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pulse

THE QUARTERLY PUBLICATION OF THE AMERICAN COLLEGE OF OSTEOPATHIC PEDIATRICIANS

SAVE THE DATE

ACOP / AOA 2005 Fall Unity Convention

October 23-26, 2005
Orlando, FL

The Program Committee is finalizing the scientific program at this time.

Tentative topics include:

- Meningitis
- Sports Injuries in Young Children
- Early Recognition of and Intervention in Infants with Spasticity
- Early Recognition of and Intervention in Childhood Myopia
- Early Intervention and Community Resources
- Counter-strain in Children
- Evaluation of Children with Head Trauma, and the Office Management of Post-intensive Care Children with Head Trauma
- New Immunizations

The program will be mailed to all members soon and will also be available at www.ACOPeds.org.

President's Message



By Lee J. Herskowitz, DO, FACOP



This April will mark the end of the first year our college has been with Ruggles Service Corporation, based in Richmond, Virginia. As we finished our business meeting last April in Boston, Stewart Hinckley took over the reins as our Executive Director. I feel this has been a very successful transition and I hope that many of our members have had the opportunity to recognize some of the changes.

First, the College is financially secure with good investment choices and profitable CME programs. Our cash flow has been able to maintain regular activities without straining our budget.

Our web site has been redeveloped and made more functional. It has current information and access to member services. Besides seeing what is being done in many of the college committees, members can find colleagues on a real-time membership database as well as register for CME and renew membership online. Additionally, there is the inception of an online job market section developing.

Recently, the College successfully sponsored one of our members for a public health fellowship in Washington, DC. This not only gives us visibility on the larger policy making community, but gives us connections to more effective legislative decision influence. We are proud to have Rob Locke representing us in this role.

Our CME committee has continued with a high standard of excellence and presents two full-credit meetings annually. We will be convening independently in Chicago for our April, 2005, meeting and then joining the AOA in Orlando for a joint "Unity" meeting in October. Both look to be great programs that can fulfill AOA/AMA Category I credit for pediatrics!

Our various committees have accomplished a lot over the last year. Some highlights include the Government Affairs Committee sponsoring proposals along with the AOA and AAP, as well as maintaining a watchdog posture for child welfare and physician reimbursement issues. The GME committee has continued to work with the AOA in maintaining high curriculum standards in our residency programs and facilitating the certification process. They have assisted several members in navigating the certification process from the reentry of ABMS residency training. Our AOA liaisons from COSS (Committee of Osteopathic Specialist Societies) have forged new networks with other colleges and have been especially successful with Emergency Medicine and Internal Medicine in problem solving.

The College has vigorously pursued new membership from our DO colleagues who have done ABMS programs and have never connected with the ACOP. Also, we have

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2004-2005

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MEMBERSPEAK

Hurried Offices, Harried Doctors: Who is Seeing the Well Babies?

By Robert G. Locke, DO, FACOP

The traditional role of the pediatrician providing care to the newborn infant may be changing. As private pediatricians are under increasing pressure to increase practice efficiency, healthy newborn infants are often under the care of hospital-based inpatient pediatricians, especially in urban and large hospital settings. Newly trained pediatricians, because of recent residency training alterations, often have less than one-half of the well-baby experience than their predecessors upon graduation. This may make them less comfortable or inclined to provide this care.

General pediatricians are also spending less time providing in-patient pediatric care, have fewer needs for staff privileges or hospital-based CME activities, and are therefore less attached to the hospital. The division of in-patient versus out-patient providers reduces the risk of competition for the newborn business, a major economic barrier in the past. In some circumstances, the inefficiency of time spent driving to the hospital, making rounds, providing night-weekend coverage, and completing medical records makes well-baby nursery care proposition ineffective.

Is this necessarily bad? Other qualified professionals have stepped into the void left by the shift in provider coverage. Studies have demonstrated that advanced nurse practitioners who are experienced in newborn care can provide care that is equivalent to, or even better than, that provided by pediatricians.

