

The Young Physicians

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™



Section Summer 2007 Newsletter

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Chairperson's Welcome

Hello and welcome to the latest edition of the SOYP newsletter. As the warm weather returns, slowly in some parts, growth is on many people's minds: grass that needs cutting, weeds that need pulling, kids that need chasing, and on and on.

Growth is also a buzzword around the SOYP. Our membership has grown to over 5000 members, we have added a new group of district representatives, our newsletter is expanding, and we continue to expand the value of membership in the Section.

The Section concluded its election and the executive committee is now district-based to allow for more communication with chapters and districts on YP issues. Your district representatives and their contact info are listed within this newsletter. Take advantage of the district representatives to let them know your thoughts and ideas for the Section.

Twenty-eight chapters applied for a young physician outreach grant from the SOYP (funded by the AAP Friends of Children Fund) and twelve chapters were funded. The program will continue in 2008 and expand to include outreach to residents and medical students.

Two young physician guides are in draft-stage: a guide for chapters on young physician outreach and a guide for young physicians on the AAP.

We are planning an SOYP reception at the NCE in San Francisco. The reception is scheduled for Sunday, October 28 at 7pm, immediately following the President's Reception in the convention center.

The SOYP is working with an outside vendor to create a peer mentoring network for our members.

The SOYP is seriously contemplating how to get leadership training to YPs across the nation. Let's work together to accomplish this.

If you have any suggestions to help the Young Physician Section address young physician-related issues, please do not hesitate to contact us.

Enjoy your summer!

David M. Krol, MD, MPH, FAAP
Chairperson • Section on Young Physicians



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Editor's View

by **Dennis Z. Kuo, MD, MHS, FAAP**

When I was eight years old I watched my father open a solo general pediatrics practice, his life-long dream. He took his own phone calls, gave his own shots, and personally wrote and mailed out the bills. I'm not even sure when he hired a secretary, but it probably wasn't for seven or eight years, and that doesn't include the summer I spent reorganizing his charts and typing up his bills. But the practice did grow and thrive, and my father practiced for 24 years.

The independence, the potential financial reward, the chance to be your own boss, and the opportunity to put your own stamp on patient care are all reasons to start your own practice. "It's too hard to start my own practice" is a comment I've heard umpteen times from ourselves, and while it's true that my father didn't have to deal with managed care and as many regulations in 1980, but I've met several ambitious and dedicated young pediatricians who have forged ahead and opened their own practices. They are living proof that it *can* be done. I'm sure you know a few yourselves.

In this issue of the SOYP newsletter you'll read about the experience of one physician who has opened his own practice. I hope Dr. Jorgensen's article will be the first of many articles this newsletter will run that will inspire and educate. For those of you who have opened your own practices, we want to hear from you.

Results 2007 Election

Chairperson

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"What's On Your Mind?"

How Having a Baby Changed My Practice of Medicine

by **Rhonda Patt, MD, FAAP**

A few years ago, I completed my pediatric residency and joined a busy practice. I spent most of my days giving anticipatory guidance to parents, and yet I was not a parent. I always dreaded hearing a parent say: "Well do you have kids? Then how do you know?" in response to any unpopular advice. Then I was a mom-to-be and disliked even more the comment, "We'll see how you do it when your baby is born" or "Do you think having a baby will change the advice that you give parents?" To these comments, I would politely reply, "We'll see." Meanwhile, I am thinking "My advice is based on scientific evidence not anecdotal experiences or wives tales. Having a baby will not change how I practice medicine." Although the former of these statements is true, the latter is certainly not. Having a baby did change me as a pediatrician but not necessarily in the ways that my patients had implied it would.

New parents are very sleep-deprived and stressed. I thought residency had prepared me for sleep deprivation, but having a newborn is like being on-call every night for 3 months straight. Nothing could prepare a person for this. This level of sleep deprivation makes parents forgetful and sometimes tearful. On top of that, everyone from the baby's grandma to complete strangers is offering them unwanted advice. It can all be so overwhelming, and parents just want to make sure that they making the right decisions. Before, I would some-

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times become annoyed with unrelenting questions about stool color and number and feel like that the parents were asking for studies to prove that their child does not have some horrible disease. Now, I realize that what parents need is reassurance and confidence in the physician's voice. "This is normal" is a great reply to the great majority of parents' concerns. Follow that up with a "you are really doing a great job" and you may see a few tears of joy.

My toughest lesson as a new mom was realizing how much pressure there is to breastfeed. I recall a girlfriend of mine telling me that she was not able to nurse her daughter, and although her daughter was now a thriving 13 month-old, the statement still brought tears to her eyes. I thought, "Man, she must really be into breastfeeding." Then, when I started back to work after maternity leave, my daughter decided that the bottle was best and refused to nurse. I recalled telling many tearful moms that bottle-feeding is okay when they had to give up nursing for any reason. However, I did not realize all of the emotions that are attached to nursing your child. First, there is the feeling that you have failed the first test of your ability to provide for your new baby. Second, there is a feeling of rejection when your baby screams because she wants a bottle and not mommy. And finally, there are the gasps in your mommy group when you pull out a bottle of formula for your baby. They are all thinking that you "gave up." The reality is that not everyone breastfeeds, and not every breastfeeding problem can be fixed. Now, I am not so quick to just hand a mom some formula samples and a card for the lactation consultant. Sometimes a mom needs to know that she is not the first mom who has ever wanted to breastfeed but couldn't, and that her baby will grow and develop well either way.

The biggest change that I have seen in my practice of medicine is that I have really learned to reason with kids. I was much more serious before becoming a mom. I suppose that the silly games that I play at home with my toddler have just spilled over into the exam room. I now realize the power of a sticker, a popsicle, or the ultimate secret weapon: bubbles. Nothing makes a parent happier than to have a smiling child in the exam room, and it is much easier to examine a happy child than a screaming one. I was in the emergency room a few nights ago singing "Twinkle, Twinkle, Little Star" while suturing a two-year old's eyebrow, and I was thinking that this is something that I probably would not have been bold enough to do a few years ago.

While I certainly don't think that you have to be a parent to be a good pediatrician, insights from the highs and lows of motherhood have changed the way I relate to both patients and their families. On the other hand, I also learned from my experiences that the advice I had been giving about feeding and sleep does work if it is followed; therefore, I have not changed in this regard. It is true that the practice of pediatric medicine is scientific and evidence-based, but I think it is important to remember that there is also an art to medicine that incorporates our life experiences. Obviously, everyone's experiences are different, so hopefully a glimpse at mine may provide a glimpse into the mind of a new parent.

The Challenges and Rewards of Being a National Health Service Corps Scholar

by Kira Marciniak, MD, FAAP

When I graduated from residency last year, I packed my car and drove two thousand miles from Seattle for my first real job: a primary care pediatrician in a public health clinic! I am a National Health Service Corps Scholar, and for seven years had known I'd be serving in primary care for underserved children. However, during my three years of residency I felt more affinity for the excitement and speed of the emergency room and the ICU. I had settled into a routine in a tertiary care hospital in a quaternary care town. I was afraid that I would be bored and powerless in an old factory town. However, working in my public health clinic has been a remarkable learning experience. I would suggest any doctor entering practice consider at least a few years serving the underinsured and underserved.

In my public health clinic I've been able to hear the most fascinating stories, invoke that advertised medical empathy, and become a truly independent problem solver. My patient population faces a myriad of issues

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that has taken me some time to digest. In my clinic I see teen-aged mothers, meth addicts, and foster children. Parents will matter-a-factly note horrific issues: "I just got over a twenty year heroin addiction"; "I was repetitively abused during my teens"; "I can't afford a four dollar bottle of Motrin. I work for six dollars an hour". They have little trust remaining for anyone, let alone a young, white doctor. I'll often leave these rooms reeling, assimilating these crazy social issues as well as quite complicated medical histories. It is more difficult than neat lists of medications and surgeries, but in the end, we entered this field to help human beings. It is also a blessing to work every day in such a clinic. I cared for underserved children during residency, but it is so different when my patients know I will be at work daily. When they know they can call and speak to me or walk in and see me, that works wonders towards winning their trust. My patients are a rich patchwork of their relatives, their towns, and their problems. Only by gaining their confidence and listening to their fears will they begin to confide in me. And until they trust, they cannot hear my advice.

