

pulse

THE QUARTERLY PUBLICATION OF THE AMERICAN COLLEGE OF OSTEOPATHIC PEDIATRICIANS

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- Business Aspects of Pediatric Medicine
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President's Message

Steven M. Snyder, DO, FACOP

To members of the American College of Osteopathic Pediatricians (ACOP)

Dear Member,

I wish to inform you that our Management Services agreement with the AOA, through the Department of State, Specialty Colleges and Socio-Economic Affairs, has been terminated by the AOA. The ACOP has been diligently working with the AOA toward a renewal of our management agreement for the last year. In November, the ACOP Board met with the AOA Management Team including ACOP Executive Director Elizabeth Harano, Michael Mallie and the Executive Director of the AOA, John Crosby. It was our understanding and hope that we had reached accord at that time to continue with Management Services under the agreed-to terms. The Board met again when the renewal contract was returned for our

evaluation. We signed the contract and returned it together with a letter to the AOA clarifying our needs and stating our desire to continue our relationship.

The AOA chose not to renew the Contract and then gave us 90 days (per the condition of our original contract), to make a transition to new management services. They have been unable to satisfy our needs and we will depart amicably.

The Board and the Executive Committee have met and assessed the state of affairs. At present, we are diligently evaluating new management services while we continue the work of the college. An RFP (Request for Proposal) is being prepared and will be sent out to a number of management services that the Executive Committee has contacted. These services have expressed interest in considering management of the ACOP to help us achieve our goals as outlined by our

ACOP FALL 2003 CME A HUGE SUCCESS

Elizabeth F. Harano, Executive Director

"The quality of lectures continues to improve and rival the MD counterparts."

"Dynamic speakers are frequently hard to find and this year the ACOP did a great job of having several... People say both last & this year's ACOP lectures were the best of the conference!"

Each year, the ACOP offers two high-quality osteopathic pediatric CME programs for its members and guests. Beginning in 2002, the ACOP Fall CME and Annual Meeting of the College have been held in conjunction with the AOA Annual Convention. The 2002 experience—held in Las Vegas—was a great success, and the 2003 program in New Orleans continued in that tradition. While the Las Vegas attendance broke all AOA records, the ACOP attendance actually increased in New Orleans. Continuing a new

tradition of offering ACOP members an updated Harriet Lane handbook as a benefit of attending was made possible by a generous in-kind contribution from Mead Johnson.

We began with the annual Perinatal Program on Sunday, October 12. Over 100 DOs attended the 7-hour session, including dozens of DOs from other colleges. The program was such a success that the Board and the CME committee have determined that next year only ACOP members will be able to come at no charge—non-members will be charged \$100 for these additional credits, lunch, and accommodations. (Be sure you renew your membership!) From the first session, Evaluation of Neonatal Seizures by Shannon Jenkins, DO, through updates on metabolic disorders by Joseph Melvin, DO, along with other key issues in the treatment of perinatal and neonatal infants, speakers earned rave reviews.



MELNICK
at large

A PARABLE

by Arnold Melnick, DO, FACOP

It rained that morning but, thank goodness, it stopped before it could interfere with that day's Special Olympics events.

The group of boys gathered on the playing field, excited, talkative, clumsy. Some activities started around the ball—a short run here, a failed pass there, a little roughhouse in between and everyone having fun.

Suddenly, from out of the

pack a runner made a mad dash with the ball heading for the goal line—more mad than dash, lumbering and stumbling, looking everywhere. But right behind him there was an awkward tackler, trying so hard but never quite catching up. As they neared the end zone, the pursuer wildly flailed his arms in a last desperate attempt to reach the runner. At that same moment, the runner fell flat

on the wet turf, sliding on his belly for the last two yards and in that embarrassing position slid across the goal line, his mongoloid face gleaming—an innocent, loving, excited, better-than-a-dream, fantasy-laden, Cheshire-cat grin, creating an instantaneous and beautiful work of art.

Had he been touched before he fell? Neither boy knew. Nobody on the field

knew. Nobody on the sidelines knew.

What to do? Assume he had been tagged and invoke all the rules and regulations? Assume he was missed and that he slid into victory? What to do?

I raised my arms straight above my head—signaling a touchdown. Who won? Everybody. And I think God forgave me that day.

