



PULSE

THE QUARTERLY PUBLICATION OF THE AMERICAN COLLEGE OF OSTEOPATHIC PEDIATRICIANS

FALL • 2013

Visit the New ACOP Website

ACOP's launched a new website in July, 2013. A fresh new design makes the site much easier to navigate with hot links and drop-down menus.

The homepage includes hot links to ACOP's online publications, conference registration information and other useful information for members and families. The menu bar features drop-down menus for Physicians, Residents, Students, Members Only and Patients & Families.

Please visit the new website at www.acopeds.org. Enjoy!

CLICK HERE



To Visit the New Website!

ACOP at the AOA OMED Conference: Up to 41.5 1-A Credit Hours

September 30-October 3, 2013 • Las Vegas, Nevada

By Robert G. Locke, DO, MPH, FACOP

During OMED 2013, DOs attending OMED from Tuesday through Friday may earn a total of 26 Category 1-A credits. However, it is possible to earn extra credit(s) by attending the Monday sessions (maximum of 9 1-A credits), four breakfast sessions* (a 1-A credit each) and AOA dinner session (2.5 1-A credits). The total number of possible credits that can be earned at OMED 2013, including the extra credit, is 41.5 credits.

ACOP sessions comprise a total of 25 Category 1-A Credit Hours as follows:

Monday, September 30 – 7 credit hours

Tuesday, October 1 – 5.5 credit hours

Wednesday, October 2 – 6.5 credit hours

Thursday, October 3 – 6 credit hours

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2013-2015

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MELNICK at large

Prevent Child Abuse

Source unknown, found on the internet

*My name is Sarah
I am but three,
My eyes are swollen,
I cannot see.*

*I must be stupid,
I must be bad,
What else could have made
My daddy so mad?*

*I wish I were better
I wish I weren't ugly,
Then maybe my mommy
Would still want to hug me.*

*I can't speak at all
I can't do a wrong,
Or else I'm locked up
All the day long.*

*When I awake
I'm all alone
The house is dark,
My folks aren't home.*

*When my mommy does come,
I'll try and be nice,
So maybe I'll get just
One whipping tonight.*

*Don't make a sound!
I just heard a car,
My daddy is back
From Charlie's Bar.*

*I hear him curse
My name he calls,
I press myself
Against the wall.*

*I try and hide
From his evil eyes,
I'm so afraid now
I'm starting to cry.*

*He finds me weeping.
He shouts ugly words,
He says it's my fault
That he suffers at work.*



*He slaps me and hits me
And yells at me more,
I finally get free
And I run for the door.*

*He's already locked it
And I start to bawl,
He takes me and throws me
Against the hard wall.*

*I fall to the floor
With my bones nearly broken,
And my daddy continues
With more bad words spoken.*

*"I'm sorry!" I scream
But its now much too late,
His face has been twisted
Into unimaginable hate.*

*The hurt and the pain
Again and again,
Oh please God, have mercy!
Oh please let it end!*

*And finally he stops
And heads for the door,
While I lay there motionless
Sprawled on the floor.*

*My name is Sarah
And I am but three,
Tonight my daddy
Murdered me.*



President's Message

Scott S. Cyrus, DO, FACOP
ACOP President

AOA House of Delegates

Every year the AOA convenes the House of Delegates (HOD) to discuss the business of the profession. Many from our college attended the HOD, representing their states and other societies participating in the many committees. Past Presidents Robert Hostoffer, DO and Stan Grogg, DO, along with our Advocacy/Media Relations representative Laura Stiles, DO, were in attendance, just to name a few. The ACOP continues to play an active role in the HOD and this year was no different.



*Scott S. Cyrus, DO,
FACOP*

The HOD voted to change the AOA constitution, limiting the number of delegates. The ACOP is represented by a delegate and an alternate delegate and this will not change. The ACOP was represented by Carl Backes, DO, Vice President, and Ed Packer, DO, Secretary-Treasurer, and I thank them for their time and service. This year, John Crosby, JD, Executive Director of the AOA for the past 17 years retired. The AOA Board of Trustees, under the leadership of President Ray E. Stowers, DO, selected Adrienne White-Faines, MPA, as the new Executive Director. For the past ten years, she has served as the Vice President of health initiatives and advocacy at the American Cancer Society and prior to that she served as the Chief Operating Officer at Chicago-based Renewal Emergency Medical Services, a healthcare-based management consulting firm for hospital and physicians. She has two children and her husband is a practicing physician. She described him as an "MD" by education but a "DO" at heart. Please take every opportunity to welcome the AOA Executive Director to the family.