I also have begun to learn to teach each patient individually. For example, I cannot use canned asthma education patter. Depending on the level of education and interest, depending of the time of day, depending on the household's primary language, you adjust. I might speak slower and use more slang for some while for others a quick cut and dried check list will suffice. Learning these more subtle communication skills was never on the roster during medical school or residency, but is one of the most rewarding aspects of my job. By listening to people who are so different from my background, I can now speak back to them in a voice they will hear and respond to.

At the beginning of my time in Illinois, I was worried about being without my massive crew of specialists. During residency, the reflex was always to consult and call in the big guns. Here, my specialists are at least a thirty minute car ride away in the nearest big city. My patients and their parents, with broken cars or no driver's license, could sooner get to Afghanistan. I more often find myself as a telephone consultant with pulmonary in Springfield and transplant in Chicago. It's been a pleasure to improve my medical-ese and to work as an equal with these consultants. I no longer feel that I am ceding the decision-making. I appreciate being allowed to communicate complicated decisions to my kids. I know that, if need be, specialists are available, but I take pleasure learning from and with each patient.

I've never been hugged by patients as often as I am now in my clinic. It is a true joy to see many of these families, watching as they learn to become parents. It is a gift to give them a face to trust, where they often have had none. My America, to my consternation, has many more needy children than I'd imagined. I know I'm touching but a handful of them, but this is truly the reason I went into medicine in my early twenties. It is a challenging path, but the rewards far outnumber the frustrations. I'd encourage any doctor to spend a few years with those who need you most in this country, or in any other. This work is emotionally taxing, but it is a great gift of the medical field, that we can have this as part of a career.

My Postpartum Darkness

by Gina N. Herrmann, MD, FAAP

It was all working out as planned. We were moving to Colorado so my husband could start his new position after finishing fellowship. I was in my 35th week of pregnancy ready to take a break from work and be home with my son. My delivery went smoothly without complication. I was so grateful for our healthy baby, especially being well too aware of what could go wrong in pregnancy and childbirth (as we all know). The birth of my son really was the "most wonderful day of my life", but I was not at all prepared for what lied ahead.

My son was a "fussy" or "high maintenance" baby (whatever the in vogue term may be) and he spent almost every waking minute crying. I was exhausted (not unlike any other new parent) and the thoughts started to flood into my head. "Why did we do this?" I would tell my husband. "We had such a good life before *this*". I had heard about other women feeling this way and thought it was normal. However, as the weeks went by I felt more and more hopeless. Interestingly, I wouldn't describe how I was feeling as depressed per se. I felt

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mostly anxious about my son's crying and had a deep sense of hopelessness that "my situation" would never get better. I sobbed everyday. The days just seemed to be endless. My appetite was completely gone and I would force myself to eat in order to maintain enough calories to continue breastfeeding. I was able to think logically about the way I was feeling and knew it seemed to be more than the postpartum blues, but I thought it would pass. I am even embarrassed to admit I kept thinking thoughts like, "what if I gave him up for adoption to a family who could really take care of him?" I was a highly educated, independent woman crying as my husband left for work begging him not to leave me alone. Six weeks after my wonderful little boy entered the world; my world was still dark and hopeless. I knew I needed help.

I walked into my OB/GYN's office for my postpartum check-up and when he asked how I was doing I simply stated, "OK". I did not respond with the usual verve I had in the past and he immediately asked if I was depressed. I said yes and this weight I had been carrying around was slightly lifted. I started on Zoloft the day after my office visit and within 2 weeks I started to notice a difference. My husband knew instantly I was getting better when I told him I had a craving for Taco Bell!

Postpartum depression is a serious disease that affects 8-12% of women. It is not partial to any race, religion or profession, for that matter. I considered myself a strong person already having dealt with the death of my father and a mother with a chronic illness leading to disability and residency, but these prior experiences carried no weight in this situation. The first six weeks after delivery left me feeling a deep sense of sadness I had never felt before. I am so happy that I sought help when I did. However, due to the taboo still surrounding depression and the guilt often associated with postpartum depression most women slip through the cracks. Therefore, I want to take this experience and share it so that other mothers may receive the help they need. As pediatricians, we are in an excellent position to screen for maternal depression given the number of well-child visits in the first year of life. The AAP Task Force on the Family has stated "health and well-being of children is inextricably linked to their parents' physical, emotional, and social health." I think it is important to ask a new mother directly if she feels depressed or anxious. A simple "how are you doing?" probably won't cut it. Ask specifically about feelings of anxiety (not just sadness), changes in appetite, feelings of indifference and/or resentment towards the baby and an inability to find enjoyment in things. It is important to have a plan for these women, whether it be encouraging them to make a timely appointment with their OB, referring them to a psychiatrist or therapist or giving them a website for more information such as www.postpartum.net (Postpartum Support International). I have a new appreciation for talking with a new mother about *her* well-being in addition to the child's. I hope you will too.

A Swiss Point of View

by Brittany Boulanger, MD, FAAP

I did not know what to expect in Switzerland. On some level, I was aware of its system of 'socialized medicine' but I had no true concept of what this meant in regard to practicing medicine, especially in comparison to the health system of the United States. Before my departure, physicians in the United States had mentioned that there would be more judicious use of antibiotics and frequent employment of herbal and alternative remedies. Although, I was curious about the manner in which pediatricians practiced in Switzerland, my primary goal was to gain basic pediatric experience in primary care before I returned to the States to start my first job as a full-time practitioner.

While my husband participated in a six-month position at an orthopedic hospital in Zurich as part of his formal fellowship training based in the United States, I was graciously welcomed into a private pediatric practice as an 'observer'.

Zurich is one of Switzerland's larger and more affluent cities, a cultural and financial mecca. Located on the beautiful Lake Zurich, its surroundings include many sleepy small towns scattered around the lake's edges. The practice that I attended over my six month stay was a two physician group in the town of Mannedorf, approximately 10 kilometers from Zurich center. Considered a suburb of Zurich, many Swiss choose

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Mannedorf or nearby villages for its more affordable costs compared to the almost prohibitively expensive Zurich city.

The practice is privately owned and has been operated by two female pediatricians since October 2003. Both physicians left two or three person groups after several years as employees in order for financial gain and scheduling freedom. Based on discussions with local Swiss physicians, the multi-physician pediatric offices of five to ten doctors or multi-specialty groups do not exist in Switzerland. Across Switzerland, the majority of physicians are in solo practice or in practice with only one to two other physicians. As a result, week-night and weekend call is shared by a large number of different types of physicians. Internists, pediatricians, psychiatrists, and general practitioners rotate call. Given the potential coverage of patients out of one's specific area of training, most patients are referred to the local emergency room on nights and weekends.

In addition to the infrequent night and weekend call responsibility, the typical day for a Swiss pediatrician is more civilized than what is usual for the United States. Each appointment is approximately thirty minutes and their work day always ended promptly by five o'clock. The pediatricians and small support staff spent the lunch hour eating together and socializing rather than answering phone calls and completing charts or paperwork. Typically when a patient called the office, it was to make an appointment rather than to seek medical advice. As a result, the physicians were not delayed and distracted during and between their office visits. Given the small size of the office, the only support staff was a secretary who handled phone calls and scheduling. There were no nurses or medical assistants. Patients were referred to the one academic children's hospital in Zurich for specialty needs or emergencies. Given the nature of the call coverage, the pediatricians had no hospital based responsibilities in regard to newborn care or medical patients. It was entirely an office based practice and this was representative of private groups in Switzerland. The office and the hospital were separate entities that for the most part functioned separately and distinctly.