AOBP Updates

Armando Ramirez, Executive Director and Elaine Bell, Program Coordinator, AOBP

The American Osteopathic Board of Pediatrics had a busy 2003, and hopes to be even more productive in 2004. 2003-year activities included appointment of four new members to the Board, the launch of a revamped website and the annual administration of certification and recertification examinations.

James M. Carl, DO, MHA; Fernando Gonzalez, DO; Philip V. Marinelli, DO; and Paul G. Smith, DO joined Chair, Jay D. Johnson, DO; Secretary/Treasurer, G. Lee Lerch, DO; and Mary Anne Morelli, DO for the Annual Examination Construction

Meeting in Chicago. In the summer of 2003, the Board revised and viewed the new digital format for the clinical portion of the examination. These enhancements were successfully utilized at the October 2003 administration. Also, the written portion of the initial certification examination went through a rigorous check for accuracy and current material was added.

In regard to recertification, many questions have been posed regarding the re-certification process: what happens if a diplomate with a time-dated certificate allows certification to lapse or fails the re-certification examination? Is it possible to deem these diplomates “Board Eligible?” Will

third parties be notified in the event that certification has not been maintained or has expired? The Handbook of the Bureau of Osteopathic Specialists states, “For physicians holding time-dated certification, failure to successfully complete the re-certification process will result in the loss of certification at such time as the current time-dated certificate expires. [B-2/97]” A diplomate who has failed to re-certify and/or has not met the requirements for maintaining certification, can no longer call himself/herself board-certified and is ethically required not to misrepresent this fact. Also, a diplomate with a time-dated certification that has either let the certifica-

tion lapse or has failed the recertification examination cannot call himself or herself “Board Eligible.” Historically the “Board Eligible” status has been associated with initial certification but has many times been misused. Over the years the allopathic member Boards of the American Bureau of Medical Specialties have discontinued use of the term due to such “diverse meanings by different agencies that it has lost its usefulness as an indicator of a physician’s progress toward certification...” AOBP will be discussing at its next meeting whether it also wishes to continue using the term “Board Eligible” or whether it

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PRESIDENT'S MESSAGE

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strategic plan. The Board has set a tentative timetable to review and evaluate submitted RFP's. The Executive Committee will meet in March to interview prospective management companies with the understanding that they will be able to take over management services by the May 4th deadline set by the AOA.

During this time I want to reassure the membership that the Board and Management Services will strive to maintain all functions of the ACOP. Certain projects that were under development, such as our Web Site, publications and development of student chapters may be temporarily delayed. The Board remains committed to fulfilling our Mission. We are committed to providing for the educational needs and well-being of osteopathic pediatricians and those interested in the welfare of children. We will continue to work collaboratively with any organization that is supportive of our goals and strategic plans. In addition, our Board is committed to

enhancing the value of membership in the ACOP.

It is our hope, and desire, that the ACOP will always be your home. We are committed to maintaining positive relationships with our osteopathic roots and fellow colleges within the AOA, as well as maintaining a collegial professional organization. Your patience and understanding during this time will be greatly appreciated. Any questions or concerns you have about future management and/or direction of the ACOP can be addressed to me personally, or any Member of the Board. We can be contacted at the listings below.

Sincerely,



Steven M. Snyder, DO, FACOP

President, American College of Osteopathic Pediatricians

American College of Osteopathic Pediatricians • Board of Trustees • 2003-2004

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OBITUARY

Nelson King

Arnold Melnick, DO, FACOP

I lost a friend recently. And so did ACOP. Nelson King, Past President of ACOP, died on July 5 at age 91. His membership spanned almost the entire existence of the ACOP.

I first met Nelson in the late 40's when we were both training in Pediatrics. In addition to his studying at Boston-area allopathic institutions, he came to Philadelphia frequently for additional pediatric education and osteopathic exposure. For Nelson was truly an osteopathic physician, and became a valued osteopathic pediatrician.

