PULSE

THE QUARTERLY PUBLICATION OF THE AMERICAN COLLEGE OF OSTEOPATHIC PEDIATRICIANS

FALL • 2014

AOA OMED/ACOP

25+ 1-A Credit Hours!

PLEASE NOTE:

You must check the ☑ **Pediatricians Box** when you register in order to receive your syllabus and specialty CME credit.

Saturday, October 25

Perinatal-Neonatal Medicine

Neonatal dermatology, congenital cardiac disease, palliative care and NICU therapies will be covered, as well as a focus on stressors of a "normal" pregnancy. The content and interactive sessions are geared for neonatologists, hospitalists and general pediatricians alike.

Sunday, October 26

Pediatric Genetic, Epigenetic and Environmental Stressors

Including eczema/dermatologic conditions, metabolic diseases, genetics, early brain growth and environmental exposures. The end of the day concludes with a lecture on pediatric telemedicine and an educational leadership workshop.

Monday, October 27

Joint Session of the American College of Osteopathic Pediatricians (ACOP), American College of Neurologists and Psychiatrists (ACONP) and American Osteopathic Association of Addiction Medicine (AOAAM)

A focus on impact of family depression on infant development, substance abuse, physical and emotional trauma, and resilience.

Tuesday, October 28

Joint Session of the American College of Osteopathic Pediatricians (ACOP) and American Academy of Osteopathy (AAO)

Additional lectures on autism, immunizations and the perennial favorite, OCC Mini-Board review will also occur throughout the Saturday-Tuesday sessions.

Register Now! CLICK HERE

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.

Dr. Jessica Mondani is a busy Pediatric Infectious Disease Fellow at Rainbow Babies and Children's Hospital. In addition to educating the house staff about the Perils and Pitfalls of Infectious Disease, she also manages to take care of her husband, an adult cardiology fellow, and her newborn son. When not saving the world one dose of Vancomycin at a time, she enjoys swimming and practicing her French cooking skills, for which her husband is forever thankful for.

You May Think it is to Early to Start Thinking About the Flu, but Winter is Coming

By Jessica Mondani, DO

A Quick Review of the Recommendations of the Advisory Committee on Immunization Practices 2014-15 Influenza Vaccines in Children

1. **For 2014–15, influenza vaccines will contain the same vaccine virus strains as the 2013–14 season.**
   a. Trivalent influenza vaccines will contain:
      i. 1.A/California/7/2009 (H1N1)
      ii. A/Texas/50/2012 (H3N2)
      iii. B/Massachusetts/2/2012 (Yamagata lineage)
   b. Quadrivalent influenza vaccines will also include B/Brisbane/60/2008 (Victoria lineage)
2. **Children six months through eight years require:**
   a. Two doses of influenza vaccine during their first season of vaccination.
   b. Only one dose is required for children six months through eight years who previously received ≥1 dose of 2013–14 seasonal influenza vaccine.
3. **If available, live attenuated influenza vaccine (LAIV) should be used for healthy children two through eight years. This is a new recommendation, but the lack of availability of the LAIV should not delay vaccination.**
   a. LAIV should be avoided in these groups
      i. Children two through 17 years who are receiving aspirin
      ii. Those with severe allergic reactions to the vaccine or any of its components
      iii. Immunosuppressed patients
      iv. Children with a history of egg allergy
      v. Children who have asthma or who have had a wheezing episode within the past 12 months
      vi. Those in close contact with severely immunosuppressed persons, or alternatively they should avoid contact with such persons for seven days after receipt of vaccine.

MELNICK at Large

No Sticks and Stones

By Arnold Melnick, DO, FACOP

That centuries-old adage "Sticks and stones will break my bones, but names will never hurt me" has been proven wrong once again by the epidemic of bullying presently with us.

Name-calling and taunting and picking on weaknesses are creating havoc with many children today, unfortunately reinforced by the pressure on children not to "squeal". (Just for completeness, it is important to note that some adults also suffer from bullying – in the workplace, in neighborhoods, and in other aspects of life.)