Overall, there were only subtle nuances in the way the Swiss practiced pediatrics compared to the U.S. standard of care. For the most part, the differences in practice were minor such as the use of a three dose enteral Vitamin K administration for newborns, Vitamin B6 for nausea associated with viral gastroenteritis, routine hip ultrasound screening of all newborns for Developmental Dysplasia of the Hip and an altered immunization schedule that excludes Prevnar and Varivax. More pronounced differences in patient care seemed to be a result of the cultural milieu in Switzerland and the socialized health care system. Since the majority of mothers choose to breastfeed, all infants are started on Vitamin D supplementation from birth through 12 months. Given that all newborns are hospitalized until at least day of life five, the first appointment with the pediatrician is not until the age of 1 month. Presumably, as a result of this prolonged postpartum stay, during my six month visit, I did not see one case of neonatal hyperbilirubinemia in the office. Similarly, there were no weight checks in the first several weeks of life.

Despite these permutations from what is practiced in the United States, the Swiss pediatricians that I worked with practiced sound, professional, consistent medicine for their patients. The care they provided was for any and all children. Since the government of Switzerland mandates insurance for all citizens, all patients have access to a high quality of health care. Of course, their system has flaws and imperfections that I do not and did not have the perspective to appreciate. And despite a well-functioning medical system, human nature inevitably prevails evidenced by the tardy or no-show patient.

When I reflect upon my experience in Switzerland, I am thankful for such a unique experience. I gained an interesting perspective about the general practice of and approach to practicing medicine. Although, I am fortunate to be a part of a practice with a reasonable call and work schedule, the Swiss clearly have prioritized their personal lifestyle in regard to the manner in which primary care practices operate. One could argue that it may be at the expense of patient care and continuity but the patients I met were very pleased with the health care they receive. And as the pressure in the United States' health care system mounts for physicians to see more patients in the same amount of time, we may want to take a closer look at how our Swiss colleagues spend their average day. Less patients, longer visits, less stress and likely more satisfied patients *and* physicians.

The Power of Hypnosis in Practice

by **Xavier Sevilla MD, FAAP**

Executive Committee Member, Section on Young Physicians

You Can't Teach an Old Dog new Tricks...or so I thought until last September. I have been in practice for 7 years in a Community Health Center in Florida. I honestly thought I had seen it all in ambulatory pediatrics, from "Jerry Springer type" brawls in the waiting room to rare and exotic tropical diseases. I didn't think I would be surprised or dazzled by much in ambulatory pediatrics anymore. However, sheer curiosities lead me to sign up for a course in Clinical Hypnosis for Children by the Society of Behavioral and Developmental Pediatrics. Even on the plane ride to the meeting I was thinking, "What was I thinking signing up for a hypnosis course!"

The experience was akin to having a loud old-fashioned alarm clock wake you up from the repetitive grind of daily practice.

Hypnosis allows us to use the power of suggestion, relaxation and the body's own healing system to improve healthy behaviors and desirable health effects with very few adverse effects. Most of us would recognize this as the placebo effect. Yes, I also viewed the placebo effect as a nuisance getting in the way of elegant research protocols. It is a great feeling to be able to use it as a positive tool.

To illustrate where hypnosis can be used in practice, picture this: You've interviewed the patient, assessed the problem and prescribed the appropriate treatment. You reach for the door. That's when you hear those dreaded words that send chills down every pediatrician's spine; "oh by the way I've also got this headache/back pain/neck pain/ stomach pain for the last year or so..."

Hypnosis is a great adjuvant for treating chronic conditions such as tension headaches, migraines, functional abdominal pain, nocturnal enuresis, and chronic back pain. You will recognize them as the dreaded quintet that frustrates both doctors and patients in any pediatric practice. I have also used hypnosis with acute illnesses such as decreasing the pain of ear infections and soft tissue injuries as well as to decrease discomfort associated with IV placement, immunizations, injections and obtaining throat cultures.

In this age of low reimbursement, bureaucratic red tape and patient overload, there is something almost magical about treating patients with you, the physician, as the physician and the treatment at the same time with full cooperation of the patient. Learning hypnosis has really increased my enjoyment of office practice and has made me approach medicine from a totally different perspective. As a result I believe it has made me a better pediatrician.

If you want to learn more about clinical hypnosis in children The Society of Behavioral and Developmental Pediatrics runs a workshop every year around the fall.

Using suggestion and imaginary in your every day practice suggestion: How to obtain a throat culture from those challenging 4-8 year olds.

1. I hand them a ball of cotton
2. I ask them "What do you think this is?" "That's right it is a cotton ball."
3. "Is it hard or soft?" I say. "You're right it is interesting how soft and fluffy it is like a cloud from the sky."
4. Then I show them the throat swab. "This is made of the same soft, fluffy cotton, see?"
5. I ask them "Would you like to be my helper playing this imagination game?" Then I tell them "I am going to touch the inside of your mouth with this soft cotton swab, is this OK with you?"
6. I will tell them "The only thing you have to do is open you mouth and imagine your favorite place. Some kids find that closing their eyes helps them to better picture this place. You may close them or keep them open, it is up to you."
7. Finally, I tell them " I am now going to touch your mouth. It is interesting how you will feel how soft and fluffy the cotton is when it touches your mouth, just like a cloud or cotton candy."

In most children I will able to get full cooperation without using a tongue depressor to the amazement of the parents.

A Complex Problem: Early Developmental Delays Presenting as Autistic Disorder

by **Bill Beechler, MD, FAAP**

"Her doctor and her preschool teacher brought up autism." Holly was three years old and her mother was trying not to appear anxious.

They had been referred to the Riley Child Development Center by their pediatrician after she had noticed several concerning developmental red flags. While Holly's motor milestones were happening at the expected times, her communication was markedly delayed. Over the past four months, she had begun using a few single words. Through her preschool and some at-home work with her parents, she had started using four or five signs for expressions such as "thank you", "please", and "more". I asked what behaviors, specifically, had prompted the question of an Autistic Disorder. "Well, she tends to play alone. She seems uncomfortable when other children try to involve her. She is very routine oriented and can become pretty upset if our day doesn't go as planned or as she thought it would go. She likes music and watching the same movies repeatedly." On the other hand, when I asked about other social interaction skills, Holly's mother noticeably brightened. "She's always held up her hands, wanting to be picked-up and held. She often tries to get my attention if I'm distracted by something else, even to the point of grabbing my face to look at her. She brings leaves and rocks to me to look at and comment on when we're outside." The only family history of any developmental delays was a first cousin with early articulation disorder, which was corrected with speech therapy.

Holly was active and inquisitive during the physical examination. She was fascinated by my stethoscope and would always look up at me before she tried to grab it. When her mother would gently try to get her to stop, she would look at her and give a huge grin. She made some babbling noises and said "mom" a couple of times to get her attention. Her growth parameters were all within the normal range for age. No dysmorphism was present. She could alternate feet when ascending a small set of stairs and had no gait or balance difficulties. When I engaged her in ball play, she was enthusiastic. An audiologic evaluation revealed normal hearing. The Bayley, a cognitive assessment, showed that her non-verbal skills were in the average range for age. The PLS-4, an assessment of language skills, indicated that while Holly's receptive language was average; her expressive language was in the moderately delayed range.

Holly was diagnosed with a moderate expressive language delay. She did not meet the criteria for Autistic Disorder or any of the other pervasive developmental disorders. She was enrolled in individual speech therapy and is making progress.

The behaviors of children with early communication delays can often appear pervasive. Because they have little or no way to let others know their wants and needs, these children will often avoid peer interactions, preferring to play alone, and be more comfortable with a strict routine. Some of these children can become so frustrated that they will behave aggressively toward themselves, hitting their head or biting themselves, and others. These behaviors, though, will usually fade as the child gains more communication through speech, sign, and alternative methods such as the Picture Exchange Communication System (PECS). While they may demonstrate pervasive appearing behaviors in some settings, most children with primary communication delays will continue to show age-appropriate social skills such as seeking and holding eye-contact, shared attention, and seeking comfort from caretakers.

