PULSE

THE QUARTERLY PUBLICATION OF THE AMERICAN COLLEGE OF OSTEOPATHIC PEDIATRICIANS

WINTER • 2015

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DOing Pediatric Education Together: Keeping our Children Safe

As a Joint CME collaborative between the American College of Osteopathic Pediatricians (ACOP) and the American Academy of Pediatrics Section on Osteopathic Pediatricians (AAP-SOOPe), we are pleased to invite you to "DOing Pediatric Education Together: Keeping our Children Safe" conference in Fort Lauderdale, FL.

The theme of this conference centers on patient safety and the most recent scientific advances in pediatric medicine and their application to clinical practice for pediatricians, both osteopathic and allopathic trained. Key topics are covered by recognized experts in a variety of areas. The sessions are specifically designed to update today's healthcare professionals who provide care to infants, children, adolescents and young adults. The course combines lectures, Q&A sessions, research presentations and small interactive group sessions in order to allow course participants the opportunity to interact with distinguished faculty.

This conference also celebrates the 75th Anniversary of the ACOP. The ACOP has positively influenced the education, training and promotion of osteopathic pediatrics for the last 75 years. What a great opportunity to celebrate the success of the ACOP at this 2015 educational conference.

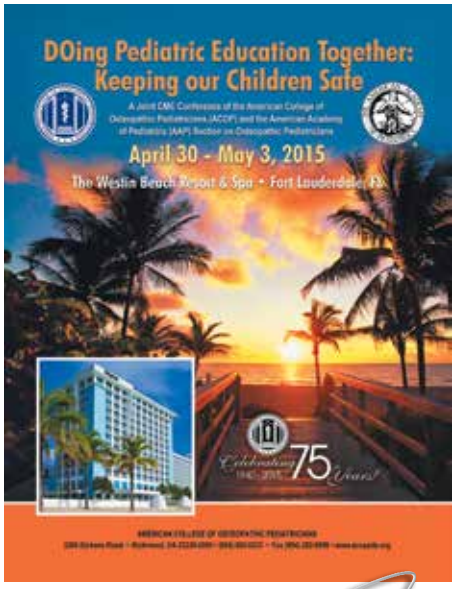
The conference is an opportunity for attendees to obtain both AMA Category 1 and AOA Category 1A credit. We look forward to having you participate in this engaging and informative joint CME program between the ACOP and the AAP Section on Osteopathic Pediatricians.

See you in Fort Lauderdale!

Ed Packer, DO, FACOP, FAAP
Program Co-Chair
Secretary/Treasurer, ACOP

Erik Langenau, DO, MS, FACOP, FAAP
Program Co-Chair
Chair, AAP Section on Osteopathic Pediatricians

Plan Now! Join the Anniversary Celebration!



what's inside . . .

Click on the article title below to view your selection!

PULSE is published four times a year in conjunction with the American College of Osteopathic Pediatricians, 2209 Dickens Road, Richmond, VA 23230-2005; (804) 565-6333 or fax (804) 282-0090.

President's Message

Scott S. Cyrus, DO, FACOP
ACOP President

The single most profound issue affecting the future of osteopathic medicine occurred this past July. The AOA House of Delegates, representing the nation's more than 100,000 osteopathic physicians, passed a resolution to support the AOA Board of Trustees and move forward to an ACGME single accreditation for all of postgraduate medical education. This vote was supported by the ACOP Board of Trustees after multiple conferences, long deliberations and many meetings with the AOA trustees. This momentous vote followed an announcement in February from the AOA and the Accreditation Council for Graduate Medical Education (ACGME) and the American Association of Colleges of Osteopathic Medicine (AACOM) that an agreement to work together had been reached. This means that all post graduate medical education programs, both osteopathic and allopathic, will be accredited by the ACGME. Previously, the AOA accredited the osteopathic residency programs and the ACGME accredited the allopathic programs. This historic agreement will allow all osteopathic and allopathic residents to match to any residency or fellowship program and prevents any osteopathic resident from being rejected for a fellowship because they didn't complete an ACGME accredited residency. Over the next five years, osteopathic residency programs will choose to be accredited by ACGME or to remain with the AOA accreditation. Those graduates from osteopathic programs accredited by the AOA after July 2020 will not be eligible for ACGME fellowships. This agreement gives more freedom of choice to our future residents, but comes with a price.

The price for this freedom is a reduction in osteopathic residency programs. Because of the standards, our programs will be required to comply with the ACGME standards and any standards not met will be addressed on a case-by-case basis. The residency directors will need to be compensated at a much higher rate and be ACGME trained. This will put a strain on financial resources for these programs. This could also mean dual program directors for some programs and more financial resources needed for those programs. The osteopathic programs will have osteopathic-focused residents and will continue the unique principles and practices of osteopathic medical profession. As of early October, we have heard of one of the osteopathic pediatric programs pursuing only ACGME accreditation and not entering into the National Residency Osteopathic Match for 2015. This will decrease the amount of osteopathic residency positions. Within the next five to ten years, it is suspected the National Residency Osteopathic Match will be non-existent.