For children, it is estimated that 28% of children in grades 6-12 have experienced bullying in some form – verbal or physical. But sometimes, we are hard pressed to differentiate bullying from other forms of bad behavior.

Connect with Kids, a producer of educational materials, has put forth an interesting definition of bullying, making it easier for non-involved (even some involved) professionals to recognize it.

They suggest that there are four elements to bullying and these can be remembered as the four P's:

THE FOUR P's

PAIN

Someone is physically, psychologically, or sexually hurting someone else.

POWER

The person who is doing the bullying is perceived as more powerful and is usually attempting to wield some power over the victim.

PERSISTENCE

Generally the bullying is persistent, which means it happens more than once. It's a repeated act.

PERMISSION

Usually someone else knows about it and is allowing it to happen. A bully almost always has an audience.

Evidence of bullying may appear in our offices. Either the victim admits it to the physician or the physician detects unusual behavior or might ask about it (when alone with the child). Often, these victims are so frightened or threatened, they do not report it to authorities or even to their parents – and maybe the intervention of a child's trusted physician will bring things to a head.

More interesting information about bullying and other childhood problems may be found at **www.connectwithkids.com** and try *Bullying Defined*. It's worth a look!

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.*

AOA/JAOA REPRINT

Join Your Colleagues in Ensuring the Public has Access to Accurate Medical Information

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Wikipedia is the top source of health care information for both physicians and patients, according to a recent Institute of Healthcare Informatics report. More than 50% of physicians said they use Wikipedia for information, especially for specific conditions. Do you think this information is accurate?

A study published in the May issue of *The Journal of the American Osteopathic Association (JAOA)* compared Wikipedia to peer-reviewed medical literature. It found that most Wikipedia articles representing the ten most costly medical conditions in the United States contain many errors when checked against standard peer-reviewed sources.

Get Involved

You can play an active role in fixing this problem. Exercise your responsibility to help keep the public informed about common healthcare conditions. Contribute to Wikipedia articles and revise inaccurate information. Use this simple guide to get started.

This illuminating study is just one of many more DOs can expect in the revamped *JAOA*, led by our new Editor in Chief Robert Orenstein, DO. Read his May, 2014 editorial to learn more about his vision for the future of the osteopathic medical profession's most prominent journal. Increasing media exposure of osteopathic research is one of Dr. Orenstein's goals, and this study has helped achieve it. Read an interview with Robert T. Hasty, DO, the study's lead author, that was published in *The Atlantic*. The article, like our study, examines whether Wikipedia can be a trusted source of medical information. Read our May 2 news release for more information that may be helpful for your patients. Watch a video with Dr. Hasty explaining the study's findings.

CLICK HERE

TO VIEW ARTICLE ONLINE

Quotes from the Members

Quote in response to comment on the number of emails, charts, clinical and administrative tasks that piled up after vacation.

> **"Doctors don't go on vacation, they go on postponements."**
>
> ~ Scott Cyrus, DO, FACOP, *President of the ACOP*

Support Our Students Donate to the PRES Fund

Pediatric Research & Education for Students (PRES) Fund

Please consider making a donation to the newly created ACOP Pediatric Research & Education for Students (PRES) Fund. The purpose of the fund is to provide a formal mechanism to support student research.

The ACOP has always been committed to its students and student clubs by keeping dues and registration fees at an absolute minimum. Once the corpus of the new fund reaches its target, the ACOP will institute an application and award system to fund students' research. All board members have already contributed to the fund and it is hoped that there will be a very high participation rate from the members at large no matter what the amounts.

The American College of Osteopathic Pediatricians is a 501(c)6 organization. Donations to the PRES Fund may be tax deductible as allowed by law and will be acknowledged by the ACOP. Why wait? Make your donation today.

DONATE NOW!

Hear Ye! Hear Ye!