There are times, though, when discerning whether a young child, a toddler or preschooler, has a communication problem or a pervasive developmental disorder or both is difficult. An excellent screening instrument is the M-CHAT (The Modified - Checklist for Autism) developed at the University of Connecticut. It consists of 23 yes/no items covering social, communication, and sensory concerns. A child fails the checklist when 2 or more critical items are failed OR when any 3 items are failed. Some of the critical items include: not taking an interest in other children, never pointing to indicate interest in something, never bringing objects to caregivers to show to them, never imitating, or never responding to his/her name. Those children need to be evaluated carefully by an interdisciplinary team, including audiology, pediatrics, psychology, social work and speech pathology, and have scheduled follow-up evaluations to monitor their progress. If the child is younger than three years, an evaluation by the 0-3 developmental intervention services in your state is a great place to start. These go by different names in each state. In Indiana, it's called First Steps. In Maryland, it's Infant and Toddlers. Know where to contact those services for your state and use them for any child whose development concerns you. For children with more complicated problems and behaviors, a referral to a developmental team is recommended.

Starting Your Own Practice

by **Andrew C. Jorgensen, MD, FAAP**

When choosing a career path many resident physicians never consider starting a practice from scratch. Many residents are afraid that the financial risks are too great or that the work involved is too difficult. For some this may be true, but with persistence and creative planning there are ways to minimize the risk and reduce the work involved.

I began to think about creating my own practice during the start of my third year of residency. When I sat down with my program director to discuss practice options I knew I was very interested in disease prevention and primary care, and was not looking to specialize. I also wanted to pursue an opportunity that would allow me to continue to work with housestaff but not necessarily in an academic environment. My program director suggested that I consider establishing a private practice in the Medical Center.

My program director went on to tell me how the doctor who saw most of the employees of the hospital and many of the faculty at the medical school closed down her practice to become a hospitalist, and that a unique opportunity was available to fill that role. Additionally, although there were many specialists working at the hospital there were not many primary care physicians in private practice.

Joining an existing Med-Peds practice was not an option. In the Houston area most Med-Peds docs are either hospitalists or have gone on to specialize. There were a few Med-Peds practices in the suburbs but I wanted to live and practice in the downtown area.

My program director introduced me to the manager of the Medical Staff Affairs department of the hospital who in turn helped me set up meetings with the Chief Medical Officer and Chief Operating Officer of the hospital. I was able to make an arrangement with the hospital to set up my practice and provide salary support. During this process patience and persistence were very important. Hospitals are large corporations and the decision to support my practice required the approval of several busy individuals. Nine months passed between my initial meetings and when all the documents were signed.

When making arrangements with a hospital it is very important to be aware of the Stark Amendments. The Stark Amendments were created to prevent conflicts of interest between physicians and those they do business with. These laws, for example prevent physicians from owning laboratories or radiology centers. The fear is that physicians would order unnecessary tests for financial gain. The Stark Amendments also prevent hospitals from directly hiring physicians although there are exceptions that allow hospitals to help support physicians to grow new practices.

Creating a practice from the ground up requires making difficult decision which residency does not prepare you for. First, the practice required a name. We decided on Houston Adult and Pediatric Medical Associates. Although the name is long it describes the unique nature of the Med-Peds physician. Another challenging decision was choosing a partner. Not only are partners important to share call with and cover when on vacation, a partner helps spread the financial risk, and as an extra bonus are great sources of advice when unsure of a diagnosis. I have been very fortunate to have a partner with a similar work ethic and practice philosophy. Finally we had to decide on everything from the billing software, to the furniture, to the color of the walls in the clinic.

Three years later, our panel includes over 3,000 patients. Fortunately we have an equal number of adult and pediatric patients with a wide range of medical problems. It is rewarding to care for entire families, watch infants grow to toddlers, and evaluate challenging cases. It is very important to always remember the rewards when dealing with the inevitable challenges.

On a daily basis we also deal with challenges that are common to every medical practice. Employees call in sick or run late, disgruntled patients show up on the wrong day, the internet goes down, the phones stop working, and the list can go on. Solving these challenges requires patience and persistence.

Med-Peds physicians have several unique challenges. Many managed care providers do not understand the

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concept of being trained and certified in both Internal Medicine and Pediatrics. It is important to be vigilant to ensure that credentialing occurs for both specialties. As many referrals to the practice come from managed care directories it is important to be listed under both Internal Medicine and Pediatrics both in print and on-line. There have been many times when we have received phone calls from patients asking why we changed to only see adults or children. Some managed care plans try to "fix" a perceived error in the listing and drop one of the specialties not realizing it is possible to be certified in both.

Promoting the specialty to the public also requires persistence. In our brochure and on our website we have a description of Med-Peds because the public is mostly unaware of the unique services Med-Peds doctors offer. My adult patients are always pleasantly surprised when they ask for a referral for a Pediatrician and my response is that I can see their children.

Relationships are very important to all physicians but even more so when starting a new private practice. Most of my pediatric referrals come from Ob-Gyns. It is very important to have active relationships with many Ob-Gyns. The Ob-Gyns we work with are very appreciative of the fact that we can also see mothers to help treat hypertension, diabetes, and other conditions that may arise during or after pregnancy. As the practice ages so does my pediatric population. The clinic is now 3 ½ years old and most of the pediatric patients we see are under that age. It is very rewarding to now have a simple conversation with a patient I saw as a newborn 3 ½ years ago.

Our practice growth is also dependant on unique opportunities that have arisen as a result of relationships with other physicians. Many of the specialists in the building are very supportive of our practice. There are several cardiologists who are on a constant look out for patients lacking primary care physicians to send to us. We also work with pediatric surgeons providing basic medical care to post-operative patients.

Healthy relationships with hospital administrators are also vital to the growth of a new practice. It is important to serve actively on hospital committees to foster these relationships. There are innumerable ways a hospital can continue to support a medical practice. We have had opportunities to lecture the hospital staff on health topics, provide pre-operative examinations for renal transplant patients, and receive referrals of hospital employees for evaluations of work related injuries.

Starting a private practice from the ground is a very realistic and rewarding goal. Although many challenges will appear, staying optimistic with patience and persistence will allow the goal to become a reality.

This article also appeared in the Section on Med-Peds Newsletter.

Editor's Note: *Dr Boss received a tie for first place for her entry in the 2007 Section on Bioethics Essay Contest. Her poignant essay, published here, is a personal reflection and as such, does not necessarily represent policy or opinions of the Section or the American Academy of Pediatrics in general.*

End-of-Life Decisions for Infants Abandoned in the NICU

by **Renee Boss, MD**

C.G. is 19 years old, and in Obstetrics lingo, is a Gravida 1 Para 0121 female admitted this evening in what appears to be preterm labor. She has received no prenatal care, but tells the Obstetrician that she thinks her due date is October 1st. It is now June 13th, which makes C.G. 24 3/7 weeks pregnant. She admits to using heroin and cocaine within the past week, and she smells of alcohol. A quick review of her electronic medical record shows that she has a history of chlamydia and HSV, although no testing has been done during this pregnancy.

As the Neonatology fellow on-call, I am asked to counsel C.G. about what might happen if she delivers her

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baby tonight. As I walk into C.G.'s room, I immediately recognize her, and notice that she is alone. I remember C.G.'s prior child who was born at 27-28 weeks less than one year ago due to placental abruption after cocaine use. As I wait for the nurse to finish adjusting C.G.'s fetal monitor, I remember that the infant, Edwin Jr., was in the NICU for two months, although he escaped the most severe complications of prematurity. While C.G. had rarely visited the NICU, her mother had. There was never any contact with Edwin Jr.'s father. Ultimately the infant was discharged into the custody of his grandmother with plans for follow-up with a Developmental Pediatrician.

In between the screaming and swearing with each contraction, I am able to get from C.G. that her mother still takes care of Edwin Jr., although she has since kicked C.G. out of the house for using drugs. C.G. is living on the streets, eating very little. In fact, she appears very thin, and hardly looks pregnant. She says she had never heard of any free clinics for prenatal care. She says the father of the baby "doesn't want anything to do with this."

