The Young Physicians Section

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

Winter 2006 Newsletter

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Chairperson's Welcome

Welcome to the latest edition of the Section on Young Physicians (SOYP) newsletter. Since the last edition much of my time has been spent working with children and families in areas of Mississippi and Louisiana who were affected by Hurricane Katrina. Many of you, also, have given of your time, money, supplies, and support to families and colleagues who are working to put lives, businesses, and professions back together. Thank you for all you have done.

Many past, present, and future members of the SOYP have had to deal with changes in classrooms, training sites, office locations, housing, and many other issues. If we at the AAP and the SOYP can help in some way, please ask and we will do our best. As an Academy and a Section, it is the least we can do for our fellow members.

I had the chance to talk with many of you at the NCE in Washington, DC. Thank you for stopping and providing me with suggestions on how to improve the Section. The SOYP Executive Committee met during that time and we are committed to making positive change in the Section and improving the value of your membership. We are making progress on an improved website, a new welcome/AAP navigation CD for new SOYP members, a pediatric board maintenance of certification survival guide, and other valuable offerings.

As always, thank you for your membership and please continue to communicate with me and the rest of the Executive Committee so that we can continue to improve our Section. Have a wonderful Winter season!

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

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Operation Assist: A Response to Katrina

by David Krol, MD, MPH, FAAP

Chair, Section on Young Physicians

As I walked through a low-income housing neighborhood in Gulfport, Mississippi making "house calls" with my team, we ran into an older gentleman. I asked him if he was in need of any medical assistance, to which he replied, "I sure do. I was just about to look for y'all." After speaking with and examining him outside of the back of our SUV (our mobile unit had broken down that morning) one of our adult docs found him to have extremely high blood pressure and six medication bottles dated from 2004 that were in various stages of nearly empty or empty.

In the same neighborhood a young boy rode up on his bike asking for "heart murmur medicine". It turned out that he didn't have a murmur, but did need glasses. He told me how his glasses had washed away in the storm and he couldn't afford to get replacements. His grandmother, another house call, told me how he was not in school because his mother was trying to find permanent housing before she found him a new school. His sister also had her glasses washed away.

Both of these vignettes hint at the great needs and great challenges for health care that existed in the Mississippi Gulf Coast region after Hurricane Katrina. Unfortunately, they point out the great disparities and lack of access to care that some of the less fortunate populations faced prior to the arrival of Katrina. It was this great need pre-storm and the exacerbation of those needs post-hurricane that led my organization, The Children's Health Fund (CHF), to respond.

Just days after the storm tore through the Gulf Coast, CHF sent two mobile units from its national network to the Gulfport-Biloxi, Mississippi area. Though there was much needed everywhere, with help from locals we were able to connect with neighborhoods where access to health care was limited before the storm and began providing health services. In addition, we connected with sites where survivors of the storm were accessing food, water, shelter, and financial resources, and offered our services there.

Soon after I arrived I noticed that our services were less "disaster relief" and more chronic disease management and primary care. Fortunately, we saw little of the feared outbreaks or severe trauma that we had expected. Interestingly, and perhaps fortunately, I saw few children. Most had simply been shipped off to stay with relatives or had moved away, if their families had the means to escape.

The large majority of our patients, like the gentleman above, could not reach their primary care providers for refills and required medications that expired, washed away, or had been ruined by the flooding. Sadly, I soon realized that many of the people who came to visit the mobile medical units had not seen a doctor in a long time and had been dealing with their illnesses in a piecemeal way, like the gentleman above, by parsing pills, visiting emergency rooms, or just enduring.

The realities of displacement, destruction, and disorganization made both accessing and providing services difficult. Patients had little knowledge of what was open and where after the storm. Barriers to transportation, from destruction of personal transportation to lack of public transportation, limited mobility of both patient and provider. Our mobility was an extremely positive asset, though at times even we and our units broke down. Taking a cue from the tremendous people of the Gulf Coast, we adapted and overcame the difficulties to do the best we could.

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Demystifyiing the Boards Recertification Process (or "2010, is that a Stanley Kubrick film?")

by Nancy Harper, MD, FAAP

Executive Committee Member, Section on Young Physicians

It seems no matter how many times I tell myself that the film is "2001: A Space Odyssey", I cannot help playing the main title theme to the movie in my head whenever I talk about Program for Maintenance of Certification in Pediatrics (PMCP) and the year 2010. The "Program for Maintenance of Certification in Pediatrics" even sounds intimidating and seems a good fit for the Vienna Philharmonic performing the opening notes of "Also Sprach Zarathustra". In the year 2010, pediatricians who are completing American Board of Pediatrics (ABP) recertification will be required to complete all four parts of the PMCP. Those, like myself, who recertify before 2010, only have to complete Parts One and Three. I admit that I was curious to see how labor intensive it would be to complete all four parts, and I wanted to demystify the process for myself and other young physicians.

Pediatrics was the fifth specialty to have a certifying board with the founding of the ABP in 1933. Over the years there were first oral, then written examinations. 1989 was the first year for the two-day, written, proctored examination that strikes fear in so many residents. The PMCP replaced the former renewal program, the Program for Renewal of Certification in Pediatrics (PRCP), in 2003. I never had the opportunity to take the computer-based home examination, but my partners thought it was much less intimidating (the fact that it was open book didn't hurt!).

The summer 2005 newsletter from the ABP reviews the PMCP creation and process. Many diplomats have also received a CD in the mail with a tutorial, and the ABP website has more information. There is PMCP-G for the generalist and PMCP-S for the specialist. You do **not** need to maintain the PMCP-G to maintain the PMCP-S, unless your specialty requires it.

