How to Succeed in your Pediatrics Clerkship

By Pattie Quigley, MD, MME, FAAP

Maybe you’ve known since third grade that you want to be a pediatrician...maybe you’ve worked at camps for chronically ill children, volunteered in the NICU while you were an undergrad, or maybe you were the president of your Pediatric Interest Group. You’re destined to be a pediatrician...so, how do you put your best foot forward on your pediatrics clerkship?

When considering how to prepare for the pediatric clerkship, there are many, many things I could advise—the best resources to read, how to prepare for the shelf, how to perform a neonatal neurological exam—the list could go on and on. But I won’t dwell on those things, because while they are important, I don’t think they are the most important factors when it comes to doing well on your pediatric clerkship. In general, your attendings and residents will care much more about your involvement and commitment to each individual patient than your performance on the shelf. So, instead, I will talk more about how to do well clinically.

In my personal experience, enthusiasm and interest are critical to a successful performance. There are many ways to express your enthusiasm. The easiest
easiest is to ask questions—but not simple things you could just look up...ask questions that demonstrate you are trying to process and integrate the information before you. Examples might include: “Why are we using ceftriaxone instead of ampicillin in this patient with community acquired pneumonia?” or “What makes you more worried about this patient’s gross motor development than the last patient we saw?” It’s even better if you can demonstrate that you’ve read about the topic in advance.

You can also convey your enthusiasm by volunteering to see more patients. Be careful with this one though—do not take on more than you can handle! A typical inpatient load for many pediatric clerks is 2-4 patients, depending on the time of year and amount of experience the student has had. Make sure you have a strong grasp on providing care to the patients you’re already caring for before you volunteer to take on more responsibility. The same is true in clinic. If someone asks you to go see a patient, never say no, but it may be okay with your preceptor if you work on notes instead of going to see another kiddo with otitis media.

Which brings me to the next point—try to determine expectations early in a new working relationship with an attending. This one can be tricky, but if done well can really help you excel. You might say something like “I’m really excited to be here. I think I want to be a pediatrician. I want to make sure I’m meeting your expectations. How can I get the most out of my two weeks working with you?” Depending on how the conversation goes, you might also ask “Which patients would you like me to see? Or “Will I write notes?” Without being pushy try to determine exactly what your attending expects of you. This conveys that you are an adult learner and you’re looking to grow in your role as a student. This will also set the stage for you to ask for feedback—which you should do regularly.

Asking for feedback seems simple, yet there are some high-yield ways to solicit the feedback you want. Invite feedback when you’re unsure about a physical exam maneuver or if you’re being observed interviewing a patient. Being specific about skills you find difficult will help your attending (or resident) focus their feedback. Speaking from experience, it is much easier for me to provide useful feedback when I know what skills my learners are most concerned with improving.
If you get better quality feedback from your teachers, it will enhance your performance and help you reach your goal of being the best pediatrician you can be.

Having been a clerkship director for several years, this is the advice I have given students for quite some time. Yes, the books and the test are important, but you’ve already heard which resources are the best and by now you’re used to taking tests. The clinical world is different. I can assure you that your clerkship director and attendings really want to watch you develop into an adult learner who is engaged and enthusiastic about coming to work each day. Asking questions, spending time with your patients, and striving to exceed your attendings’ expectations will get you well on your way to shining in your pediatric clerkship.

**If you have a question you’d like to Dr. Quigley to answer next issue, please email:**

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**Mastering the Pediatric Clerkship: Advice from a Fourth Year Medical Student**

By Shrilynn Althea Chu

Hi, I’m a 4th year medical student at Ross University School of Medicine. Since I recently finished my pediatric clerkship as well as several 4th year pediatric electives, I wanted to provide some information for students interested in pediatrics. If your medical school is anything like mine, you might have had a short orientation to clerkships, often with a mixture of lectures, skills labs, or even an outpatient experience. This orientation or “mini-rotation” was supposed to be like the wading pool before diving in. However, aside from this small transition from basic sciences, the preparation for individual clerkships was not really provided and we were encouraged to seek out our own resources. So how exactly should medical students prepare for a pediatrics clerkship?

Below I’ve provided some general advice that applies to all students; however, since I come from an international medical school, I’ve also provided some advice about how IMGs can excel in their clerkship.

