Medical Students Become National Members of the AAP!

Christian Pulpini, MD, Medical Student Subcommittee Chair and PGY1, Children’s Hospital of Pittsburgh

For the first time ever, medical students will join residents and fellows in the “In Training” membership category of the AAP thanks to an official vote conducted during the Fall of 2014. What does this mean? It establishes medical students as national members in the American Academy of Pediatrics (as opposed to affiliate members) and opens the door for increased benefits, more engagement in the AAP, and potentially additional leadership positions within the AAP. These benefits will eventually include access to vital publications of the AAP that medical students currently do not have access to, including AAP News, AAP Federal Affairs Advocacy Materials, and potentially on-line access to AAP publications such as Pediatrics and Peds in Review.

If you want to become more connected with the AAP and its members and trainees across the country, please contact your district leadership with the contact information included on the last page of this newsletter.
Medical Students “Explore New Horizons” at the 2014 AAP NCE

Christine Thang, MS4, David Geffen School of Medicine at UCLA

Bright-eyed medical students filled the Indigo Conference Room of the San Diego Hilton Bayfront Hotel as Dr. Lisa Chamberlain, keynote speaker for the medical student plenary session, inspired the next generation of pediatricians-in-training to be patient-centered, compassionate physician leaders. With a focus on advocacy, Dr. Chamberlain spoke about the importance of advocacy efforts, especially through engagement within the Academy. It was a fitting introduction to the medical student program of the 2014 American Academy of Pediatrics National Conference and Exhibition (NCE) held in sunny San Diego, CA, attended by over 225 medical students from across the U.S.

The five-day conference started on Friday, October 10 with an evening welcome reception to kick off the NCE. On Saturday, October 11, the Section on Medical Students, Residents, and Fellowship Trainees (SOMSRFT) started its full day of educational sessions. Attendees gathered in the Sapphire Conference Room of the Hilton Bayfront Hotel overlooking the beautiful San Diego harbor. At this session, entitled “Be Our Guest: An Invitation to Learn How to Be an Effective Child Health Advocate and an Academy Leader within Your Professional Home”, attendees learned about the achievements and ongoing projects of the SOMSRFT.

Medical students then regrouped for their own plenary session led by the Medical Student Subcommittee (MSSC). After MSSC student leaders provided an update on their ongoing efforts and projects, Dr. Chamberlain, from Stanford University School of Medicine, took to the stage with her keynote speech on advocacy in pediatrics. “It is through my advocacy work every day that I don’t get burnout in the clinic,” explained Dr. Chamberlain as she shared stories about her patients, their challenges, and social determinants of health during the Great Recession.

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“"It is through my advocacy work every day that I don’t get burnout in the clinic”

– Dr. Lisa Chamberlin, Pediatric Residency Director, Stanford School of Medicine
Dr. Chamberlain was then joined by Dr. Adam Rosenberg and Dr. Jason Homme, Pediatric Residency Program Directors at the University of Colorado, Denver, CO and the Mayo Clinic, Rochester, MN, respectively for a panel on preparing for residency. During this panelist discussion, medical student attendees had the opportunity to have their questions answered by the residency program experts themselves. Dr. Rosenberg explained pediatric residency training as a new terrain for medical students, where residents could “individualize to make it what you want [it] to be.”

When it comes time to apply to pediatric residency programs, all the panelists agreed on the importance of finding a “goodness of fit” between the applicant and the program. Dr. Homme advised, in his closing remarks, “See enough different programs of different styles to determine your goodness of fit. But, remember, at the end of the day, peds is a great field. Tell your friends.”

The day ended with a “subspecialty speed-dating session” where guest speakers rotated around tables of medical students to share information about their respective fields and answer questions. Physicians representing the areas of general pediatrics, pediatric surgery, neonatology, emergency medicine, critical care, neurology, hematology-oncology, and cardiology were in attendance to answer students’ questions and offer guidance on entering that respective field.

For first-year medical student Crystal Deedas, from the University of California Riverside School of Medicine, “This was the first medical conference I have ever been to, so it was incredible to just be around so many accomplished individuals who are all passionate about the same thing as I am.

Being a first-year medical student, I found the section on medical students to be very eye-opening, helping me prepare for what’s to come.” Following the day’s program, the evening’s main event was a SOMSRFT Reception and Poster Display Session highlighting and celebrating the academic work of fellow SOMSRFT members. Attendees enjoyed complimentary food, drinks, and entertainment aboard the USS Midway! On Sunday, October 12, attendees joined their respective district breakfasts to learn about local AAP efforts. The Medical Student Subcommittee also met this morning to plan their vision and goals for the upcoming year. The group decided to expand leadership opportunities for students across the county with the addition of 10 new Assistant District Representative positions!