New York Times Feature Article on Osteopathic Medical Training:

The DO is In Now

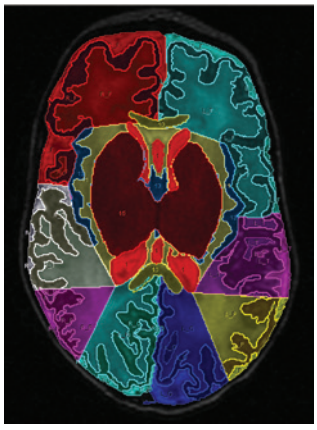
www.nytimes.com/2014/08/03/education/edlife/the-osteopathic-branch-of-medicine-is-booming.html

MEMBERS ...in the News!

Mapping the Neonatal Brain

By Robert Locke, DO, MPH

Nehal Parikh, DO, MS, a neonatologist and neuroscientist at Nationwide Children's Hospital is pushing the envelope of neonatal medicine by seeking to create an atlas – or map – of the neonatal brain. The information gained from this atlas will improve the understanding of brain growth, injury and repair in infants born prematurely. The atlas and serial MRI technique also hold the promise of providing real-time assessment of interventional therapeutic efforts to improve premature neurodevelopmental outcomes.



Dr. Parikh graduated from the New York College of Osteopathic Medicine, completed his pediatric residency at SUNY Stony Brook School of Medicine and, I can brag, completed his fellowship in Neonatal-Perinatal Medicine/Neonatology at the combined program at Jefferson Medical College/A.I. duPont Hospital for Children/Christiana Care Healthy System. Dr. Parikh's research has been featured in multiple news and research formats.

A video link and more information on the Brain Atlas project can be found at: **http://youtu.be/L4WUSehjgT4.**

Historical Highlights

The ACOP 1990 Annual Meeting was notable in that it was held outside the United States in St. Thomas, VI. Michael Ryan, DO, was President, and he arranged an especially interesting program, including the production of the first ACOP history book titled, *The Golden Anniversary History of the American College of Osteopathic Pediatricians*. It was written by professional author Robert Phillip Bomboy.

FYI STAY IN THE KNOW!

Single Accreditation for GME

AOA House of Delegates Votes to Support Single GME Accreditation System

The AOA House of Delegates voted to support the AOA Board of Trustees efforts to form a single accreditation system for osteopathic and allopathic graduate medical education training. The AOA effort is a combined activity with the American Association Council for Graduate Medical Education (ACGME) and the American Association of Colleges of Osteopathic Medicine (AACOM). The current plan is to create a phased-in process that will be complete in 2020.

The AOA perspective is provided at www.osteopathic.org/single GME.

Additional Commentary from a public health policy perspective (Dr. Kelley) and an Osteopathic Medical School Dean (Dr. Connett) are provided in the *JAOA*.

Impact of the Single Accreditation Agreement on GME Governance and the Physician Workforce, Cynthia S. Kelley, DO, *J Am Osteopath Assoc* July 1, 2014 114:518-523 doi:10.7556/jaoa.2014.102 **http://www.jaoa.org/content/114/7/518**

Effect of the Single Accreditation System, David A. Connett, DO, *J Am Osteopath Assoc* July 1, 2014 114:524-526 doi:10.7556/jaoa.2014.101 **http://www.jaoa.org/content/114/7/524**

Updates from the AOBP

The Board of Specialties (BOS) of the American Osteopathic Association (AOA), including the American Osteopathic Board of Pediatrics (AOBP), met in August to discuss the ACGME Unified Accreditation Pathway, Recertification Examinations, Job Task Analysis (JTA), Component 4 and Specialty CME.

Kayse Shrum, DO, Chair of the AOBP, has posted an update on the AOBP website on these important issues affecting osteopathic pediatric certification, **www.aobp.org/From%20the%20Chair%20%20BOS%20Summary.pdf.**

If you are interested in applying for an exam, want to understand more about Osteopathic Continuous Certification (OCC) or other aspects related to the AOBP, check out the AOBP website, **www.AOBP.org** for additional information.

2015 Harold H. Finkel, DO and Arnold Melnick, DO Community Pediatrician of the Year

Nominations Being Accepted Now

The American College of Osteopathic Pediatricians (ACOP) is accepting nominations for the **2015 Harold H. Finkel, DO and Arnold Melnick, DO Community Pediatrician of the Year Award.**

Do you know a pediatrician who is worthy of this honor?
If so, please click here to submit your nomination.
The nominations deadline is Friday, October 3, 2014.