**What study materials should I use?**

There are numerous study materials available, but the same rule of thumb applies to pediatrics as well as to other clerkships. **Pick just one or two resources to study well - do not try to study them all.** The specific study resource you choose does not matter. While the presentation of that material may be different depending on resource, the content is mostly the same. Choose the resource...
that best fits your learning style, whether it is pictographic, text, or a combination of both. The simplest way, is to search which resources your peers are using, ask why they prefer those resources and then proceed to find out which best fits your personal learning style. Then, stick to that resource. If you try to study multiple books at once, you’ll probably get overwhelmed. My personal choice for studying for the pediatric clerkship involved a question bank like Uworld and the Case Files series published by McGraw-Hill Medical.

How can I stand out?
This is a question that is posed by all medical students, IMG or not. However, my experience as an IMG student has been that it is drilled into our heads that we must stand out because we are at a “disadvantage.” So, how do you stand out? I think the best way to stand out, is to show up. Often this means, showing up early – try not to be late. If you show up early and work hard, you will stand out. I found that amongst my peers it was easy to get caught up in trying to out-do one another, when the real focus should be on trying to improve your skills and your knowledge base. From my interactions with residents and program directors at clerkship sites, the most important thing is self-improvement. They want to know that you are interested, and that at the end of the clerkship you have gained some new knowledge. Therefore, speak up, ask questions, and do not be afraid to be wrong. If you are wrong, own up to it and acknowledge that you do not know the answer; the attendings do not expect you to know everything. When you get asked a question and do not know the answer, go home and look it up. Then, the next time you are asked, you will know the answer and stand out.

How to get the most out of the clerkship?
To get the most out of the clerkship, it’s important to reflect. We are all tired when we get home from a long day at the clinic or the hospital, but it is important to decompress and reflect. While you wait for your food to warm, why not take time to jot down some of the interesting cases you saw, or new terms you learned, or questions you need to look up. By reflecting, you give yourself the opportunity to see the deficits in your knowledge base and by writing things down you allow yourself the time to look up the answers. The next best thing is to ask the residents questions. If there is any downtime during the day, ask the resident to teach you something. If you were confused about a procedure or were confused about why the patient is on a certain medication, first look it up, and then ask. Again, you are not expected to know everything, but you are expected to be actively learning and interested. Often residents or attendings will ask if you have any questions. If you’ve taken the time to reflect on your experiences, you’ll find it easier to ask relevant questions, which will show your interest. Lastly, correlate the cases you see in rotation to things you have learned in basic sciences or through your study materials. By connecting examples from your experience, you solidify that knowledge in your mind.

What if I can only schedule outpatient pediatric electives?
As an IMG student looking for...
pediatric electives, I found that scheduling inpatient pediatric electives was challenging. My school did not schedule pediatric electives, which meant I had to reach out to hospitals on my own. Most pediatric electives I was offered were outpatient, at a general pediatric office or if I was lucky, at an outpatient pediatric subspecialty office. My advice for others with similar scheduling conflicts is this: do the best you can with any rotation. For example, since I knew that scheduling in-patient pediatrics would be difficult, I took the opportunity to visit the neonatal ICU and new born nursery during my OBGYN rotation. During my outpatient pediatric electives, I would ask the attending if I could accompany him to the hospital to round on his admitted patients. As a student, a sub internship in pediatrics that allows you to see admitted patients in the hospital, in the pediatric ICU, or the pediatric emergency room would be ideal; however, lack of in-patient exposure is not the end of the world. Do the best you can with each rotation and take from each experience any skill that you think will help you be a better pediatric resident and physician.

From one student to another, I hope these tips provide a good start for you to mastering the pediatric clerkship. And whatever you do, remember to read, reflect, and refine your skills! But, most importantly, have fun!

What to Expect on your Pediatric Clerkship: A close up look at UVM College of Medicine’s Pediatric Clerkship Program

By Denise Powell

Settled in 1783 on the eastern shore of Lake Champlain, Burlington, Vermont is known for more than Senator Bernie Sanders, Maple Syrup, and its Green Mountains; the city also has a thriving Department of Pediatrics at the University of Vermont (UVM) College of Medicine with an integrated Pediatrics Clerkship Program for medical students in their Clerkship Year.

