I am honored to have been elected to Chair of the Section on Urology (SOU). Those of you who have held this position understand that the responsibility is primarily one of reflection; the heart, soul and work of our section is fostered by the Secretary (Nicholas Cost), Executive Committee (Stephen Canon, William DeFoor, Rama Jayanthi, Kathleen Kieran, Armando Lorenzo, Edwin Smith, Mark Cain, and Christopher Cooper), and members of our working committees (Chester Koh, Jason Van Batavia, Blake Palmer, Gina Lockwood, Benjamin Whittam, Jeffrey Campbell, Douglas Storm, Bryan Sack and Jennifer Reifsnyder). And most importantly, nothing would be accomplished within our Section without the oversight and direction provided by our Section manager, Kathy Ozmeral. To each of you I express thanks and appreciation for the work you do, the time and effort that you put into the success of the SOU, and importantly the influence it has on the urologic care of children.

Over the years I have been given opportunities that I never expected would come my way. It seems like yesterday when a small group of now “elders” (you know who you are) were lamenting our lack of involvement and discussing how we could come of age and break into a leadership role. All of you have succeeded and I follow in your footsteps having learned from the success each of you have had. My own journey follows a path similar to that described by Malcolm Gladwell in Outliers, and has more to do with simply being in the right place at the right time and the willingness to put in a little effort. Honestly, at my first Fall American Academy of Pediatrics (AAP) meeting in 1985, my thoughts were not focused on anything but completing my fellowship without a disaster. It was during my short fellowship that I truly appreciated the importance of a strong work ethic through the actions of my mentors.

With time comes change, and Pediatric Urology is no exception. Our credibility as a pediatric urologist in the past was acknowledged by achieving “Fellow” status within the AAP, and tacking on the moniker FAAP at the end of our degree. The battles of past leaders have successfully led to formal recognition of our expertise as a certified pediatric urologist. That was accomplished because of the efforts of many strong forward thinking pediatric urologists; the mission of the American Board of Urology to serve the best interest of pediatric patients receiving urologic care; and the steadfast support of our pediatric colleagues locally and nationally through the AAP.

We now have expanded diversity within the subspecialty of Pediatric Urology. This has led to the advancement of special interest groups and societies with very important independent agendas. While our subspecialty continually evolves, we are likely reaching a plateau in overall numbers with those entering equaling those leaving. Our subspecialty is strong but will always remain relatively small in number, and the special interest groups even smaller. It was appreciated by insightful leadership and management that we would have greater strength and effect accomplishing the goals of each special interest group if we remain unified. With that, the Societies for Pediatric Urology (SPU) has evolved into our unifying society. This is a significant step to assure the long term future success of Pediatric Urology.

I strongly support the new version of the SPU and the central role it has on our future. I also have the perspective of why (from an educational and financial point of view) a change from the past was needed. In particular, the support received from the AAP to hold our annual educational meeting wasn’t balanced with the expense of membership and cost of meeting registration making...
Reflections from the Chair  Continued from Page 1

continued participation difficult to justify. The addition of FAAP at the end of your name was once perceived as a requirement for credibility as a Pediatric Urologist; many are now questioning the value and cost effectiveness of membership. I will include myself in that group.

Again, unexpected opportunity has reaffirmed my commitment to the AAP and the importance of supporting pediatrics through membership. I recently attended the AAP Annual Leadership Forum (March 15 - 18, 2018). The immediate work at hand -- approval of resolutions -- provided little need for urologic expertise. But the opportunity to talk with pediatricians from my Chapter, District and across the nation was enlightening and reaffirmed the important role we play in the urologic care of children, and the influence we have on the education of our pediatric colleagues. Many pediatricians commented on their appreciation of the courses the SOU has planned at national meetings. It seemed clear from many discussions that the common goals and hurdles we face regarding the care of children bind us closer to pediatricians than it does with our adult colleagues. We need to remain supportive and active within the AAP and that starts with continued membership.

The Annual Leadership Forum also brought me together with the AAP Surgical Advisory Panel (SAP). We have much in common with our pediatric surgical peers. We have similar challenges and can learn from each other’s experiences. The SAP has built strength in numbers and its strong voice has been recognized by the AAP. SAP has long advocated for greater surgical representation on the AAP Board. Soon, the AAP will be holding a bylaw referendum to add three new at-large positions to the AAP Board – one of whom will be a surgeon. SAP also caused me to reflect on collaborative multidisciplinary educational sessions we have had at past meetings. We still have much we can learn from each other. As we plan future educational meetings, it will be to our benefit to explore opportunities that allow for collaborative events at the AAP National Conference.

Those of you reading this appreciate the importance of membership. I encourage you to mentor your partners, the recent fellow graduates, and the current fellows on the value and privilege of achieving FAAP status. A strong membership is required to sustain the influence that the SOU has within the AAP. It’s a win/win/win, especially for our patients.

I look forward to seeing you in San Francisco.

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The first full year of the new union of pediatric urology under the Societies for Pediatric Urology is almost complete. It has been an extremely busy and exciting year as we developed new initiatives, forged relationships across the spectrum of urology, and met challenges to the specialty.

The new SPU committee structure was envisioned to address clinical areas of the specialty and to gather experts to advise and guide SPU policy. We were thrilled with the enthusiastic responses received to the open call for committee volunteers, and were encouraged by the number of SPU members who are willing to commit their time and energy to the organization. We are formalizing committees by priority and hope to have many of the committee rosters announced before the annual meeting.

The importance of the coalition of all pediatric urology could not have been more relevant and the timing more perfect, as the need for an organized, unified voice occurred almost immediately after the meeting last May. Pediatric urology was faced with a challenge related to DSD and was made aware of pending legislation in Nevada that would have severely restricted genital surgery and the ability of parents to make health care decisions for their infant children. Initiated and fueled by a patient advocacy group and funded by Human Rights Watch, the legislation threatened a moratorium on all genital surgeries until the patient could participate in the decision.

The SPU DSD Task Force was immediately engaged and under the leadership of co-chairs Earl Cheng, Pat McKenna, and Rick Rink mobilized forces across the specialties that comprise the multi-disciplinary teams that treat these patients, fought against the legislation and successfully stopped the bill from moving forward. But the conflicts and challenges have just begun.

In response to repeated press releases and negative actions by Human Rights Watch, the SPU DSD Task Force has been working tirelessly with a consortium of organizations to address the issues and released a statement outlining our position in November (http://www.spuonline.org/HRW-interACT-physicians-review/). The Task Force is developing a tool kit to address individual state legislative issues as they arise and is working with the AUA and AACU to monitor state legislation (currently working with the California Urology Association on pending legislation in that state.) The Task Force will be attending the AMA House of Delegates meeting in June to address the Council on Ethical and Judicial Affairs to provide comments on the report “Supporting Autonomy for Patients with Differences of Sex Development.”

Also under development are resources for members such as informed consent criteria, recommendations for long-term studies, and a collection of patient testimonials from those who are grateful to have had early surgery.