The Harold H. Finkel, DO award was established in memory of Dr. Finkel whose illustrious career spanned over 50 years of community pediatric practice. He was known for his exceptional care and availability to his patients, his commitment to students, interns, residents, addressing community child health needs, advocating for the most vulnerable children and service to the ACOP.

Through this award, we honor his memory by recognizing colleagues who have embraced those values and by their actions have distinguished themselves in their community and served our profession with distinction.

In 2013, the ACOP, with the blessing of Dr. Finkel's family, added Arnold Melnick, DO to the name of the award. Dr. Melnick, who serves as Emeritus Editor of PULSE, has served the ACOP in many capacities since 1946. Both are Past Presidents of the ACOP. Close personal friends, they collaborated for years on many ACOP activities, and this award memorializes their friendship and partnership.

Award Criteria*

1. Must be a DO pediatrician
2. ACOP membership preferred, but not mandatory
3. Has demonstrated community leadership in addressing the healthcare of children
4. Has accomplished something innovative that has improved the care of children
5. Has advocated for children's needs on either a local, state or national level
6. Is recognized by peers as a respected colleague and mentor to students and residents
7. Stands out as a role model for practicing and future pediatricians

** Candidates do not have to fulfill all of the stated criteria in 3-7, but should have distinguished themselves in one or more of these criteria.*

Please contact kim@acopeds.org with any questions.

CLICK HERE **FOR NOMINATION FORM**

TALES FROM ADOLESCENT MEDICINE

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

Fun at Juvenile Detention

By Jessica S. Castonguay, DO, MPH

Teens go to jail. Sometimes it is for an offense such as truancy or unruly behavior. Other times, the offense can be much more serious. Regardless, these youth need health care. Unfortunately, many of them are "on the run" when they are brought to a detention facility or have very chaotic home lives, so healthcare was not a priority. Many of the youth I see in detention can't even remember the last time they saw a doctor.

There are many common issues among detained youth. Injuries are one. Some come in with injuries from resisting arrest like abrasions or pulled muscles. Others get into fights with other detainees causing black eyes and fractured orbit or nasal bones. Some like to punch walls. I have tried to explain that punching a pillow won't cause the boxer's fracture that many of them sustain, but invariably they laugh at that suggestion. In juvenile detention, I apparently know nothing.

Infection is another frequent reason for visits to the medical clinic at detention. Fungal skin infection is a frequent offender and easily treated with topical creams. Many youth have tattoos that were done at home by a friend of a friend. I assure you that these tattoos are very interesting to look at. New tattoos should be cared for according to typical recommendations. Other skin infections such as folliculitis, cellulitis, or abscess may be seen. Treatment should be determined based on the prevalence of MRSA in the community. Incision and drainage is a quick procedure that can be performed at the facility if warranted. Despite what the detainees think, not every rash on their skin requires a trip to the emergency department and an antibiotic.

According to the Center for Disease Control, among females aged 14-19, the chlamydia prevalence rate is 6.8%. Youth in detention are more likely to have STIs such as gonorrhea or chlamydia compared to age matched samples. In fact, chlamydia rates in detained youth are as high as 14.4% in males and 28.1% in females. That's almost seven times higher than the general population. This supports the need for screening for gonorrhea and chlamydia at intake. Other screening, such as HIV testing, should be offered based on each youth's risk. When getting the sexual history, I always have to wear my poker face.

Mental health and substance abuse concerns are prevalent among detained youth. Unfortunately, many programs do not have dedicated psychiatric and psychological support for all youth. Many issues such as insomnia, hyperactivity, and impulsiveness fall to those who staff the medical clinic. Plans should be in place for any detainee that requires acute care for suicidal ideation, psychosis, or withdrawal.

And then there are the fakers, those who are bored and want a field trip to the local emergency room or think they can escape more easily from another location. I don't think that they realize the orange jumpsuits and shackles make them very noticeable. My favorite malingerer was a youth who presented to clinic and stated that he was having seizures during free time. No one had witnessed a seizure. I offered to put him on medical isolation so that we could see a seizure. He owned up to the lie once he realized that he would not be able to attend gym or eat in the dining hall. The presence of malingerers makes it difficult to determine real need for some of these youth.