In one’s medical education at UVM College of Medicine, the Pediatric Clerkship Program is an immersive experience in clinical medicine that is discipline specific. The program’s purpose is to assist medical students in reaching a standard of universal competencies both within the College of Medicine and the world of Pediatrics. Dr. William Raszka, Jr., M.D. has been Pediatric Clerkship Director at UVM College of Medicine since 1996 and gave an in-depth look into the world of Pediatrics at his institution.

UVM’s Pediatrics Clerkship consists of a 7-week program that can be done at one of three medical institution sites in addition to the main campus of UVM – St. Mary’s Hospital in West Palm Beach, Florida, Eastern Maine Medical Center in Bangor, Maine, or Norwalk Hospital in Norwalk, Connecticut.
When it comes down to inpatient versus outpatient experience, medical students spend approximately 3.5 weeks in each setting. This means an equally allotted time for the student to be immersed in acute hospital care and primary care pediatrics.

While on the inpatient service, students take complete admission histories and physicals and perform interval histories and examinations on the hospitalized patients they follow. The inpatient rotation usually requires the medical student to be at the hospital from 6:30 am to 4:30 pm. Students also rotate through a night service, where they are in the hospital from 4:00 pm until midnight, with the purpose of allowing students to see slightly different types of patients. The students are active participants in the management of the patients. On the outpatient portion of the rotation, students spend ten days doing primary care. There they may see health care supervision visits, children with acute minor illness, and children with special health needs. Again, the students are responsible for taking complaint specific histories and physicals and developing a differential diagnoses and management plan. Depending on the practice, students may attend deliveries and make rounds in the newborn nursery. Finally, students rotate through a variety of clinics and services (e.g. cardiology, pulmonary medicine, newborn services). This allows the student to see a variety of practices and patients. On the outpatient service, students generally begin the day at 8 am or 8:30 am and finish by 5 pm. While all students have to rotate through newborn services, the Pediatric Clerkship Program does its best to give students their requested subspecialty rotations (e.g. cardiology, pulmonary medicine). Regardless of the placement or hours, at the end of the day, the medical student will be part of one team with a common goal — assuring the well-being of the patient while honing the clinical skills of the medical students!

For a medical student on a Pediatrics Clerkship at UVM, what does pre-rounding and rounding include?
While pre-rounding a medical student will perform histories and physicals on their own patients each morning prior to formal team rounds. The goal is to establish how the patient is doing at that time, to assess any overnight issues or changes in the patient’s condition, and review new laboratory information. Having great communication and teamwork skills is a huge asset, as the medical students will be working closely with residents and all members of the health care team. As far as rounding is concerned, the important concept is that there is an exchange of information among a team; this is when the plans for the days are organized and coordinated. The overall structure of the inpatient rounds while on the Pediatrics Clerkship at UVM is “family-centered rounds” approach— a core group of people meeting and taking care of a pediatric patient with the patient and family present and actively involved in the management. This team must be able to get across vital information to the family in laymen’s terms and directly address the families concerns.

When asked what one of the most important themes of this Pediatrics Clerkship is, Dr. Raszka replied with, “realizing that conducting a history in a 62-year-old is vastly different from that of a 2-year-old.” It seems like an obvious difference, but the physiological, anatomical, cognitive, social, and emotional differences between children, adolescents, and adults all impact the presentations and treatments of different diseases. The Pediatrics Clerkship Program at UVM teaches medical students to be aware of the context in which these differences affect their roles as future Pediatricians and healthcare professionals. Most importantly, Dr. Raszka emphasized the crucial need for medical students to use every patient interaction as a learning experience.