SPU was pleased to participate in the recent AUA Advocacy Summit in Washington, DC. Members of the urology community visited with Senators, Representatives and their staffs to discuss many issues facing the specialty, including federal funding for urological research, the need for the creation of a federal office of men’s health, and the burden of the certified electronic health record. In addition, SPU was well represented in a panel discussion “Advocacy in Pediatric Urology: Intersex” featuring Lane Palmer, Rick Rink and Pat McKenna which outlined the advocacy efforts being undertaken by the SPU on the issues surrounding DSD.

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for the exceptional applications that the committee receives each year.

We are looking forward to the upcoming SPU Annual Meeting at the AUA Annual Meeting, May 18 – 20, 2018 in San Francisco. Program Chair, Caleb Nelson, has developed an outstanding program, including the Meredith Campbell Lecture “Pediatric Urology Grows Up” presented by Philip G. Ransley from Great Ormond Street Hospital in London.

We also encourage you to submit your abstracts and make your plans to attend the Pediatric Urology Fall Congress, September 14 - 16, 2018 at the Westin Peachtree Plaza, Atlanta. Jonathan Routh, Program Chair, has some innovative ideas to make this another successful meeting and we are looking forward to it.

I am privileged to work with such dedicated and talented members of SPU and I am looking forward to the future of the specialty under the cohesive umbrella of the Societies for Pediatric Urology.

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**From the Editors’ Desk**

**Welcome to the AAP SOU Newsletter!**

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Welcome to the inaugural edition of the AAP SOU newsletter! Jason and I are honored to serve as the Membership co-Chairs for the Section and we thank you for the opportunity. One of our first tasks was to create this newsletter, which was enthusiastically supported and approved by the Executive Committee.

The Section newsletters in the AAP serve as a message board for the sections to inform its members with up-to-date news in their respective fields. It is one of the many benefits that are supported through AAP membership, and the newsletter will supplement the other excellent publications within our field including the well-received “Dialogues in Pediatric Urology” edited by Elizabeth Yerkes.

Perhaps like many of us, you may have cancelled the home delivery of the local newspaper but kept the delivery of the Sunday paper when one usually has more time to read it. So consider the newsletter as the “Sunday Paper” of pediatric urology, where one can catch up on our field’s activities and pertinent issues in a single edition.

The AAP SOU newsletter will be published twice a year with planned release dates just prior to the two major North American pediatric urology meetings (Spring and Fall), where each subcommittee will have the opportunity to highlight their activities at least once per year.

We hope that you enjoy reading this inaugural edition of the AAP SOU newsletter, and please share it with a colleague or friend. We welcome all suggestions for articles, and encourage you to consider submitting one. It is an avenue of communication for our community, and for those who share the passion of caring for children and improving our urologic care in children.

*Continued on Page 5*
As noted in David Joseph’s and Julia Barthold’s messages, we look forward to seeing you at the two major North American pediatric urology meetings this year in San Francisco (May 18 – 20, 2018) and Atlanta (September 14 - 16, 2018).

Safe travels!

Upcoming Meetings of Interest (in addition to the 2 major meetings):

**May 17, 2018** – NARUS Advanced Robotic Urinary Reconstruction Master Course for Adult & Pediatric Urology, Sunnyvale, California – narus-masters.com


**September 13, 2018** – 7th Annual Pediatric Urology Hands-On Master Class on Robotic Ureteral Reimplantation and Robotic Urologic Reconstruction – Atlanta (Norcross), Georgia - narus-masters.com

**September 20 – 24, 2018** – World Congress of Endourology, Paris, France – wce2018.com


**November 2 – 6, 2018** – AAP NCE, Orlando, Florida - aapexperience.org

**Mid-February, 2019** – 3rd Annual NARUS North American Robotic Urologic Symposium including a Pediatric Urology Track, Las Vegas, Nevada – narus.us

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(Editors' note: Destined for each edition, this section spotlights an example of basic science research in pediatric urology and hopefully serves as a resource and inspiration)

Basic Science Research Spotlight:

**The Pediatric Urologist and Basic Science Research – Rewards, Challenges, and Strategies for Success**

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The importance of basic science research in advancing patient care in urology has been emphasized repeatedly in the strategic plans of the NIH/NIDDK and AUA. It is by no means an overstatement to say that biomedical researchers are currently experiencing perhaps the most exciting time in scientific history. While sequencing the first human genome required $2.7B and almost 15 years to complete in 2003, it now takes only ~$1,000 and several days. This same period has also witnessed dramatic advances in using mice to model diseases, manipulating stem cells for tissue regeneration, developing tools for *in vivo* genomic editing, phenotyping patients with -omics technologies, and numerous other areas. Still, pediatric urology lags significantly behind other specialties as its NIH-funded basic science research laboratories can be counted on one hand. The purpose of this column is to share our rewarding experiences in

Continued on Page 6
basic science research over the last 18 years and provide a roadmap for navigating its challenges to other pediatric urologists considering this path.

**Benefits of a Surgeon-Scientist Career Path.** Conducting basic science research has undoubtedly been one of the best decisions of my career. Our laboratory is a collaborative environment in which surgeons and scientists use their complimentary skillsets to conduct research aimed at overcoming key clinical barriers. My research time not only provides intellectual stimulation but also improves my ability to treat patients as I obtain a deeper understanding of urologic disorders and critical treatment decisions. This cycle continues as my clinical time enhances our research and I think about ways to advance discoveries at the bench towards improving patient care at the bedside. Finally, being a member of the tightknit urology research community has increased my recognition at the national level, facilitated my career advancement, and provided countless new opportunities.

**Transitioning to Research.** The possibility of conducting basic science research may seem unachievable given the time demands of a surgeon. However, the team-based approach of research laboratories allows for flexibility and a gradual transition to basic science. I began as a junior faculty member by working several hours per week in an established molecular biology laboratory where I applied my surgical skills to extending their prior studies of cellular proliferation in mouse models of obstructive uropathy. This role evolved over time as I developed a publication record, obtained a NIH K08 Mentored Career Development Award, and eventually established an independent NIH-funded laboratory.

**Obtaining Institutional Support.** The first step is to gain support from your division chief in the form of protected research time and funding. This will not be easy since poorly planned research ventures result in significant financial costs and wasted valuable clinical time. Accordingly, your plan should include a stepwise institutional investment with benchmarks for success, take advantage of established resources (e.g., training in existing labs), and involve significant support from experienced mentors. Moreover, you will need to present a vision of how your research will benefit the institution. This can include international recognition (e.g., papers, presentations), extramural funding, improvement of fellowship training programs, synergism with ongoing clinical research, and other institutional goals. By similarly identifying others at your institution that may benefit from your research, you can build a support network that is invested in your success.