The AOA/OMED is just around the corner and will be held in Las Vegas, September 30-October 3, 2013. The ACOP CME Committee promises another spectacular educational program. This is one of the hardest working committees and I would like to remind everyone to thank the members of the committee for the service. Osteopathic Continuing Certification, as well as a new AOA educational cycle began in January of 2013, which means additional educational requirements to maintain your board certification. ACOP is committed in assisting you in completing OCC over the three year AOA educational cycle. The CME will present an "OCC Boot Camp" designed to complete one component of the requirements. We hope to see you there. I will represent the ACOP serving as the AOA OMED Convention Chair and will have the rare honor and privilege of participating in the opening ceremony of the convention.

As Fall approaches and students are headed back to school, I'm sure some of your practices are busy getting all the last minute well-child exams completed. Obviously, being in different areas of pediatrics, not all our members feel this crunch. We have pediatricians in a wide diversity of access points including education,

emergency departments, research and administration. The medical schools are starting new classes. Students that graduated in May are well into the third-year rotations and the fourth-year students are looking to match to programs in the early part of 2014. The GME Committee has worked diligently to expand the residency positions as well as to approve new programs. This is in response to the national shortage of primary care physicians. Thanks to the committee members lead by Bob Hostoffer, DO, for their fine work. This expansion will provide growth in the ACOP membership. The ACOP continues to be committed to providing a strong professional home for all DO pediatricians.

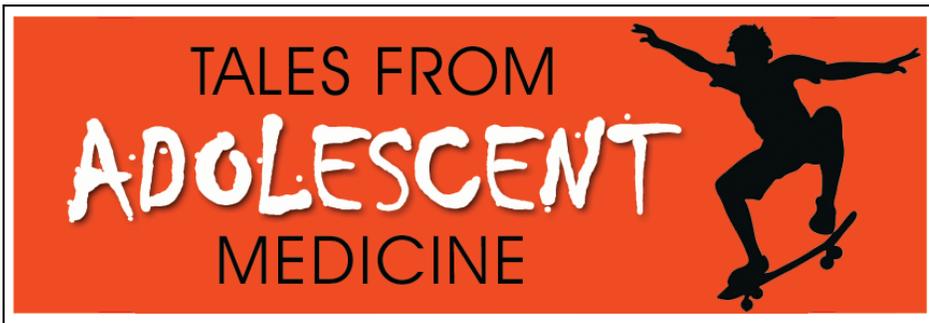
I would like to bring your attention to something new at the ACOP. The administrative staff, along with the Board of Trustees, has rolled out a new webpage design. We have enjoyed the previous webpage, but felt it was time to give the website a new look. The website is full of information and the different menus make navigation easy throughout the site. Thanks go to the administrative staff lead by our Executive Director, Stewart Hinckley, to Association Manager, Kim Battle and to Website Designer, Beverly Bernard for their efforts in completing this project. I hope you will take time to peruse the site and feel free to give us any suggestions to improve or make the website easier to navigate.

As Osteopathic Physicians, we have heard how structure and function work together to move the body. ACOP committee structure is the backbone and participation is the function which moves our college. The college is always eager for the members to become active in our many committees. On our website is a list of committees where you can volunteer. I challenge you to "DO" make a difference. Volunteering can help the organization grow which is very important to the ACOP. Contact Kim Battle at kim@acopeds.org or myself at drcyrus@mykiddsdoc.com to get started volunteering.

I'm look forward to seeing our many colleagues in Vegas and want to remind you of our Spring Conference in Kansas City, MO, April 25-27, 2014, at the Sheraton Kansas City Hotel at Crown Center. We selected Kansas City as another training site, as we did with Columbus, OH, last spring. The success of our last conference spurred us to select Kansas City, not only for the educational experience, but also the camaraderie and good food. The Spring Conference presents the ACOP Harold H. Finkel, DO, and Arnold Melnick, DO, Community Pediatrician of the Year Award and other awards along with an outstanding educational experience. Be safe in your travels.



In perhaps the 70s/80s, ACOP formed an alliance with the American College of Osteopathic Obstetricians and Gynecologists for a combined annual convention. It was successful with numerous exhibitors and outstanding speakers. After running about five years, the partnership was disbanded and ACOP went back to an individual meeting. Harold Finkel, DO, was a key activist in this meeting.