Scott S. Cyrus, DO, FACOP

The ACOP GME Committee is working with the current residency program directors to help them maintain the Osteopathic distinctiveness and prepare them to apply for accreditation through the ACGME. On November 14, 2014, a new committee of the ACGME named the Osteopathic Principles Committee (OPC) and the Osteopathic Neuromusculoskeletal (ONMM) Review Committee, released proposed standards for ACGME osteopathic training.

The OPC's draft standards for Osteopathic Recognition and the ONMM RC's draft standards for the ONMM specialty are posted on the ACGME website and can be accessed under the "Review and Comments" tab to the right of the home page. Comments on the proposed standards were accepted through December 29, 2014 and members should know the ACOP Trustees and the GME Committee have reviewed the standards and prepared comments as necessary. The ACGME Committee on Requirements will review the standards before they are sent to the ACGME Board of Directors for approval in February 2015. The ACOP is closely monitoring the changes taking place and working with the program directors to maintain as many osteopathically focused programs as possible.

Continued on page 11

MELNICK at Large

Two Attributes Equal "Best"

By Arnold Melnick, DO, FACOP

It has taken me a long time – actually years and years of private practice, hospital practice, conducting medical education in various phases, plus other experiences in life – to reach my conclusion. And that conclusion is: The role of physicians – all physicians regardless of specialty or field of interest – is two-fold: Medical Care and Patient Care.

Yes, there is a difference. Sometimes, a doctor will be great in one and not in the other or many are great in both. The latter group really defines our "best" doctors. Being the best "cutter and sewer," in my opinion, does not qualify one as the "best" surgeon; being the best cardiac diagnostician does not define, in my opinion, the "best" internist; being the "best" in pediatric sciences does not make one the "best" pediatrician. All of them need skills in Patient Care (or Parent Care).

Permit me my own view of the two types. Medical Care obviously is the clinical application of scientific and medical knowledge to the patient's illness or complaints – offering medication or other treatments. Patient Care, on the other hand, is a bit more nebulous. My own view is that it covers such things as ability to understand the patient (not just the illness), to communicate easily, to have and to show interest in the patient's concerns, being supportive, and responsive to questions. Patient comments such as "difficult to talk to," "seems disinterested," or "shows concern for me" or "a joy to go to" offer good patient-pictures of both sides of Patient Care. It is not a question of being humorous or straight-laced, personal or impersonal or such personality characteristics.

Two sample experiences. For my wife's thoracic surgery, I took her to the reputed "best thoracic surgeon" in South Florida. He operated. In effect, the only words he spoke to her in five days were "We'll operate Tuesday morning" and "Are you ready to go home today?" Almost nothing in between, no routine hospital visits, all resident care. Poor, poor Patient Care. On the other hand, my neurologist comes to the waiting room for me when it's my appointment time, we sit in her consultation room (no medical equipment), and discuss my problems and if I need any examination, she takes me next door to her clinical examination room. And always in a communicative and conversational mode.

Both types of care are needed – and wanted – by patients. And it takes both types of care to keep patients really satisfied and happy – good Medical Care and good Patient Care, a combination we should all strive to develop.

Do you have some favorite anecdotes? Personal? Office? Are you willing to share them with me? I'd like to collect them and maybe share them with others. Please send them to ***melnick5050@comcast****.net and be sure to include your name and address (street or e-mail). They will be appreciated.*

Boys' Youth Ice Hockey

Body checking in boys' youth hockey results in a two- to three-fold increased risk of all types of injury, concussion and severe injury. The AAP recommends that restriction of body checking be reserved to elite boys' youth ice hockey levels and not before the age of 15.

Reference:

Reducing Injury Risk from Body Checking in Boys Youth Ice Hockey. Council of Medicine and Fitness, AAP. **www.pediatrics.org/cgi/doi/10.1542/peds.2014-0692**

Osteopathic Education

Difficult Patients

By Tami Hendriksz, DO, FACOP

It is when I think back on my most "difficult patients" that I realize how lucky I am to be a pediatrician. Difficult patients usually fall into one of three categories:

1. Patients with heart-breaking diagnoses
2. Patients whose caregivers challenge the healthcare system/ medical science
3. Patients who are victims of neglect and/or non-accidental trauma

As a pediatrician, it is an honor to work with patients and their families during their most difficult and challenging times. As heart breaking as it may be to deliver an incurable or disconcerting diagnosis, I also know that it is in those moments when my relationship changes with that family forever. I am given the opportunity to help them find some peace and light in all of the darkness. I can help them navigate the sea of new medical terminology, treatment options, second/third opinions, referrals to specialists, hospice care, and more. It is in those moments, through those relationships, when I feel that I can do some of my best and most rewarding work as a physician. The family and I become a stronger team. They are left with the majority of heart-break, and the tough decisions. If I can help ease that path in even a small way, I feel that I have done my job.