**Planning Projects.** Developing ideas for research projects is relatively straightforward and should be a natural extension of your clinical expertise and the barriers you encounter in patient care. Although the uncharted territory of basic science in urology offers limitless research possibilities, it also increases the importance of reviewing the literature in other fields to learn state-of-the-art methods. It is critical to focus your research only on directions with long-term funding potential. The limited amount of funding available for basic science research in urology is a significant barrier and requires creative solutions. A key decision in our journey was to focus on research areas overlapping between urology and nephrology to access additional funding sources. This multidisciplinary approach also provided an expanded foundation for building research collaborations, obtaining mentorship, and other benefits. Finally, consult others to develop a realistic understanding of the technical difficulty, time requirements, costs, and potential pitfalls involved in your research plan.

**Conducting Research.** The anticipation of results in the scientific process is exhilarating, but it is even more frustrating when technical problems are encountered and precious resources are wasted. Accordingly, significant emphasis should be placed on planning experiments. Do not hesitate to consult others as most laboratories are more than willing to share detailed protocols and even provide demonstrations. It is often beneficial to utilize institutional research cores for techniques that require considerable expertise or expensive equipment. Experiments should be designed to not only definitively test a hypothesis, but also reveal the next directions to pursue irrespective of outcome. Research strategies have evolved over time, but we prefer to focus on the study of in vivo animal models and clinical samples. In vitro models can provide additional information, but their use should be well-justified as they invite reviewer criticism. Finally, accurate record keeping is essential and the use of online electronic laboratory notebooks streamlines this process.

**Publishing and Funding Research.** ‘Publish or perish’ is an often-repeated axiom since publications are the lifeline for institutional support and extramural funding. The ability to market your research is a critical and often overlooked skill for differentiating yourself in the scientific world and the AUA offers excellent workshops on preparing manuscripts and grants. Start publications by building a clinical and scientific context that generates enthusiasm, then present results in a stepwise manner that emphasizes your well-reasoned approach, and end with a discussion of future directions that leaves the reader anxiously awaiting the next chapter. The same principles apply to grants but a key point here is an effective utilization of
cutting edge techniques that brings your proposal to the forefront of research. Since reviewers are busy and have diverse backgrounds, it is essential to write a grant that is easy-to-read and appeals to both experts on your topic and a broader audience. Commit to completing your grant early and obtaining reviews from colleagues so potential criticisms can be addressed. Finally, embrace rejection as part of the process and an opportunity to improve your next grant submission.

Managing the Laboratory. The basic science laboratory is essentially a small business and its most valuable asset is unquestionably the research personnel. The hiring decision is associated with many risks which can be dramatically lessened by placing considerable emphasis on recommendations from respected colleagues. We have also benefited from developing roles for clinical fellows since research is a significant training opportunity and they can provide surgical skills, access to clinical resources, and other benefits. It is optimal to establish a set of ‘best practices’ for the laboratory at its inception since these are difficult to change thereafter. Scheduling a weekly lab meeting with data presentations is important for maintaining progress while regular ‘journal club’ meetings stimulate the growth of research personnel. Since research and clinical responsibilities are exceedingly difficult to balance, it is ideal to employ an experienced scientist as the director of research operations, a primary contact for administrative issues, a budget manager, and other key roles needing daily attention.

Building a Research Portfolio. As your research progresses, it is beneficial to develop a strategic plan for sustaining this success and growing as a laboratory. The end-goal should be to establish a unique research niche in which your expertise facilitates new projects and builds credibility for submitting papers and grants. The research in our laboratory is unified by a common theme of improving renal outcomes in obstructive uropathy. Our initial project employed a novel mouse model to demonstrate the requirement for BMP7 in kidney repair following obstruction-induced renal injury. We followed by showing that the HDAC-dependent repression of BMP7 contributes to the dysregulated wound healing response and renal fibrosis observed in chronic obstruction. Over the course of these studies, our experiments revealed several other promising targets for developing anti-fibrotic therapies and biomarkers that we evaluated in subsequent projects. We are currently extending this research to models of congenital urinary obstruction and exploring injury responses in the developing kidney. It is often stated that ‘good research raises more questions than it answers’. While this is certainly true, success in research can also be a double-edged sword since focus and careful selection of projects are crucial skills for maintaining a high-level of research productivity.

Basic science research is full of challenges, but they are easily outweighed by its rewards. While we have presented only one perspective, most who have gone down this path would likely agree that building relationships with mentors who can advise you on these and other areas is the key element to successfully navigating this journey and building a research career. An increased involvement of clinicians in basic science research is an important endeavor since it will create training opportunities, establish pediatric urology as a viable career option for Ph.D.-trained scientists, and accelerate advances in patient care.

AAP Advocacy: New NIH policy will require crucial age-based pediatric research data

When the NIH recently strengthened its policy on including children in research, the AAP finally saw the fruits of decades of advocacy. The new NIH policy takes effect in 2019 and for the first time requires researchers to report the ages of participants in clinical research studies funded by the agency.

Age-based data are crucial to pediatric research, said Clifford Bogue, M.D., FAAP, chair of the AAP Committee on Pediatric Research (COPR). “It will allow us to really have specific data to know how many research dollars are actually going to pediatric research… And we’ll have clear data that show how many children are being included, what studies are including children. …It may allow people to aggregate data across multiple studies. This has been the effort of many people over many years … to just be persistent and not give up, and I think it’s a great testament to the work of the AAP in advocating for children.”
Technological innovations are an ongoing reality in clinical medicine, most dramatically in the operating room. Each advance is often heralded as an improvement in patient care, promising to correct deficiencies and advance standard operative procedures. Unfortunately, these new technologies often lack sufficient evidence to support such claims.

Robotic assisted laparoscopic (RAL) surgery continues to gain popularity among pediatric surgical specialists, particularly for reconstructive procedures such as correction of ureteropelvic junction (UPJ) obstruction or vesicoureteral reflux (VUR). In these operations, where traditional open surgery yields a nearly 95% clinical success rate, it is difficult to demonstrate improvement with a new surgical technique. Despite these impressive outcomes with the open approach many pediatric urologists are shifting towards newer RAL approaches, claiming faster recovery and improved cosmesis with a nominal increase in surgical cost. To date, no randomized controlled trials exist in the pediatric population comparing robotic to open surgery. However, this is not unusual. There is a striking dearth of comparative effectiveness research in pediatric surgical specialties, especially given the wide range of available therapies for a variety of surgical problems. Conducting randomized controlled trials of surgical interventions can be very difficult, especially in the pediatric population. One barrier frequently encountered is difficulty recruiting patients and families to participate in randomized controlled trials (RCTs) that involve surgical procedures. Patients and their families often reject RCTs, because they do not wish treatment to be decided by chance, the family is concerned that the doctor-patient relationship may be affected by participation, or the parent may have feelings of personal responsibility if the treatments are unequal. In order to use RCTs to determine treatment superiority, appropriate and meaningful outcomes must first be identified and measured.