I tell C.G. that if this baby is born tonight, he will probably be much sicker than Edwin Jr. was. Ultrasound shows him to be just under 500 grams. I tell C.G. that babies born this early and this small have a very high risk of dying in the delivery room or in the NICU. They often suffer bleeding in the brain, which can lead to long-term problems of mental retardation and cerebral palsy. They are on breathing machines for weeks or months, have trouble eating, may need surgeries, and get frequent infections. I tell her that such babies and their parents can suffer a great deal. I say that some doctors and parents choose not to use any of the medicines or machines, and the parents hold the baby as he or she passes away soon after birth.

C.G. immediately responds: "I want you to do everything you can to keep my baby alive, I don't care what you have to do, I know you doctors have lots of new treatments. Nobody is going to give up on my baby. You do everything that you can! I don't want to talk about this anymore." After a few more failed attempts on my part to explain that many people think that allowing such babies to die without intervention is not giving up, but is a choice to spare them pain and suffering, it appears that C.G. has stopped listening to me and I leave.

Forty-five minutes later, C.G. delivers. Our team is ready at the warmer with our equipment and a dose of surfactant. The baby appears very small, blue, and with no spontaneous movement. We place him in a plastic bag and attempt positive pressure ventilation. Our smallest mask is too big for his face and we cannot get a good seal. The resident tells me that the heart rate is around 60. I intubate the infant on the second attempt, and after about a minute of bagging through the endotracheal tube, the heart rate reaches 100. We administer surfactant, place the infant in the isolette and prepare for transport. I approach C.G., who is looking the other way. I tell her that we are taking her son to the NICU, and that she should come visit him as soon as she feels well enough.

As predicted, the infant is quite ill from the beginning. He weighs 513 grams and has translucent skin. We struggle to obtain IV access; his initial glucose is 23. We work for several hours to stabilize him, placing him on the oscillator and Dopamine. As the end of my shift nears, C.G. has not yet come to see her baby, although the residents have gone to her room to give her an update and obtain consents.

When I arrive the next morning, I learn that the infant's head ultrasound shows bilateral grade III intraventricular hemorrhage (IVH). He has needed multiple transfusions and is on significant ventilator support. C.G. did visit once overnight, and named the infant "Ezekial." When I go by her room later that morning, her affect is flat and she barely looks at me. I tell her about the IVH, and the almost certainty of future disability. I tell her that he is the sickest baby in the NICU, and I worry that he might die. I pause, but C.G. says nothing. I say that there may come a point where we decide that Ezekial has been through enough, that he should not suffer any more and we should turn the machines off. She tells me, "You just keep going, you just keep going, don't stop anything, he is going to be fine."

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And so we keep going. The social workers talk with C.G., attempt to identify resources that will keep her off the streets and sober. She is known to Children's Protective Services (CPS) because of her previous child, and they are notified of the new infant. As C.G. predicted, her mother is unwilling and unable to take her back home. Within 36 hours of delivery, C.G. is discharged from the hospital. She leaves Ezekial's nurse with a cell phone number, and her mother's street address.

And so we keep going. Ezekial remains very ill, withdrawing from the heroin his mother used, with unstable blood pressure and increasing post-hemorrhagic hydrocephalus. C.G. visits about every 48 hours, each time giving the nurse a new phone number because the others she had given did not work. Every time she visits, someone from the team tries to talk with her about how sick Ezekial is, how worried we are about his future quality of life, and how we are not sure how aggressive we should be. "We are never going to stop," she will say.

And so we keep going. Over the first month, Ezekial gradually stabilizes, is switched to a conventional ventilator, no longer needs pressors. But his hydrocephalus worsens, and he will need neurosurgical intervention. He is too small for a shunt, and his fontanel must be tapped every 2-3 days to remove cerebrospinal fluid (CSF). C.G. visits rarely. Her CPS worker is having a hard time finding her.

And so we keep going. Ezekial is 5 weeks old now, still with very bad lung disease on a ventilator, poor tolerance of enteral feeding and subsequent liver dysfunction, an IV infiltrate on his hand that will likely need Plastic Surgery, and Pseudomonas growing from his blood and ETT. His neurologic exam is abnormal, and he often seems agitated.

And so we keep going. By 2 months of age, Ezekial is large enough to have a CSF reservoir placed. We are unable to reach C.G. for consent. Her CPS worker warns C.G.'s mother that if C.G. is not available for consent, Ezekial will be put into temporary CPS custody. Although C.G.'s mother denies knowing C.G.'s whereabouts, the next day C.G. arrives in the NICU. She signs the consent for surgery, and is told by the social worker that she must visit or call regularly or she will lose custody of Ezekial.

And so we keep going. For 1-2 weeks, C.G. calls every few days to ask about Ezekial. Soon after, she disappears again. By 3 months of age, Ezekial is still on the ventilator and has developed seizures due to fungal meningitis. His CSF reservoir functions poorly due to the infection, and Ezekial's head seems to grow larger and more tender daily. He has desaturations and bradycardia with minimal stimulation, therefore receives very little human touch. The doctors and nurses caring for Ezekial voice pain from watching the infant suffer and anger at the absent mother. Although each new attending assuming care of Ezekial has a slightly different threshold for limiting the "escalation of care," they feel that their hands are tied to withdraw medical care without the mother's consent. The hospital Ethics Committee is consulted. They are sympathetic, but agree that the doctor's should not remove medical treatment without the mother's consent.

And so we keep going. C.G. has completely disappeared, and CPS agrees to take custody of Ezekial. Unfortunately, as a policy, CPS is unwilling to authorize withdrawal of medical support. The attending of record speaks directly to the CPS supervisor to convey how ill Ezekial is and how much he appears to be suffering. The supervisor is sympathetic, and thoughtful, but states that she cannot authorize withdrawal of medical support, especially when the parent has expressly opposed it.

And so we keep going. We reintubate Ezekial each time his endotracheal tube becomes plugged with secretions. We repeatedly instrument his arteries and veins for blood samples. He has multiple central lines placed. He is transfused. He still does not tolerate human touch. At 5 months of age, Ezekial develops profound sepsis, has uncontrollable seizures, and slowly, over the course of 48 hours, dies. His nurse holds him as he passes away.

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While several details of Ezekial's story are unique to him, that he is a critically ill, extremely premature infant who has been abandoned by his parents shortly after birth is not unique. The large, level IV, inner-city NICU where I am a Neonatologist-in-training nearly always has at least 1-2 patients whose parents visit rarely, if ever. Poverty, drugs and poor education predictably result in addiction, joblessness, and violence in the neighborhood surrounding the hospital. The girls and women who become pregnant in this environment are at increased risk of giving birth to babies who are small, sick, and premature. Their social situation makes it extremely difficult to care for a multiply medically handicapped child, and parents with few resources easily become overwhelmed. A critically ill or dying newborn leaves many of these parents unable to cope. Some abandon their infants. Others visit just enough to maintain legal custody. These parents, who often only appear when they are threatened with legal consequences, rarely participate meaningfully in decisions about their child's care.

Despite the relatively common occurrence of critically ill newborns who suffer neglect from their parents, no system is in place to manage end-of-life decisions for these infants.

Systems that do exist, composed of health care providers, medical departments or divisions, hospitals, hospital lawyers and ethics committees, favor, at a minimum, maintaining current levels of medical therapy. It is also not uncommon for there to be an escalation of care. But it is much more difficult for medical staff to limit medical care without parental consent, even if it is agreed to be in the infant's best interest. Physicians, lawyers, and ethics committees rarely allow for the withdrawal of medical support of an infant in such scenarios. The standard of care is to "keep going."

As in the case of Ezekial, frustrated medical providers look to the state's legal system for authority to make medical decisions when parents are not available. The state legal system will nearly always provide consent for another procedure or intervention needed to prolong life. But they are unwilling to limit or withdraw medical therapies without the parent's consent, even when the outcome is bleak and the infant is suffering. One of the state's concerns is that, because most of the children in their custody come from disadvantaged backgrounds, decisions to limit medical care of these children might be perceived as motivated by prejudice. And so the standard of care is to "keep going."

As the days and weeks of these very difficult situations evolve, the infants are at the mercy of medicine and technology. They are maintained on machines, they undergo painful procedures, and they get repeated infections. Because they are so ill, they rarely tolerate being held or touched, and spend their lives alone in an incubator. In another context, this would be considered both child neglect and abuse.