The next two groups of difficult patients have nothing to do with the patients themselves; it is their caregivers who are the difficult ones. I have a much easier time understanding the first set of caregivers. They simply want to do what is best for their child(ren). Often times, these caregivers and family members are well educated. They have listened to people in positions of assumed authority (actors, actresses, talk show hosts, scientists, other physicians, and educators). They have heard about the dangers of modern medicine. My husband, who is not a physician, finds this group of people to be very offensive – as though they are suggesting that the knowledge they have gained through media and online resources is worth more value than the knowledge that I gained through medical school and residency. I see it slightly differently.

As a parent, I know what it is like to worry that something bad may happen to your child. That intense, and yet impossible, desire to protect your child from everything can be all-consuming. I see a fantastic opportunity to engage and educate the caregivers who come into my practice with the notion that they don't want to vaccinate their children, or wish to otherwise ignore medical advice. I earned the degree of Doctor of Osteopathic Medicine, not to keep medical knowledge and scientific reasoning to myself, but to be able to share that knowledge with my patients and their families so that they can make the most educated decisions. I share with them the choices I have made for my own children, and teach them how to interpret all of the information they receive from varied sources. Although these relationships are difficult and challenging at first, when I am able to see that the caregivers are trying to do what is best for their children and what will cause the least harm, then our lines of communication open up.

The third and final group is certainly the most difficult. For me, there is nothing worse than to witness the suffering of a child from the hands or neglect of another human. I cannot empathize with those caregivers. One of the biggest roles of a pediatrician is to protect children from harm. We are trained to recognize signs of early abuse and are mandated to report any possible abuse or neglect. The reporting is not the issue for me – it is the knowledge and recognition that such terrible things happen to our children. One of my first patients in residency suffered from "Shaken Baby Syndrome." She was about nine-months-old, and the trauma that she suffered rendered her with very limited ability to move or communicate. She had these big, gorgeous brown eyes that I would get lost in every time I went in to check on her. I found myself spending any free time that I had during my nights on call, not catching a few quick moments of much needed sleep, but in her room. I would hold her, and speak to her gently. She would look at me with those precious eyes. I hoped, above all, that she might start to see that not all people were set out to cause her harm.

The heart and the soul of children remain the same – whether they have an unfortunate diagnosis, well-meaning but misguided caregivers, or have suffered the impossible. That is what makes pediatrics such a beautiful and rewarding specialty. Our "most difficult" patients are still worth all the time, energy, and care that we give to all.

Tami Hendriksz can be found on twitter @ drhendriksz. Send her a tweet about your most difficult patients, your most rewarding patients, why you love pediatrics, or anything else.

Oral Health: < 5 years of age

- Dental caries is the most common chronic disease of children in the US.
- 42% of children 2-11 years of age have dental caries in their primary teeth.
- One-half of pediatricians report examining the teeth of 50% of their patients ages 0-3.

Recommended Practices: (United States Preventative Services Taskforce – USPSTF **http://www.uspreventiveservicestaskforce.org/Page/Topic/recommendation-summary/dental-caries-in-children-from-birth-through-age-5-years-screening**)

1. Prescribe oral fluoride supplementation starting at age six months for children whose water supply is deficient in fluoride.
2. Apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption.
3. Routine oral screening examinations – no recommendation made.

From the EDITOR'S DESK

Choosing Wisely: Moving Beyond "Did You Order the Right Test?" to "Was That Test Necessary?"

By Robert Locke DO, MPH, FACOP
PULSE Editor

Frequently on teaching rounds, individuals question whether someone ordered the right test. The Choosing Wisely Campaign goes beyond that to question, whether the test was necessary. The goal is to increase physician awareness and responsibility to not engage in commonly practiced, but unnecessary or potentially harmful, testing. The campaign started with the slogan, "Five Things Physicians and Patients Should Question." Some societies, such as the AAP, have expanded to ten points as they gain comfort and experience with the campaign. In addition to the greater than sixty subspecialty medical societies participating in the Choosing Wisely Campaign, consumer groups such as Consumer Reports are advocating parent/family awareness of the campaign and engaging in discussion with parents.

The lists of "things to question" are created using a Delphi method. General comments are solicited from a wide group of providers. These are then honed down to a select list of five (or ten) practices that a few subject matter experts can all agree are standards of care.

As a neonatologist, the pertinent lists for me include the Obstetrical and Maternal-Fetal Medicine Societies in addition to the pediatric-based organizations. You might also check out the lists of societies covering family practice, emergency medicine, orthopedics or sports medicine at: Choosing Wisely Campaign **http://www.choosingwisely.org/doctor-patient-lists/**. One goal is reduce healthcare costs, but the most important goal is to improve patient outcomes. The lists are not meant to be absolute exclusions, but to help providers pause and determine if a chosen test or therapeutic intervention is necessary and wise.