For a medical student, Dr. Raszka’s advice is that the best way to prepare for the SHELF exam is “to see patients! Read about the cases you’re seeing, so that you have a rich mental network.” While on the clerkship, students need to think about universal issues and not get lost in details of rare diseases. Using Menkes Disease as an example, Dr. Raszka emphasized how important it is to look for the common threads, regardless of the underlying medical condition. Menkes Disease is a state in which altered copper levels in the body cause a multitude of symptoms – kinky hair, failure to thrive, deterioration of the nervous system, hypotonia, seizures, intellectual disabilities, and vomiting. In a patient with Menkes who presents with vomiting, the key issue for a medical student is, “why is the patient vomiting? What are the characteristics of the emesis that suggests why the patient may be vomiting?” Students do not need to know everything about Menkes Disease but should have an approach to any child who presents with emesis. It is easy to get lost in the details of copper metabolism but first, one must have a differential of emesis. For a medical student interested in a career in Pediatrics, the ability to properly diagnose a patient should be just as important as that patient’s access to healthcare. Vermont fully embraced the federal Medicaid expansion. There was a 17% reduction in the state’s uninsured rate from 2013 to 2014, and the rural poor have, by many standards, great access to primary care. However, subspecialists do tend to be concentrated in Burlington, Vermont, so these patients may have to travel to see them. The public health department, Department of Pediatrics and Family Medicine, and the Medical Center, which is now part of an Accountable Care Organization (ACO), are all committed to providing high quality care to all residents of Vermont and upstate New York. The Department of Pediatrics emphasizes patient advocacy and problems faced by children and families of rural or urban Vermont is combatted with great training, competence, and prowess.
The UVM College of Medicine’s Pediatric Clerkship Program in Burlington, Vermont is enhanced by the medical center’s role as a tertiary referral hospital, Level I Trauma Center, and teaching hospital. The city of Burlington puts a huge emphasis on “going green,” especial “green driving,” and in 2008, the United States Center for Disease Control and Prevention reported that 92 percent of the Burlington population was in good health. The city ultimately ranks the best in exercise and lowest in obesity, diabetes, and other measures of ill health. As far as children’s health is concerned, in 2009, Children’s Health Magazine rated Burlington as the absolute best city to raise a family in the country. Fast food options and Wal-Marts are far and few between with most of the city’s residents owning a bicycle or using walking and running as a means of transportation and exercise. The UVM College of Medicine Pediatric Clerkship Program is situated in the epitome of a beautiful landscape with the perfect culture for health living habits and is as good as it gets for a medical student looking for a medical institution dedicated to bettering the standard of living for our youngest Americans.

Denise Powell is a second year medical student at the University of Mississippi Medical Center.

**Subspecialty Spotlight**

The Many Faces of a Pediatric Infectious Disease Specialist

By Rana F. Hamdy, MD, MPH

Throughout the course of my fellowship training in pediatric infectious diseases, I have been struck by the diversity of careers among the peds ID-trained physicians with whom I have crossed paths. From academic medicine to public health to industry, there are many career choices of a peds ID specialist. Here are some examples:

**Academic Medicine**

Because my fellowship training is at a university-based hospital, most of the peds ID physicians I have worked with throughout my training are in academic medicine – these are the physician-scientists who “do it all” – take care of patients in the inpatient and/or outpatient setting, teach students and trainees, and conduct research. This rewarding mixture can also include administrative roles in infection prevention and control and antimicrobial stewardship. Some specialists within this path may only practice clinical medicine, some may only conduct research, and others do a mixture with various distributions.

Basic science research

Within ID-related basic science research opportunities are a broad spectrum of fields including vaccine development, immunology of host defenses, analysis of virulence mechanisms of invasive bacterial pathogens, and mechanisms of antibiotic resistance, to name a few. Dr. Deborah Persaud leads a team of pediatric HIV researchers in her laboratory in order to better understand the mechanisms of HIV persistence in reservoirs in children, and the ability of HIV to mutate and to develop resistance to drugs. Her research on clearing and preventing establishment of viral reservoirs has brought us closer to a cure for children infected with HIV.
Clinical research
Some are clinical researchers that focus on the clinical epidemiology, treatment, and outcomes of children with infections. Dr. Brian Fisher specializes in the care of immunocompromised children with cancer who are at increased risk of severe invasive infections. By studying the optimal prevention and treatment regimens in this high-risk population, his work provides the data we need to improve our management of their infections and ultimately reduce the morbidity from infections in these children.

Public Service
Others focus on the health of populations in their work with public health agencies.