Currently, most studies in pediatric robotic surgery have focused on traditional outcomes, e.g., length of stay, pain scores, pain medication usage, scar perception, cost analysis, and capital gains benefits. While these measures are important to study, we believe that researchers must also focus on patients’ treatment experiences or patients’ evaluations of their own outcomes. By focusing on these patient-centered outcomes, we will be able to improve outcomes from surgical procedures in ways that are most important to patients and their families. The field of urology has a tradition of patient engagement in surgical outcomes, but in general, patient and family input into outcomes measured in surgical clinical trials has been sparse.

We are currently undertaking a pilot randomized controlled trial comparing robotic and open techniques for surgical correction of congenital UPJ obstruction (pyeloplasty) in pediatric patients. This study will demonstrate the feasibility of recruiting pediatric patients to participate in a randomized study for surgical procedures and delineate patient-centered outcomes to measure in larger multi-centered trials to follow. We are uniquely poised to conduct this type of qualitative research given our institution’s Patient Engagement Core (PEC). The PEC is an interdisciplinary group of pediatric research specialists with patient engagement experience, visual communications experts, and panels of parents and their children. One focus of the PEC is to help develop and implement protocols involving pediatric research subjects so that we can more easily disseminate research findings to target populations.

We conducted four patient advisory board sessions with a combined 28 participants. We have determined the dominant factors considered by families when deciding between RAL or open pyeloplasty, identified the specific domains of QOL affecting these children, and identified

Continued on Page 9
barriers to randomization and blinding.

In the first session, we found that patients and their families struggled with the idea that two surgeries could be completely interchangeable. From that first session, we learned to specifically frame the discussion not as two different operations, but as two approaches to the same operation. Results from our second session demonstrated that very few families or patients remember or think about the specific type of operation the surgeon used.

Using the knowledge gained from these first two sessions, we then developed two educational videos that would introduce parents of children with UPJ obstruction to the idea that were two approaches to the operation their child would have and what the differences and similarities were in these two approaches. The first video explained the procedure using more general terms, and the second went into detail about each approach.

We then held a third session where parents of 2-8 year old patients with no history of surgery watched the two videos and discussed what their choice would be, and if the videos altered that choice. We learned from that session that with both of these videos the idea that two approaches could be interchangeable was now fairly easy to grasp, but there was still considerable resistance to the idea of randomization and blind studies. In the fourth session, we learned that most of our core concepts were effective at communicating the essential facts to the audience, but found that some language missed the mark and needed to be altered (e.g. “flipping a coin” for randomization). We used these lessons to create a final video using an “Impartial Physician” that we now use as a recruitment tool for our pilot study.

To date, 6 patients have met inclusion criteria and were approached, and 4 have participated in our blinded, randomized controlled trial. Interestingly, of the 2 patients who elected to not enroll in the study, one had a brother who had undergone a robotic surgery and the other was briefly counseled that she should undergo robotic surgery. This further supports the idea that the initial physician interaction and suggestions are the most important in the patient and family decision making process.

Should this study prove randomization is feasible, we will seek funding to conduct a large, multicenter, randomized comparative effectiveness trial with sufficient power to determine if either open or robotic-assisted pyeloplasty is superior (or equivalent) using both traditional clinical outcomes and patient-centered outcomes. Furthermore, we have found that the stepwise, systematic approach to engaging patients in clinical research is essential to overcome the many unique barriers we face when seeking to perform high quality pediatric surgical comparative effectiveness trials.

References:


Subspecialization in medicine and technologies continue to evolve, resulting in an increase in physicians’ interdependence on one another. It is impossible currently to be up to date on all aspects of medicine and surgery. This is not a new problem. In fact, Dr. William J. Mayo noted in a commencement speech he gave at Rush College in 1910, “As we grow in learning, we more justly appreciate our dependence upon each other. The sum-total of medical knowledge is now so great and wide spreading that it would be futile for one man to attempt to acquire, or for one man to assume that he has, even a good working knowledge of any large part of the whole. The very necessities of the case are driving practitioners into cooperation. The best interest of the patient is the only interest to be considered, and in order that the sick may benefit of advancing knowledge, union of forces is necessary.”

While this quotation demonstrates that the importance of collaboration among physicians is not new, many new challenges in the professional environment have emerged complicating our professional life. These distractions include productivity requirements, decreased reimbursements, increased bureaucracy, and the electronic medical record. The increasing commercialization of medicine has created many struggles that can cause physicians to become less engaged, cynical or even demoralized. At times, physicians can feel alone in the pursuit of excellence, at times victimized by the system. The breakdown of morale of the medical staff has many ramifications, including the widely publicized epidemic of burnout. These feelings can create a negative work environment with mounting territorialism and excessive competitive feelings.

At Baylor College of Medicine, a small hedge against this epidemic is the Power of Professionalism Award (POP Award). The POP Award can be given to anyone who demonstrates the finest qualities of professionalism. The award was created to show appreciation of positive professional behavior, such as compassion, integrity, honesty and humility, inspire peers to emulate these behaviors and demonstrate an institutional culture that values these positive behaviors. A recent nomination came in that was thought provoking. It was submitted by a medical student who wanted to honor a urologist she had observed respond with kindness when a gynecologist called from the OR to ask for help managing an intraoperative complication. The medical student was impressed that the urologist immediately agreed to come in without judgement, without any smack talking or eye rolling. For me, the significance of this nomination wasn’t that a urologist responded to a colleague in need with generosity of spirit, but that this generosity appeared highly unusual to the medical student. Apparently, the medical student had seen repeated incivilities among a variety of specialists during her rotations. So have I.

Incivilities in the health care system flow in many directions, between primary care physicians and specialists, between surgeons and internal medicine physicians, between emergency room physicians and inpatient consultants. Poor behavior can manifest in many ways such as becoming impatient, easily annoyed, argumentative or dismissive. Common courtesy among colleagues has become less common. In fact, surveys in medical schools indicate that a large majority of medical students throughout the country acknowledge that they have witnessed faculty bad mouthing other physicians and other institutions. The impact of witnessing this behavior on medical students is interesting and concerning, but equally or more important is that these conflicts threaten respectful communication and that damages patient safety as well as physicians’ sense of satisfaction in their careers.

Physician-to-physician conflicts impact patient safety by limiting cooperation and communication among care team members. A study by the Institute of Medicine points to poor communication and deficient teamwork as common causes of adverse patient outcomes, even more common than lack of knowledge or clinical skills. Poor communication results in medical and surgical errors as well as poor patient compliance with recommended treatments. Conversely, the benefits of improved teamwork exceed purely patient-centered benefits; it also creates a more satisfying and pleasant work environment for physicians, which, in turn, helps to combat burnout. In other words, improved communication and teamwork is not purely altruistic, you will also personally benefit by working in a more civil and enjoyable setting. Of course, I applaud kindness to patients, however, kindness to colleagues is also very important, yet is infrequently discussed.