BOOK REVIEW

By Robert Locke DO, MPH
PULSE Editor

Nothing is Risk Free in Healthcare: A Handbook for Patients

by Arnold Melnick, DO, Msc, DHL (Hon), FACOP

Patient participation – educated patient participation – improves health outcomes. (See article about the Choosing Wisely campaign on above.) In Dr. Melnick's thirteenth book, he tackles the issue of improving the patient-family awareness of the numerous risks patients encounter while receiving medical care. The book is written from the perspective of a highly educated physician and administrator for patients and family members. Dr. Melnick's perceptions are wonderful and his practical advice is down-to-earth. Families that read this are likely to reduce their risk of an adverse event and, I would suspect, would have greater satisfaction with their physicians and their healthcare.

By the NUMBERS

Preventive Screening Services

By Robert Locke, DO, MPH, FACOP

98%	Newborns screened for hearing loss
50%	Newborns with documentation of follow-up after a failed hearing screening
21%	Infants/toddlers formally screened for developmental delay
33%	1-2 year olds screened for lead
14%	Children receiving preventive dental care (dental sealant or topical fluoride application)
78%	Children screened for vision by age six
69%	Adolescents/young adults screened for tobacco use
20%	Cessation counseling or treatment for youth who screened positive for tobacco
33%	Adolescent females who completed the HPV vaccination series
40%	Sexual adolescent females with symptoms of infection who were screened for Chlamydia
100%	Health disparities based race/ethnicity or socioeconomic status for all measures
100%	Children who should have received the above preventative clinical services For further information: **http://www.cdc.gov/mmwr/pdf/other/su6302.pdf**

PESTILENCE PARAGRAPHS: Pediatric Infectious Disease

Winter is Here and So Is Influenza Season

By Jessica Mondani, DO

As I lay here on the couch with a fever and chills under a mountain of blankets, I am kicking myself for not buying stock in the company that sells Vicks products.

During flu season we, as physicians, are asked repeatedly what we can do to make patients suffering from influenza feel better. Here is a review of the indications for antiviral treatment and chemoprophylaxis in children. As we all know, the sooner this medication is started, the more effective it is likely to be. Giving it within 48 hours of symptom onset, regardless of immunization status, is preferred.

Treatment Indications:

- Any child that is hospitalized, or has severe illness with presumed influenza
- Children in which there is a high risk of complications secondary to influenza infection
  - Children < 2 years of age
  - Patients with immunosuppression
  - Children receiving long-term aspirin therapy and < 19 years of age
  - American Indian or Alaska Natives
  - Patients in chronic care facilities
  - Children with chronic diseases
  - Physician discretion

Chemoprophylaxis Recommendations:

- Children that cannot receive the influenza vaccine or who are immuno-suppressed and at high risk for complications
- Children at high risk who present with symptoms during the two weeks after influenza vaccination
- People who are unimmunized and likely to have exposure to high risk children
- In institutional settings with children at high risk, prophylaxis can be used to help control an outbreak
- For high risk children in close contact with an infected person

Some Helpful Pearls of Wisdom for the Flu Season:

- Take the chance to encourage all your patients to receive the influenza vaccine
- Teach your patients to always wash their hands
- Start chemoprophylaxis early, especially if there is a pregnancy in the household as this has been associated with mortality. Encourage your patients to see their primary care provider
- The capsule form of Oseltamivir may be easily mixed with chocolate syrup or a product of similar consistency for those without access to a liquid formulation

Please refer to the CDC website **http://www.cdc.gov/flu/** for specific dosing instructions based on weight and age. They also have a report called Flu View (**http://www.cdc.gov/flu/weekly/**) that gives weekly surveillance information, so you can stay up to date on the influenza activity in your region.

Celebrating 1940 - 2015 75 Years!

American College of Osteopathic Pediatricians

75th Anniversary Gala

Saturday, May 2, 2015 • 6:00-9:00 pm

$75 per ticket • Black Tie Optional

Tickets may be purchased online through the conference registration form.

Join your friends and colleagues to celebrate the 75th Anniversary of the American College of Osteopathic Pediatricians. Enjoy a reception, dinner and entertainment while reminiscing about our past and looking forward to the future of the College and the osteopathic pediatric profession.

TALES FROM ADOLESCENT MEDICINE

What Can We Do About Bullying?

By Jessica S. Castonguay, DO, MPH

Bullying is a real problem. When I was a resident, we visited local schools and talked about bullying. We discussed what it looked like at home, on the playground, and in the classroom. We taught the children that not intervening was as bad as being the bully. We made everyone participate in role play. More recently, I have been struck by the amount of online bullying in the news and my office.

Often there is discussion about what even constitutes bullying. Bullying may include teasing, spreading rumors, intentionally leaving other kids out, talking about hurting someone, yelling at them, or actually striking them. But kids will be kids, right? Sticks and stones, right?

