. Practitioners that personify the ACOP will succeed.

**A**vailability – With most families working between 9 and 5, office hours must include evenings, early mornings and weekends. Patients must be secure in knowing that they have easy access to their medical home. Be certain that all after-hours inquiries are handled with courtesy and respect.

**C**ommunication – It takes time to explain to an anxious parent why you reached the conclusion you did. Time invested in hearing what the parent's real concerns are and clearly explaining yourself will pay divi-

dends in patient satisfaction and adherence.

**O**rganization – Patients are comforted by a predictable, smooth-running operation. The physical environment should be clean and neat. The staff should be well trained to manage all routine requests (referrals, insurance questions, location of consultants, etc.). A well-organized practice runs more efficiently and inspires confidence.

**P**ersonal Attention – No one wants to be considered simply a patient any more than a physician wants

to be considered just a provider. So get to know your patients well. Jot notes that will remind you of personal aspects of this particular patient, such as names of pets, hobbies, career aspirations, employment, vacations taken, etc. Bring up something that will humanize and individualize your encounter. Judiciously share something about yourself - like hobbies, interests, experiences, etc.

By personifying the ACOP in your professional activities, you will have a healthy practice to manage.



**MARK YOUR CALENDAR**

*American College of  
Osteopathic Pediatricians*

**2003 ACOP ANNUAL  
MEMBERSHIP MEETING  
& FALL CONVENTION**

*New Orleans Convention Center  
New Orleans, LA*

**OCTOBER 12 - 15, 2003**

## Distance Learning in Modern Pediatric Education

By Edward E. Packer, DO, FACOP

Decentralized training of our students during their third and fourth clinical years presents many challenges to those of us charged with the task of educating students. Consistent curriculum, particularly didactic material, uniformly presented among all of the various locations is an almost impossible task.

As a partial remedy to this dilemma, our department of pediatrics is using our distance learning equipment that we have installed at our core pediatric rotation sites. The equipment consists of

video cameras and monitors in a designated lecture hall at each location. The instructor, who is located at one of the sites, is able to speak to all of the locations and see and hear all of the locations simultaneously. Using a portable computer, the instructor can transmit computer-generated slides to all of the participating sites to be viewed on their monitors.

Our department's goal is to have a core lecture program broadcast to all of our students during their pediatric rotation to ensure a consistent curriculum. While the goal may be very worthwhile, many challenges are present-

ed. First, the mere task of having students leave their rotation and come to the presentation, at every site, can be overwhelming. Often someone else will have scheduled the room, or the technician will have neglected to have the equipment ready. Preceptors at the clinical sites frequently do not want students to leave when an interesting patient is being presented.

Another challenge is promoting participation from the students. The strength of a distance learning system is the ability to have two-way conversations with all of the students. In a large room with

a television monitor, it is difficult to get students to feel that you want them to speak and answer questions. The instructor usually will have to recruit participation directly from the students to begin any constructive dialogue.

With the modern changes taking place in medical education, newer technologies will become a frequent source of enriching our students' learning experience. Overcoming the challenges posed by the new distance learning technology will ultimately prove to be worth the effort through the rewards it will offer to our students and their educators.

## The American Osteopathic Board of Pediatrics

The American Osteopathic Board of Pediatrics (AOBP), in conjunction with the ACOP and AOA is embarking on an enhancement mission in 2003. From appointing an executive director to revamping the AOBP website, we are hoping to streamline your experience and interaction with the board.

Armando F. Ramirez has been appointed executive director of the AOBP. Mr. Ramirez has been instrumental in all aspects of board operation for more than five years. Not only will he continue in his current role and provide operational continuity but also assist in the creation of a long-term business

plan and continued implementation of AOBP policies.

Our exams scheduled on Oct. 11-12 in New Orleans include General Pediatrics, General Pediatrics Re-Certification and Neonatology Re-Certification. With the institution of time-limited (7 years) certificates in 1995, our first re-certification exam was held last October in Las Vegas. Some of our lifetime diplomates did take advantage of this offering. Other than being both professionally and personally enriching, participating in this board-sanctioned exam may also benefit those whose state licensure or managed care providers require proof of re-certification, regardless of

having a lifetime certificate. The exam application process has been made one step easier also. Our on-line version allows you to enter your information from your PC, print, gather all required support material and mail. This eliminates the print and type step from the process. Another feature: information asked for multiple times is completed for you after it is entered once. This is only one of the enhancements we hope to bring you this year.