PRESIDENT'S MESSAGE

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fostered the development of student chapters of the ACOP at all of the osteopathic medical schools. Both of these groups are learning of the benefits offered by the College and hopefully will decide to become integral and long-term members of the College.

The Pulse has continued under the seasoned guidance of Arnold Melnick, and his associates Rob Locke, Janet Goldberg, Greg Garvin and Stewart Hinckley. It has taken on a slightly different format as well as being available at our web site!

With all the things going on, we know there are many more things that can be done.

The pediatric hospitalists at my institution see five times more mothers/infants in the well-baby setting per year than the average private out-patient pediatrician. In three years, the hospitalist will accrue 15 years of general pediatric newborn experience. These hospital-based pediatricians provide greater continuity of resident teaching, parent communication, nursing education and interface with medical care plans. They can afford to keep up with rapidly changing protocols and medical information. They also have the opportunity to provide multiple visits within a single day, for those parents/infants requiring this attention, without leaving the office. Does this compensate for the pause in continuity of care from the newborn nursery to out-patient pediatric home? That is not clear. Several pediatricians informally noted that they provided the well-baby care out of interest and commitment, not economics. As residency training time declines in the well-baby nursery, it will be interesting to see what the future holds.

MemberSpeak a new feature of *PULSE*, in which any member who desires may speak his mind or express an opinion or offer important information. The subject can be practice tips, education ideas, socio-economic discussions, teaching suggestions, residency training thoughts or anything germane to Pediatrics that a member wants to share with the rest of our members. Each column should be about 250 to 400 words, and should be submitted electronically, referencing *MemberSpeak*, to the Editor of *Pulse* at Stewart@ACOPeds.org.

We continue to make our core competencies, membership recruitment and fulfillment, and high quality CME programs in attractive and accessible locations for all of our membership. We solicit input from our members for their interests and involvement. You can reach me at drdawg@earthlink.net. There are always new projects that we are willing to take on, as long as there is manpower to keep things going. Make the ACOP even better in 2005!



MELNICK at large

By Arnold Melnick, DO, FACOP

Title is Vital

That title, in a nutshell, is a full lesson on putting a heading on your article or book – or even your talk. It tells the story and is attractive and catchy. Maybe it even eliminates the need to do this article. But no.

What I Did Last Summer is dull and already sounds boring but maybe *A Spiel on a Wheel — Ferris, That Is* or *The Seashore Isn't Sandy Anymore* might attract more readers, depending on the subject matter. *The Rhet Butler Story* might not have sold but *Gone With the Wind* sure made a great hit.

Not every title needs to be cute. *Textbook of Pediatrics* is a textbook of pediatrics and cannot be disguised very much. It probably would not draw readers if titled *Some Ideas about the Illnesses of Children*, which it is.

On a personal note, I think my best title was *Platitudinous Garrulities Ain't Readable*. It is somewhat punny, but succinctly tells you what's contained in it, if you know what *platitudinous* and *garrulities* mean (then the pun becomes obvious). If you don't know those words, perhaps your curiosity will be aroused. Similarly, my *Summarize Your Child* is a funnier way of saying *Summary of Summer Care for Your Child*. And when I wrote *Blowing the Whistle on the Writers*, I thought it told the storyline without being trite with titles such as *The Role of Referees in the Acceptance of Articles by Medical Journals*.

The greatest personal lesson was taught to me by Warren Green, the publisher of my first book. While he kept most of the book content intact, he suggested changing the title. I had written *Some Uncommon Views on Some Common Problems in Pediatrics* which said it for me. He pointed out that in indexing often just the first few words may be used and that the indexing would be thrown off with my title. He thought merely reversing it would do it and it became *Pediatrics: Some Uncommon Views on Some Common Problems*. And my book was in-

dexed under *Pediatrics* instead of *Uncommon Views*!

So what do we look for in titles? Generally, the 3 Cs of titles are clarity, conciseness and clues to the contents (contents and scope). For the most part, they should not be vague, misleading

or inappropriate. If you are writing for a scientific journal, they will probably want straightforward titles that conform to those parameters. Variations are allowed in books and in non-scientific articles (with some exceptions).