He always held on to his osteopathic philosophy and heritage. He was proud of that. He was an ardent student and almost always even-tempered. He discussed rather than argued and found a whole cadre of friends in ACOP. He worked hard for our organization and was rewarded with the ACOP Distinguished Service Award

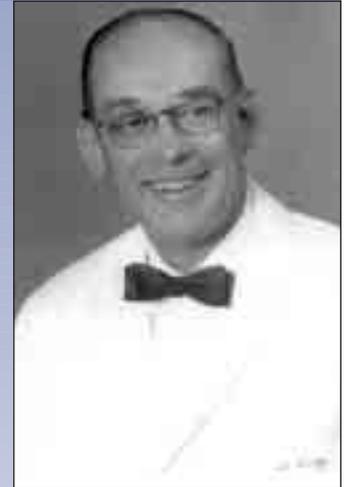
in 1958, followed by his presidency in 1961. (His wife, Alice Maxine King, DO, who survives him, is both a pediatrician and pediatric psychiatrist, and she received the DSA in 1984, the only husband-wife duo in our records.)

Astute student, outstanding teacher and strong advocate for children—these were the keystones of his years as a pediatrician. He gave up his practice in New England in 1957 and spent years of distinguished service as Professor and Chairman of Pediatrics at the Kirksville College of Osteopathic Medicine. Later in his career, he continued to enhance his pedagogical reputation at the Des Moines University College of Osteopathic Medicine and the New York College of Osteopathic Medicine. He served as Director of Residency Programs at several osteopathic institutions and med-

ical colleges. In every instance, his outstanding teaching ability and personal dedication were recognized. He retired in 1996 but continued to provide Nelson King-type of service as a volunteer at the Peace River Center.

Hal Finkel, who preceded Nelson by one year in the presidency, remembers him as “an academician and great teacher who contributed much to the ACOP.” Hal added, “Nelson was an especially nice person who enjoyed teaching. In the ACOP, he would do anything asked of him and do it willingly.”

A former fellow New Englander and ACOP president, Mike Richardson, remembers Nelson for his New England accent and his always well-dressed appearance. “Nelson was a knowledgeable and practical pediatrician and a splendid teacher,” said Mike.



“He was my mentor, my friend, and my advisor,” commented Chuck Kline who was associated with Nelson for many years at KCOS. “From the first hour of my residency, he challenged me to be intuitive, aggressive and thorough. He was one of the Great Professors in this profession.”

He was surely a prince of a gentleman and a nobleman in pediatrics—and just as surely he was a King his entire life. We shall miss him.

STUDENTS' CORNER

**Cassandra Eakin, MS2
Student Trustee, ACOP**

Greetings to all students! It has been a busy year for us, and I'd like to thank everyone for his/her help in making the student chapters of the ACOP successful.

We are still working on

details, but we are confident that our student chapters will continue to grow into a recognized institution within the AOA. I'd like to make known our own student website, www.acopstudents.freeservers.com. This website was constructed to provide ACOP

students with the latest information, to allow communication among students and doctors, and to keep everyone up to date on what is going on in our student chapters. This website is limited only by our students, and so I want to encourage everyone to browse

the site, submit suggestions and research, and be sure to communicate with each other at our message posting center! Keep up the good work in school, and make sure you continue to keep us informed of your activities into your third and fourth years!

Recap of ACOP Program Directors and Pediatric Department Chairs with ACOP GME Committee Meeting

John W. Graneto, DO, FACOP

The meeting occurred on October 14, 2003 in New Orleans and was chaired by Dr. John Graneto who substituted for Dr. Michael Ryan, Chair, ACOP GME Committee. The GME Committee's role is to:

- 1) review new program applications;
- 2) inspect current programs;
- 3) update and revise Program Director Report forms and Resident Annual Report forms; and
- 4) update and revise basic

training standards documents.

It was reported the West Virginia OPTI at the Charleston Medical Center will offer a combined ACGME and AOA-approved program. In addition, NSU and its Florida OPTI will offer a program at the Palms West Hospital. It will be an AOA-approved program.

Updates were provided on efforts to integrate OPP/ OMM didactic and practical information into postgraduate pediatric education. More attention is still needed to pediatric-specific topics. The

Dean of Touro University also presented an idea of improving the curriculum delivered to undergraduate students through our profession. The idea has been discussed by the Council of Deans of the AACOM and will be moving forward. The Program Directors also discussed the desire to have as a program requirement an 80% "pass rate" in order for the program to remain accredited. This will be further re-examined by the GME Committee.