The board has also reaffirmed its policy regarding who is deemed eligible to sit for the certification exam. A candidate is eligible to sit for the exam if he or she is training-complete. Training-com-

plete means the ACOP and the AOA have approved a candidate's training. This must be done prior to the candidate sitting for the board exam. Please note the board cannot make exceptions to this requirement.

Look for the launch of a revamped AOBP website, [www.aobp.org](http://www.aobp.org), soon. Presently, the site is up and running with lots of valuable information. We hope to change the look and update the site with more detailed information and links to other useful sites.

We hope to see you all in New Orleans at the AOA and ACOP conventions this October!

## They say...

"Soda is no longer on the menu in Los Angeles public schools. Responding to increasing obesity among youth, the School Board of the Los Angeles Unified School District voted in August to ban sales of soda and other nutrition-poor beverages...before, during and until one half-hour after the school day at all accessible campus sites."

*The Nation's Health (APHA)*

**[Comment:** "Go ahead, make my day." How exciting and affirming that a school district would ban soda pop sales during school hours, acting in the best interest of its student population (despite what has to be a significant financial hit) and sending a very powerful message. This should increase for us health promoters our ammunition to encourage similar changes in our own school districts and support our efforts in nutritional anticipatory guidance with our patients. So a toast to the LA School Board, glass of skimmed milk in hand: "To your health."

— Ruth Worthington, DO]

"Babies are born with a protective instinct to be afraid of new foods"

*Start Healthy*

*Gerber advertisement, approved by American Dietetic Association*

**[Comment:** All species have innate instincts for self-preservation, including selecting foods that are not only nonpoisonous but are nutritionally appropriate for survival. Babies are more instinctive than older children, and therefore need intuitive reassurance to overcome these instincts when presented with unfamiliar foods. Successful feedings are more likely with a parent who is relaxed and non-pressured, and willing to be patient with a more tentative child. Babies easily pick up on verbal and nonverbal cues, and any display of anxiety on a parent's part might be interpreted as a warning about the safety or palatability of a food, and thus lead to its rejection by the infant.

— Janet M. Goldberg, DO]

"The impact of these guidelines (National Heart, Lung and Blood Institute revised guidelines for asthma care) on asthma care in the United States is unclear; since hospitalization rates and mortality continue to rise."

*Philip V. Scribano, DO*

*Connecticut Children's Medical Center  
reported in AHRQ Research Activities*

**[Comment:** It is true that the guidelines have not made a large impact on hospitalization and death rates. This is due to a fatal flaw found in the guidelines. They do not adequately reflect the day-to-day management of asthmatic patients. The guidelines describe fixed situations in the patient's asthma course. The guidelines do not adequately describe visually the ebb and flow of the asthmatic's severity course. In particular, the guidelines fail to show the physician visually how to sail through the swells of asthma management.

— Robert W. Hostoffer, DO]

## SITES FOR SORE EYES

By Gregory L. Garvin, DO, FACOP

Last month I introduced the concept of looking for pertinent journal articles through Medline, and this month I thought I would evaluate a website that allows you to obtain continuing medical education (CME). I recently got a postcard from Medscape about their CME center and Medscape

DrugInfo, so I decided to log onto the Medscape site: <http://Pediatrics.Medscape.com>.

This popular website is part of WebMD, which is a very well known site not only to health-care practitioners but also many of your patients' parents. The homepage for the pediatric site is: [www.medscape.com/home](http://www.medscape.com/home) page and so far I would recommend this as a good site. The links to other specialty and primary care sites are easy to access and it has several nice features you might find helpful in your daily happenings.

The CME center is a link found at the top of the page. This webpage has features of "hot topics" relating to pediatric issues. Registration for a weekly email from the site

with a link to the site can be set up in the registration process to "remind" the subscriber what is happening in the various journal articles that are out there. It is nice from the standpoint that the title will be shown with a synopsis; by clicking on the title of the article you can read

the article and then take a post-test. Best of all this CME is "free," although it won't for sure be

1-AOA credit. I suspect it will be for some lower category. Currently, Medscape offers 3 types of credit: AMA/PRA Category 1 credit hours for MD/DOs; ACPE contact hours for pharmacists; and ANCC contact hours for registered nurses. CME certificates are issued to physicians, and I suspect this is how you will need to get the CME credit for this website at this time and then mail it in with the appropriate form for the AOA. This would be a good site for the AOA or ACOP to work on to simplify the process because another feature of the CME Center is to have a CME tracker, which will keep track of all of the CME you do on the Medscape site. After successful

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By Erika Stewart

**U.S. CONGRESS – HEALTH POLICY OUTLOOK**

*Senate.* Majority Leader Bill Frist (R-Tenn.) outlined an aggressive legislative agenda that he hopes to complete by the Fourth of July recess. Debate on Medicare reform and the prescription drug benefit likely will predominate. The operative deadline for getting any serious business completed during the session is Labor Day 2003 – after that, campaigning for the 2004 presidential election will be under way.