The truth is that many of them just don't have the support that they need at home. The attention that they receive from the medical staff may be the most positive adult interactions that these detainees have had in months, years, or maybe their whole lives. I recently received a huge smile and bear hug from one such youth. I wasn't sure if I should hug her back. Then I thought about the youth's story and how guarded she was when I had met her a few months prior. I had gained her trust. And I hugged back.

iPerch

Reflections by Past Presidents of the ACOP

Edited by Steven Snyder, DO, MS, FACOP

The Advent of Dual Residencies

By Michael Ryan, DO, FACOP

In 1990 the ACOP was celebrating our 50th anniversary and I was the in-coming President. My instructions were clear – this needs to be a celebration of the past 50 years. We decided to hold the ACOP Annual Meeting in St. Thomas in the Virgin Islands. The list of speakers was quite impressive and Terry Goeke and her staff at the ACOP helped to make it a great success.

As part of the celebration, the ACOP commissioned Robert Bomboy to write a book about the history of the first 50 years of the ACOP. Bob, a friend of mine, traveled around and interviewed all the senior members he could find and produced a valuable treasure for our college. As I read this book, it reminds me just how far we have come; from hiding in the back of the lecture hall at CHOP to now giving the lectures at CHOP or any of our other great children's hospitals in the country.

We also decided at this time that we needed a second or mid-year meeting. The original ACOP meeting was always held in the spring and we decided to have another meeting in the fall. Politics were such with the AOA that a joint meeting was not going to happen at that time. Our first mid-year meeting was held at the Embassy Suites in Old Town Alexandria, Virginia, and was well attended. We were off to a good start and held subsequent mid-year meetings there for the next two or three years. It was (and still is) a great location with easy access for most of our members who were primarily along the east coast. Lots of well known pediatric speakers were also nearby.

But probably the issue that I wanted to accomplish most involved our pediatric residents. At this time, we had only two DO pediatric residents in the entire country. If this were to continue, the ACOP would cease to exist in the next few years. After much thought and lots of discussion, we decided to try what became known as a dually accredited residency. The idea was revolutionary at this time. It involved creating an osteopathic pediatric residency and an allopathic residency that were one and the same. A new osteopathic graduate could choose to get certified by both the ABP and the AOBP. This idea included changing the rotating internship to a more focused pediatric internship. It included eight months of pediatrics while still counting as a rotating internship which was required by several states for licenses. The leg work involved was monumental and involved many trips to Chicago to sell the idea.

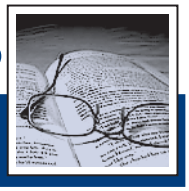
In 1993, the pediatric residency at Geisinger Medical Center in Danville, Pennsylvania, was the first dually accredited residency. Michelle Di Lorenzo, DO, was our first pediatric resident. We also selected a student from the Texas Osteopathic School, who never showed. But the program took off and we have never looked back. In the years that followed, we (ACOP) would advise and help other children's hospitals and osteopathic medical centers to establish dually accredited programs in pediatrics, internal medicine, OB/GYN, etc. We went from two DO pediatric residents in osteopathic programs to over 75 osteopathic physicians in dually accredited pediatric programs in this country today.

At Geisinger each year, half of our class of incoming pediatric residents are DOs in this dually accredited program. Since 1993, we have trained over a 100 DO pediatricians, a record that makes me very proud.

But what gives me the most satisfaction is the small role I have played in the training of all our pediatric residents over the last 34 years. It has been a labor of love.

So if 1990 was our 50th anniversary, then 2015 must be our 75th anniversary. Can the current ACOP leadership top St. Thomas? I hope so!

In the JOURNALS



ACOP Members in Print

Prolonged Early Antibiotic Use and Bronchopulmonary Dysplasia in Very Low Birth Weight Infants

American Journal of Perinatology. May 2014.
[Epub ahead of print]

Robert Locke, DO, MPH, FACOP and colleagues.