There are four parts to recertifying. Part One is "Evidence of Professional Standing". All you need to do is maintain an unrestricted medical license in at least one jurisdiction in the United States, US territories, or Canada. Please pay attention to your state's maintenance requirements such as CME. In addition, Federation of State Medical Boards (FSMB) and the American Board of Medical Specialties (ABMS) do send final disciplinary reports to the ABP.

Part Two, "Evidence of Lifelong Learning and Self-Assessment", is a web-based program accessible through the ABP web site under PMCP activities. This part is more time consuming and has two sections. The first section is the Knowledge Self-Assessment (KSA), which consists of 200 multiple choice questions that need to be completed only once in a seven year cycle. This is an extremely useful section as it is tailored to simulate the recertification examination. There is no minimum score required to pass. They do give you a percentile score, standard deviations, and a table that you can check to see your likelihood of passing the boards. A score of 75% or better is a "good indication that satisfactory performance may be achieved on the secure examination" (from www.abp.org). You can stop and start the KSA at any time as long as you complete it before December 31st. I highly recommend it as a tool to use in studying for the examination even though it is not required until 2010. You can substitute PREP for PMCP-G and NeoReviews for PMCP-S (for neonatology of course). However, KSA is free, and while you do pay to recertify, KSA is included in the recertification fee.

The second section of Part Two is Decision Skills Analysis (DSA). It is also accessible through the ABP web site and consists of 50 clinically-based scenarios complete with history, physical exam, and laboratory or radiology findings. It is multiple choice, often with eight choices. This needs to be completed once in seven years. You can also start and stop at anytime as long as it is completed before December 31st. There is a minimum score required to pass (80%), but you have two tries each year to do so. I found it both practical and

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educational.

Part Three is "Evidence of Cognitive Expertise", also known as **"The Secure Examination"**. (Okay, time to play the 2001 theme song again in your head.) The new format of the examination is administered at Prometric Testing Centers. PMCP-G is available from January to June and September to December. There are spring and fall windows for PMCP-S, which are specialty dependent. There is a significant sticker shock of $1195, but it is still less expensive than the initial certification ($1570 for 2006), and the cost covers all four parts including the KSA and DSA, which I found useful for studying. If for some reason you need to reapply, the fee drops to $195. It is a 200 question, 4 hour, closed book examination.

I recently took the examination just so that I could write knowledgeably about it (no, not truthfully, it was my time). Just a warning to all, you cannot take your morning Carmel Macchiato or Latte into the examination. You cannot even have a stray Tic-Tac in your pocket. It was not an unpleasant experience, though. Once you verify your license and pay the (ouch) $1195 fee, you can choose your date and time. I chose the morning because I know I tend to fall asleep in the afternoon. The first computer they gave me did not work (minor panic attack), but the second had a nice lamp for mood lighting. You are given two copies of a paper verifying that you completed the examination. One copy should be faxed or mailed to the ABP. Only a week later, I received notification to check my result on the ABP website. There is a section to track your progress at the ABP, which monitors which parts of the four you have completed in a seven-year cycle. After opening "my progress report", I saw at the top "certificate: 10/28/1998 to 12/31/2005". Naturally, I panicked and thought I had failed. However, opening the tab "details" showed my score and thankfully, I did pass. Now I have another seven years to think about….PART FOUR.

Part Four is "Evidence of Satisfactory Performance in Practice". This has two "activities" which need to be completed once in seven years. The first activity involves peer and patient feedback. The physician distributes surveys to peers and patients. There is NO minimum score and it is meant to serve as feedback to the physician for self-improvement. (Phew, fantastic since I am currently a fellow in child abuse and many of my patients are not my biggest fans). The second activity is web-based quality improvement. The only currently approved program is the AAP's eQIPP at www.eqipp.org. There are other modules planned such as one on patient safety. Activity two poses some difficulties for physicians in administrative functions or in clinics where you cannot measure your improvement in areas such as diagnosis and treatment of ADHD or Asthma. These issues are supposed to be addressed before 2008 for those physicians not in direct patient care or specialty clinics.

Time commitment, you ask? According to the ABP, it takes less than an hour to verify licensure (Part One), 4-5 hours for KSA (Part Two), 4-5 hours for DSA (Part Two), 4 hours for the examination (Part Three), less than 2 hours to pass out peer and patient surveys (Part Four activity one), and a variable amount of time (10 hours plus) to complete eQIPP. However, this does not include the umpteen hours I spent studying for the secure examination (at least 50 hours). Parts One, Two, and Three are currently available and I encourage those of you recertifying in the years prior to 2010 to try Part Two. Part Four will be made available in 2008.

When you have a few minutes, try exploring Part Two or learn more about PMCP activities. Once you click on the ABP website, www.abp.org, look under the far right column "Recertification (PMCP)". You will need to register and update your information. Once in the PCMP online activity center, there are question and answer sections, tutorials, and the four parts under PMCP-G or PMCP-S. I just went to the "Track Your Progress" section and learned that I had earned 25 AMA PRA category I credits. 25? Is that all? The anxiety alone was worth 50!

Good luck to all who are recertifying this coming year. Feel free to email me any questions at nsharper@alum.dartmouth.org.