*House.* In contrast to the Senate, the House has aligned itself closely with President Bush’s agenda. The House voted and approved legislation on patient safety (H.R. 663), medical liability (H.R. 5), and smallpox compensation, which the President signed (PL 108-20) on April 30. Votes on Medicare reform/prescription drug benefit, Medicare regulatory and contracting reform (H.R. 810), uninsured, and association health plans are expected by the end of summer.

**PROFESSIONAL LIABILITY INSURANCE (PLI)**

On March 13, the House passed legislation (H.R. 5), sponsored by Rep. Jim Greenwood (R-Pa.), by a 229-196 vote. The bill would cap non-economic damages at \$250,000 and punitive damages at the greater of twice the amount of economic damages awarded to the plaintiff or \$250,000. Economic damages are unlimited. In the Senate, no GOP leadership bill has been introduced. Senator Dianne Feinstein (D-Calif.) worked with Senators Bill Frist and Mitch McConnell (R-Ky.) on a proposal to cap non-economic damages (\$500,000) and provide exceptions for raising the cap to \$2 million or 50,000 times the patient’s life expectancy. However, several groups criticized the plan, causing Sen. Feinstein to cease discussions, thereby jeopardizing bipartisan support for the measure. The Bush Administration strongly endorses the House bill (H.R.5) and is likely to pressure the Senate to act on the issue in hopes of getting a House-Senate conference. Anticipating a Democrat filibuster, Republicans face

an uphill climb to get the 60 votes needed to pass the bill.

**MEDICAID & STATE CHILDREN’S INSURANCE PROGRAM (SCHIP)**

*Administration proposals.* The President’s FY 2004 Medicaid and SCHIP budget reform proposals change the structure of Medicaid and SCHIP funding; states receive a single lump-sum payment instead of annual matching funds. In the President’s plan, states are required to maintain comprehensive Medicaid coverage for the two-thirds of beneficiaries whose income meets federal criteria for coverage. For beneficiaries covered at the states’ discretion, states would have the ability to change eligibility rules and revise benefits. The reform plan also includes legislation to extend the availability of expiring SCHIP allotments to Oct. 1, 2004. A task force of the National Governors Association met on April 10 to help the Administration fill in the details of the reform plan. However, many members of Congress and stakeholders are skeptical of the reform proposal, concerned that it will harm children.

*Medicaid funding.* Meanwhile, members of Congress are trying for a second year to move Medicaid legislation that would temporarily increase the federal medical assistance percentage

(FMAP). Bills in the House and Senate (H.R. 816 and S. 138) are similar to bills that failed during the 107th Congress. Prospects for the House bill are slim as it languishes in the Energy and Commerce Committee. The Senate bill is still in the Finance Committee. The Administration supports more Medicaid funding only within the context of its reform plans.

*SCHIP funding.* The Centers for Medicare & Medicaid Services (CMS) plan to redistribute \$1 billion of \$2.2 billion in unspent SCHIP FY 2000 funding. The distribution plan is limited to one-half of the funds to those states that fully spent their allotment by Sept. 30, 2002. Until Congress passes legislation addressing the issue of expired SCHIP funds, CMS’ interim strategy is to distribute the FY 2000 funds to fourteen states (Alaska, Kansas, Kentucky, Maine, Maryland, Massachusetts, Minnesota, Mississippi, New Jersey, New York, Rhode Island, South Carolina, West Virginia, Wisconsin). SCHIP law allows states three years to use a fiscal year’s allotment. Any unspent funds are reallocated to states that spent their allotment, then eventually returned to the U.S. Treasury.

Reps. Billy Tauzin (R-La.) and John Dingell (D-Mich.) introduced H.R. 531

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# Two New Residency Programs Begin

Two new osteopathic pediatric residency programs have been established and will be starting this year. Edward E. Packer, DO, FACOP, is creating one in South Florida and Robert W. Hostoffer, DO, FACOP, is heading one in Ohio. With the reduction of such programs in recent years, these two start-ups may signal a renewed growth.

The Nova Southeastern University College of Osteopathic Medicine residency will be housed at Palms West Hospital in Palm Beach, the adjacent county to the university. It will be a fast-track pediatric residency of three

years, with three slots for each year—a total of nine residents at capacity.