If you or someone you know has an article in print, share the good news and let us know at ACOPublications@gmail.com.

It's polite to brag!

Osteopathic Student Pediatric Club and Residency Programs – Are you doing something exciting? Making a difference? Share your success with colleagues. Let us know what you are doing at your Student Pediatric Club. We'll highlight it in the PULSE. It is polite to brag -- if you share it in the PULSE. Write to **Kim@ACOPeds.org** or **ACOPublications@gmail.com** with any questions or submissions.

Welcome New Members!

Fellow

Bridget Bryan, DO, FACOP.....Blanchard, OK
Heath A. Parker, DO, FACOP.....Dothan, AL

Special

Alberto Marante, MD.....Loxahatchee, FL

General

Shawn Kapoor, DO, MHA.....Pittsburgh, PA

Resident

Ali Ahmad, DO.....Miami, FL
Amanda Brown, DO.....Brooklyn, NY
Lauren M. Castner, DO.....Brooklyn, NY
Jenie S. Ferrer, DO.....Dearborn, MI
Katheryn Hudon, DO.....Grosse Pointe Woods, MI
Michael Ignat, DO.....Brooklyn, NY
Erin Jakubowski, DO.....Lansing, MI
Aimee E. Leisure-Martins, DO.....Okemos, MI
Sara McDonald, DO.....Tulsa, OK
Lee Murphy, DO.....Holt, MI
Nastassia Richardson, DO.....Lansing, MI
Christine Saracino, DO.....Brooklyn, NY
Ilyssa Scheinbach, DO.....New York, NY
Krystal S. Sharpe-Kamer, DO.....Lansing, MI
Ankita Singh, DO.....Canton, MI
Danelle Stabel, DO.....Troy, MI
Amanda M. Terwey, DO.....Tulsa, OK
Jess Thompson, DO.....Brooklyn, NY
Megan R. Thompson, DO.....Tulsa, OK
Amanda Torgeson, DO.....Jackson, MI
Gregory H. Treado, DO.....Royal Oak, MI
Samantha Weinstein, DO.....Stratford, NJ

Intern

Carrie A. Baker.....Tulsa, OK
Okyro C. Claudio, DO.....North Babylon, NY
Mary A. Cross, DO.....Smiths, AL
Polina Frolova Gregory, DO.....Sterling Heights, MI
David M. Geisinger, DO.....Danville, VA
Sana A. Hameedi, DO.....Bethpage, NY
Enin M. Harpenau, DO.....Evansville, IN
Stephanie B. Jarnagin, DO.....Lansing, MI
Matthew J. Kolosky, DO.....Longwood, FL
Meyling J. Oei, DO.....New York, NY
Eric Puster, DO.....Indianapolis, IN
Mayadha Rasheed, DO.....Brookfield, CT
Tara M. Schaaf, DO.....West Islip, NY
Maggie Seblani, DO.....Weston, FL
Pallavi Shankaraiah, DO.....West Palm Beach, FL
Adam P. Wahlstrom, DO.....Owasso, OK
Chelsey D. Yurkovich, DO.....Berkley, MI

Pediatric Student Club

Richard L. Baggaley.....Holly Springs, NC
Catherine E. Bixby.....Saco, ME
Devin M. Burr.....Spanish Fork, UT
Brittany M. Corrigan.....Lewisburg, WV
Michael P. Coughlin.....Biddeford, ME
Alvin C. Der.....Dothan, AL
Katie Eggerman, MPH.....Brookfield, MO
Julie Kay Furmick.....Peoria, AZ
Elizabeth Koh.....New York, NY
Katrina Lin.....Tulsa, OK
Glennda Tiller.....Tulsa, OK
Pianpian Wu.....Belmont, MA

eJOURNAL of the American College of Osteopathic Pediatricians

The ACOP eJournal, 24th Edition, Summer 2014, has now been posted on the ACOP website.

CLICK HERE to view the latest edition!