The suffering that the staff who cared for these infants day after day should also not be minimized. The nurses and physicians are the people who watch the child suffer, indeed are responsible for delivering the treatments and interventions that are painful. A recurrent worry of providers caught up in these scenarios is that limitation of care will violate the so-called Baby Doe laws, which in their strictest interpretation prohibit limiting medical care based on quality of life considerations. But in reality, decisions to limit life-sustaining therapies for neonates are often made by parents and physicians who agree that the predicted quality of life is extremely poor. Why is it then, that when the parent has abandoned their dying infant, no one is trusted to make decisions to limit that infant's suffering?

Infant abandonment in general receives little attention in the medical literature and there are no published studies about abandonment of a hospitalized infant. But in the 7 short years of my medical training, I have seen enough children in this situation to believe that a system must be devised to advocate for them. There must be a process by which the medical interventions and therapies can be limited if it is in the infant's best interest. If the medical staff caring for the infant concludes that further care is futile, and that the infant is suffering unduly, there should be a process whereby they are able to obtain legal authorization to withdraw medical support.

Dedicated to Baby Boy M.

Concussion Management

by Kelsey Logan, MD, FAAP

A concussion is a mild traumatic brain injury, affecting mental status and ability of the brain to process information normally. Fortunately, the vast majority of patients with concussion recover quickly and without significant intervention. However, it is important to recognize patients who need neuroimaging and intensive symptom management.

Most concussions are sustained by head impact. However, forces can be transmitted to the head by blows to the neck or body. Symptoms of concussion can be many, but most common are headache, dizziness, and a feeling of mental fogging or slowness. Nausea, problems with balance, vision, or hearing, irritability, increased emotionality, confusion, and amnesia (either before or after the incident) are other symptoms that may be present. On initial exam, the athlete may have difficulty answering simple questions or following directions, be easily distracted, have poor balance or coordination, slurred speech, or have 'glazed' eyes. Most pediatricians will not have the benefit of seeing the athlete immediately, so history from teammates, coaches, and parents is important. The athlete may not remember events of the injury or how she felt afterward. Presence of loss of consciousness is not as important as previously thought, but prolonged LOC (>1 minute) should warrant more careful evaluation for focal neurologic problems. Transport to an emergency department for further evaluation and possible neuroimaging is needed for athletes with focal neurologic symptoms, seizure, LOC >1 minute, or worsening symptoms.

Sport concussion management has changed in the last several years. Grading scales (e.g., American Academy of Neurology, Cantu) have been historically used to guide management, and most use LOC as a large determinant for concussion grade and, therefore, return to play. Concussion severity has not been shown to be related to LOC. Scales also created an algorithm for rest from sport that often under or overestimated athlete recovery and readiness for return to play. In addition, many research studies have shown that children and adolescents do not recover from concussions as quickly as college athletes or adults. In part for these reasons, the 1st and 2nd International Conferences on Concussion in Sport recommended abandoning grading scales, making diagnosis and treatment of a concussion individualized.

There are now 2 categories of concussion: simple and complex. Simple concussions resolve within 7-10 days and do not have focal neurologic complications. Pediatricians can manage these, advising rest from physical activity and strenuous cognitive activity until symptoms resolve. Neuroimaging is usually not necessary, as the injury is a functional, not structural, one. Formal neuropsychological screening is not needed. The athlete may return to sport gradually after symptoms are gone for at least 24 hours, starting with light exercise and progressing to more intense game play.

A typical exertional return to play protocol is:

- Day 1 – Fast walk/stationary bike work out for 15-20 minutes
- Day 2 – Jogging/running for 20 minutes
- Day 3 - Non-contact sport related drills and conditioning
- Day 4 – Full participation in practice without contact
- Day 5 – Full practice participation
- Day 6 – Return to game play

Athletes only advance in the protocol if asymptomatic with each activity. It is best to have exercise progression occur over days because symptoms can return hours after exertion. Athletes are usually very determined to get back to play quickly, and they may not be honest about symptoms due to strong desire to play. It is important to observe the athlete during exertion to detect fatigue, nausea, and general malaise that cannot

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be hidden. Athletic trainers at school, coaches, and parents are useful supervisors for exertion. Alternatively, exertional testing can be done in the clinic if there is an area nearby for them to run or walk.

Complex concussions are those that do not resolve in the expected 7-10 days, have persistent symptoms (with or without exertion), or have any focal neurologic defect. These are best managed by a sports medicine physician or neurologist with experience with concussions. Managing long-lasting effects from concussion involves significant modifications to academic and athletic involvement. Symptom management is important, particularly with headache. Formal neuropsychological testing is appropriate, especially when symptoms are present for over a month.

Neurocognitive testing (ImPACT and others) has become a useful tool to objectively assess brain function. These quick tests (30 minutes) measure brain processing speed and reaction time by various tasks. Tests are computer based, and a person trained to administer testing is needed. Optimally, baseline testing is done before the season so comparison to post-concussion scores is possible. However, baseline academic performance can be used to obtain general guidelines for scoring. Some high schools have started to purchase programs, with the school athletic trainer administering the test when needed. A physician should be involved with test interpretation and incorporation into athlete return to play. Neurocognitive testing is only one aspect of management and should not be relied on for return to play decisions; physical exam, symptoms, and performance on exertional testing should continue to play the major role in returning to sport.

School accommodations play an important role in recovery and management of symptoms. For athletes with a recent concussion, staying out of school for a day or two until symptoms start to improve can help speed recovery. Athletes with severe headaches, nausea, concentration problems, memory loss, or extreme fatigue with cognitive exertion should not continue performing mental tasks through these symptoms. Asking the school to temporarily excuse or reduce homework and classwork is helpful. Important projects and tests should be delayed if possible to avoid lower than normal scores. Outside of school, decreasing time involved playing video games, on the computer, and watching television is necessary if symptoms are exacerbated with these activities. With complex concussions, long-term school adjustments are often needed and can require significant teamwork between the physician, student/parents, and school.

Back Pain in Adolescents - Above and Beyond "Muscle Strains"

by John P. Batson, MD, FAAP

Back pain is a common complaint in adolescents. Pediatricians should be familiar with pertinent history questions, physical exam techniques, and appropriate treatment strategies. An important distinction in the history and exam is the location of the pain. Symptoms isolated to the back itself are termed "axial" while radiating symptoms into the legs are known as appendicular or "radicular." It is important to elicit any history of trauma or sports participation due to associated diagnoses. Certain conditions tend to cause pain more often with forward flexion (i.e. disc herniations, muscle strains) as opposed to extension/rotation of the spine (i.e. spondylolysis, facet sprains, SI joint pain). The most important aspect of the physical exam in a patient with back pain is a thorough neurologic exam of the lower extremities. Palpation and mobilization of the spine can help elicit as best as possible where the pain generator is located.

Spondylolysis is a defect (developmental or trauma related) in the pars intertransversaria. Spondylolysis related pain is typically axial and worse with extension. There may be a precipitating traumatic event or repetitive motion (flexion/extension or rotation) of the spine such as in sports participation. "Normal" radiographs should in no way reassure the physician a "spondy" is not present. A single photon emission computed tomography (SPECT) scan of the L-spine is a highly sensitive test to detect an "active" pars defect. If the SPECT scan is positive, further imaging is warranted. A CT with thin slices through the affected vertebrae can con-

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firm the diagnosis and help differentiate lesions with healing potential verses those which are likely chronic or developmental defects. Treatment strategies vary, but often include a bracing protocol, limiting sports participation, and physical therapy. Unilateral lesions and those detected early carry a more favorable prognosis in terms of achieving bony healing.