Although as physicians we may feel powerless to reverse many of the negative aspects of the march toward the commercialization of medicine, we can personally address...
The Annual AAP Legislative Conference was held in Washington, DC, from April 8 – 10, 2018. Three hundred and fifty general pediatricians, pediatric subspecialists, advanced practice providers, residents, and fellows attended two days of informational sessions and training before taking to Capitol Hill to meet with lawmakers. Along with me, pediatric urology was represented by Dr. Richard Sutherland of North Carolina and Dr. Audrey Rhee of Cleveland.

The first day introduced attendees to the basic “ins and outs” of advocacy, delineating the current issues challenging our nation’s children, prioritizing the AAP’s message to lawmakers on the third day, and providing coaching on how to craft a message, build a coalition, and effect change through advocacy. Current topics include access to primary and subspecialty care (particularly for children with special healthcare needs), the opioid epidemic and its impact on children, advocacy for immigrant children, child nutrition, and global and local social determinants of health. The second day involved a mock “re-election” campaign where attendees learned to juggle the many demands on lawmakers’ time and attention, and an afternoon workshop to practice meeting with elected officials.

On Tuesday, it was off to Capitol Hill! This year, the AAP asked those of us at the Legislative Conference to focus on firearm violence and its public health impact. In the United States, 74 children per day are either killed or injured by a firearm; the AAP is asking legislators to direct $50 million to the Centers for Disease Control in the next fiscal year for research into the public health aspects of firearm safety, as well as to raise the age for firearm purchases to 21 years old and to ban semiautomatic assault weapons. As such, this was our primary message; however, legislators with whom we had more time were also receptive to hearing about challenges specific to pediatric urology, in particular access to subspecialty care, insurance challenges, and proposed legislation in several states to make genital surgery illegal below the age of consent. Nonetheless, staying “on message” with the AAP’s “big asks” enabled us as pediatric urologists to connect with our senators and representatives, underscore our commitment to child safety and public health, and promote the involvement of specialists in advocacy.

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Perhaps the most important “take-home” message from the Legislative Conference was that, among the many pediatric advocacy issues, there is a single common theme: we all want to help children be safe and healthy, regardless of political beliefs and parties. Emphasizing this important concept helped to open the dialogue on gun violence, rather than allowing it to devolve into a fruitless argument. Staying true to this message for other potentially contentious topics, such as genital surgery, will be crucial. As we move forward with other pediatric urology-specific issues, please become involved with advocacy: call and write your senators and representatives, come to the annual AAP Legislative Conference, and help our voices be heard.
The SPU DSD task force was formed after the Fall 2017 meeting in Montreal. The co-chairs are Earl Cheng, Patrick McKenna, and Rick Rink. Members are: Linda Baker, Larry Baskin, Julia Barthold, David Diamond, Tony Herndon, Tom Kolon, Brad Kropp, Lane Palmer, Dix Poppas, and Margarett Shnorhavorian. In addition, the AUA has commissioned a separate DSD Task Force. Members include Julia Barthold, Tony Herndon, Lane Palmer, Earl Cheng, Pat McKenna and Rick Rink.

The present political environment as it relates to the care of individuals with DSD has become quite complicated in the past year. This is in large part due to the recent activities of various advocacy groups. Most notably, InterACT has teamed with the Human Rights Watch Group (HRW) to issue a report that was released in July, 2018. The conclusion of this report was that there should be a moratorium on genital surgery in infants that is not medically necessary. This philosophy has the support of many advocacy groups and has resulted in proposed legislation in several states to outlaw all forms of genital surgery that are not medically necessary in individuals without their assent. This would apply to many different type of surgeries (not necessarily related to DSD), including hypospadias surgery. To date, none of these measures have passed but there is new proposed legislation in California that is currently being reviewed.

The SPU and AUA task forces have engaged in numerous activities since the Fall 2017 meeting to address the HRW report as well as coordinate our activities with other organizations to ensure that there is a cohesive effort to preserve genital surgery as an option for infants with DSD and related conditions. The following is a brief summary of some of these activities. There will also be an update at the Spring 2018 meeting on Friday, May 18, 2018 in San Francisco, California. We strongly encourage all of you to attend since this is a vital issue for our specialty.

1. SPU Response to HRW: After several months of revisions and review by outside organizations, the SPU released a response to HRW and InterACT. It is available on the SPU website. It has been endorsed by the SPU, AACU, AAPU, PES, SAU, and NASPAG. Many thanks to Pat McKenna who has been instrumental in getting this response written along with the endorsement of the other medical societies.

2. AMA: A proposal from the medical student organization to the House of Delegates of the AMA was brought forth for consideration last year. The proposal called for a resolution that the “AMA affirm that medically unnecessary surgeries in individuals born with differences of sex development are unethical and should be avoided until the patient can actively participate in decision-making”. The AMA delegated this proposal to the Council of Ethics and Judicial Affairs (CEJA). The members of the SPU / AUA task Force have worked very closely with the AUA and AACU to ensure that our voice is heard in the consideration of this proposal. The proposal has 2 parts: 1) a preamble that states the need for consideration to change policy and 2) recommendations for specific changes to the code of ethics. The initial proposal had a preamble that was a bit biased in its content that was more in line with the need to consider eliminating surgery in infants with intersex/DSD. However, the actual recommended changes to the code of ethics were not restrictive and preserved parental rights. At the AMA Delegates meeting this past year, testimony and input was heard from various groups including the AIJA, AACU and HRW. Following this, the AMA decided to delay a vote on this proposal until June 2018. This was done in part to better flush out the areas of disagreement and allow the medical student organization (that brought forth the original proposal) to have conversations with other medical societies and organizations to better understand their position on this. These conversations have taken place and there is consensus from numerous organizations (SPU, AUA, AACU, NASPAG, ACOG, PES and others) that surgery should still be an option for infants with DSD and that parental rights in these situations should be preserved. Despite this consensus and detailed discussion of the literature with the medical student organization, they still maintain their original stance and will move forward with their proposal. Their position is also supported by GLMA (Health Professionals Advancing LGBT Equality). A written response from the combined societies (led by the AUA, SPU, and AACU) to the proposal has been submitted to the CEJA. In the coming weeks, CEJA will determine whether the proposal should be modified and whether it should be put forth for a vote by the AMA delegates in June of this year. If so, members of
Health Policy Corner Update from the SPU Task Force . . . Continued from Page 14

the AUA, including those on the DSD task force will likely be asked to testify before the delegates. Many thanks to all the members of the AUA DSD task force who have spent countless hours on this proposal over the past 3 months in review of written documents, conference calls with leadership from other medical organizations, and coordination of the combined written response to CEJA / AMA from these organizations.

3. AAP: The AAP issued a formal statement in response to the HRW report. In addition, the AAP has convened a preliminary task force to develop a policy statement in the next 1 - 2 years regarding the role of surgery in infants with DSD. David Joseph has asked Earl Cheng to initially represent us in these efforts. More to come in the next 2 months once a timeline and more detailed plan is developed.

4. Informed Consent Video: Rick Rink and Tony Herndon are working with the CARES foundation to develop an informed consent for feminizing genitoplasty. This will be very important for all of us. Funding may need to come in part from contributions from DSD centers and/or the SPU.