Dr. Castonguay is a physician at the Adolescent Health Center, Division on Adolescent Medicine, Department of Pediatrics, Akron Children's Hospital, Akron Ohio. She has completed a Fellowship in Adolescent Medicine and a Masters of Public Health at Nationwide Children's Hospital and Ohio State University School of Public Health. Questions or suggestions for future topics to be covered in this column? Write us at acopublications@gmail.com.

Pills, Patches and LARCs...Oh My!

By Jessica S. Castonguay, DO, MPH

Teen pregnancy has been declining steadily over the last several decades. However, when compared to other developed countries, the United States has significantly higher rates. According to the Centers for Disease Control, in 2008, there were 68 pregnancies per 1000 girls aged 15-19 in the US. Live births totaled 40 per 1000 girls in this age group.

Approximately 85% of sexually active women using no method of birth control experience unplanned pregnancy within one year. Other non-hormonal methods such as withdrawal and condom use improve this significantly (30% and 25% pregnancy at one year respectively). Eight percent of women using hormonal contraception such as the pill, patch, or ring experience unplanned pregnancy, while 3% of those using the shot became pregnant in 12 months of use.

Increasing use of hormonal contraception is accepted as the leading reason for the decline in teen pregnancy. Most clinicians treating teens are aware of the risks and benefits of the pill, patch, ring, and shot and may even prescribe them in their office. The problem with these methods is that they rely on a patient, who sometimes can't remember to brush their teeth in the morning, to take a pill every day. Or find transportation to the pharmacy every month or an appointment every 12 weeks. For the most at-risk young women, these are true barriers.

Enter long-acting reversible contraceptives or LARCs. LARC options include a subdermal implant and intrauterine devices (IUDs). Effectiveness of these methods is similar to tubal ligation at $\leq 0.8\%$ of users experiencing unplanned pregnancy in 12 months of use. Etonogestrel releasing

subdermal implants such as Nexplanon are inserted into the upper arm during an office visit. Local anesthesia is used and the implant is placed with a special insertion device. In the United States, the etonogestrel subdermal implant is approved for three years at which time it can be removed in the office. The most common reason for early removal is irregular bleeding.

Currently available IUDs include the levonorgestrel intrauterine system (Mirena and Skyla) and the CuT380A IUD (copper T). Depending on the device used, length of use ranges from three to ten years. Many concerns historically surround the use of

IUDs in the adolescent. These include placement only at menses, increased risk of pelvic inflammatory disease (PID), or increased expulsion rates. IUDs may be placed at anytime if pregnancy can be reliably ruled out. While there is increased risk for PID for about three weeks following placement of an IUD, pre-placement screening and treatment for sexually transmitted infection and continued appropriate use of condoms reduces this risk. After the first three weeks post placement, the risk of PID is no different than other adolescent females. The literature on expulsion rates in adolescents is variable. Recent data from the CHOICE study reports that at 12 month follow-up, expulsion rate for adolescents was 6.3% and for nulliparous participants was 4.1%.

Training classes for insertion and removal of the subdermal device is available for providers that would like to insert it. For those interested in placing IUDs, classes at national meetings and observing/placing with a local teacher are options. If these two sentences just sent a shiver of down your spine, have no fear! Call your friendly neighborhood adolescent medicine specialist. We are ready and willing to fight this monster for you.

For more information about the Contraceptive CHOICE Project, visit <http://www.choicproject.wustl.edu/>

By the Numbers: Binge Drinking Among High School Students

		Current Alcohol Use (%)	Binge Drinking (%)	Binge Drinking Among HS Drinkers (%)
Grade	9	30	13	45
	10	37	18	50
	11	40	23	58
	12	45	27	62
Race/Ethnicity	White/Non-Hispanic	39	22	58
	Black/Non-Hispanic	32	10	35
	Hispanic	42	22	55
	Other/Non-Hispanic	32	17	55
Total		38	27	62

Binge Drinking is associated with death, unintentional injury, unintentional pregnancy, acquisition of HIV/STI, breast and other cancers, cognitive decline and alcohol dependence.

Data modified from MMWR. 2013;1:9-13



MEMBERS IN PRINT

Editor's Note: Arnold Melnick, DO, MSc, DHL (Hon.), FACOP, has a storied career in osteopathic medicine that has traversed seven decades. Dr. Melnick was a founding Dean of the Southeastern College of Osteopathic Medicine and the first osteopathic physician accepted on staff at University of Pennsylvania and the Children's Hospital of Philadelphia. He has published over 220 professional articles and ten books.