Fig. 1.a. Coronal SPECT image showing bilateral uptake

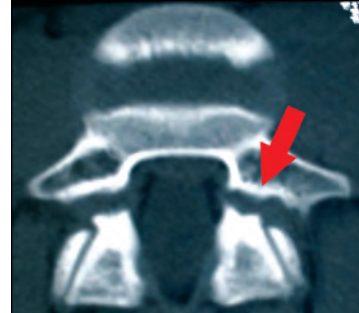


Fig. 1.b. Axial CT showing a bilateral chronic spondylolysis (arrow pointing to left side)

Zygapophyseal (facet joint) “sprains” or pain can also present with axial back pain worse with extension and/or rotation. It is important to point out this diagnosis would be considered after a SPECT scan is confirmed negative. While more common in adults, facet joint related pain can occur in younger individuals as well, especially after trauma or associated with sports participation. Facet related pain in younger individuals should respond to activity restriction, medications such as NSAIDS, perhaps “soft” bracing for comfort, and back stabilization exercises. For patients with persistent pain, diagnostic and therapeutic facet joint injections or diagnostic medial branch nerve (which innervate the facet joints) blocks with local anesthetic may be helpful.



Fig. 2. Oblique fluoroscopic image showing right sided L3-4, L4-5, and L5-S1 facet joint injections (pre-contrast)

Disc herniations causing nerve irritation are less common in younger individuals, but do occur. This pain is radicular in nature and worse with forward flexion of the spine. The pain pattern follows known dermatomes in the leg (L4- anterior aspect of the thigh to the knee and medial lower leg, L5- lateral aspect of the thigh and top of the foot, and S1- down the posterior aspect of the leg and bottom of the foot). Deep tendon reflexes in the leg may be affected (L4- patella, L5- medial hamstring, or S1-

Achilles). Plain radiographs typically are normal. A MRI of the L-spine can confirm the diagnosis. Treatment strategies include relative rest, icing, and soft bracing. Medications such as NSAIDS or a steroid taper may help with inflammation. For those with severe or persistent pain, referral to a physician trained in interventional spine procedures should be considered. A fluoroscopic guided epidural injection is relatively safe and can be effective.

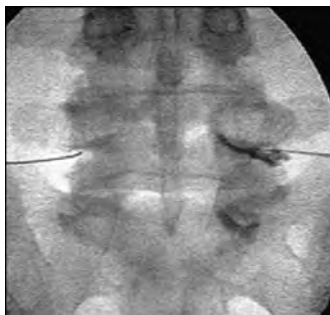


Fig. 3. AP fluoroscopic image showing bilateral L5 transforaminal epidural injections (right side with contrast)

Sacroiliac joint (SI joint) pain or dysfunction is another possible cause of axial related back pain. This pain is typically in the buttocks and unilateral. Many physical exam tests for SI joint problems have been described (i.e. Patrick’s, Gillet’s, and Gaenslen’s test), though their specificity has been questioned in recent literature. Pain as described above and tenderness on the physical exam at and

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just inferior to the posterior superior iliac spine appear to be sensitive findings for SI joint pathology. Diagnostic tests (radiographs, MRI, SPECT scan) will be negative in the adolescent with SI joint pain. Treatment is geared toward core muscle stabilization, mobilization techniques, and rest from aggravating activities. A fluoroscopic guided SI joint injection can not only confirm the diagnosis, but also help break the pain cycle in patients with persistent symptoms.

Adolescents with scoliosis may also present with back pain. This pain is typically more in the thoracic or peri-scapular region. It tends to be worse with activity or carrying loads such as book bags. Patients often respond well to a therapy protocol correcting any muscle imbalances or weakness. It is important to ask about any systemic symptoms, changes in bowel or bladder habits, or balance difficulties. Many syndromes have associated scoliosis. Therefore, the physician should perform a complete examination looking for findings such as abnormal stature, joint hypermobility, birthmarks, cavus deformities, or neurologic deficits. Potentially worrisome scenarios include a left thoracic curve, rapidly progressive curve, or pre-teen presenting with scoliosis. Also, a child presenting with severe back pain and a “new” diagnosis of scoliosis should prompt a referral and work-up.



Fig. 4. *Typical location of SI joint related pain (arrow marking the right PSIS)*



Fig. 5. *Adams forward bend test showing a right thoracic prominence due to scoliosis*

Fortunately, the majority of conditions in adolescents respond to conservative measures. Pediatricians play an important role in identifying back pain, which warrants referral. Given the complexity of the spine and associated conditions, this task may be a challenge even for experienced providers. The “spine” care team for adolescents with back pain consists of sports trained physicians, pediatric orthopaedists, interventional spine physicians, and physical therapists. Ultimately the

goal of all involved is coming up with an expedient diagnosis and appropriate treatment plan. Ideally, in the process, the young patient will learn proper spine care and preventive strategies to decrease chances of recurrence in adulthood.

Practice Management Corner

Why Should I Care About Practice Management?

by Christoph Diasio, MD, FAAP

Most of us fresh out of residency have absolutely no interest in practice management/coding/documentation. Many of us had little to no training in the realities of the business of medicine at the academic center— and there certainly was a lot of medicine to learn! Between family life and trying to get settled in a new job and location, why bother with this at all?

I believe understanding coding/documentation and practice management is controlling your destiny! Whether you are a general pediatrician or a subspecialist, no money is no mission. No matter how noble

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Practice Management Corner Why Should I Care About Practice Management? *Continued from page 18*

our intentions are, if you can't pay for your staff and malpractice insurance, you can't achieve any of your goals.

Other professionals such as lawyers and accountants don't have as much trouble with this as we do- Can anyone imagine a lawyer not knowing how to bill? I would never advocate over-billing or anything even close to fraud-but why should we work for less than we are worth so that the CEOs can continue to receive their record-breaking salaries?

Coding and documentation can be frustrating but the reality is that it is just not that difficult. Think about what you knew about meningitis before medical school versus what you know now. Think about your interactions with mothers of desperately ill preemies in the NICU- that is difficult! Coding and billing, by contrast, is mindlessly easy.

My interest in coding and documentation stems from what I learned at the first AAP coding and documentation workshop at Williamsburg, VA. I returned from that meeting to my practice and led many changes that greatly improved our bottom line. My senior partners were all too happy to implement these positive financial changes and send me to any national coding/documentation/practice management meeting I thought helpful! I now lead all our insurance contract negotiations.

So what to do?

Recommendations:

- 1) Attend an AAP sponsored coding and documentation workshop! You will learn information that will improve your coding and documentation and you will start to do this correctly. It is just as illegal to chronically underbill as to overbill. I strongly encourage you to attend a pediatric specific coding course, the adult coding courses are painful since most of their talks focus on other issues that are irrelevant to you like the "Welcome to Medicare" physical! The next national practice management track is at the Future of Pediatrics Conference at the Hilton at the Walt Disney World Resort June 29 - July 01, 2007. You can find these courses by searching for CME at www.pedialink.org.
- 2) Join the Section on Practice Management and Administration (SOAPM). This is the hottest listserv at the AAP. You will learn a tremendous amount about practice management from other pediatricians with an interest in practice management, most of whom learned from the school of hard knocks. Even if you just lurk, there's a tremendous amount to be learned from your colleagues on the listserv. Just fill out the application located at www.aap.org/moc/memberservices/sectionform.cfm (online) or www.aap.org/member/AppforSectionMembership.pdf (pdf). Questions about SOAPM may be directed to Heather Fitzpatrick, Section Manager at hfitzpatrick@aap.org.
- 3) Check out Practice Management Online (PMO), a new online resource for pediatric practice information. PMO can be accessed <http://practice.aap.org>. It's free to all AAP members!
- 4) Attend the SOAPM section meetings at the AAP National Conference and Exhibition (NCE). This is a great way to meet experts in practice management face to face.
- 5) Read the AAP's book [Coding for Pediatrics](#) - this is an incredibly useful book every pediatric practice ought to have! You can purchase this from the AAP bookstore at www.aap.org.

Dr. Jill Stoller and I are interested in your questions and suggestions for this column. Dr. Stoller's email is jsstoller@mac.com, and I can be emailed at cdiasio@gmail.com.