Socioeconomic/Coding Corner


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In this inaugural issue of the Socioeconomic/Coding Corner, we hope to demystify Current Procedural Terminology (CPT) codes. Selection of an appropriate CPT code can, at times, be a challenge. One might also find themselves wondering how a particular code came about, how a relative value unit (RVU)/reimbursement was determined for that code, why/how reimbursement for a particular code changes over time, and what the role of a Relative Value Update Committee (RUC) survey is in this regard? To better understand these issues, this article will focus on the history of CPT coding, how new CPT codes are developed, and how RVUs are determined.

The basis for all physician reimbursement is the CPT code. CPT codes are the most widely accepted medical nomenclature used to report medical procedures and services within public and private health insurance programs, and they are used in claims processing and in the payment of medical claims. CPT codes can be found in the CPT Manual, a copyrighted publication published and maintained by the American Medical Association (AMA). The first edition of the CPT Manual was published in 1966 to encourage the use of standard terminology to document and report procedures and services provided by physicians. In 1983, CPT was adopted by the Centers for Medicare and Medicaid Services (CMS), and has subsequently been adopted nationwide by both government and commercial insurers.

There are defined steps, called the CPT process, for requesting a CPT code through the AMA (see flowchart). The first step is to submit a request for review to the AUA Coding and Reimbursement Committee (CRC). The request may be submitted by committee members, individual urologists, or industry representatives and is considered based on AMA criteria.

The AUA CRC is comprised of volunteer urologists from diverse practice settings representing expertise in various urologic subspecialties, including pediatric urology (Jeffrey B. Campbell, MD and Edwin A. Smith, MD). The mission of the AUA CRC is to serve as urology's representative in the area of coding, terminology development, and reimbursement. They seek new and updated codes to ensure accurate identification of urologic conditions. Continued on Page 16
Socioeconomic/Coding Corner . . . Continued from Page 15

and procedures. The CRC will occasionally issue coding guidance on urologic procedures, if requested. This guidance may result in determining the necessity for a new or revised CPT code to report the procedure/treatment/device in medical claims to third party insurers. Healthcare Common Procedure Coding System (HCPCS) for supplies, products, and services that may be submitted to public and private insurers may also be reviewed.

Selected committee members represent the AUA before the AMA CPT Editorial Panel to request new and revised CPT codes to ensure accurate identification of services and procedures in the treatment of urologic conditions. The CPT Editorial Panel meets three times a year to review requests received from specialty societies, manufacturers, and individuals. The panel is supported in its deliberations by a larger body of CPT advisors known as the CPT Advisory Committee.

If the AUA CRC approves a request for a new or revised CPT code, AUA staff or industry representatives then submit a Code Change Proposal (CCP) to the AMA, where it is posted for comment and review by the CPT Advisory Committee. The request is then slated for the agenda of the next AMA CPT Editorial Panel meeting, where the CCP is either approved or rejected.

Once a CCP is accepted by the CPT Editorial Panel, the next step in the CPT process is to determine the reimbursement for the code through a survey of physician work and determination of direct practice expense (PE), which is referred to as the Relative Value Update Committee (RUC) process. This process is an important step in both establishing or revising a CPT code, and in the periodic reevaluation (valuation) of established CPT codes.

The RUC is a joint AMA/Specialty Society decision-making body which reviews all survey recommendations of physician work values. The volunteer members of the RUC are supported by staff and advisors from over 100 national medical specialty societies and health care professional organizations, representing the entire medical profession.

Surveys are performed and the results are submitted to the RUC for negotiation for a mutually acceptable value. These surveys provide the basis for the reimbursement rate determination. The AUA, like other specialties, conducts surveys for the RUC of its membership to obtain physician work and PE inputs on specific codes that are pertinent to procedures and services performed by our members.

Completion of surveys is essential! Survey results received from physicians who are familiar with the service or procedure in question provide the foundation for accurate valuation of the code, and the subsequent reimbursement assigned to that code. Without this input, the appropriate level of work, skill and mental effort needed to perform the procedure cannot be properly assessed. Only experienced physicians can supply this critical information. Thus, when you receive an email from the AUA requesting your participation in a RUC survey, it is critical that you respond. Your answers are crucial in determining proper reimbursement for urology codes.

After a rigorous review of survey results and a voting process, the RUC determines an RVU for a procedure based on comparisons of other valued CPT codes and submits their recommendations to the CMS for reimbursement consideration. Once CMS approves a RVU, it is then published in the Federal Register Final Rule. The approved CPT code and its associated RVU are also published in current coding manuals for use by physicians and their coding staff.

Clearly, the process to approve and/or revise a CPT code and its associated RVUs is a complicated one. However, it is important to note that the process begins at the individual physician level and also depends upon physician interaction to determine the correct application of a CPT code and its assigned RVU. Thus, physician engagement and participation are critical in the CPT and RVU process.

If you have questions regarding the CPT process or the RUC process, or would like to submit a request for review to the AUA CRC, please contact Susan Crews, CPC, AUA’s Reimbursement Policy Manager at susancrews@auanet.org or Stephanie Stinchcomb, CPC, AUA’s Director of Reimbursement and Regulation at sstinch@auanet.org.

We would like to thank Susan Crews, CPC for her assistance in drafting this article.

Health care transition resources for youth and families

Got Transition provides information and resources for youth and families to assist with the transition from pediatric to adult health care. These resources include questions families should ask health care providers, sample medical summaries and emergency care plans, a transition readiness checklist, information on guardianship and decision-making, and more. Visit www.gottransition.org.
Understanding the Path to Medicare Payment

Medicare payments are often used as the basis for private insurers. Learn how payments are determined and how your input can make a difference.

**Payment for New Codes**
The AUA Coding and Reimbursement Committee evaluates code proposals based on medical need and utilization from committee members, individual urologists and industry. If approved, a Code Change Proposal is submitted to and reviewed by AMA CPT Editorial Panel with comments from the CPT Advisory Committee.

CPT Editorial Panel accepts or rejects the code and sends to Relative Value Scale Update Committee (RUC) to determine valuation.

**Payment for Existing Codes**
The Centers for Medicare & Medicaid Services (CMS) and the RUC identify misvalued codes using screens such as fastest growth, Harvard codes, and high expenditure.

RUC SURVEYS: YOUR INPUT MATTERS!
Be accurate and honest and consider documentation, practice expense, and physician work intensity.

At least 30 completed surveys are required for a new code to be considered; for a current code, completed surveys are based on Medicare utilization.

Values are published in proposed and final Medicare Physician Fee Schedule rules.

RUC recommends reimbursement for codes to CMS.

Proposed reimbursement is submitted to CMS for final approval and implementation.
Effective education of parents is arguably one of the most challenging parts of our work in Pediatric Urology. Parent understanding of diagnoses and treatment strategies can affect compliance, decisional conflict, satisfaction, and ultimately outcomes. Education is especially crucial in the modern era in which we as providers are expected to be less paternalistic and more family-centered. We strive to engage patients and parents in the decision-making process, empowering them to become active participants in their own care. Achieving this goal within the confines of a 15 to 20-minute office visit can prove to be difficult. Supplemental educational information can be useful for parents to digest medical information at their own pace. However, resources for parents that are relevant, unbiased, clear, honest, current and accessible often hard to find.