Money? What Money?
Practical Advice about Money Management

by Manny Ng, MD, FAAP

Congratulations, you've made it out of residency and you've landed your first real job! Your days of working for about minimum wage and sleeping in hospital call rooms are over! You've delayed gratification long enough, now you're making big doctor bucks! That's what you hoped for when you entered medical school, didn't you? Come on, be honest with yourself, there was a piece of you that thought that…

Here's the reality check. According to The Association of American Medical Colleges, the average educational debt of medical school graduates from the class of 2004 was $115,218. At 6% over a 10 year term, that's $1280 a month. You're probably tired of living in apartments, so you bought a home. The real estate market has been anything but stagnant. Add your mortgage to the monthly payments. Don't forget the real estate taxes. Depending on where you live, that may add 20% to your mortgage payment. Tired of driving the jalopy you kept through college, medical school, and residency? What's your car payment? Uncle Sam wants a piece too- most of us in SOYP in general practice are probably in the 28% tax bracket. Don't forget those state taxes too. Got half your paycheck left? We didn't talk about food yet. Not to mention "basic" communication needs. By the time you add on cell phone, cable (digital plus the premium channels— because you want the best!), home phone, internet access, that's about another $200 a month. How about credit cards? What's a gallon of gas cost these days? Got a family? If your spouse works, what percentage of that income is paying for day-care? Unless you have a trust fund or a close family member with deep pockets, you're barely scraping by.

I don't know about you, but money management wasn't in the curriculum at medical school or residency. So here's a crash course. Minimize what goes out, and maximize what comes in. Duh! In this article, we'll talk about the expense side of the equation. We'll address the income side in the next issue.

BUDGET!

You should have learned this in high school between Western Philosophy and Trigonometry. But this you really need to use. Buy some financial management software and keep track of your money. It will be best $50 you ever spent. The major packages let you download transactions from most banks and credit card companies. Not only do you have a chance to catch someone stealing your information, it will help you see where your precious cash is going. Keep in mind, this does require the effort to enter the information yourself.

You know what comes in. Your take home pay is about 60-70% of your gross. Hopefully, you're withholding enough taxes that you won't have a nasty surprise in April. Okay, time to look at what's going out. The big items are going to be your loan payments.

Look into consolidating those student loans.

Interest rates are rising lately, but odds are they're still lower than the rates on some individual loans. Besides, the single payment will make your record keeping that much easier.

Have a mortgage? Consider refinancing, if you haven't already done so.

You've missed the lowest rates in history, but the rates will creep up. Don't forget to calculate the cost of refinancing, which can run up to $3000. Got one of those cheap adjustable rates? Think about going to a fixed rate if you like predictability. If you're lucky and you have equity in your home, taking out a home equity loan to pay off some of the educational debt has some tax advantages.

Consider a used car.

Are you the type that needs the latest and greatest gadgets? Unless you're a collector, cars are NEVER a good

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investment. Keep in mind, a new car loses 7% of its value the second you drive it off the lot. There are lots of great cars coming off of leases that you can get for a steal, if you're willing to drive a 2 or 3 year old car. If you like luxury makes, the folks that lease these cars generally don't abuse them. I'd be wary about any car that looks like it's been in *The Fast and the Furious* though. Look at Consumer Reports when investigating a used car. You can get a lot of reliability information in there. Ask your neighbors about an honest mechanic too (he makes more money than you do, by the way).

Bills, bills, bills.

Remember when you turned the lights out when you left the room? The same philosophy applies to those monthly utilities. Some you don't have a choice on. Electricity is a given. Most companies offer fixed payments over a year, if you want to know what you're going to spend each month. Of course, make your house as energy efficient as you can afford to. But the biggest adjustable cost will be your cable/telephone bill. How many channels do you really need? How many minutes on the cell phone plan? How about long distance? There are several companies that offer 3 cents a minute calling with the same reliability as your mainstream carrier. They lease the lines for a lot less. Same phone lines, different company. If you're a chatterbug, look into those all-inclusive plans, they may end up cheaper. Then again, how often are you home? If you're the mobile type, skip the home phone altogether. Keep the cell phone charged, and just pay the cable bill!

Credit cards.

Uh, how about spending less than you actually have? Americans on average are generally spending about 1% more than they make! Doesn't take a doctor or an economist to figure out what that means.

The little things.

The hardest thing to keep track of in any budget is the real cash in hand. A few bucks here and a few bucks there. Do a little experiment. Count up all the cash you have today (skip the coins in the piggy bank). Write down everything you use cash for in the next week. At the end of the week, count your cash again. Add in what you got from the ATM. Does the total match? Probably not. Even the most disciplined person has cash leaking out somewhere. Most likely it's food. Maybe it's a few bucks for lunch, or the daily trip to Starbucks. Maybe you have a habit like smoking or the Powerball. Where can you cut your expenses? Perhaps bring lunch if there's no drug lunch. Drink the office coffee? We all have to sacrifice somewhere.

Any money left? Think long term first.

The old adage in investing is ***pay yourself first***. Technically, this should come before the little things. Before you do anything, make sure you have 3 to 6 months of income in a money market or savings account.

If you're reading this newsletter, you're at least 20 years away from retiring, and so the stock market is a good way to go. While it has its ups and downs, in the long run, it still grows money at a rate of 8% a year. Put a little in every month using an automatic debit and forget about it. But where do I put my money, you ask? There are two schools of thought. The first group is to focus your money and energy into certain areas. However, this requires a lot of time and energy, which you don't have to devote (you are practicing medicine, remember?) So for poor saps like us "amateurs", the other rule in investing is ***diversify, diversify, diversify***. Personally, I have a collection of 5 to10 mutual funds covering different financial sectors I started with 3 years ago. You'll have to determine things like how risk-averse you are and the like. There are lots of websites that can help you get started. A good idea is to find no-load, no-fee mutual funds and put a little in each month. You'll need a little money to start up (most funds require $1000, or $2500 initial investment), but once you get going, you should just check it every quarter or so.

If your company offers a 401K plan, take advantage of it. You're not going to pay taxes on this money until much later. Try to put in as much as you can afford. If you're reading this, you probably can't contribute the maximum ($14,000), but try to contribute as much as you need to maximize your employer's match. That's

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free money there.