Pediatric Clinical Pharmacology/Toxicology

- Consult: Intentional Iron Overdose
- Clinical Challenge: Nicotine Exposure and The e-Cigarette Boom

Allergy Review

- A Retrospective Review of Macrolide Use in Asthma

From the Sidelines

- Basic Concepts in Acute Management of Sport-Related Concussions

Case Presentations

- Herlyn-Werner-Wunderlich Syndrome with Comorbid Appendicitis and Endometriosis
- Pericardial Tamponade in a Newborn from Umbilical Venous Catheterization: Are Current Methods of Catheter Monitoring and Placement Effective?
- Henoch-Schönlein Purpura (HSP) in a 44-Day-Old Female Infant

Did you miss seeing the last issue of the *eJournal?* It is still available at the **ACOP Website**
http://www.acopeds.org/ejournalarchive.iphtml

After the Earthquake: A Renewed Sense of Perspective

By Tami Hendriksz, DO

Two events occurred last Sunday, a mere 4 days ago, and their coinciding was, in retrospect, quite perfect. A large earthquake hit Northern California, in particular the Napa Valley (where I live) and Solano County (where Touro University California is located). I was woken up by a tremble that increased in intensity and violence as I ran down the hallway to check on my two small children. The sound of breaking glass and objects hitting the floor was almost deafening. It was frightening, but it was also over fairly quickly. Once the world became still again, my family, my neighbors, and my community were able to look up and assess the damages. Most of all, we were left with the profound benefit of renewed perspective. There was no doubt left in anyone's mind about what was important. Yes, we lost almost all of our glassware, and quite a few personal belongings. Our streets are broken, cracked, and arched, and our sidewalks are in shambles. But we had our well-being and our community. That is what matters. Everything else can be purchased again, rebuilt, and repaved. In our family, no-one was hurt (including our pets), and we had family members and friends come and find us (there was no cell phone service, electricity or water for quite a few hours following the quake), comfort us, feed us, and help us clean up and rebuild. An unfortunate natural disaster struck us, and we were left feeling lucky.

About nine hours after the earthquake, I kissed my family goodbye, promised them to stay safe, and I drove to the Touro University California campus for the Class of 2018's White Coat ceremony. Including my own, I have been to six of Touro's White Coat ceremonies, and this one was by and large the best. The auditorium was packed with more family members, loved ones and friends, then I had ever seen before. It was also bubbling over with excitement, pride, and that renewed sense of perspective. Everyone in that auditorium had experienced the earthquake that morning, and they had all still chosen to come to the campus to celebrate. Our incoming class was at the top of everyone's priority list.

As I read the names of the students as they crossed the stage and put on their white coats, I was tempted to whisper something else to them:

Remember this moment. Take mental pictures of the audience, your faculty, the school administration, and your peers. Everyone is here for you. Supporting you because you are amazing, and we all believe in what you can and will do. Giant plates on the surface of the earth moved today – they rattled us and shook us. And we are still here. You are that important. Remember back on this day as you face and overcome challenges in the next few years. Never lose sight of your dreams, your abilities, and your self-worth.

As I reflected on my overwhelming feelings of gratitude towards my family members, friends, and larger community in Napa, I was reminded of another time when I was also dependent on loved ones: medical school. Medical school is challenging and exhausting. It often forces you to lose track of your priorities. Certain exams and call-shifts become top importance. Were it not for the support, guidance, and humor of my classmates, friends, and family, I wouldn't have been able to get through it. There are times to stand on your own two feet, and overcome challenges on your own. Natural disasters, and medical school, are not one of those times.

For Membership Questions or to Join ACOP

Contact Greg Leasure

greg@ACOPeds.org - (804) 565-6305

PELC WORKSHOP

Giving the Medical Student Feedback Workshop: What to Say and What Not to Say

Sponsored by the ACOP Pediatric Education Leadership Committee

Presenter:
J. Michael Metts, DO, FACOP, FAAP
Chair, Department of Specialty Medicine
Des Moines University

Sunday, October 26, 2014
5:30 pm -7:00 pm
Location - Room 201
Washington State Convention Center

Do you teach medical students or residents? Do you ever wonder what to say to the learner when they are doing well or when they are struggling? Are you interested in having a real impact on your learners with your feedback? Then this workshop is for you, a chance to discuss with other physician educators ways to effectively communicate with the millennial generation.