In an era in which 89% of American adults access the Internet, parents are not using healthcare providers as their sole source of medical information. A 2015 survey of parents whose children were presenting for day surgery showed that 98% use online resources for their children’s health. The clear majority (80%) of respondents used public search engines as their starting point for seeking information, yet only 24% of parents regarded information accessed by public search engines as being “safe” and “accurate.” Studies have shown variable results in the overall quality of online content in the realm of Pediatric Urology. Parents walking into our offices are potentially saddled with misinformation, bias, and mistrust, depending on where their Internet searches have taken them.

HealthyChildren.org, powered by the American Academy of Pediatrics, is a useful resource in our educational armamentarium. The website’s goal is to make evidence-based medicine accessible to parents to promote childhood well-being. Currently, there are over 5,000 articles written by healthcare professionals on various children’s health and safety topics. Each month, the website receives over 4 million page views, and thousands of parents follow on Facebook, Twitter, and Pinterest, to which updated content is promoted daily. With regards to Pediatric Urology, there are currently more than 20 articles dedicated to genital and urinary tract conditions, as well as a separate section with extensive information on toilet training and bedwetting. The AAP Section on Urology Education Committee was recently asked to update content for the site. Articles created by Pediatric Urologists were compiled on topics like ureteropelvic junction obstruction, vesicoureteral reflux, post-circumcision care, voiding dysfunction, recurrent urinary tract infections, and genitourinary reconstruction. This content is currently being edited for upcoming publication on the site.

Articles on the website can be printed and emailed with one click and are available as a toggle between English and Spanish. They are also available as audio files in either language. These materials can reinforce in-office conversations, allow parents to discuss conditions and treatments with family members and friends, act as a hard copy to refer to when making decisions, and give to others with similar issues. We know that trusted information created by our peers will be formatted in a way that is accessible and easy-to-understand for parents of different backgrounds and education levels.

As AAP Section on Urology members, consider use of this free resource in your practice to provide better care. The Education Committee is planning on submitting further articles soon, so if there is a topic that you want to be addressed or content you are interested in submitting to HealthyChildren.org, notify us through Kathy Ozmeral at kozmeral@aap.org. Continued on Page 19
Update from the Education Committee . . . Continued from Page 18

References:


As we have moved through each aspect of our training, we have put an inordinate amount of trust on the matching system algorithm when entering residency and fellowship. At the time, the matching process was incredibly stressful, but in hindsight it was much less anxiety provoking when compared to finding a staff position. We knew at the outset that residency and fellowship would only be for a relatively short period of time. And many of us did not have family relationships or dependents that would be impacted by our decision to move anywhere within the country. A few years ago, when Jason and I started our job search, we had no idea what our approach should be. Fortunately, Jason and I had become friends during fellowship interviews and soon after the match we started a conversation on how to find a job. We would talk for long periods of time asking many questions, often only being left with more questions. We asked our co-fellows and recent fellowship graduates about their experience. Much of the anecdotal advice we were given varied significantly, and left us even more confused at times. Given these experiences, we decided to design a survey that we would distribute to the current and past five years of graduated fellows.

We emailed a RedCAP based online survey to 153 participants and achieved a 61% response rate. The questions were categorized and asked about: the timeline for starting the job search; details on the job search; negotiation and signing the contract; and overall impression and satisfaction with the job search and a career in pediatric urology. The largest group of applicants (44%) started their job search around the time of the spring American Urological Association (AUA) meeting, 14 months prior to graduation. This seems reasonable as this affords the applicant the most amount of time to find a job. Also, programs are more likely to know their hiring needs at the start of the following academic year.

How wide should one cast their net? The survey provided us the information that the mean number of programs that the applicants contacted was 3-4, and the median number of programs visited and offers received was two. This data helps provide expectations to the fellowship programs on how long the fellow will be away from the service. It also helps the applicant to know how to budget time and money (although most financial costs will likely be covered by the interviewing program).

Two questions had consistently sparked varying opinions when we queried our friends and colleagues: (1) what should we negotiate for and (2) do we need to hire an attorney. The survey responses also varied -- less than half (38%) the respondents hired an attorney. The information we gleaned from the survey on whether or not it is beneficial or necessary to hire an attorney was inconclusive. Regarding negotiations, 22% said they negotiated for nothing, while 35% negotiated for salary. Based on prompted responses, it was concluded that the applicant should not be intimidated about negotiation and should pursue discussion in a polite and honest manner.

For the majority (50%), the overall impression of the job market was as expected. Unfortunately, 41% thought that the number of desirable positions were expectedly or surprisingly low. The definition of “desirable” varies significantly from person to person. Additionally, finding the “one” job that meets all your criteria -- in the perfect location, with the best work-life balance, division of research and clinical time, and income -- is almost impossible. The conclusion we drew from these findings is that the applicants need to prioritize these variables to understand what is most important to them as they start interviewing and comparing offers.

The most comforting finding from this survey is that 98% of the respondents stated that they would still choose to specialize in pediatric urology. Although many felt that the perfect job may not have been available, the overall satisfaction of the current and recent fellows is quite high. The information from this survey helped Jason and me to identify and secure our current and future positions. We are hopeful that this information that we have already distributed to the current fellows will make the process of finding a job less stressful, more efficient and ultimately more successful for future fellows.
Announcements from the AAP
Report of Section Activities, Spring 2018

Kathleen Ozmeral
Manager, AAP Section on Urology
Email: kozmeral@aap.org

As an organization of 66,000 members and 450 staff, the American Academy of Pediatrics (AAP) dedicates its efforts and resources to the health, safety and well-being of infants, children, adolescents and young adults. Visit www.aap.org for more information on AAP priorities, www.aap.org/subspecialty, and the AAP site targeted to parents www.healthychildren.org. The AAP President is Dr Colleen Kraft; President-Elect is Dr. Kyle Yasuda; Immediate Past President is Dr Fernando Stein; and CEO is Dr Karen Remley.

Urology Medal
The 2018 Urology Medal will be presented to Dr Robert M. Weiss for his dedication to improving the care of children. The Urology Medal is one of the highest honors conferred upon pediatric urologists. The award is presented by the AAP Section on Urology to individuals who have made outstanding contributions to the field of pediatric urology. Recipients receive a bronze medallion embossed with the Della Robbia – the swaddled baby symbol that dates back to the Middle Ages. The Medal is sponsored by the American Academy of Pediatrics Section on Urology, and will be presented at the Pediatric Urology Fall Congress, Sept 14 – 16, 2018, in Atlanta.