In *Diary of a Wimpy Kid*, a popular children's book series, no one wants to be the kid that gets the "cheese touch." The kid that gets it is teased and excluded at recess. While fictional characters are teased about touching cheese, others are very self-conscious about their height or ears or nose because their differences have been pointed out by the cool kids. Teasing about weight is a risk factor for disordered eating. Many of my eating disorder patients report being told that they were fat by classmates or oinked at in the cafeteria.

Rumors spread like wildfire! In the movie *Grease*, Kenickie learns pretty quickly while at the drive-in, that Rizzo missed a period. At some point during adolescence, all are part of the rumor mill. It can be as simple as repeating a rumor like the movie-goers in *Grease*. With the advent of social media, rumors spread even faster. Facebook and Twitter add a layer of anonymity to bullying. It makes the bully feel more secure in their brand of mistreatment.

Social media makes it easier to spread rumors about other teens as well. A teen recently let me read her Facebook feed and I was horrified at what I saw. Susie Q is easy. John Doe is gay. Mary is pregnant. It didn't stop there. Embarrassing photos had been posted as well. Other ways that teens use social media to bully includes making fictional profiles on dating sites or Twitter and posing as the victim.

What should physicians tell their patients about cyberbullying? First, think about whether they would want their grandmother or mother to read the post. If the answer is no, they should not post it. Second, be careful with your passwords and sign out of computers in public places. Third, don't be everyone's Facebook friend or Twitter follower. The more connected you are on social media, more likely that something you say will be taken out of context.

As for the bully, I find that they often have concerns that need to be addressed. Are they getting their needs met at home? Are they feeling insecure and put people down to feel better? Are they depressed? Are they bullied elsewhere and they find that they like the feeling of power? The victim deserves to be protected, but the bully might also need support in addition to consequences.

For more information about bullying, visit **http://www.StopBullying.gov**.

By the NUMBERS

Preventing Measles

By Robert Locke, DO, MPH, FACOP

R0 = 12 - 18	One person with measles can infect 12 – 18 other susceptible people – measles is one of the most contagious vaccine preventable diseases
92-94%	The herd immunity level to prevent sustained spread of measles
94%	Effective immunity of single vaccine dose in second year of life
>99%	Immunity in non-immunocompromised children after full measles vaccination series
122,000	Childhood deaths from measles (2012)
100	Number of measles cases in US in 2000
600	Number of measles cases in US in 2014
2-15%	Case fatality rate in the low-middle income countries
0.2-0.3%	Case fatality rate in US
$800,000	Cost investigating and controlling seven measles cases in two Arizona hospitals
48/30	48 US cases of measles, imported from 30 countries

"But vaccines don't save lives – vaccinations do. Vaccines that remain in the vial are completely ineffective." – information and quote from Walter Orenstein, MD and Katherine Seib, MSPH, NEJM Oct 31, 2014.

iPerch

Reflections by Past Presidents of the ACOP

Edited by Steven Snyder, DO, MS, FACOP

By Robert Hostoffer, DO, FACOP

Robert Hostoffer, DO, FACOP ACOP President 2007-2009

When I first joined the American College of Osteopathic Pediatricians (ACOP), I was a first year student attending in the Allergy/Immunology Program at Case Western Reserve University in Cleveland, Ohio. Up to that point, I had never heard of the ACOP despite doing an American Osteopathic Association (AOA) pediatric residency in Columbus, Ohio. The reason for my joining sprouted from my allopathic mentors encouragement to become more active in national societies in order to be promoted in the tenure process.

I soon found out the ACOP mainly acted as a CME society. Individual member's scholarly work was not recognized at meetings. In fact, I brought the first poster to an ACOP meeting in Alexandria, Virginia. There were no poster boards only tables on which I rolled out my poster.

At the ACOP, there was a strong resentment of the AOA and little communication between the two organizations. The American Academy of Pediatrics (AAP) was a non-player since no DO trained pediatrician could join. As I progressed through the ranks, both the AOA and the AAP became more receptive to osteopathically-trained pediatricians. I started attending the AOA House of Delegates and developed political relations with the AOA.

As ACOP President, I needed to connect the three populations of members, those that wanted us merged into the AAP, those that wanted closer relationships with the AOA and those that wanted us to remain independent. I accomplished this by holding meetings alone, with the AAP and then with the AOA. This seemed to work, as it remains our current pattern. I was the first ACOP President to meet with a sitting President of the AAP. We discussed their need to provide AOA 1A CME without the ACOP. We held our ground and continued to do what we had done since I joined.

We started meeting with the AOBP and strengthened our boards. We developed vaccine, resolution, student and resident committees. We needed an outlet for scholarly work for our students, residents and attending physicians. The *eJournal* was born. An *eJournal* Committee and editorial staff was formed and a professional submission service appeared. The *eJournal* provides a vehicle for scholarly activity to complement the *PULSE* and as an important avenue for OCC for ACOP members. To add to the scholarly activity, we developed poster sessions at our meetings. These have exploded and competitions between residencies to enter the most posters has evolved. A Research Committee was developed to judge the best posters.