The newly revised Program Director Report form and the Annual Resident

Report were circulated. The GME Committee will only accept the NEW forms that have been recently approved and those that have been finished correctly and completely. Two issues were raised that have been resolved. The website has been updated to include the most current versions of the Program Director Report form and the Annual Resident Report. In addition, the user can now download the forms and enter the information directly onto the forms and print without the need for a typewriter.

ACOP FALL 2003 CME A HUGE SUCCESS

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On Monday, the Emergency Medicine (EM) track began with lectures on shock, respiratory failure, and poisons, and the highly regarded James Brien, DO offered "ID Vaccine Update" & "What's Your Diagnosis?" talks. The evening ended with an excellent Watson Memorial Lecture offered by past president and 2003 Distinguished Service Medallion Recipient Michael N. Musci, Jr., DO during the ACOP President's Reception.

Our joint lectures with the American Osteopathic Academy of Sports Medicine on Tuesday brought in tremendous crowds, including many EM specialists who gave thumbs up to our speakers and

topics. Most AOASM lecturers didn't provide handouts, which were extremely missed by our participants. In response, ACOP has taken action to rewrite its speakers' agreements to ensure "no handout—no honorarium."

Wednesday morning began with a highly rated OMT lecture and workshop from Karen Steele, DO who was honored to be personally sponsored by ACOP CME Committee member, Connie Jo McCarroll, DO. Over lunch, we adjourned to the American College of Osteopathic Neurologists and Psychiatrists' room for our half-day session. The talk by Jimmie Leleszi, DO on

ADHD in children was to a standing room only crowd. The turnout was so great for this last-afternoon-of-the-convention session that we all moved back into the larger ACOP quarters!

Many thanks are due to Director of CME Scott Cyrus, DO; Program Chairs Will Moore, DO and Michael Hunt, DO; and the entire CME committee; particularly active members were Marta Diaz-Pupek, DO; Connie Jo McCarroll, DO; and Ed Packler, DO. Managing registration and the sessions were ACOP Executive Director Elizabeth Harano and AA/Account Coordinator Alicia Bryant Swary.

Special Thanks... go to all of our sponsors—please be sure to let their representatives know that you appreciate their financial support:

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2004 Osteopathic Pediatrician of the Year

**Gregory L. Garvin, DO, FACOP
Awards Committee Chair**

It is again time to begin the selection process for the next ACOP Pediatrician of the Year award. This award will be given at the Fall ACOP meeting at the annual AOA convention.

This will be the fifth recipient. Over the last few years it has been difficult for the Awards Committee to select a candidate as we have not had any recommendations from the membership. Since this is a national organization, this makes the selection process very hard for the committee since we must have nominations from the membership before we can pick an ACOP member to recognize his/her accomplishments.

This award will be given to an ACOP member who has

made an outstanding impact upon his/her community in regard to child healthcare issues, emphasizing humanitarianism in pediatrics. Examples of activities that will distinguish nominees include community health issue advocacy or work on behalf of special populations of children or children with needs not always addressed adequately by the community.

Nominations for the Osteopathic Pediatrician of the Year Award are being solicited from the general ACOP membership. However, if you believe a community group could best nominate the member, please feel free to include a statement from that organization with your nomination letter. Nominations will be reviewed by the Awards Committee. Once the committee

has chosen a recipient, it will be confirmed by the Board.

Include in your letter the nominee's name and describe in detail the nominee's contribution to the community (e.g., community, area, state, region, nation) regarding child health issues and why you support the nomination. Describe the measured impact on the community and any tangible evidence supporting the impact (e.g., published studies, reports, media coverage; community, public or professional recognition or awards, etc.) of the nominee's efforts. List independent confirming sources and describe your first-hand experiences with the nominee's contribution. Please also disclose your personal, professional and business relationship to the individual you nominate.

Nominations must be typewritten and not exceed two pages. They must be signed in order to be accepted. **THE DEADLINE FOR SUBMISSION IS JULY 15, 2004.** Please send all nominations to ACOP at 142 E. Ontario, Suite 1023, Chicago, Illinois 60611, 1-877-231-ACOP. Mail will be automatically forwarded.

Please put your thinking caps on and send us a viable candidate! Maybe one of your partners or some other ACOP member you know deserves to be recognized for his/her accomplishments in the area of child advocacy. We have a lot of hardworking and talented members who can be in the running so help out our committee. Also, we will keep the names of those not chosen on file for future years.