Policy Review
The AAP Section on Urology shapes national policy by reviewing content authored by other AAP Committees and Sections. Recent reviews included:
- Preventing Home Medication Administration Errors
- Surgical Comanagement: Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of All Children
- Progress in Optimizing Resources in Children's Surgical Care
- Criteria for Critical Care Infants and Children: PICU Admission, Discharge and Triage Guidelines and Levels of Care
- Clinical Practice Guideline: Maintenance Intravenous Fluids in Children

Policy Creation
The Section on Urology, the Section on Radiology, and the Section on Nephrology have submitted a request to write an AAP Clinical Report on “Perinatal Urinary Tract Dilation: Practice Implications for the Pediatrician.” Dr. Tony Herndon and Dr. Gina Lockwood are authors.

Collaboration
The AAP Surgical Advisory Panel (SAP) is comprised of a chair/representative from each of the Surgical Sections – anesthesiology, neurosurgery, ophthalmology, otolaryngology, oral health, orthopaedics, plastic surgery, radiology, surgery, and urology. During the SAP meeting, the surgical chairs discussed matters of common interest. Dr David Joseph was the Section representative at the most recent gathering in March.

Dr Chester Koh sponsored a resolution at the AAP Annual Leadership Forum (ALF) - a gathering of leaders from AAP Sections, AAP Committees, and AAP Chapters. The attendees passed his mandate that “the Academy continue to advocate for improvements to existing regulatory approaches as well as the development of new regulatory approaches, pathways and incentives for the timely approval of safe and effective medical devices for children younger than age 18” in preparation for the FDA’s meeting on Pediatric Device Development in August, 2018. - https://www.aap.org/en-us/my-aap/alf/Pages/default.aspx (Member log-in is required).

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Greetings from the AAP SOU Membership Committee!

Jason and I are honored to serve as the Membership co-Chairs for the Section and we thank you for the opportunity.

It is an exciting time to be involved in the Section with the new Societies of Pediatric Urology structure that will move our field forward for years to come. Those of you reading this newsletter are likely SOU members, and we rely on your help to recruit others to become members of the Section. AAP membership ensures that we have a strong advocacy voice in the urologic care of children.
Membership Committee Report  Continued from Page 22

If you or any potential members have any questions about membership, please contact Jason (vanbatavij@email.chop.edu) or Chester (cxkoh@texaschildrens.org) or our Section Manager Kathy Ozmeral (kozmeral@aap.org)

Welcome New Members
Welcome to the following individuals who have joined the AAP Section on Urology from January 2017 – March 2018.

**Candidate Members**
Pankaj Dangle, MD, MCh  Birmingham, AL
Derrick Johnston, MD  Tucson, AZ

**National Affiliate Members**
Jeanna Padilla, CPNP  Wichita Falls, TX

**Post Residency Training Members**
Jennifer Ahn, MD  Seattle, WA
Shuvro De, MD  Brentwood, TN
Adam Howe, MD  Albany, NY
Deborah Jacobson, MD  Chicago, IL
Gina Lockwood, MD  Iowa City, IA
Joseph McQuaid, MD  Cambridge, MA
Adam Rensing, MD  Indianapolis, IN
Kyle Rove, MD  Saint Louis, MO
Bryan Sack, MD  Boston, MA
Amanda Saltzman, MD  Denver, CO
Catherine Seager, MD  Boston, MA
Abby Taylor, MD  Nashville, TN
Anthony Tracey, MD, MPH  Greenville, SC

**Specialty Fellows**
Nicholas Cost, MD FAAP  Aurora, CO
Vesna Ivancic, MD FAAP  Ann Arbor, MI
Benjamin Whittam, MD, MS, FAAP  Indianapolis, IN

Why Join the AAP Section on Urology?

• Membership in the academic group (section) most influential in the development of pediatric urology as a true specialty with a separate CAQ
• Support for the group (AAP) that recognized our development as true specialists long before the AUA, ABU, or anyone else did so

Individual Benefits
• Identification, with a degree of legitimacy, as a specialist in the care of children
• Tangible support for local pediatricians who are the source of most patient referrals
• Opportunity to serve on the Section's Executive Committee and sub-committees
• Opportunity to serve on national AAP committees that draft clinical policy and guidelines
• Access to Section and AAP websites and educational information
• Opportunity to shape and implement child health policy at a local and regional level

Continued on Page 24
• Use of the AAP Division of Health Care Finance & Quality Improvement to adjudicate disputes with third party private and governmental payers

Section Benefits from an Active Membership
• Leverage to help develop (or respond to) AAP policy statements, clinical reports and practice standards
• Opportunity to educate general pediatricians at their National conference and other venues
• Opportunity to participate in children's health advocacy particularly as it relates to pediatric urologic issues
• Potential partnering with the AAP for development of MOC materials
• Pediatric representation on the American Board of Urology via the AAP Section on Urology nominee
• Outlet for publication of pediatric urology information in AAP News, healthychildren.org, and other AAP publications and resources
• Collaboration with other pediatric surgical subspecialists in establishing criteria for referral and for standards of surgical venues for children

Who Can Join? (membership criteria can be found online)
1. AAP Members
   Membership in the section is open to Board Certified Pediatric Urologists, Board Eligible Pediatric Urologists, Fellowship Trainees, and National Affiliates (nurse practitioners and physician assistants)

2. Other Allied Health Providers – Section affiliate members who are physicians, osteopathic physicians, nurses, research scientists, and nephrologists who advance the care of pediatric urology patients but who are not eligible for membership in the Academy.

How To Join?
1. Go to the Member Center of the AAP website and create an AAP login and password.
2. Choose a membership type (see above)
3. Fill out the application. Check the box for “Section on Urology” -- and any other Sections or Councils that interest you.

Questions? Contact Section Manager Kathy Ozmeral at kozmeral@aap.org or 630/626-6668

Notice of a FDA public meeting on Pediatric Medical Device Development

The Food and Drug Administration (FDA) is organizing a public meeting entitled “Pediatric Medical Device Development.” The purpose of the public meeting is to identify strategies to enhance the medical device ecosystem to cultivate development and innovation of devices that serve the unique needs of pediatric populations. (The Federal Food, Drug, and Cosmetic Act (FD&C Act) defines pediatric patients, for medical device purposes, as age 21 years or younger at the time of diagnosis or treatment and specifies categories of pediatric subpopulations) Topics for discussion include ways to improve research infrastructure and research networks to facilitate the conduct of clinical studies of pediatric devices, extrapolation, use of postmarket registries and data to increase pediatric medical device labeling, assistance to medical device manufacturers in developing devices for pediatric populations, and identifying barriers to pediatric device development and incentives to address such barriers. Submit either electronic or written comments on this public meeting by September 14, 2018.

The public meeting will be held on August 13 and August 14, 2018, from 9 a.m. to 5 p.m at the FDA White Oak Campus in Silver Spring, Maryland.

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We welcome contributions to the newsletter on any topic of interest to the pediatric urology community.

Please submit your idea or article to:
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or Jason Van Batavia, MD at vanbatavij@email.chop.edu