Department of Health
Dr. Nicole Alexander-Scott is Director of the Rhode Island Department of Health. She was drawn to the field of infectious diseases (ID) during her med/peds residency because the holistic perspective essential in the field of ID fit well with her background in human development and family studies. During her ID fellowship she cared for a newborn infected with HIV whose mother was not known to be HIV positive until after delivery. Caring for this baby inspired Dr. Alexander-Scott to lead an effort to implement routine screening of pregnant women throughout the state, and this effort ultimately changed the state law so that pregnant women are now tested on an opt-out basis. Since that time, the incidence of perinatal transmission of HIV has decreased in Rhode Island.

Center for Disease Control and Prevention (CDC)
The CDC works to protect the United States from health, safety and security threats, both domestic and foreign. Following completion of her pediatric infectious diseases fellowship, Dr. Annabelle de St. Maurice joined the Epidemic Intelligence Service (EIS) of the CDC. She is working in the Viral Special Pathogens Branch, where her investigative field work has taken her to Brazil, Uganda, Liberia, and Guinea to help develop and implement epidemiologic studies to investigate diseases caused by Ebolavirus, Marburgvirus, Lassa fever virus, Rift Valley fever virus, Crimean-Congo hemorrhagic fever virus, other Arenavirus and Hantavirus species.

Federal Drug Administration (FDA)
Dr. Doran Fink did not know much about what people at the FDA do on a daily basis until he serendipitously came across an opportunity at the FDA during his pediatric infectious diseases fellowship. He learned that the primary mission of the FDA is to protect the safety of the public with respect to food and drugs. As a medical officer in the Office of Vaccines, he reviews clinical trial protocols and safety reports to weigh the risks of a new vaccine to the benefits for an individual patient. In essence, he is practicing clinical medicine on a population level, which is one of the aspects he loves most about his job.
Industry
Pharmaceutical companies continue to develop and manufacture vaccines and anti-infective agents for use in children. Pediatric ID specialists are integral in all the steps in this process, including basic science research, clinical trials, drug evaluation, and policy efforts focused on ensuring access to new medicines for pediatric patients. For example, as antibiotic resistance increases, there is a pressing need to develop new antibiotics to combat bacteria resistant to currently available antibiotics. These drugs must be studied in a series of phases before they can be approved for use. Typically, drugs are first studied and approved for use in adults, and then studies are conducted in children to ensure safety for pediatric patients. Dr. Amanda Paschke, employed by Merck, leads a team developing a new beta lactam/beta-lactamase inhibitor combination antibiotic for the treatment of highly resistant bacterial infections. Her day to day work includes designing and running the clinical trials to demonstrate the safety and efficacy of drugs under study, monitoring patient data coming from ongoing studies, participating in the analysis and reporting of data when studies conclude, and interacting with regulatory agencies around the world about approved drugs that Merck makes as well as new drugs in development. Developing new anti-infectives for adults and children is an exciting way to combine general medical knowledge with knowledge of peds ID and clinical research skills.

For any medical students or residents with an interest in any of these potential career paths, please reach out to any peds ID fellow or faculty member at your institution or beyond. We are a friendly and welcoming community! The AAP offers a Mentorship Program that can connect you with a potential mentor with similar interests.

For more information on the AAP’s Mentorship Program, please check out this link.

Rana F. Handy, MD, MPH is an Infectious Disease Fellow at Children’s Hospital Pennsylvania.

When a Code is Not a Code: One intern’s story

By Ketan Nadkarni, MD

Remember the pilot episode of Scrubs where JD is doing everything he can to survive the first day of residency, despite fear of patients, lack of experience, and the difficult logistics of a new hospital? Well, a TV show has never before been so accurate.

On my first day of intern year, I did not have a functional login to the electronic medical records system. I was late to work after getting lost in the bowels of the hospital at 5:30 AM. The profuse sweating across my face could have been from the stress of the first day or the hell-like humidity of North Carolina summers. And to top it all off, my clinical brain had turned to mush after the joy ride that is the 4th year of medical school. At this point, I barely knew how to how to spell “auscultation”, much less provide care to sick children.

The one thing that was functioning that day was my pager. And boy was it functioning well. Morning rounds stretched on for an eternity that day, with each patient being a testament to how little we knew at the time. The word struggle was an understatement to describe the morning. Eventually we made it back to the workroom in the afternoon to work on documentation and orders - everyone’s favorite part of residency.