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Signing with Networks

Joseph A. Dieterle, DO, FACOP



In this age of increasing costs and decreasing reimbursements, it is extremely important to maximize every opportunity for revenue flow.

As distasteful as it may be to consider “money” in our practice of medicine, in today’s milieu it is essential to understand the “business” of our day-to-day operations.

One of my favorite areas to hone in on is the company that sends contracts to our office for signature in order to join its network. The contract is usually accompanied by a letter touting the growing number of businesses and patients in our area now serviced by this particular insurer. What amazes me is that the company rarely sends a list of reimbursements for services rendered!! Even more amazing is that physicians sign this contract in order to remain competitive in their market. What a mistake! Do we know any other vendor (sorry for the use of such a plebian word)—our plumber, car mechanic, builder or others—who would sign a contract to

provide services without knowing what the reimbursement will be?

It is not unrealistic to ask for a representative to come to your office to discuss reimbursements, “carve-outs,” and so on. Be sure to have your most favorable rates from another insurer available for comparison. Let them compete for your service. Our practices are important to them. They need us more than we need them...

Remember when reading through contracts that the devil is in the details! Read them carefully and require full disclosure of reimbursements. Take no wooden nickels.

PEDIATRIC POINTERS

Pink Eye

H. Lauren Vogel, DO, FACOP

Pink-eye may be the most common eye complaint seen by the practicing pediatrician. The term has been used to describe any inflammatory process that involves the conjunctiva. Most causes are benign but can be problematic to patients and parents.

For the clinician, decision points include diagnosis, treatment and isolation. Pink-eye can be divided into those

caused by conjunctivitis, iritis or corneal trauma. Symptoms overlap and history is the most important element in differentiating them; once corneal trauma and iritis are ruled out, the next step is determining etiology for the conjunctivitis.

Pink-eye may be bacterial, viral or allergic; only two physical discriminators are needed. Is the patient febrile? Are sub-conjunctival follicles present? Briefly, bacterial has no fever and no follicles, viral

has both fever and follicles, and allergic has follicles but no fever.

Staphylococcus and streptococcus are responsible for most bacterial infections but bacterial infection is uncommon in children over five years of age. Topical tobramycin, erythromycin or sulfa in divided doses should be used for 5 days. Adenovirus is the most common viral agent. It is highly contagious and meticulous hand-washing is an important com-

ponent of treatment. Allergic conjunctivitis is usually self-limiting. Evaluation for precipitating causes should be initiated if symptoms become chronic.

Patients with infectious conjunctivitis should be presumed to be infectious until symptoms have resolved. Children should be allowed to remain in school or day care unless there are symptoms, or close contact with others cannot be controlled.

Ownership and Framework: Keys to a Good Learning Environment

By Robert G. Locke, DO,
FACOP

Ownership, or perception of ownership, is a powerful tool. For a student/resident who normally feels little or no control of day-to-day activities, ownership over a portion—any portion—is an unexpected delight and a powerful motivator. Not only will this endear you to the student/resident, more importantly, it allows the student to become a stakeholder in his/her learning. By allowing

them to participate in setting their learning experience, they become more interested and focused. This precipitates an environment conducive to learning and educational/academic exchange. This practice does not sacrifice learning as most students list objectives identical to what I would have dictated.

Learning needs to occur within a framework. A framework provides goals and objectives that allow students to place the knowledge and

activities of their upcoming rotation in a context relative to previous experiences and knowledge. This provides an understanding of what they should learn and what is expected of them both during and at the completion of their rotation. A clear understanding of these objectives and performance activities at the start of the rotation allows students to integrate this new knowledge and behavior within their existing framework. This permits efficient

learning, since the student can personally find those connections as the knowledge and performance expectations are presented in real time. Similar to what we all experience in our busy lives, the rate of real-time presentation of new information without this pre-existing contextual framework may be too fast for the student to absorb or understand.

Ownership and a contextual framework. Easy to implement. Rewards are endless.

ACOP Fall 2003 General Membership Meeting Recap

Elizabeth F. Harano
Executive Director

More than 50 pediatricians and students attended the ACOP General Membership Luncheon and Annual Business Meeting on Tuesday, October 14, 2003. Held during the ACOP/American Osteopathic Association's Fall Convention in New Orleans, LA, it took place at the Hilton Hotel - Riverside.