If you have children, it's a good idea to also put money away for college savings. Check your alma mater's website and see how much tuition is in 2006. How does it compare to what you paid (or are still paying?) By the time your children hit the halls, who knows what the cost will be? Maybe you'll qualify for financial aid, but don't count on it. There are several ways to save for higher education, but the most popular are the 529 plans. You can contribute up to $11,000 a year for each person annually before triggering the gift tax. After 2010, the proceeds are taxable at the student's income bracket. Coverdell plans are another option, but contributions are limited to $2,000 a year and will be in the child's control at maturity. Websites such as www.savingforcollege.com are a good resource for learning more.

What about real estate?

Most of America has seen a real estate boom. Is the bubble going to pop? Again, it's a risk issue. In the long term, it will make you money, but there is a significant cost associated with it. What if your renters are slobs? What if they don't pay the rent on time? You probably don't have that much in reserves to cover an extended period of vacancy. There are certainly headaches to contend with, but they may be worth it, if you have the patience. If you have a lot of time and some handyman skills, you may want to try the sheriff's sales, but odds are you're a doctor who doesn't know how to get his or her hands real dirty. The best bet is probably a duplex, so you can keep an eye on things. If you can, how about buying a piece of your office building? That's always going to have an occupant.

Protect your investment.

That includes your brain and your abilities. Much as we hate to admit it, there may come a day when we may be disabled and can no longer practice. An occupation specific policy is a must. You can get coverage for up to 66% of your current income in the case of disability where you can't practice pediatrics. You can still get another job and collect that insurance. Also, if you pay for that policy yourself, the proceeds when you collect are not taxable. There are many companies offering these policies, but the AAP Group plan is the most economical.

It's not a bad idea to get a financial planner, but you have to ask questions. These folks are operating on commissions (yes, they make more money than you do), and almost all their products have fees. Mutual funds fees are called loads, and they'll sell you insurance too. Variable life insurance can be a good investment, but a significant chunk goes to fees, so beware. Do your research and ask questions. Don't fall for high-pressure sales.

Keep a low profile.

I don't know about you, but I don't advertise to people what I do when I conduct non-medical business. The assumption is you have deep pockets and they'll take you for all they can get. (That's why you wear your beat up clothes when you buy a car, rather than the Armani suit.) Need some work done on your house? Who's going to get a lower quote from the contractor? The house with a Kia in the driveway, or the one with a Bentley? Sure, you've earned it, but if you had that much money to throw around, you wouldn't be reading this article.

Stay tuned.

In the next issue, we will discuss ways to improve your income. How much do you know about the business end of your practice? Are you getting paid for what you do? It's another topic that was glazed over in your medical training, but I bet you think it's important now!

On Considering Pediatric Hospitalist Medicine

by Jennifer Daru, MD, FAAP

Executive Committee Member, AAP Section on Hospital Medicine

Over the past few years pediatric hospitalist medicine has evolved from a short term moonlighting job after graduating residency to a field providing long-term career opportunities for physicians. For a young physician or graduating resident this is an ideal time to choose a career in hospital medicine for several reasons.

First off, there are tons of jobs. Just ask for the pediatric hospitalist on call at your local hospital or join the AAP Section on Hospital Medicine (SOHM) for $25 and look at our website: www.aap.org/sections/hospcare. If you are even thinking about hospitalist medicine as a career join the SOHM listserv™ for free (email Niccole at nalexander@aap.org). The listserv gives you access to the voice of hospitalists from across the nation, who chat daily about care issues, program structure issues and job opportunities (there's a weekly post). Listening in to the listserv will give you a good sense of the field.

So there are jobs, but are you prepared? As a young physician you have the skill sets necessary to be a hospitalist. While fellowship can always add to one's knowledge, it is not necessary to be a pediatric hospitalist. In fact, if the field moves towards a fellowship requirement, physicians who get involved now will likely be grandmothered in. If you are interested in research or further training opportunities for other reasons, check out the article in the AAP's SOHM newsletter in January 2006. The SOHM newsletter comes out twice a year to members of the SOHM and will be focused on "Choosing Hospitalist Medicine" in January. About 5 formal fellowships are available across the nation and many others informally (you can likely inquire with your local residency program director about setting one up). Even if you have just finished residency or a fellowship in the past five years, it is critical that you look closely at any hospitalist practice you are considering joining and make sure you have the necessary skill sets. Some programs require time in the delivery room with premature babies, others in the pediatric intensive care unit or sedation suite. Still others involve emergency room care. Be prepared to ask about skill expectations during your interview and how these skill sets are mentored or maintained.

Here's what is really exciting about hospitalist medicine. As a young physician in hospitalist medicine, you will have the opportunity not only to help define your job, but to help define the field. Opportunities for leadership and input abound. Many academic centers are only just beginning to consider divisions of hospital medicine. With a little knowledge and insight over the next 5 to 10 years young physicians can help hospitals build these divisions and define reasonable expectations for hospitalists of the future. Community pediatrics also needs strong leaders in hospitalist medicine in order to maintain the field of pediatrics in smaller community hospitals. The SOHM is working to develop this leadership through conferences and mentorship. The next big pediatric hospitalist conference sponsored by the section along with the Society of Hospital medicine and the Ambulatory Pediatric Association will be in the summer of 2007.

If you look at yourself and wonder what your career will hold, be sure to place pediatric hospital medicine on your list of opportunities. If you are not sure if a clinic practice (private or hospital-owned) is right for you and you like set hours with an aspect of diagnostic and likely hands-on challenge without (or with) a fellowship, hospitalist medicine might be the field for you. If you have questions or need support contact the Section on Hospital Medicine through nalexander@aap.org. We have hospitalist medicine leaders and mentors available in every state, ready to answer questions and provide support.