In his latest book, *Osteopathic Tales: Stories tracing one DO's travel along the path of the Osteopathic Profession from Rejection and Discrimination to Recognition and Acceptance*, Dr. Melnick presents a riveting collection of eye-opening personal anecdotes and reflections on the history and growth of osteopathic medicine and pediatrics. His stories cover the early days of institutional and individual advancement, ostracization, transformation and adaptation that are poignant, humorous, informative and a delight to read. The following is one historical excerpt.

Osteopathic Tales

Stories tracing one DO's travel along the path the of Osteopathic Profession from Rejection and Discrimination to Recognition and Acceptance

By Arnold Melnick, DO, MSC, DHL, (HON.), FACOP

Tale 7: "Drafting Doctors (MDs) Helped"

Tales from the rise of the osteopathic profession are interesting and sometimes fascinating, and they are examples of the profession's fight for obtaining equity. They gained us recognition from official government agencies and from commercial sources. But they did not put patients into DO's waiting rooms!

Probably different people place emphasis on different forces as giving the profession increasing numbers of patients – and with it, acceptance as full-fledged physicians.

One phenomenon cannot be overlooked. It was evident in the 1940s.

At the time I graduated (1945), World War II was ending. Most of us in osteopathic schools received deferments from the draft to complete our medical studies. But an interesting situation was playing out. The allopathic profession, backed by allopathic organizations and powered by MD leaders in the armed-services Medical Corps, declared osteopathic physicians to be "quacks", unqualified to serve in the armed services as physicians, so we were not eligible for commissions. So for the entire war, no DO held a commission as a physician. A few who were drafted rather than deferred were assigned as medical corpsmen.

(Today, that discrimination is gone; our DOs are totally eligible. In fact, just a few years ago, Ronald R. Blank, DO, served as Surgeon-General of the U.S. Army, after a term as Commanding General of Walter Reed Hospital.)

So our graduating DOs went into private practice, mostly as general practitioners. Some (the lucky ones) served one-year internships, and then opened private offices. Overwhelmingly, that is what DO graduates did.

What a situation! MDs were being drafted out of their practice or out of residencies, up to the age of 50 or 55, tremendously diminishing the supply of MD physicians in civilian life serving the general public. Entire neighborhoods were bereft of physicians. Closed offices were everywhere. Meanwhile, increasing numbers of osteopathic physicians were opening offices and being available for seeing patients.

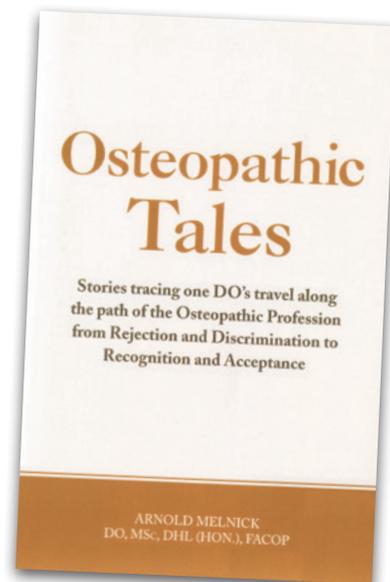
What happened?

Patients seeking medical care had lost their doctors (MDs) and their doctor's colleagues were gone, too. Many patients were desperate. People talk. A neighbor, or friend, or relative, hearing of the distress, responded in one of several ways, such as:

"My doctor is a DO and I get great care. Why don't you call him?"

"I had the same problems; my physician was drafted. I was referred to this DO and I find that he's a regular doctor. I recommend him."

Many patients found competent care, holistic medicine and genuine personal interest – and when the crush was over, they remained loyal osteopathic patients. (It is probably redundant to say that half the credit here goes to the DOs whose splendid medical care convinced the new patients



that they were real doctors.) Of course, some patients retained feelings for their first doctor, or many preferred the old "doc" (and returned to them), but a landslide of patients became patients of the osteopathic physicians – almost by necessity – and many of them stayed.

Literally, the patient load of DOs increased tremendously because of the absence of the drafted MDs. Even the newly-minted DOs were able to build practices very fast.

Thus, this discrimination against DOs by the armed forces backfired. It led to a shortage of civilian MD doctors, and hordes of patients were essentially forced to use osteopathic physicians. Many of these patients appeared to be happy – or at least satisfied – and DO practices flourished. So this MD discrimination actually helped the osteopathic profession to grow. And as these practices grew, many of the satisfied patients referred families and friends to DOs.