At this point in the day, I had the words “mock code call” written on my schedule but was not sure what that entailed. Was this a phone call? Would I be walking through an algorithm with my senior? Regardless, it was my first day and I assumed nobody would have the audacity to put a brand spanking new intern through the stress of a simulated code situation. Well, you know what they say about assumptions...

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Around 2:30 in the afternoon, my pager went off... “beep beep beep”. After fumbling with it to open the message, it read “MOCK CODE CALL! Hurry, 7CH-ED2 needs your help!”. I froze. My heart stopped. I could taste the turkey Panini from lunch in the back of my throat. My first thought: Where the hell is that!? I ran upstairs to the 7th floor, jumped out of the elevator, and asked a few nurses where to go. Nobody knew.

I stormed into room 2 on the 7th floor. In the room was a perfectly complexioned blonde mannequin that was almost ethereal looking, flanked on either side by two women wearing blue pants and dark t-shirts. The room was dark, and the patient motionless. I said to the women "hey there, I am here for the 'code'", making air quotes with my hands. They stared at me. I showed them my pager, and still...nothing. So I thought: "Hmm, this must be part of the gig."

I gently shook the mannequin's chest, trying to arouse it. Nothing. I heard equal breath sounds with my stethoscope, so I said "well that's reassuring", hoping for some assistance from the preceptors. All I got was raised eyebrows. I then felt a pulse and was reassured further - the mannequin looks to be in no acute distress. I then stood up, wheeling around to the monitor, and scrolled through the recent blood pressures. During these 30 seconds, I heard a groan from the bed. Confused, I gave a second gentle chest rub. The mannequin moved a bit, turning its head towards me, the smooth hair moving in harmony. I caught a glimpse at the eyes and was astounded at the attention to detail from the mannequin's engineers. Another groan and a small cough. Again, I thought "wow, its movements are so realistic". Clueless as to the medical cause of this mock code, I turn to both women, throw my hands to my side exasperated, and say "Alright, I give. I've done my ABCs. Give me a hint at the next step - maybe getting an ECG?". They looked at each other in utter disbelief, and then said the words that I was least expecting: "Who are YOU?"

After what seemed like an eternity of a blank stares, I glance at the patient, noticed a few beads of sweat on the forehead, and saw the arm gently scratch the chest before falling to the side. Then I heard a deep breath. All of a sudden it hit me like a ton of bricks.

The two shocked, speechless women on either side of me.
The perfectly normal rate and rhythm on the bed side monitor.
The incredibly realistic breath sounds and facial expressions on the mannequin.
The full, blonde head of hair.
This was no mannequin. And the two women in the room were not nurse preceptors. Most importantly, this was no mock code. I glanced down at my pager, and then at the room number listed on the door: 7CH-2. "Uh oh". It turns out the 7CH-2 is quite different from 7CH-ED2. It also turns out that despite having the complexion and lifelessness of a mock code mannequin, the figure lying in the bed happened to be an 8-year-old boy in deep sleep. I ran so quickly out of that room it would have given Usain Bolt a run for his money.

To this day, I cannot explain why neither of these women, who I assume knew the patient, said anything to me. It must have been like watching a train wreck unfold when all one could do is stare. Similarly, I cannot explain why they were wearing matching outfits resembling UNC nurses. Eventually I made it to the actual mock code 20 minutes late and managed to be the conductor for the second train wreck in one afternoon. The only difference? This "patient" did not groan and turn towards me when I touched him.

I do not tell this story out of jest - nor do I tell it out of contempt, frustration, or anger towards intern year. I tell it for perspective. Residency is a grueling path full of obstacles and hurdles with Day 1 simply being the beginning of the journey. But if I could make it past a first day like this one and manage to laugh at the end, there is hope for new interns everywhere in July.