We slowly developed residency positions throughout the country. With the help of many people, the positions have increased. Student membership expanded beyond expectations. New basic standards were created and our profession developed unique training scenarios.

I have been proud of our students, residents, fellows and attendings. Their strength, intensity, consistency and courage allowed me to lead our college into a strong future. Our leadership now is poised to continue the vision of the osteopathic pediatric profession.

My frustrations as President were never with the ACOP, but with organizations that wished to interact, control or absorb it. I struggled to keep the college independent, cohesive and offering opportunities to the membership no matter what their slant.

New challenges lie ahead for the ACOP with the new merger of the AOA and ACGME. The future Presidents dealing with this merger will need to offer more and different opportunities to their members. I, like all Past Presidents, will never leave my beloved ACOP, but will be silently in the wings guiding our future Presidents through the wakes of medical education.

CALL FOR ABSTRACTS

ONLINE ABSTRACT SUBMISSIONS

Abstracts are currently being accepted for DOing Pediatric Education Together: Keeping Our Children Safe; a joint CME conference of the American College of Osteopathic Pediatricians (ACOP) and the American Academy of Pediatrics (AAP) Section on Osteopathic Pediatricians.

The submission application and guidelines are only available online. Visit www.acopeds.org/conference for the link to the abstract submission page.

No abstracts will be accepted after the submission deadline date.

SUBMISSION DEADLINE
Friday, February 6, 2015 4:59:59 PM EST

NEW - DIGITAL POSTERS

For the first time, ALL posters accepted for presentation will be displayed digitally on large video monitors in the poster hall. If your abstract is accepted, you will receive full details and instructions for submitting your poster electronically. Printed posters will not be accepted or displayed.

2015 ACOP/AAP CONFERENCE
April 30-May 3, 2015
CONVENIENT ONLINE REGISTRATION!

Visit **www.acopeds.org/conference** to register for the conference and to book your hotel reservations online. Registration rates increase after March 27, 2015. Printable forms are also available at **www.acopeds.org/conference**.

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Kaitlin K. Park, DO ..... Detroit, MI
Amy Vagedes ..... Columbus, OH

Resident

John Lukeman, DO ..... Tulsa, OK
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Salma Mohammadi ..... Fuquay-Varina, NC
Courtney Moore ..... Coats, NC
Kelly J. Moore ..... Pikeville, KY
Shylah K. Napier ..... Pikeville, KY
Jacqueline Nghiem ..... Voorhees, NJ
Nina Ngo ..... Yakima, WA
Samantha Nieves ..... Dothan, AL
Lindsay K. Noah-Vermillion ..... Yakima, WA
Alexander L. Nourse ..... Dothan, AL
Alyssa N. Nowak ..... Lansing, MI
Samantha R. Paglinco ..... Voorhees, NJ
Jessica Parker ..... Lillington, NC
Lindsey A. Peragallo ..... Voorhees, NJ
Kelli R. Pratt ..... Pikeville, KY
Deseree S.A. Prentice ..... Dothan, AL
Cara Puzzio ..... Fuquay-Varina, NC
Jessica M. Rankin ..... Taylor, MI
Carolyn V. Ranten ..... Yakima, WA
Jillian Rau ..... Fuquay-Varina, NC
Joshua M. Reynolds ..... Lynchburg, VA
Shannon Rodgers ..... Coats, NC
Luisa F. Rodriguez ..... Paterson, NJ
Marcos Rosado ..... Dunn, NC
Thomas F. Rutherford ..... Decatur, IL
Austin D. Rutledge ..... Pikeville, KY
LeAnne Sancrainte ..... Brighton, MI
William Scharpf ..... Buies Creek, NC
Shannon M. Seckel ..... Selah, WA
Aditi S. Shah ..... Voorhees, NJ
Prachi Shah ..... Pikeville, KY
Adena Shahinian ..... Dothan, AL
Kevin M. Sigley ..... Yakim, WA
Samantha N. Silvent ..... Voorhees, NJ
Meredith St. Clair ..... Buies Creek, NC
Megan Stangeby ..... Coats, NC
Joseph G. Stathos ..... Pikeville, KY
Adam T. Stranberg ..... Yakima, WA
Kristin Stuive ..... Lillington, NC
Erin L. Swieter ..... Sedro-Woolley, WA
Lindsey M. Tanaka ..... Auburn, WA

Continued on page 10

Inside Look at ACOP Board Member

Student Trustee: Christine Beeson
Third Year, A.T.Still University/KirksvilleCOM

By Katherine Locke

How are you participating in ACOP?

In my first year of medical school, I joined the school's chapter and I was elected first year representative. In my second year, I was elected pediatric club President. I connected from the beginning, but I really became active in my second year. I went to the ACOP Conference in the Spring of 2014. And then I applied for, and was chosen to be, one of the student trustees.

What made you want to increase your engagement with ACOP?