This anomalous situation was in great part responsible for the rapid acceleration of the growth of the osteopathic profession by creating innumerable patients available for osteopathic physicians.

Pediatric News & Updates

Newborn Sepsis Calculator: Another Tool for the Pediatrician

By Robert Locke, DO, MPH

Optimal management of the asymptomatic newborn at risk for sepsis is a source of controversy. The predominant guideline used by physicians to determine if an asymptomatic newborn should be evaluated and empirically treated with antibiotics for possible early onset sepsis is the *CDC Guideline for Prevention of GBS Sepsis* (<http://www.cdc.gov/groupbstrp/guidelines/guidelines.html>).

This guideline has both a maternal (obstetrical) component and a pediatric component. The maternal component has been so highly effective that the risk of culture positive sepsis in an asymptomatic newborn infant is a rare event. Empiric treatment with antibiotics of the asymptomatic infant often requires separating an infant from his mother for 24-48 hours.

The *CDC Guideline* is dependent upon the obstetrician's determination whether a mother has chorioamnionitis. As any pediatrician caring for newborn infants knows, the obstetrician's determination of maternal chorioamnionitis can be a fairly subjective determination. Since it is the obstetrician that makes the determination of chorioamnionitis, it is the obstetrician and not the pediatrician who is the medical provider that is determining whether an infant receives antibiotics.

These factors have led a group of physicians and the Kaiser-Permanente Health System under a NIH grant-funded project to develop a Neonatal Sepsis Calculator. The advantage of the Neonatal Sepsis Calculator is that it does not dictate to the pediatrician what should be done, nor does the decision pathway depend upon the obstetrician's determination of maternal chorioamnionitis. Instead, the sepsis calculator provides the pediatrician with predicted risk of neonatal sepsis. It is then up to the pediatrician to determine at what level of risk is it worthwhile to engage in a neonatal sepsis evaluation and empiric treatment with antibiotics. The general risk of early onset sepsis in a newborn ≥ 34 weeks gestation is 0.5/1000 infants.

The Neonatal Sepsis Calculator can be found at: <http://www.dor.kaiser.org/external/DORExternal/research/InfectionProbabilityCalculator.aspx>

Test Yourself

You are called to evaluate a 38-week gestational aged asymptomatic newborn. The obstetrician declared maternal chorioamnionitis. Is there an elevated risk for early-onset newborn sepsis? Mother had a temperature of 100.4° F and rupture of membranes for 14 hours prior to delivery. She received two doses of ampicillin starting over four hours earlier. Group B strep status is unknown.

Answer: Predicted risk is 0.37, which is lower than the population risk of 0.5/1000

AOA and ACGME Fail to Come to an Agreement on Combined Accreditation Pathway

By Robert Locke, DO, MPH

The AOA and ACGME have temporarily dissolved their intention to create a joint postgraduate education accreditation process. The AOA and ACGME have released slightly different versions of why an impasse was reached. Both sides, however, seem to be leaving the door open for future discussions, although there is no information about the timing or construct of next steps. Mechanisms and oversight of licensing and board certification appear to be the unresolved aspect.

Controversy has existed about whether this process will benefit our osteopathic students and profession, although many commentators have felt joint accreditation would benefit osteopathic physicians. Fifty-six percent of osteopathic students receive subsequent postgraduate training in ACGME programs. In 2013, there will be 2000 more osteopathic students graduating than there are osteopathic-approved residency programs.

In the short term, there is the threat that osteopathic physicians who have trained through an AACOM residency may not be eligible for an ACGME-accredited subspecialty fellowship programs. The majority of pediatric programs are dual accredited. In addition, an osteopathic transitional year would not be recognized for credit by ACGME programs. Otherwise, no immediate impact is expected according to AOA statements. Interested parties should view the following two links:

- **AOA FAQ's concerning the failed status of joint accreditation:** <http://www.osteopathic.org/inside-aoa/Pages/acgme-frequently-asked-questions.aspx>
- **Video of Boyd Buser's, DO, video presentation to AOA House of Delegates on July 19, 2013.** This is 35 minutes long, but if you are interested in getting the most amount of information and underlying context from the AOA's perspective, this may be your single best source. (*Note, the AOA website mistakenly states this presentation was in 07/19/12 but the correct date of this video is 2013*). <http://www.osteopathic.org/inside-aoa/Pages/acgme-hod-video.aspx>

Corresponding ACGME statement:

<http://www.acgme.org/acgmeweb/Portals/0/PDFs/Nasca-Community/NascaLetterGMECommunityJuly232013.pdf>

Looking for a Sports Concussion Toolkit?