**Ketan Nadkarni, MD** is a year pediatrics resident at UNC Medical Center

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**Physicians and Lawyers Team Up to Help Children and Families**

**By Kiran K. Soni, JD**

In March 2016, the American Academy of Pediatrics released a policy statement which highlights how poverty adversely affects the health and wellbeing of children.¹ To address the impact of poverty on health, physicians and lawyers work together in medical legal partnerships to improve the health of children and low-income communities.²³ A pediatrician “gets very tired of this thing: sending a child with asthma home to an apartment full of roaches and mold; telling the parents of an anemic toddler to buy more and healthier food when they clearly do not have a cent; seeing babies who live in unheated apartments coming in again and again with lung ailments.”⁴ For this reason, since 1993, the Medical Legal Partnership (formerly Boston Medical Center’s Family Advocacy Program) has partnered lawyers with pediatricians under the philosophy that “if I [as a pediatrician] can improve [a child’s] housing conditions, then I am treating their asthma.”⁵

Medical legal partnerships practice preventive law and medicine.⁶ Specifically, lawyers work with physicians to help low-income families address issues of food insecurity, housing safety, access to health care, and immigration status.⁷⁷ By advocating for patient’s legal health rights, lawyers help physicians improve patient health. Not only do patients benefit but the community does, too. A recent study of the largest medical legal partnership, LegalHealth, located in New York City found that “every dollar spent on LegalHealth services generates about $2 in direct financial benefit.”⁹

Physicians welcome this partnership with lawyers. One pediatrician at Boston Medical Center said, “it’s ok to ask the questions now because I know what to do about it...It’s hard to ask if there is enough food at the end of the month when you don’t have the resources to help if the answer is no.”⁵ Therefore, medical legal partnerships enable physicians...
to provide better care to their patients and families.

Lawyers in medical legal partnerships help low-income families obtain critical public benefits, such as food stamps, Medicaid, and Social Security Disability Income. “One-third of those eligible don’t get food stamps, according to the Census Bureau, and about 30% of the poor who are entitled to Medicaid are not enrolled.” Lawyers also help low-income families enforce federal and state housing laws that impose duties on landlords to provide adequate heating or a mold-free environment. Thus, lawyers in medical legal partnerships help to ensure that children live in healthy, safe environments.

The unique structure of medical legal partnerships uses the health care setting to increase patient access to lawyers. Placing lawyers in the health care setting addresses practical concerns by affording parents the convenience and time saving of a single trip. “Many working people simply can’t take the time off the clock to trek from waiting room to waiting room.” Additionally, when a trusted physician recommends a patient to a lawyer, that lawyer gains credibility in the patients’ eyes. For all these reasons, medical legal partnerships purposefully and physically intersect medicine with law.

In medical legal partnerships, physicians function as gatekeepers. Specifically, lawyers train physicians to ask screening questions regarding access to food, housing, and income in order to identify medical problems capable of legal solution.

Physicians can refer qualifying families to lawyers who advocate for patients’ legal health rights.

Lawyers also recruit physicians to serve an evidentiary function in the legal process. For example, once physicians understand the governing legal standard, they can write stronger advocacy letters in support of Social Security Disability Income applications or to appeal a wrongful denial of public benefits.

Currently, about 231 medical legal partnerships exist nationwide. In 2002, about 25 existed. At that time, I first learned about medical legal partnerships as a student at the University of Miami School of Law. One of my professors, Anthony V. Alfieri had founded the Community Health Rights Education project in collaboration with Dr. Arturo Brito in the Department of Pediatrics at the School of Medicine.

In our medical legal partnership, a mobile pediatric clinic traveled across Miami to provide healthcare to low-income children. As children received medical care, I provided legal consults to their parents. I tailored legal solutions to the unique legal problems of Miami’s low-income families. Specifically, I advocated for the legal health rights of HIV+ mothers and undocumented parents. Additionally, I drafted living wills, child guardianships, and authorizations for cremation for HIV+ mothers. These documents prevented family disputes regarding end of life care and child custody. I successfully represented undocumented parents before immigration judges and secured
their legal residency. Dr. Brito and I presented at Pediatric Grand Rounds in order to raise awareness and increase the number of legal referrals from pediatricians to us.

During the ten-year interval between my legal and medical education, medical legal partnerships have grown dramatically. New medical legal partnerships have expanded their focus beyond children, and ones specifically created for cancer, sickle cell, end of life, and palliative care patients have emerged.

I welcome this expansion of medical legal partnerships. I have witnessed first-hand how preventive law and preventive medicine benefit children, their families, and their communities. When lawyers advocate for children’s legal health rights, lawyers help pediatricians better help children.

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