From the start, I loved what ACOP represented. I've always wanted to be a pediatrician, but I wasn't committed to the DO way of life until medical school. I wanted to be involved with an organization promoting that.

What is ACOP doing for you?

ACOP provides really great conferences with great topics where one can learn cutting-edge testament modalities, new information and new guidelines. There are lots of opportunities to collaborate with healthcare professionals around the country. ACOP also offers great opportunities for students to network with residents concerning applications. I really appreciate the collaboration that happens.

What are you doing for ACOP?

I helped Bret Nolan, the other student trustee, organize the student track for conferences, the residency program directors presentations that all students really love, and the interactive sessions. I act as a bridge of communication between all of the individual medical school clubs. I also help organize and maintain the email account and the social media accounts. That helps with connecting not just at conferences but also inspires year-round collaboration between student chapters.

What are your future plans?

I want to be an osteopathic pediatrician and I might be interested in neonatology. I would like to practice in Oklahoma where I'm from and stay involved in an Oklahoma chapter of ACOP. I'm passionate about doing a DO residency in pediatrics.

What's the best part of participating on the Board?

My favorite part of participating on the Board as a Student Trustee is getting to know the other Trustees! The Board of Trustees can be an intimidating group. It's been neat to see how down to earth and friendly all of the Board members are. Students crave that one-on-one face time with them. It's been great to know them on a professional level and a social one, like going to dinner and having great conversation about things that aren't medicine. That face-to- face time has been very rewarding to me.

Any advice and insight that you'd like to pass along to your peers?

Don't be intimidated just because someone is a Board of Trustee member. Get involved in as many ways as you can on both the local and national levels of the organization. Take advantage of all the resources ACOP makes available, from conferences to the PULSE newsletter. Stay current on things that are changing. Be a part of the discussion, especially early on, because it's not going to get any easier with residencies and moving and careers. If you wait until you're already a professional to get involved, there will be too much on your plate. Get involved early and often!

Tell PULSE something interesting that your fellow Board of Trustees and ACOP members may not know about you?

I play the oboe in my community orchestra!

New Members

Continued from page 9

Kate Taylor	Raleigh, NC
Alison L. Toback	Marlton, NJ
Thao B. Tran	Yakima, WA
Violeta G. Tregoning	Yakima WA
Kimiko Tsuchiya	East Lansing, MI
Jessica M. Tyrrell	Voorhees, NJ
Jillian N. Uzdzinski	Cherry Hill, NJ
Scott C. Ventre	Lindenwold, NJ
Richard W. Wadsworth	Yakima, WA
Jamie Weaver	Lillington, NC
Dean M. Weich	Dothan, AL
Caitlin Whaley	Buies Creek, NC
Christina M. Wika	Pikeville, KY
Shelby R. Zaremba	East Lansing, MI
Hannah R. Zeltzer	Dothan, AL

Protecting Pregnant Women and Infants Through Family Vaccination

Women are at high risk of having serious complications from influenza during pregnancy. Infants are highly susceptible to acquiring and developing significant illness from influenza and pertussis. An excellent strategy to protect a pregnant woman, the pregnancy and infant after delivery is for the mother and other family members to be vaccinated. Tdap is recommended between 27-36 weeks of each pregnancy. Inactive influenza vaccine is recommended during any trimester. Pediatrician promotion of vaccinations during pregnancy to a mother and other family members are essential component of keeping a mother-fetus and new infant healthy.

President's Message

Continued from page 2

This past October, the ACOP once again joined the AOA at OMED 2014 in Seattle, Washington. The ACOP CME Committee again put together a wonderful educational program. My congratulations go to Judith K. Thierry, DO, MPH, FACOP, FAAP, Program Chair and Edward E. Packer, DO, FACOP, Program Co-Chair, as well as Marta Diaz, DO, FACOP, FAAP, CME Committee Co-Chair and Ed Spitzmiller, DO, FACOP, CME Committee Co-Chair and the entire CME Committee. On Saturday, the perinatal/neonatal program occurred and I congratulate Chair, Barbara D. Ianni, DO, FACOP and Co-Chair, Abraham Bressler, DO, FACOP for a spectacular seminar. The work of so many physicians is greatly appreciated and I also want to thank the staff and Executive Director of the ACOP. My CME theme for past two years has been "A Check-up from the Neck Up" and is focused on the toxic stress that our children are dealing with every day. A number of lectures were presented to address this issue for the practicing pediatrician. We also joined the AAO for our OMT workshop. This was very well attended and provided hands-on demonstration of OMM techniques for children.

The next CME conference will be April 30 - May 3, 2015 in Fort Lauderdale, FL. This will be the 75th Anniversary of the ACOP. This meeting will be in conjunction with the American Academy of Pediatrics Section on Osteopathic Pediatricians and promises to be a conference to remember with a 75th Anniversary Gala Celebration as well as a spectacular educational meeting.