About the Author: Now five years out from residency, Jennifer Daru, MD, FAAP is an assistant professor of Clinical Pediatrics at Northwestern's Feinberg School of Medicine and site leader for a hospitalist outreach site of Children's Memorial Hospital (CMH) in Chicago. She also works as a consultant building hospitalist programs at CMH and elsewhere. She has been on the AAP Section on Hospital Medicine Executive Committee since 2003. Write to her at jdaru@childrensmemorial.org.

Child Abuse and Neglect

by Jonathan D. Thackeray, MD

2nd Year Candidate Fellow and Member of the Section on YP and Child Abuse and Neglect

Since 1990, more than 10,000 American children have died at the hands of their parents or caretakers as the result of abuse or neglect. *Four children die every day* in this country from child abuse and neglect. It is important for us as young physicians to take a leadership role in the protection of children and the prevention of child abuse and neglect. As April 2006 (National Child Abuse Prevention Month) quickly approaches, this article will provide three approaches to physicians on how to become proactive in this role.

Pick an issue and become a legislative advocate: The United States spends an estimated $258 million annually on foster care, incarceration and other societal costs because of the abuse and neglect of children. This amounts to $1,460 per family per year. Despite these high costs, the federal government invests only $10 in prevention research for every case reported. Make an appointment with your local Congressman or Senator (or his/her representative) to secure support for an issue near and dear to you. Prepare carefully and thoroughly for your meeting. Review your legislator's past votes or statements on the issue and his/her party's position. Know your talking points in advance and be prepared to make your case. Research the opposition's arguments against your position and attempt to rebut those arguments in your presentation. Be sure to follow-up after the meeting as necessary – a simple "thank you" letter or sending promised additional information will go a long way to building a long-term relationship with your legislators. If you have further interest in legislative advocacy, access the AAP's advocacy website at http://www.aap.org/advocacy.html.

Enhance the public awareness of child abuse and neglect: Many communities still have the "not in my neighborhood" approach to child abuse. Two programs are gaining popularity across the country to enhance public awareness: The Blue Ribbon Campaign and Pinwheels for Prevention.

- The Blue Ribbon Campaign began in 1989 when Bonnie Finney, a Virginia grandmother lost her own grandson to child abuse. She took a stand against abuse when she tied a symbolic ribbon to her van. It was a signal to her community of personal commitment to involve everyone in the battle to stop child abuse. Today many hospitals and communities distribute blue ribbons or blue bracelets to spread the message of child abuse prevention.
- Prevent Child Abuse Georgia invented the "Pinwheels for Prevention" campaign and it has now been duplicated in several states. A county area (e.g. community park) is selected and one pinwheel is placed there for each case of child abuse or neglect reported to the county's public children services agency. In some counties, thousands and tens of thousands of pinwheels show the public in a dramatic way that child abuse and neglect happen in their community and encourages them to focus on prevention as part of an overall plan to break the cycle of abuse.

Get into the schools and educate youth: Lack of parenting skills and knowledge is a well-recognized risk factor for child abuse and/or neglect. The story of Sharon, Brent and Charlotte Snyder is truly inspiring. Born 100% healthy, Charlotte suffered severe brain damage after her biological father repeatedly shook her to quiet her cries. As the result of her injuries, Charlotte will never walk, never talk and never eat food by mouth. Sharon and Brent adopted Charlotte in October 2001. Today, the family visits Central Ohio high schools to share their experiences with teenagers in an effort to educate them on the tragedy of child abuse. Students stare intently at Charlotte's extensive tubing and intricate wheelchair as her adoptive parents explain a typical day for their little girl. Sharon and Brent complete each session by encouraging the students to share what they have learned with two other people. Targeting these "future parents" early on will hopefully save children down the road.

If you would like more information on how you can contribute to the success of Child Abuse Prevention Month, go to www.preventchildabuse.org and access your state chapter's website.

The Section on Child Abuse and Neglect is dedicated to improving the care of infants, children and adolescents who are abused and neglected by providing an educational forum for the discussion of problems and treatments relating to child abuse/neglect and its prevention. If you are interested in joining the Section on Child Abuse and Neglect, please contact our section manager Tammy Piazza Hurley at thurley@aap.org.

Portions of this article taken from the Fall 2005 edition of the Prevent Child Abuse Ohio newsletter.

Watch Out for Hidden Exclusions in your Medical Liability Insurance

by Gary McAbee, DO, JD, FAAP

Chairperson, AAP Committee on Medical Liability

So you're employed, you've got professional liability insured and your career is moving along nicely—life is good. But having liability insurance is just a first step, you really need to understand your coverage. It isn't something you can trust your employers or business advisors to handle for you. You need to understand the limits of coverage and be fully aware of what your policy does and does not cover. Like most important things this takes time, effort and some careful reading. Physicians with insufficient liability insurance jeopardize both their professional and personal lives.

What are coverage exclusions?

The first step is to get out the policy and give it a thorough read. Most policies have what is called an exclusion section, which stipulates specific actions or events that will not be covered under the terms of the policy. For example, some professional liability policies do not protect the physician from allegations of sexual misconduct, criminal acts, claims for libel, slander or false imprisonment, claims arising from the physician assuming liability under a contract, or anti-competitive behavior.

Your response is probably, "So what? I don't do any of those awful things." But that doesn't safeguard you from being accused of them and defense costs are not cheap. According to the Physician Insurer Association of America, the average cost to defend a pediatric malpractice claim closed in 2004 was $34,919.

Most professional liability insurance policies will not indemnify the insureds (that's you-the insured person) for anti-trust law violations. Pediatricians with access to good legal advisers know this and are careful to steer away from anti-competitive business arrangements. However, peer review activities can also result in exposure. Depending on the insurer and the policy, you may be covered for peer review activities as long as you abide by your state's peer review statute. But let's say you didn't and your insurance didn't provide this coverage. You could run into trouble if someone disciplined or denied privileges/membership alleges that the peer review was based on economic rather than quality of care motives or was intended to hinder business competition. Such allegations can be expensive to defend, and if you are found liable the damages can be trebled (i.e., multiplied by three).