Palms West Hospital recently constructed, atop their pediatric emergency room, a new 32-bed inpatient unit, including 8 intensive care beds. The ER recorded over 15,000 pediatric visits last year. The hospital has a full complement of pediatric medical and surgical specialties on campus.

The hospital has an active nursery, with 100 deliveries a month. Residents will also serve four months (over the three years) in the intensive care nursery at a sister hospi-

tal, Plantation General, to round out their experience.

In addition, Dr. Packer, the director of the program and Chairman of the Department of Pediatrics at NSU College of Osteopathic Medicine, will be assisted by pediatrician Susan Shamaskin, DO, in providing experience in ambulatory care pediatrics: Residents will have their own mini-practices on the campus site to focus on primary care pediatrics. They will also spend five months working with chronically ill children at the Palm Beach County Health Department, and serve a rotation working with rural migrant children in a nearby

Belle Glade clinic.

The Cleveland, Ohio residency program will be housed at Richmond General Hospital of University Hospital. Pediatric rotations will be done at Rainbow Babies and Children's Hospital of University Hospital.

The program will have a 3-year fast-track course. Residents will be able to take both allopathic and osteopathic boards with opportunity to participate in advanced fellowship training.

Rainbow Babies and Children's Hospital is rated as one of the top children's hospitals in the U.S.

## CAPITOL HILL ROUNDUP

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to extend availability of the allotments from fiscal years 1998 through 2001.\* Senators Jay Rockefeller (D-W.V.) and Olympia Snowe (R-Maine) introduced the companion bill (S. 312) in the Senate. Both bills differ from the Administration's budget proposal to extend the funds for one year only. \*ACOP sent letters to Reps. Tauzin and Dingell and Senators Rockefeller and Snowe in support of their respective bills.

### PEDIATRIC DRUG TESTING

The "Pediatric Research Equity Act of 2003" (S. 650)\* would require pharma-

ceutical companies to test new and already marketed drugs in children. The measure passed the Senate Health, Education, Labor and Pensions Committee. Supporters hope it will pass the full Senate by the end of the session. The Administration supports the bill's effort to codify the pediatric rule. It is unclear if the House will take up the bill this session.

\*ACOP sent letters to Senators Mike DeWine (R-Ohio) and Christopher Dodd (D-Conn.) in support of their bill.

### FYI...

For more information about specific legislation, federal

policy or your legislators, visit any of the following websites:

- *Thomas* <http://thomas.loc.gov>: This Library of Congress site allows you to search for bills by bill number, subject, legislator, even by date. You can learn more about the legislative process or the voting record of your members of Congress.
- *The U.S. House of Representatives* [www.house.gov](http://www.house.gov): Look up your representative, vote information, or committee activity. The key health committees are: Ways and Means and Energy and Commerce.

- *United States Senate* [www.senate.gov](http://www.senate.gov): Research your senators or look up the key health committees: Finance; Health, Education, Labor and Pensions
- *Dept. of Health and Human Services* [www.hhs.gov](http://www.hhs.gov)
- *Centers for Medicare and Medicaid Services* [www.cms.hhs.gov](http://www.cms.hhs.gov)
- *Federal Register* [www.gpo.gov](http://www.gpo.gov): This is the official daily publication for Rules, Proposed Rules, and Notices of Federal agencies and organizations, as well as Executive Orders and other Presidential Documents.

## Sites for Sore Eyes

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completion you can even have the certificate printed immediately by selecting the “View & Print Your Certificate Now.”

As far as MEDLINE articles, which can be searched by a link from this site, you can order full text articles by clicking the “view” link next to the article title in the results list. In the top left of the abstract view is a button, “order full text article \$.” Click this button and follow the instructions. The cost comprises the copy-right fee (generally the bulk of

the total cost) and a retrieval and delivery charge. (This is I think an easy and less costly way to get full-text articles from MEDLINE; rather than belonging to a costly subscription service as I had mentioned in the PULSE article that dealt with MEDLINE.)

To keep things short, I’ll stop here. There are members out there who I know surf the web more regularly than I do, so email me with sites you like and I will pass them on to the other members. My address: ggarvin6@mchsi.com.

## Whaddya Know?

Probably a lot. Probably some keen clinical observations. Probably a few good business tricks.

How about sharing one or two of them with other ACOP members? Contribute your experience in

### **PEDIATRIC POINTERS TEACHING TIPS BUSINESS ASPECTS OF PEDIATRIC MEDICINE**

We’ll help with the writing and editing, if needed. Send your “stuff” to ...

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*Just think: You will actually be helping your colleagues.*



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