Last, but certainly not least, I would like to congratulate one of our own, Michael Hunt, DO FACOP. He spoke at this year's AOA OMED and has been named to *Becker's Hospital Review's* "100 Hospital and Health System CMOs to Know." This is a list based on individuals' experience in overseeing medical and quality affairs at their respective organizations. Currently, Dr Hunt serves as the CMO and CMIO of St. Vincent's Health Partners in Bridgeport, CT. Congratulations to him and please be sure to share your own accomplishments so that we may share them with the rest of the ACOP family.

I hope your holidays are blessed and that 2015 brings you success, happiness and good health for you, your family and your patients.

Meeting of the Advisory Committee on Immunization Practices (ACIP)

Centers for Disease Control and Prevention
October 29-30, 2014

By Stan Grogg, DO, FACOP, FAAP
AOA Liaison

Summary of Significant Discussions at the ACIP Meeting:

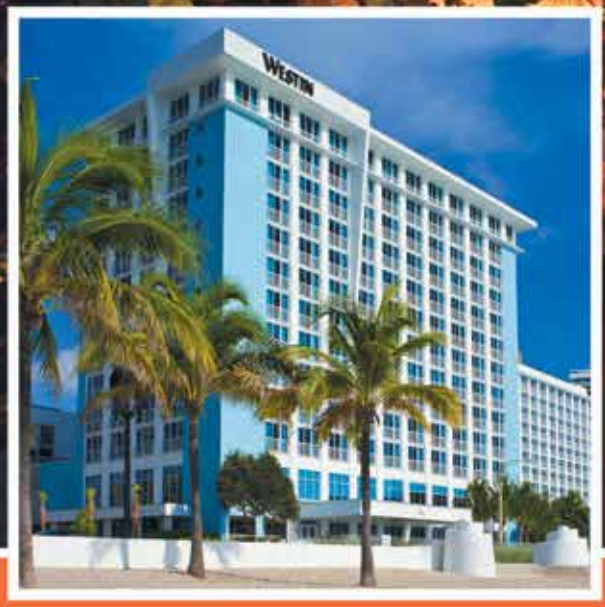
- The Live Attenuated Influenza Vaccine (LAIV) was found not to be effective against H1N1 pdm09 for the 2013-14 seasons. LAIV was highly effective against B strains.
- Several agencies are working to develop an Ebola Vaccine.
- Afluria Influenza Vaccine administered via PharmaJet stratis Needle-free Injection has good satisfaction surveys.
- H5N1 (Bird Flu) remains a global concern.
- ACIP Pertussis Vaccines Work Group (WG) does not propose changes to the current ACIP Tdap recommendation for Health Care Providers (HCP)
- The ACIP voted to accept the General Recommendation Work Group's updates.
    - Injectable Influenza Vaccine (IIV) and Pneumococcal Conjugate Vaccine (PCV13) can be given at the same time (minor increased incidence of febrile seizures).
    - Vaccines can be given pre- and post-op period.
    - Multi-dose vials are to be used for more than one patient.
    - If a dose of Hep B is given Sub Cut, another dose should be given IM.
    - If Rabies Vaccine is given Sub Cut, it should be repeated IM in gluteal area.
    - If Human Papillomavirus Vaccine is given Sub Cut, it should be repeated IM.
    - If Meningococcal Conjugate Vaccine (MCV4) is given Sub Cut, it does not need to be repeated.
    - Polysaccharide vaccine meningitis vaccine (MPSV4) is approved for Sub Cut.
    - Hepatitis A Vaccine, if given Sub Cut, does NOT need to be repeated.
    - Hib if given Sub Cut, does NOT need to be repeated.
    - PCV13 and PPSV23 should NOT be administered simultaneously because of decreased immunologic responses. PCPV13 should be administered first.
- ACIP voted to approve the Child/Adolescent 2015 Immunization Schedule – these will be posted on the ACOP website upon final approval.
- ACIP voted to approve the Adult 2015 Immunization Schedule – these will be posted to the ACOP website upon final approval.
- Hepatitis A is increasing. It is believed to be related to travelers not receiving the recommended second dose.
- Vaccination is recommended for young children and adults at increased risk of Hepatitis A infection, e.g., travelers and people with chronic liver disease.
- Rates of Meningitis in the U.S. continues to decline, Serogroup C and Y are decreasing more rapidly than serogroup B.
- Men B by Pfizer was Approved by FDA on October 29, 2014.
- ACIP voted to approve the administration of typhoid vaccines to be used according to vaccine PI (had not been reviewed since 1994).
- Discussions continue on Merck's Investigational 9-valent HPV vaccine and a two dose schedule.

DOing Pediatric Education Together: Keeping our Children Safe

A Joint CME Conference of the American College of Osteopathic Pediatricians (ACOP) and the American Academy of Pediatrics (AAP) Section on Osteopathic Pediatricians

April 30 - May 3, 2015

The Westin Beach Resort & Spa • Fort Lauderdale, FL



Celebrating 75 Years! 1940 - 2015

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