Check out the American Academy of Neurology's Sports Concussion Toolkit at <http://www.aan.com/go/practice/concussion>

Guidelines • Checklists • Teaching Slides • Case Examples

Welcome New Members!

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Castonguay Appointed to Faculty

Jessica Shannon Castonguay, DO, MPH, has joined the faculty of Akron Children's Medical Center, Division of Adolescent Medicine. Dr. Castonguay recently completed her fellowship in Adolescent Medicine at Nationwide Children's and a Masters of Public Health at Ohio State University. Dr. Castonguay served as the Chief Resident at Nationwide Children's and the dual program at Doctor's Hospital/Nationwide Children's Hospital. Dr. Castonguay graduated from West Virginia School of Osteopathic Medicine and writes the "Tales from Adolescent Medicine" column for the PULSE.

ACOP at AOA OMED Conference

Continued from page 1

The ACOP Pediatric Track

(Please remember to check off "Pediatrician" when registering in order to receive your syllabus.)

Monday: Perinatal/Neonatal Program

The ACOP Perinatal/Neonatal program will focus on such topics as: fetal imprinting; review of umbilical cord and cord blood stem cells; pre-term birth issues; nutrition for the NICU infant; and improving communication in the NICU. What better way to start out a wonderful program than a focus on the newborn.

Tuesday: Adolescent Medicine Program:

This day focuses on adolescent medicine topics, including: talking about sex; eating disorders; addiction; and sexually transmitted infections.

Wednesday: Latest in Clinical Pediatric Research, Pediatric Cardiology and Outpatient Asthma Action Plans

This day will feature a full morning of the latest pediatric research topics including: head acceleration, concussion and helmet design; pediatric allergy research, bacteria on binkies; pediatric dermatology research; childhood obesity research; and EMR research. The afternoon sessions will feature pediatric cardiac lectures and an outpatient asthma action plan lecture.

Thursday: Joint Session with AAO and AAOA

The morning will feature lectures on vaccine resistance, OMM for parents, and teaching parenting skills. There will also be a two-hour OCC Mini Board Review session and a joint afternoon session with the American Osteopathic Academy of Addiction Medicine on human and drug trafficking.

**Some breakfast sessions are tentative. This may affect the total number of CME credits available.*

Visit ACOPeds.org to register!

AMERICAN COLLEGE OF OSTEOPATHIC

PEDIATRICIANS

AOA/ACOP PEDIATRIC TRACK

at OMED 2013

September 30-October 3, 2013

**REGISTER
NOW!**

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iPerch

Reflections by Past Presidents
of the ACOP

Edited by Steven Snyder, DO, FACOP



By Mark Jacobson, DO, FACOP

Mark Jacobson, DO, FACOP
(ACOP President: 1993-1994)

In the 20 years since my ACOP Presidency, I have seen changes in medicine (particularly pediatric medicine) that are mind-boggling: EMR, capitation, increased regulation, use of physician extenders, fewer physician-owned practices and an increase in institutionally-owned practices. I am frustrated and concerned that as the management of primary care falls into the hands of career bureaucrats, the value of the medical professional staff will go lower and lower.

Decisions often made to comply with the needs of regulators, insurance carriers and government agencies can change the quality of care for the patients and the quality of life for the practitioner. Unfortunately, those changes are not always for the better.

Management strategies are often crafted without adequately consulting the clinicians they will affect. The art of achieving National Committee for Quality Assurance (NCQA) recognition or Joint Commission certification are measures of "success" used by the medical management community that may be of little help in the day-to-day practice of ambulatory primary care pediatric medicine.

New medical graduates have grown up in a digital age, giving them a leg up in adjusting to many of today's changes. Unfortunately, primary care has fallen out of favor with those same newcomers, leaving much of the work to those who grew up in a different age. Many established professionals, who remember when a "tablet" was a pad of paper, are often challenged by the increase in work associated with achieving goals set by someone who sits behind a desk much of the day.

The only professionals who can stem the tide of change gripping the medical community are those who are involved in teaching the young people planning to make a career of medicine. The curriculum in medical schools needs to include serious and extensive instruction in the business of medicine. This includes the skills necessary to become part of the medical management team, rather than subject to the management team. Medical schools should be teaching students about the regulators who will control their careers and who will be making the rules. It would make sense for medical curriculums to include courses designed to encourage students to form their own coalitions of medical professionals in the form of multi-specialty practices and other forms of physician-owned and controlled medical care businesses. These entities could be owned and operated by the physicians themselves and would be able to compete in today's world.