Punitive damages, sometimes called exemplary damages, also are typically excluded by medical malpractice policies. Like antitrust law damages, punitive damages are awarded as punishment for conduct considered by the law to be willful, as opposed to negligent. In contrast to antitrust law claims, however, most insurers will defend, but not pay indemnity for a claim seeking punitive damages if it arises from a treatment occurrence otherwise covered by the policy. Punitive damage actions can pose a significant economic threat to physicians because punitive damages can be trebled under some state laws. Some awards running into several millions of dollars have been made. The U.S. Supreme Court has been wrestling with what constitutes "unreasonable" punitive damages and has issued guidelines to help courts make these determinations more equitably.

Contract exclusions

Contracts can trigger policy exclusions, particularly contracts in which you assume an obligation to others. What does that mean? Managed care contracts frequently contain a clause in which the physician agrees to indemnify the plan (hold harmless) against any claims arising from the services provided to patients under the terms of the contact. Physicians signing such agreements may find themselves taking on additional liability that will not be covered under their existing medical malpractice insurance. You can avoid these problems by having your legal adviser review all your contracts before you sign them. Medical associations including the AAP have published information on such agreements.

Some states have restricted insurers from including "hold harmless" clauses in their contracts. Check with your state AAP chapter or medical society to see if such a clause is permissible or not. Many insurers have boilerplate contracts that cross state boundaries.

What should a physician do if the assumption of liability in the managed care contract is not covered in his

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or her liability insurance? There are several possible options. Negotiate with the managed care organization to limit indemnification to losses arising from the physician's services only; this is a fairly common solution, with the physician and the plan each accepting responsibility for their own acts only. Or negotiate to delete the hold-harmless clause from the contract. Or simply refuse to sign the contract.

Fee disputes

Another common exclusion in liability policies is a fee dispute with a patient, which is considered a contract issue rather than a malpractice action.

Territorial restrictions

Territorial restrictions are often specified in professional medical liability insurance policies. For example, some policies limit coverage to professional activities that take place within a given state, unless it is notified in writing and out-of-state practice is approved or unless the insured renders emergency services in another state. This may represent a problem for a physician practicing in a border area who sees patients in more than one state, or a pediatricians providing care to out-of-state college students via email or telephone.

Know the territorial restrictions on your liability insurance coverage when you are traveling, especially if you are considering one of those "volunteer-vacations" in which physicians provide care to underserved people in remote (often beautiful) parts of the world. These are wonderful opportunities, but you need to be sure that the organization sponsoring the trip provides adequate liability coverage if your traditional policy does not.

Volunteer activities

Most pediatricians engage in volunteer activities in their communities. You need to know whether you have liability protection for this good work. Don't ***assume*** that it is taken care of by the charitable organization, your private insurance or indemnified by the state or federal government.

Some insurers will provide coverage for emergency situations outside the typical coverage boundaries, such as medical services provided while acting as a Good Samaritan. Although the Good Samaritan doctrine differs from state to state, it typically requires that services be rendered in an emergency situation with no expectation of payment. Few, if any, malpractice actions have arisen from the rendering of Good Samaritan care.

Finally, for those solo practitioners, be aware that malpractice insurance is not likely to cover you if a patient is injured on your property (e.g. falls on the ice when entering your office). A more traditional "negligence" insurance policy, such as premises liability, will be needed to protect you from this liability risk.

Follow up periodically

Once you have established a baseline understanding of your liability coverage, take a few minutes periodically to compare your current professional activities against your current policy and look for any potential "exposures." Once you know where potential problems can arise, you can take steps either to limit the exposure or secure additional coverage, if it is available.

To learn more, turn to the Academy's authoritative manual ***Medical Liability for Pediatricians***, 6th edition. This greatly expanded edition of the definitive AAP liability guide focuses on practical approaches to avoiding liability exposure, with updated material on risk management; vaccine liability; newborn, adolescent, emergency care; and more. http://www.aap.org/bst/showdetl.cfm?&DID=15&Product_ID=956

Adapted from an article by Jerome F. Buckley, MD, FAAP and George Dikeou, Esq. ***AAP News*** *Vol 18, February 2001, p. 61. American Academy of Pediatrics.*

Reflection: First Step Towards Balance

by Hanna B. Sherman, MD, FAAP

Chair, AAP Physician Wellness Special Interest Group

In my work as a medical educator on physician well-being and professional renewal, I am most often asked to teach about balance. As physicians, we are pulled in many different directions of work, family, personal interests, and community, to name a few. Finding balance in our lives becomes an ongoing pursuit for most of us. In the past six years of being in this work, my thinking about balance has evolved into something quite different from where I began. Initially I thought balance was about reminders, checklists of activities and actions, such as eating a healthy diet, exercising each day, and having a spiritual life. While reminders are helpful, my understanding of balance now is that the items on our checklists are offshoots of something much deeper. To find balance in our lives we must first identify and grapple with what gives meaning to our lives. Being in balance is about aligning what we do with what we value. This way of approaching balance invites us to ask ourselves how we might put what it most important to us in the forefront of the way we lead our lives. In order to do that, we must have a process of self-reflection that we can turn to when we are making decisions that affect our balance.

Reflection is a practice that requires continuous attention and maintenance. For some physicians it is natural to be reflective and for others it is more of a learned skill. In addition, medical education and training can impede personal reflection, leading to the need to redevelop our reflective skills as we move into practice. Traditionally we have been taught to set the self aside. While altruism is an important core principle of medicine, it can be diminishing to set the self too far aside, causing a loss of our sense of self and an understanding of our own desires and needs. Rather than distancing our selves, the intensity and intimacy of being in life and death situations with patients could instead be compelling invitations for us to examine our responses and to learn along with our patients how to live fully in the unpredictability and vicissitudes of life. We can only do that if we have an ongoing process to understand how what we do impacts us, both within our work and outside of it.