Book titles are often vague and too long but almost always with an eye to being catchy and attractive to potential readers (the object is to sell books). Probably the smallest title, was the book usually referred to as *We* by Charles A. Lindbergh (actually the full title was *WE: The Daring Flyer's Remarkable Life Story and His Account of the Transatlantic Flight that Shook the World* – but probably not one person in a million remembers anything but *We*.). Other book titles run from 15 to 20 words.

Medical articles not meant for scientific publications may be more informal and sometimes humorous (sometimes unintentional as *Bone and Joint Tuberculosis in Humans De-*

rived from Cattle – an actual article). So you must decide where your article is to be published and by whom it will be read.

I am intrigued by humorous titles, especially those that play on the words or the subject. Here are some examples of ones I love (and there are many more).

The most popular and longest running workshop of the American Medical Writers Association is *The Queen's English...and so is the King*. 'Nuf said. So clear. How about the book *Sleeping Dogs Don't Lay...and that's no lie*.? Obviously a book on grammar – and entertaining. Or, similarly, *Woe is I*. And how about *If you Can Talk, You Can Write*? What about chapter headings that say it loud and clear: *The Witch (That or Which) Trials, Whom Sweet Whom, Pompous Circumstances, The It Parade, Grammar Moses, Revise and Consent, If at First You Don't Succeed, Don't Be Surprised*, and many other brilliant ones.

Maybe the prize for “cutest” title goes to the Denver Post. Reporting on a dispute between fishermen who used boats and those who fished from shore, the Post's beautiful headline was *Row vs. Wade*. They can write mine anytime!

Anything I add would be superfluous!



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the 2005 Spring Conference:**

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SITES FOR SORE EYES

Update Your Pager

By Gregory Garvin, DO, FACOP

Do you ever wish you could take your pager and pitch it? If you are like me it can be frustrating to have three devices to carry around on your belt... but you can eliminate at least two of them. I'll make this short and sweet. I have taken my pager, PDA (personal digital assistant) and phone and had them combined them into "one."

If you are like many of us "techies", you know what I'm talking about. You have a pager, a cell phone and either a Palm Pilot or Win CE device that you have packed with "stuff" that you find essential to have when you are on call. You may just use the "stock" items on your hand-held device like the organizer or phone book to carry pharmacy numbers or you may have taken advantage of the various software "add-ons" such as the *Harriet Lane Manual* or the ever-popular *Epocrates*, but you hate having all of this "equipment" on your belt and what if you don't even have a belt to carry them?

Anyway, I bought a Kyocera 7135 "smart phone" that is a palm pilot and phone in one. Sure it has limitations but it syncs with Outlook and other software like Outlook (I use a software called *Groupwise*) and so that eliminates one of the devices I need to carry. There are a variety of "smart phones" that are available and all of them have different pluses and minuses. I can't discuss the ins and outs all of the various smart phones such as Blackberry or the Samsung. Take your pick based on your cell phone vendor.

The next hurdle to jump over is to get either "text messaging" or "email" sent to your phone. Working with my local cell phone carrier (US Cellular) and my local Physicians Exchange, I have been able to get emails sent to my phone instead of a page to my pager. Other physicians with other carriers here locally use text messaging. It costs \$1.50 a month to have unlimited emails sent to an email address given to me by my cellular carrier. The Physicians Exchange also sends a CC: (carbon copy) to my email work address which I can then cut and paste into a Word document and I can then save the message and download to a "sticky note" that can be placed in the patient's chart. Physicians in the ER actually "email" to my cell phone about patients they want to be seen in my office in follow up and therefore eliminate the "middle of the night" phone calls to tell me about a patient they want to have follow-up. They don't like waking physicians up to tell them they want to send patients home from the ER, but would like them followed up in say 1-2 days. The Pediatrics floor and Nursery can also send me an email directly to my phone and eliminate calling through the exchange to let me know about laboratory work or new babies that they want me to see, but I prefer to have them call my cell phone directly about more urgent matters. This again bypasses the exchange and decreases charges from them and therefore decreases costs to my cost center.