Without these tools, the graduates from medical schools throughout this country will only know the business of medicine as it was presented to them in their postgraduate training programs, which are often a part of the same institutional business model with which they will someday compete. Considering the cost of medical education, students should expect to be given the skills not only to provide the best care for their patients, but also to ensure that they themselves will have a rewarding career professionally, financially and emotionally.

The opinions that I have expressed in this article come from having spent the last 15 years as an employed physician at a highly regarded Children's Hospital. The professionals with whom we negotiated a relationship have moved on in their careers. A new breed that has little respect for medical professionals has replaced them. They are frequently motivated by dollars and their own personal advancement. They create red tape, which gets in the way of efficiency. They look retrospectively at quality metrics and rather than creating programs to seriously improve quality, they use their statistics as a means to penalize the professions who are at their mercy. They walk around touting the high marks that their institution gets for quality of care, but rarely give credit to those who actually provide that care.

I recognize that my experience may be limited to the institution with which I chose to partner, but I wanted to express my feelings and tell my story so that young physicians just going into their careers have their eyes wide open.



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Timely and Effective Teaching in a Busy Clinical Practice

By Tami Hendriksz, DO, FACOP

There are a number of different reasons why physicians choose to educate medical students or residents. These reasons include a sense of obligation to return some of the teaching that they received during training, a feeling of personal fulfillment, the ability to refine one's own skills as a clinician and educator, and the necessity of keeping up with the latest medical knowledge and advances. Studies have shown that medical students and residents are looking for a large number and wide variety of patient encounters, quality didactic sessions, supervision by a passionate preceptor who gives prompt feedback, and preceptors who are willing to discuss their clinical reasoning and delegate responsibilities. Finding enough time to adequately teach medical students and residents while meeting some of these expectations can be increasingly challenging in a busy clinical practice.

Educational researchers and experts have explored a variety of ways in which a preceptor can deliver quality medical education in a timely manner. Ideally, a medical preceptor would not need to spend extra time in the clinical setting in order to catch up on work, or see fewer patients during the days when they are with students or residents. One simple technique that can be utilized involves the process of actively thinking out loud. By telling the medical students and residents what they are thinking, the preceptors are able to model good clinical reasoning skills. This teaches reasoning steps, demystifies the medical decision-making process, and gives justification to the plan. Not to mention that it can be done in a very time-effective manner. One example of thinking out loud might be, "Let's see here... he has a dry cough that is worse at night, and a family history of atopy. He has not had any fever, rhinorrhea, or reflux symptoms. At this point, I am leaning towards the diagnosis of asthma. I may not hear any wheezing on the physical exam right now, but I may be able to detect a prolonged expiratory phase which would increase my suspicions." This can foster open communication as well as set the stage for asking questions of the learner, e.g., "What would be the most appropriate next step in management of this patient's cough?"

An additional time saving and successful teaching tool involves having the learner present in front of the patient. With this

technique, the students or residents perform a history and physical exam on the patient and then they bring the preceptor into the room to present their findings. This may be a little intimidating for the learning initially, although they tend to adjust quickly to this format and usually make more concise presentations in front of patients. It also gives the preceptor the opportunity to model history, physical exam, and patient-focused decision-making. Patients also prefer this method because they can hear what is being said about them, get to spend more time with their physician, and have the opportunity to add to or correct the information that is delivered. This approach is not ideal for sensitive issues, but does validate the patient's concerns and strengthens the learner's data collection and presentation skills.

One final efficient and effective concept that is widely utilized at academic medical centers is called the "One-Minute Preceptor." This model involves a cycle of concrete experiences (or encounters with patients), reflection upon those experiences, formulation of conceptualizations and generalizations from those experiences, and then testing those in new situations. In a way it encourages the learner to develop and expand upon their internal illness scripts (methods of organizing and prioritizing syndrome recognition through comparing and contrasting key clinical features in making a diagnosis). There are five basic components to the "One-Minute Preceptor," and these components enable the preceptor to analyze the case and the learner, as well as to take appropriate action to teach the learner. The five components are:

1. Get a Commitment: "What do you think is going on?" The first step in diagnosing learners' needs is to ask them how they interpret the data.

2. Probe for Supporting Evidence: "What led you to that conclusion?" Before offering their opinion on the learner's diagnosis, the preceptors should ask the learner for their supporting evidence. This will reveal the learner's thought process, and



allow both the preceptor and learner to see the extent of the learner's knowledge and the gaps in their knowledge.