Learning Objectives:

Upon completion of this lecture, the participant will be able to:

- Distinguish between different generational learning styles to increase teaching effectiveness
- Define Formative Feedback and Summative Feedback Create a glossary of terms and phrases for use in feedback and evaluation of the medical student
- Recognize the consequences created by positive and negative evaluations of a medical student on the student and the evaluator
- Use the experiences of other attendees to effectively improve the process of feedback and evaluation at your institution

ACS Announces Tiers of Children's Surgical Care

By Arnold Melnick, DO, FACOP

Another move to promote better surgical care for children was announced recently by the American College of Surgeons for their Task Force for Children's Surgical Care.

The ACS has developed a new classification system for pediatric surgical centers based on the their level of care. It is similar to the system that classifies trauma centers.

Studies have shown that among infants and children who have surgery performed in hospitals with special resources, there is much better survival and shorter hospital stays.

More than five million infants and children have surgery every year. Surgery ranges from simple outpatient procedures to complex heart-defect repairs that can take long periods of time, like 12 hours or more in the operating room. The most significant risk is sedation. In spite of many recent advances, death and complication rates are still higher in children than in grown-ups. Researchers have estimated that for infants younger than one year the risk of cardiac arrest under anesthesia is about five times as high as for adults. And for newborns it is about ten times as high.

Because of these statistics and because of their anatomy and growth stage, children have unique needs, including specialized anesthesiologists, radiologists and emergency physicians. On the other hand, almost half of all pediatric surgeries occur in general hospitals.

The new plan has been endorsed by the American Pediatric Surgical Association and is under consideration by the American Academy of Pediatrics.

Centers designated at each level will have the resources of the levels below, plus selected additional resources.

LEVEL I: Comprehensive Care, Highest Level

Complete surgical procedures in newborns and children, including those with the most severe conditions and birth defects

- Staffed 24/7 with pediatric specialists including surgeons, anesthesiologists, diagnostic and interventional radiologists and emergency physicians.
- Level IV neonatal intensive care unit (NICU), the highest level of critical care for newborns
- Operates a transport service

LEVEL II: Advanced Surgical Care

Advanced surgical care for children, including those with existing moderate-risk medical conditions. Generally, surgeries involve a single organ system

- Staffed 24/7 with a pediatric surgeon, anesthesiologist and radiologist; other pediatric specialists available for consultation
- Level III or higher NICU
- ICU capacity with pediatric critical care
- Ability to stabilize critically ill children, transfer to Level I

LEVEL III: Basic Surgical Care

Low-risk surgical procedures in children older than 6 months who are otherwise healthy

- Staff a general surgeon, anesthesiologist, radiologist and emergency physician with pediatric expertise
- Ability to stabilize and transfer critically ill children to Level II or Level I
- Pediatric nursing surgical experience
- Pediatric resuscitation in all areas, and pediatric rapid response team 24/7

Source: Journal of the American Colleges of Surgeons; Task Force for Children's Surgical Care

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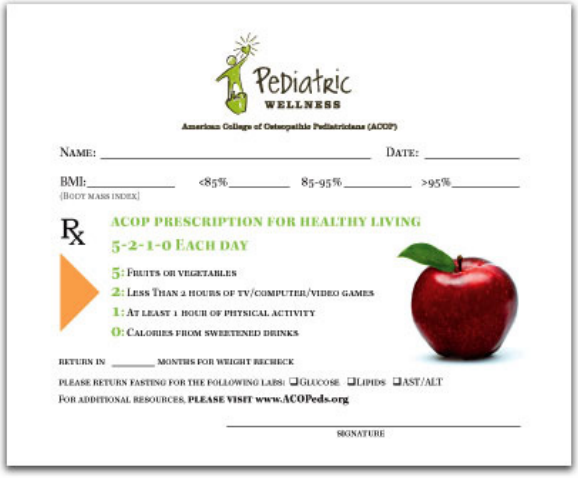

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