The exchange people tell me they think that email will be the preferred way we physicians will get our pages. When an email is sent, it is almost immediate and if I do not pick up the email when it is paged, my phone keeps intermittently "beeping" or "vibrating" (depending on my settings) to let me know I have a message. If a page is sent out to the "tower" and the "tower" is down, the exchange has no way of knowing that the message is actually sent, so basically I get no more missed pages.

So my advice to all is to start talking to your vendors and your local answering services to see if you can eliminate your pager and be more efficient and at the same time save a little money. Happy computing...

MEMBERS IN THE NEWS

Dan Taylor Honored

Daniel Taylor, ACOP member from Philadelphia, was honored recently by the American Academy of Pediatrics. He was featured in the AAP Member Spotlight in their AAP publication.

Dan established the Children's Advocacy Project of Philadelphia to create a list of social service resources for psychosocial problems. Such information was not readily available to health care practitioners in the area. The site was developed to bridge the gap between families in need and social service agencies available to serve them. He received a \$6,000 grant from St. Christopher's Hospital to expedite this project.

Dan commented on his work, "It will make pediatricians better social workers, better advocates for their patients."

To search files of CAPP and see the results of Dan's work, go to www.capp4kids.org.



Kudos to Steven Shapiro

Good things happened double to Steven Shapiro, DO, of Norristown, PA. A couple of months ago, he was appointed Chairman of the Department of Pediatrics at Abington Hospital, Abington, PA, a major community hospital (500 beds) in suburban Philadelphia. He heads a staff of 40 pediatricians.

About the same time, his son, Joshua, still in his twenties, ran for a seat in the Pennsylvania House of Representatives and was elected.

Students, Interns and Residents

Congratulations to all of you who are about to graduate or whose internship or residency is about to end! Before the next phase of your career begins, we would like to ask that you take a moment to upgrade your membership with the College.

You may now upgrade your membership category to one that will allow you a much greater role in the College!

Here are your options:

- **Student** members may now become a Candidate member as an intern. Intern members, though unable to vote or hold elective office, may serve on all ACOP committees.
- **Interns** may now upgrade to a Resident member. Resident members, though unable to vote or hold elective office, may serve on all ACOP committees.
- **Residents** may now upgrade to Associate member. Associate members may vote on all governance matters, hold elective office and serve on all ACOP committees.

Please contact the ACOP Membership Coordinator, Joye Stewart at joye@ACOPeds.org for more details!

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Understanding Certification

Following several requests, we have attempted to simplify the understanding of the two certification programs and the route for ABP-certified pediatricians to become AOBP certified.

Organization Structure

Osteopathic

ACOP is a membership organization, a component society of and responsible to the AOA. ACOP elects and is responsible for the AOBP.

AOBP operates under the jurisdiction of the AOA and has the responsibility for evaluating and approving candidates' training, administering certifying examinations and recommending successful candidates to the AOA.

AOA is a membership organization, and the parent of ACOP and all other osteopathic specialty groups. Its Bureau of Osteopathic Specialists confers certification upon recommendation of AOBP.

Allopathic

AAP is an independent membership organization. It is not under the control of the AMA. The AAP has no direct connection to specialty certification. It has recently opened its membership to AOBP-certified pediatricians (*does not entitle applicant to sit for ABP certifying or recertifying examinations*).

ABP is a free-standing board and an affiliate of the American Board of Medical Specialties. It is charged with evaluating and approving specialty training, administering certification examinations and certifying successful candidates

AMA is a membership organization. It does not control either AAP or ABP, nor do they report to it.

Note: The AOBP and the ABP do not see their certifying examinations as interchangeable and they do not accept each other's certification.

Membership in ACOP

Applicants for ACOP membership are acceptable with either AOBP or ABP certification or eligibility.

AOBP (Osteopathic) Certification

Candidates with "outside" training or ABP certification must be a member of AOA, apply and submit credentials of training to AOBP ("outside" training will be evaluated on an equal basis with osteopathic training) and if approved, take the AOBP certifying examination

Recertification

AOBP recertification is open only to holders of AOBP primary certification. ARP recertification is open only to holders of ABP primary certification.