It is as important as ever to keep the self-close by as we enter our work lives and need to discern how to commit our time and energies. The first step in finding balance is identifying where our time is directed. After this, we might ask ourselves, is my time aligned with my values? Is my time directed where I want it to be? We each can only answer these questions for ourselves. Balance is deeply personal and highly individualized. What may constitute balance for one physician may be very different from balance for another since balance is dependent on our own paradigms of meaning.

Here are some guidelines that can be helpful for recognizing the foundation of your sense of balance:

- *Develop a reflective practice.* Begin by setting aside time to reflect on a regular basis, each day, each week, each pay period, whatever is a good routine for you. You might contemplate in the morning while in sitting meditation or exercising. Or you may capture time while driving to and from work by turning off the radio and focusing your thinking. You may set aside time in the latter part of the day to reflect and write in a journal, externalizing some of your thoughts and securing them on paper. One physician I know has shelves of journals he has kept since medical school. Once you have developed a conscious practice, being reflective begins to be internalized so that it becomes a regular habit that slips into spare moments. Reinforce and extend your self-reflections by nurturing reflective, thought-provoking relationships with your life partner, friends, family, and colleagues.
- *Reflect on your life priorities.* What do you hold precious in your heart about your life? In what moments do you feel alive and well? When you have lived your life and are reflecting back on it, how will you want it to look? What will give you satisfaction and fulfillment? Are your energies devoted to what holds meaning and worth for you? What would living what you love look like for you?
- *Consider your life responsibilities.* Is the way you are working now moving you towards goals that are important to you? If your life is balanced more in your work, is the work meaningful to you? Are the finan-

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cial securities and benefits allowing you to have meaning elsewhere in your life? Are there other tangible and intangible rewards? While you are working hard, are you attending enough to what else is immediate and meaningful in your life? Are you sacrificing too much for future goals? Where is the right place for you to set the line between work investment and personal life?

- *Work close to your heart.* Are you conducting your work in ways that are in keeping with your concept of how your work should be performed? What parts of your work identity do you want to be certain don't get lost as you do your work? Have you aligned the work of your heart with the work of your hands? If there are barriers, how can those barriers be challenged and who can be your community of kindred spirits and allies in doing so?

The opening of May Sarton's poem, "Now I Become Myself," offers some useful notions about maintaining meaning as the foundation for balance.

Now I become myself. It's taken
Time, many years and places;
I have been dissolved and shaken,
Worn other people's faces…

Finding balance is being our selves in the truest sense. It is wrestling with the beautiful fullness and turmoil of our lives. It is using the strength of knowing who we are to hold back the forces that can deform our lives by asking us to wear someone else's face. It is answering the longing in our hearts while meeting our responsibilities. It is attending to the meaning in what we do each day, at work and at home. It is knowing when to stop and when to be active, when to rest and when to create. Finally, being in balance is having the courage and commitment to live *our* lives.

2006 Neonatal Resuscitation Program

Research Grant and Young Investigator Award Call for Applications

The American Academy of Pediatrics (AAP) Neonatal Resuscitation Program (NRP) Steering Committee and the Section on Perinatal Pediatrics are pleased to announce the availability of the 2005 Neonatal Resuscitation Program Research Grant and the NRP Young Investigator Award. The awards are designed to support basic science, clinical, or epidemiological research pertaining to the broad area of neonatal resuscitation.

Physicians-in-training or individuals within four years of completing fellowship training are eligible to apply for up to $10,000 through the **NRP Young Investigator Award**.

Any health care professional with an interest in neonatal resuscitation can submit a proposal for up to $25,000 through the **NRP Research Grant Program**.

Researchers from Canadian and US institutions are invited to apply.

Potential applicants should submit an intent for application to the NRP Steering Committee by **Friday, May 5, 2006**. All intents will be reviewed and the committee will ask a select group to submit full proposals. Those selected to submit a full proposal will receive the formal application by Friday, June 30, 2006. Completed applications will be due on Friday, September 1, 2006.

To obtain the NRP Research Grant or NRP Young Investigator Award Program Guidelines and the Intent for Application, please contact:

American Academy of Pediatrics
Division of Life Support Programs
800/433-9016. Ext. 4798
Or go to www.aap.org/nrp and select the science tab

Practical Pediatrics CME Courses are Practical for You

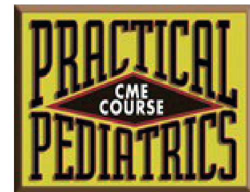
by Rickey Williams, MD, MPH, FAAP

Chairperson, Practical Pediatrics Course Planning Group

Dr. Williams

Congratulations!
You're through your training.
Your residency is behind you, and you're a practicing pediatrician.
Now what?

Like your colleagues before you, you've found that you're not done learning. Your patients are presenting with rashes you don't recognize and fevers you can't explain. Black-box warnings have you questioning which treatments are best for ADHD and depression, and you're not sure which sports injuries you can treat and which you should refer.



AAP Practical Pediatrics CME courses (PPCs) are just right for you. With the emphasis on "practical," these courses offer answers to the kinds of issues all of us face in our daily practice. Each course features seven expert faculty discussing both the common problems and hot topics we all encounter, and each course provides general session lectures and breakout seminars to ensure you have direct access to the course faculty and their expertise.

Practical Pediatrics CME courses also offer a practical way for you to combine CME with R&R. Scheduled with half-day sessions over three days in vacation destinations, PPCs are designed to give you the best and most practical pediatric CME while also providing you and your family with a relaxing getaway. Whether you and your family enjoy skiing, the beach, the desert, an amusement park, or a world-class city, there's a PPC course to meet your educational and recreational needs.