ACOP President Steven Snyder, DO, FACOP, presided over general membership matters and recognition of ACOP leadership. The President's Report to the Membership included ACOP priorities for 2004: focus on membership and quality CME. One amendment to the bylaws was unanimously approved; it clarified ACOP authority to charter Student Chapters. The financial report

was submitted on behalf of Treasurer Robert Hostoffer, DO, FACOP, who could not attend; it was approved.

Awards

The Pediatrician of the Year Award was presented to Captain Margaret Orcutt Tuddenham, DO, FACOP. The Distinguished Service Medallion had been presented on Monday evening to past president Michael N. Musci, Jr., DO, FACOP, following his well-received Watson Memorial Lecture during the Presidential Reception. Committee chairs attending were presented with certificates of appreciation and CME Fall 2003 Program Chair Will Moore, DO, was presented with a crystal plaque. Gerard Cleary, DO, FACOP, Chair of the 2003 Perinatal Program, had

received his crystal plaque at the Sunday evening Board meeting before flying home to join his wife as she delivered their baby.

Elections

Two new Board members were proposed by the Nominating Committee, and the Membership elected James E. Foy, DO, FACOP, and John W. Graneto, DO, FACOP, to serve as trustees on the 2004-2005 ACOP Board. Dr. Foy is Chair of the Department of Pediatrics at Touro University in Vallejo, CA. Dr. Graneto is a pediatrician and an emergency physician with Swedish Covenant Hospital. He is Treasurer of the Illinois Osteopathic Medical Society, and serves on the ACOP GME Evaluating Committee. They will replace Cyril Blavo, DO,

FACOP and Bruce Peters, DO, FACOP who reached the maximum time for Board service. Elizabeth Harano was elected to serve as the Executive Director.

VP and Certifying Board Reports

Vice President Lee J. Herskowitz, DO, FACOP, who is also the president-elect, offered a brief report on the successful Fall 2003 CME, and encouraged members to get more involved. Jay Johnson, DO, FACOP, reported on the work of the American Osteopathic Board of Pediatrics and discussed the revised standards for eligibility, certification examination requirements, and issues regarding re-certification.

The meeting adjourned at 1:23 pm.

They say...

"Everyone loves a clean baby, but apparently there's such a thing as too clean: Kids from birth to age 3 who are bathed or washed more than twice a day are more likely to develop asthma or severe eczema."
Jennifer Kelly Geddes in Parenthood

[Comment: Many infants and young children on a frequent bathing regimen to keep their skin "clean" develop increased atopic symptoms. To keep skin both hygienic and healthy, baths should be short and a mild soap or a water-free cleanser should be used, with shampooing done at the end of the bath. Lubricating creams or emollients should be applied within the first few minutes after the bath. Studies have suggested that lack of microbial exposure during infancy due to excessive bathing causes a great likelihood of atopic disease. Parents must therefore learn to distinguish between good hygiene and over-cleansing that can be relatively harmful to the immune system.

—*Janet M. Goldberg, DO, FACOP*

"The health care needs of low-income children who participate in WIC may be better met than those of low-income children not participating in WIC."

*Paul A. Beuscher et al
Child Participation in WIC
American Journal of Public Health*

[Comment: This study involved children from 1-5 years old who were enrolled in the North Carolina Medicaid program. Those children also enrolled in WIC received more preventive care than those not involved with WIC. They also had more ER visits and hospitalizations. Are we seeing selection bias (the sickest get enrolled in WIC), or inadequate attention to serious pathology in non-WIC participants? In any event, the ability to coordinate services to meet multiple needs points out the essential role of a team — nurses, dentists, physicians, mental health professionals, outreach workers, protective services, and others.

—*Margaret A. Morath, DO, FACOP*

"Nearly two out of three Americans are overweight or obese—that is a 50 percent increase from just a decade ago! Nearly 15 percent of our children and teenagers are overweight, and overweight children usually grow up to be overweight adults."

*Richard H. Carmona, MD
U.S. Surgeon General in Commissioned Corps Bulletin*

[Comment: Not only do overweight children lead to overweight adults but toddlers who are obese as early as 18 months of age and continue to be obese at age 4 are also high risk for adult obesity. So we should be very aggressive in following our patients' BMI, other risk factors and family history, and start intervention early. This is especially important in minority populations where access to health care may be an issue along with fewer resources. Physicians have to be even greater advocates for these patients and more aggressive in their approach for these high-risk children and their families.