3. Teach General Rules: "When this happens, do this." Instruction is both more memorable and transferable if it is offered as a general rule. For example, "The key features of this illness are..." Or, "Patients with otitis media often experience some pain and fever. The tympanic membrane is usually erythematous, dull, and bulging or retracted."

4. Reinforce What Was Done: "Specifically, you did an excellent job of..." Right away, the preceptor should reinforce the good behaviors and comment on the specific good work and its effects. This helps to build the learner's self-confidence and develops more self-directed learning.

5. Correct Mistakes: "Next time this happens, try this." Both positive and negative feedback are best when they are delivered as close to the incident as possible, and when they are as specific as possible. As soon as the preceptor is able to, they should find an appropriate time and place to discuss what was done incorrectly, and how the learner can avoid or correct the error in the future.

With these techniques and tools, teaching medical students and residents in busy clinical practices becomes more doable and less stressful. The preceptor can focus less on the clock and more on the numerous rewards that come from teaching.

A good website resource can be found at: UCLA Department of Medicine Website, The One-Minute Preceptor Webpage. <http://www.med.ucla.edu/modules/wfsection/article.php?articleid=98> Accessed May 1, 2013.

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Rx of Antidepressants Often Done Off-Label

Pediatricians often prescribe antidepressant drugs off-label to children and adolescents. The use of antidepressants in patients 6-18 years old has grown dramatically in the past decade, in small part because of FDA approval for a handful of conditions.

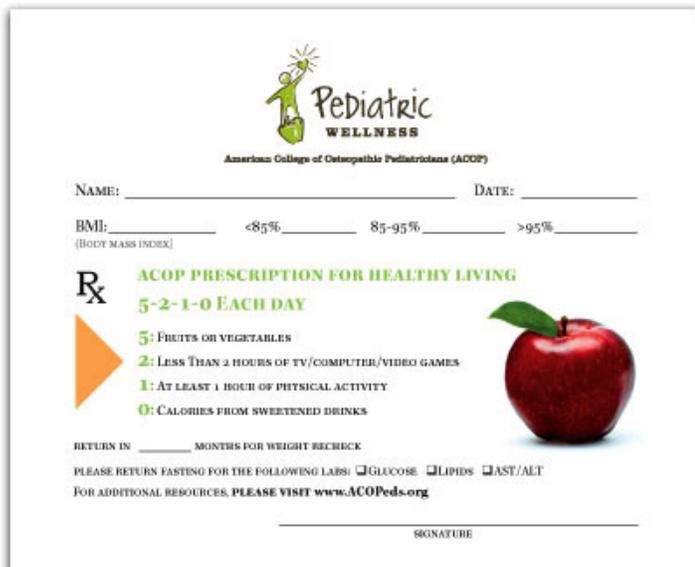
However, only 12 of 32 FDA-approved antidepressants are OK'd for treating pediatric depression or for those over six with obsessive-compulsive disorder or enuresis.

In this study, visits to pediatricians were more likely to be associated with off-label antidepressant orders than were visits to pediatric psychiatrists.

Researchers suggest that lack of available approved pediatric drugs may account for much of this off-label prescribing.

Prescription Pads are Available to ACOP Members

These prescription pads can be used to deliver clear, consistent messages to your patients during the well child exam. This simple tool can help you get your patients and families to start making changes. You can help educate, motivate and encourage all patients to live healthy lifestyles.



The image shows a prescription pad titled "Pediatric WELLNESS" from the American College of Osteopathic Pediatricians (ACOP). It includes fields for NAME and DATE, and BMI (Body Mass Index) with categories <85%, 85-95%, and >95%. The main heading is "ACOP PRESCRIPTION FOR HEALTHY LIVING" with the goal "5-2-1-0 EACH DAY". The goals are: 5: FRUITS OR VEGETABLES, 2: LESS THAN 2 HOURS OF TV/COMPUTER/VIDEO GAMES, 1: AT LEAST 1 HOUR OF PHYSICAL ACTIVITY, and 0: CALORIES FROM SWEETENED DRINKS. There is a red apple illustration. At the bottom, it says "RETURN IN _____ MONTHS FOR WEIGHT RECHECK", "PLEASE RETURN FASTING FOR THE FOLLOWING LABS: GLUCOSE LIPIDS AST/ALT", and "FOR ADDITIONAL RESOURCES, PLEASE VISIT www.ACOPeds.org". A signature line is at the bottom.

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