So I encourage you to attend a PPC course in 2006 in one of the following outstanding locations:

Orlando, Florida
March 9-11

Seattle, Washington
May 18-20

Hilton Head Island, South Carolina
May 25-27

Miami, Florida
(PPC Sports Medicine)
June 15-18
Cosponsored With the AAP Council on Sports Medicine and Fitness

Ottawa, Ontario, Canada
July 7-9
Cosponsored With the Canadian Paediatric Society

Baltimore, Maryland
October 6-8

Santa Fe, New Mexico
December 7-9

You can find more information and register online at www.pedialink.org/cmefinder.
We look forward to seeing you in 2006.

Upcoming CME Events

Practical Pediatrics CME Course - Orlando, FL
Lake Buena Vista, FL
Hilton in the Walt Disney World Resort
Mar 09, 2006 - Mar 11, 2006

Uniformed Services Pediatric Seminar (USPS)
Portsmouth, VA
Renaissance Portsmouth Hotel
Mar 13, 2006 - Mar 16, 2006

PREP® The Course - Tampa, FL
Tampa, FL
Marriott Tampa Waterside Hotel and Marina
Mar 25, 2006 - Mar 29, 2006

Workshop on Perinatal Practice Strategies 2006
Effective Leadership in an Evolving Environment
Scottsdale, AZ
Doubletree Paradise Valley Resort
Mar 31, 2006 - Apr 02, 2006

SuperCME 2006 - Practice Makes Perfect: Linking Your Office and The Community
Washington, DC
Omni Shoreham Hotel
Apr 26, 2006 - Apr 29, 2006

Practical Pediatrics CME Course - Seattle, WA
Seattle, WA
Westin Seattle
May 18, 2006 - May 20, 2006

Practical Pediatrics CME Course - Hilton Head Island, SC
Hilton Head Island, SC
Hilton Head Marriott Beach & Golf Resort
May 25, 2006 - May 27, 2006

Practical Pediatrics Sports Medicine CME Course - Miami, FL
Miami, FL
Inter-Continental Miami
Jun 15, 2006 - Jun 18, 2006

PREP® The Course - Denver, CO
Denver, CO
Denver Marriott City Center
Jun 24, 2006 - Jun 28, 2006

News from the AAP

The National Immunization Program at the Centers for Disease Control and Prevention has created a Web page noting new and pending Vaccine Information Statements (VIS) for several vaccines. Under federal law, all vaccine providers must give patients, or their parents or legal representatives, the appropriate Vaccine Information Statement (VIS) whenever a vaccination is given. Details are available at the Centers for Disease Control and Prevention Web site www.cdc.gov/nip/publications/vis/vis-news.htm.

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Waivers are part of a well-designed financial policy for pediatric practices. A waiver is a statement that the responsible party (patient/parent/guardian) signs accepting financial responsibility for a requested medical service, which may or may not be covered by health insurance. To assist pediatric practices, the AAP Department of Practice has gathered information on waivers. An article on waivers for pediatric offices will be available in January's *AAP News*. Questions and answers on waivers can be accessed on the AAP Member Center, private sector advocacy page www.aap.org/moc/.

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If you received an orange **Last Issue** sticker on your December *Pediatrics* and *AAP News* publications, your membership dues were not received prior to the November 1, 2005, deadline. In addition, your online access to the Member Center, *PediaLink®*, *Pediatrics*, and *AAP News* has been discontinued.

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It's easy to reactivate your membership by paying your past-due balance at the AAP Web Site https://nce.aap.org/eablazelive/aap/events/login.asp. Once payment is received, all member benefits and privileges will be reinstated. Call the AAP Customer Service Center at 866-THE-AAP1 (843-2271) for membership status and information.

Resources and Events

- **Test Your Skill using the new ICD-9-CM codes**

The December issue of AAP New "Pediatric Coding Companion™" monthly newsletter features a quiz on the ICD-9-CM codes, Coding E/M service and hospital admission on the same day, and How to Apply for Your National Provider Identifier Number. For more information or to review a sample copy visit the AAP Coding Web Site http://coding.aap.org/.

- **New Brochure on Emergency Contraception Available**

AAP has developed a new brochure to help answer parent and teen questions on AAP's new policy supporting the availability of emergency contraception-Plan BTM and PrevenTM. For more information visit the AAP Bookstore www.aap.org/bst.

- **Sports Participation Brochure Revised**

A revised "Sports and Your Child" Patient Education Brochure is now available. A bestseller, this brochure discusses ways to reduce injury risk, prevent sports-related stress, and help parents determine age appropriate sports, quitting and more. For more information visit the AAP Bookstore www.aap.org/bst.

2006 NCE Update

Mark your calendars!

The **2006 AAP National Conference & Exhibition** will be held in **Atlanta, Georgia**, **October 7-10**.

October 2006

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SAT/SUN
					1
2	3	4	5	6	7 8
9 Columbus Day	10	11	12	13	14 15
16	17	18	19	20	21 22
23 30	24 31	25	26	27	28 29

Atlanta has first-class accommodations, outstanding restaurants and one-of-a-kind historic and cultural attractions. Members will enjoy more than 350 educational programs, 320 exhibitors and a career fair along with family friendly tours and events.

Check **www.aap.org/nce** frequently for updates, and registration and housing information in the June issue of *AAP News*.

The Young Physicians Section

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

Winter 2006 Newsletter

This newsletter is the official publication of the Section on Young Physicians of the American Academy of Pediatrics. Statements and opinions expressed in this publication are those of the authors and not necessarily those of the American Academy of Pediatrics.