From the AAP

Healthcare Non-System: Solution to Our Nation's Health-Care Crisis

by Robert Zarr, MD, MPH, FAAP

We 300 million Americans pay not once, but twice for health outcomes that put us at number 37 according to the World Health Organization. Per capita health expenditures in the US is twice any other developed country, but we are not living longer, infant mortality is higher, we have fewer nurses per million population, shorter average hospital stays, and fewer CT scanners and MRIs per million population. We waste over \$400 billion a year on administrative costs running the largest bureaucracy of over 1200 private insurance companies. Our rising healthcare costs are not because of over utilization, but rather enormous administrative waste in the duplicity of an inefficient private insurance industry. In contrast, Medicare, single-payer for Americans over age 65, runs an overhead of 3%, compared to an average of 18% overhead for the private insurance industry. In the case of health insurance, private is **not** better. Every other developed country in this world has some type of government-assured insurance for all its residents.

Rather than our current non-system, let's imagine an efficient Healthcare system, not government run, financed by taxpayers, where health care services are provided by the private sector, "us". This is what we call single-payer national health insurance, some rendition found in every industrialized civilized country in the world, except the United States of America. Imagine a system where children and their families are free to choose their own doctors, hospitals, outpatient centers, and specialists without having to call their insurance company first. Imagine a Healthcare system where pediatricians are paid fairly and timely for every visit, electronically, saving us enormous overhead. Imagine a system where our patients no longer have to choose between purchasing medicines and paying their electric bill. Imagine a system where we stopped losing patients because of a family's change of insurance plans. Imagine a system where every child, parent, and grandparent has a "medical home."

This "system" change is outlined in HR 676, the single-payer bill, co-authored by Reps. Conyers and Kucinich, cosponsored by nearly 70 Congress-people. It is important, especially during this time of national debate, to remind ourselves and our presidential candidates that all Americans can have access to quality and comprehensive Healthcare, like the rest of the civilized world. It's time that we pediatricians stand up, and speak out for our patients, their families, and ourselves by passing HR 676 into law.

What's New at the AAP 2007 NCE?

Plenty!!!

The magic begins with our exciting pre-conference events, Friday, October 26, which are free to all National Conference & Exhibition (NCE) registrants. The Friday afternoon **Peds-21 symposium** series (noon-5:30) focuses on the determinants of child health and the role of community pediatricians. Evening social events in the San Francisco Marriott, sponsored by *AstraZeneca*, include a **pirate-themed Kids Camp** (5:30 – 8:00 pm) and **Tiki Island Welcome Reception** (7:30-9:30 pm).

Beverly Wood, MD, MEd, PhD, FAAP – *Pedialink*[®] Editorial Board Member, Committee on Continuing Medical Education Chair, NCE Planning Group Member – and Ivor Hill, MB, ChB, MD, FAAP – NCE Planning Group Member and Education Committee Member for the Section on Gastroenterology and Nutrition – will

host daily informational sessions (12:15-1 pm) in the Moscone Center. **"Presentation Tips That Work"** is geared to anyone interested in becoming faculty at live CME events or wanting to maximize presentations.

Begin your conference with the annual Education Awards presentation and an inspirational address from AAP President, Jay E. Berkelhamer, MD, FAAP. Then economic pioneer and **2000 Nobel Laureate**,

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American Academy of Pediatrics



October 27-30, 2007 ■ San Francisco

From the AAP What's New at the AAP 2007 NCE? Plenty!!! *Continued from page 20*

James J. Heckman, in Saturday's keynote will discuss the evidence for investing in disadvantaged young children, evaluating proposals and policy. For a complete schedule of plenary sessions, visit www.aap.org/nce and click on Conference Highlights | Plenary Schedule.

Batter up! Be part of another spectacular Saturday **AAP Night Out** (7-10:00 pm) sponsored by *Johnson & Johnson Consumer Products Company* when we storm the field at **AT&T Park, home of the San Francisco Giants**. See what the players see—all games, food, and entertainment will take place on the field! Shuttle service to and from the event will be available.

Join us in our inaugural **NCE Friends Fund Run/Walk**. We're literally taking our first steps at the NCE for children everywhere on Monday, October 29 (6-7:30 am). This healthy 5K run/2-mile walk is open to all attendees and their companions. We want to encourage some friendly competition, so talk with your colleagues about participating as a group! Pre-register online, or register on-site at the Moscone Center.

The NCE is family friendly and affordable. Families attending the NCE are encouraged to register for *CPR Anytime™* on Sunday (4-6:00 pm) or Monday (10 am-12 noon). This program teaches lifesaving skills to non-healthcare providers (parents/new parents, grandparents, siblings, babysitters, etc). We also offer child care services (consult program or web site for details) and a mothers' lounge on site.



For those traveling with only adult companions, we have a series of investment seminars Saturday (8 am-12 noon) "Effective Real Estate Investment Strategies"; Sunday (8 am-11 am) "Effective Investment Strategies"; and Monday (8 am-11 am) "Effective Retirement Plans and Distribution Strategies."

Are you ready for an adventure? If you're tagging on a vacation before or after the NCE, you'll want to check out the "Tourism" area of our web site. We list San Francisco's "must see" sights, and what's new in the **AAP Tour Program**. We've added complimentary walking tours (Farmers Market at the Ferry Building, Dynasty of Chinatown, Earthquake Walk, or Little Italy), and we have several exciting new paid tours like the Randy Strong Glass Studio & Scharffen Berger Chocolate Factory. If you're up for a more adventuresome California excursion you can journey to wine country, hike through majestic redwoods of Muir Woods, or plan to take your family to Legoland, Universal Studios-Hollywood, or Disneyland. Whatever you decide, you'll make the most of your trip to the NCE if you plan ahead.

Debuting in the largest pediatric **Technical Exhibit (open Saturday through Monday)** will be a new coding booth "**The Doctor Is In: Coding Confusion,**" staffed by AAP's coding publication experts, and a hands-on, interactive "*Pediatric Office of the Future*" sponsored by Microsoft Corporation.

Come cheer on your favorite group of residents as Stanford and UCSF face off in Tuesday's **Pediatric Bowl** (12:15-1:15 pm). Thankfully, their 'smack-talk' (pg S-42 of the Preliminary Program) is no indication of their performance.

Saving the BEST for last... if you **register for the 2007 NCE anytime between June 1 and September 14**, not only will you **save money**, if you reside in the U.S. or Canada, you will **receive your badges and tickets pre-conference by mail!** Totebags can then, at *your* convenience, be picked up on site. Stay where all the action is! Book housing through the AAP Housing Bureau 800/468-6322, and be among the first to receive the morning hotel door Dr Bags containing the daily NCE newspaper, special highlights, symposium invitations, and/or products.

To learn more visit www.aap.org/nce. Preliminary Programs will be available in the June issue of AAP News. If you do not receive a program, we're happy to send one to you. Just call 866/843-2271 or e-mail csc@aap.org.

Finally, we want to give our past conference attendees a voice. If you have any travel advice or special conference tips you'd like to share with fellow conference-goers, e-mail us at nce@aap.org.

What's New at PedJobs

PedJobs continues to provide quality resources and tools you need to find the right fit. With the new PedJobs **CV Builder** (<http://www.pedjobs.org/rtfin.asp>), you can leave the guesswork out of composing and formatting a logical and attractive CV.



To further help prepare you for your job search and interview process, PedJobs created the Job Search Portfolio. It's a **FREE** guide to CV's and cover letters with tips to find the perfect fit for your ideal position. **Click on** (<http://www.pedjobs.org/resource/jobportfolio.html>) to download from the PedJobs web site or reply to this email with your full name and address and we'll mail it to you while supplies last. It's that easy.

As the official employment resource of the American Academy of Pediatrics, PedJobs.org brings pediatric healthcare professionals together in a convenient and reliable forum online. Registration is easy and FREE.

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2008 CATCH Call for Proposals

Applications due July 31, 2007

- **CATCH Planning Funds** Grants are provided in amounts from \$2,500 to \$12,000 for pediatricians to plan innovative, community-based projects to increase children's access to health care and address health disparities among children. **The Planning Funds** <http://www.aap.org/catch/planning-grants.htm> area of the CATCH Web site has more details on this program.