—*Bruce Peters, DO, FACOP*

SITES FOR SORE EYES

10 OF MY (WEB) SITES

By Gregory L. Garvin, DO, FACOP

1. www.pediatricneurology.com—a site based out of NY with nice links to topics in pediatric neurology.

2. www.allscripts.com—a leading provider of clinical information software. This site also has software for the Pocket PC using Win CE format.

3. www.generalpediatrics.com—a general pediatrician's view of the internet by Donna M. D'Allessandro, MD, a pediatrician at the U of Iowa. This site has nice links.

4. <http://medscape.com>—"free CME"

5. <http://pedscm.wustl.edu>—a multidisciplinary resource of original & distributed educational & practical materials for pediatric critical care practitioners.

6. www.vh.org—U of Iowa links to the children's hospital webpage with a section "for providers." (I'm from Iowa so naturally I "surf" those sites).

7. <https://home.po.com>—register for free e-mail with member ID & password. An old "standby" with a "new face." Also has "Online CME".

8. www.docs.com—Homepage for SOAPware—a reasonably priced barebones "EMR" with an "a la carte" menu.

9. www.SayICan.com—A great website to get the Dragon Voice Recognition Software & help in getting started. (I'm over 2 1/2 years into using Voice Recognition to complete my daily notes etc... HOW COULD I LIVE WITHOUT IT!!!)

10. www.drgreene.com—A nice web site with general information and an A-Z guide with printable versions. (Might make nice handouts for parents, but I use the CRS advisor edited by Barton Schmidt, MD.)

I hope that those "surfers of the net" out there will find at least one site to their liking.

HAPPY SURFING!



By Erika Stewart, ACOP Legislative Assistant

The President's FY 2005 Budget

President Bush released his \$2.4 trillion budget proposal in early February. Under the budget, total spending for the Department of Health and Human Services (HHS) is \$580 billion. Mandatory spending for the Medicare and Medicaid programs accounts for more than 80% of the total federal budget.

Health Spending Budget Highlights:

- **Medicaid:** Medicaid provides health coverage for 25% of the nation's children. Estimated FY 2005 spending is \$322 billion.

- **State Children's Health Insurance Program (SCHIP):** The Administration still supports legislation, introduced in FY 2004, to allow the federal government to provide fixed rather than matching funds. The Administration also wants to change Vaccines for Children (VFC) program by removing the price cap on the tetanus-diphtheria booster and allowing children to receive VFC vaccines at state and local health clinics rather than at federally qualified ones.

Medicare Physician Payment: What the 1.5% Increase Means in Real \$\$\$

Provisions included in the "Medicare Prescription Drug, Improvement Act of 2003" (MPDIA) greatly stabilized physician reimbursements for the next two years. The legislation provides for a positive 1.5 percent update in 2004 and 2005. This follows the 1.6 percent increase physicians received in February 2003.

In total, the reforms enacted in 2003 will result in physicians receiving an average additional \$39,500 in reimbursements over 3 years (2003-2005) or \$13,167 per year. This does not include any additional increases in reimbursements a physician may receive as a result of adjustments to the geographical cost of practice indices reforms or the rural 5 percent add-on, both of which were included in the MPDIA.

Professional Liability Insurance (PLI) Reform

Senator Judd Gregg (R-NH) introduced the "Healthy Mothers and Babies Access to Care Act of 2003" (S. 2061) on February 12. The legislation attempts to establish medical liability reforms for obstetrical services only. The bill is part of an incremental approach taken by Republican leadership on PLI legislation after the Senate failed to pass a broader bill last year. At press time, the Senate was expected to vote February 24 on a procedural motion to end debate and allow a direct vote on the bill. The motion is expected to fail and Majority Leader Bill Frist, MD (TN) predicts that the legislation would not pass. He has indicated that Senate Republicans would introduce similar bills in the next six weeks that apply to trauma surgeons and rural physicians.

AOBP Updates

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will follow in the steps of other AOA Boards that have discontinued the use of the term. Information regarding failures is also not released to third parties as this information has been deemed by the Bureau of Osteopathic Specialists to be confidential and may also be subject to state law such as the Illinois Medical Information Act.

During its summer 2003 meeting, the Board also made the difficult decision to place some of its sub-specialty examinations into dormant status due to lack of demand for those subspecialties but more importantly because of the massive resources required for examination development. The following sub-specialties were not placed in dormancy:

Neonatology, Pediatric Pulmonology, Pediatric Allergy/Immunology, Pediatric Endocrinology, Adolescent & Young Adult Medicine. AOBP will also consider whether to withdraw from the Conjoint Examination in Sports Medicine as no AOBP diplomate has requested to become certified in the area since the creation of that examination.

Finally AOBP is pleased to announce its annual board examinations will be administered November 6 & 7, 2004, in San Francisco, CA, in conjunction with the AOA Convention and Scientific Seminar. We encourage those interested to visit www.aobp.org for more information.

Scoliosis in Children



Charles T. Mehlman, DO, MPH

Pediatric Orthopedic Spine Surgeon
Associate Professor Pediatric Orthopedic Surgery
Cincinnati Children's Hospital Medical Center
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Idiopathic scoliosis still eludes complete understanding despite collective experience spanning two thousand years. As in ancient times we know that certain signs of body asymmetry are important clues. We also know that patients with small curves are at risk for significant progression during periods of rapid growth. We still do not know exactly what causes scoliosis but it seems likely that it represents a genetically determined disturbance in spinal growth.

Those who diagnose and treat scoliosis follow certain conventions. Curves less than 10 degrees are simply referred to as spinal asymmetry. Curves of 10 degrees or more represent true scoliosis and require intermittent clinical or radiographic observation or both. Full-length (36-inch cassette) radiographs are the best. Scoliosis demanding treatment (curves exceeding about 25-30 degrees) strikes girls nearly ten times more frequently than boys. Confusing terms such as “dextroscoliosis” and “levoscoliosis” should also be avoided in favor of describing curves in terms of their rightward or leftward apex.

A common myth is that idiopathic scoliosis should never be painful. Patients may suffer from back pain up to about 25% of the time. It is important to verify that an appropriate screening neurological examination is normal and that lateral lumbosacral x-rays show no evidence of spondylolysis or spondylolisis-



thesis. Then the back pain should be treated as typical somatic dysfunction. If the screening examination or radiographs are abnormal or if the patient fails first-line efforts at back pain management, then appropriate referral should be considered.

The literature on school screening for scoliosis is at best mixed, with some authors hailing its utility and others voicing great concern regarding inappropriate referrals. Be that as it may school screening is nearly

as ubiquitous as school nurses in the United States and kids who “screen out” will show up in your office. A clever leveling device called the SCOLIOMETER has been shown to increase the accuracy of the physical examination when screening for scoliosis. This simple and inexpensive tool should be available to the pedi-

atrician. A rib or paravertebral muscle prominence of 7 degrees or more has been shown to correlate with significant scoliosis.

Idiopathic scoliosis that reaches or exceeds the 25-degree range will trigger brace treatment in a skeletally immature patient. This is based on slim scientific evidence and abundant observational studies. Most commonly, a brace for patients with idiopathic scoliosis is a rigid molded plastic brace that may be generically

referred to as a TLSO. Many versions of this basic brace concept exist including the Boston brace and the Wilmington brace. The best results with such braces have been shown with full-time wear (allowing patients one hour out of brace each day). Newer flexible or elastic braces or both have appeared in recent years (such as the St Justine or SpineCor brace). Such braces appear to be equally effective while allowing patients greater latitude in their sports activities and four hours a day out of brace. Bracing success is typically defined as halting curve progression and not as curve correction.

Idiopathic scoliosis that exceeds the 40-50 degree range warrants serious discussion of the risks and benefits of surgical intervention. This would most commonly involve posterior spinal fusion with instrumentation (hooks, screws, rods, etc). Modern minimally invasive techniques such as video-assisted thoracoscopic surgery (V.A.T.S.) have also greatly aided management of larger rigid curves. Patients who undergo scoliosis surgery today should expect to stay in the hospital for less than one week, to return to school within several weeks, and to return to nearly all normal activities by about six months after their procedure. In the long-term these same patients should expect to enjoy health-related quality of life similar to their age-matched peers without scoliosis.



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