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“See enough different programs of different styles to determine your goodness of fit. But, remember, at the end of the day, peds is a great field. Tell your friends.”
– Dr. Jason Homme, Pediatric Residency Director, Mayo Clinic, Rochester, MN
Medical students who attended the NCE on Monday, October 13 and Tuesday, October 14 were able to sit in on informative educational sessions according to their interests, explore the Exhibit Hall to learn about the industry’s latest innovative products, and participate in each day’s special events.

With opportunities to engage in advocacy efforts, learn from panelists and network with other medical students, residents, fellows and practicing pediatricians, AAP NCE medical student attendees reaffirmed their commitment to pediatrics and walked away with renewed energy and knowledge to share with their fellow students back home. As Jennifer Han, second-year medical student from the University of California Riverside School of Medicine, shared at the end of the medical student plenary session, “I am looking forward to sharing and putting into practice what I've learned during the 2014 AAP NCE at my school and community.”

If you have any questions, the Medical Student Subcommittee is here to answer them. Please do not hesitate to contact us with any questions. We look forward to seeing you at the 2015 AAP NCE in Washington, DC!

“I like how the [NCE] program gives me a chance to network.”
- Ijeoma Ohadugha, MS2, Meharry Medical College
Pediatrician Advocates Meet in Washington D.C. for 2014 AAP Legislative Conference

Eli Freiman, MS4, University of Massachusetts and Jenni Kusma, MS4, Ohio State University

The AAP held its annual Legislative Conference from Sunday June 15th to Tuesday June 17th, 2014. The conference consisted of two days of programming (Sunday & Monday) and one half-day of visits to Capitol Hill (Tuesday) with an afternoon wrap-up.

Sunday morning’s programming focused broadly on advocacy and child health topics, and included distinguished speakers such as outgoing AAP President Jim Perrin, MD and Nevada Assemblyman Andrew Eisen, MD. In the afternoon, there were breakout sessions on topics including the Affordable Care Act, Tobacco, E-cigarettes & Youth, and the Children’s Health Insurance Program (CHIP). There were also sessions geared towards becoming effective advocates, which included breakout groups on Social Media, Crafting your Message, Art of Negotiation and Coalition Building. Monday’s programming was specifically focused on the core issues we would be advocating for at our Legislators’ offices. This programming included distinguished speakers such as USDA Under Secretary Kevin Concannon, Executive Director of Let’s Move!

The AAP’s core issues this year focused on language used in both the House and Senate FY15 Agricultural Appropriations bills. With the current language, both of these bills sought to roll back on previous healthy food guidelines for the national school lunch program. In short, the Healthy and Hunger-Free Kids Act, which passed in 2010 with bi-partisan support, called upon the USDA to update nutrition guidelines for the national school lunch program. These guidelines called for more fruits and vegetables, more low-fat options, incorporating more whole wheat, and lower sodium and calorie counts per meal. These new guidelines went into action in 2012 with updated snack guidelines being passed in 2013. The impact of this new bill is highlighted in a recent study by the Harvard School of Public Health. However, both the House and Senate FY15 Agricultural Appropriations bills would look to roll back these guidelines to previous recommendations and allow waivers for schools to opt out of the guidelines entirely. In addition, these bills contain language that would mandate the inclusion of white potatoes into the WIC supplemental nutrition package, the first time in WIC’s 40-year history that Congress would be dictating which foods WIC should include. WIC’s current recommendations are based on scientifically backed data from both the Institute of Medicine and...
the USDA and are intended to fill gaps in nutrition not already covered by the diets of WIC recipients.

On Tuesday morning, distinguished Senator Harkin (D-Iowa) addressed all attendees and spoke about healthy nutrition being a key component of the national school lunch program. As one of the writers of the Healthy and Hunger-Free Kids Act, he spoke about his disappointment with the possibility of taking a step backward in nutrition for children. After this talk, we walked to Capitol Hill and met with the offices of our state’s Senators and Legislators. We had many fruitful discussions and made sure to voice our opinions as future pediatricians; opinions that were very well received. This was followed by a debriefing session with all attendees where we discussed our struggles and successes on the hill. There was much to be learned, and even more for us still to fight for!

**UPDATE:** On December 11, 2014, Congress passed the Omnibus Appropriations Bill for Fiscal Year 2015. This bill increased funding for a variety of child health programs including funding for the National Center for Birth Defects and Developmental Disabilities, Child Care and Development Block Grant, and Global Health Programs. However, the bill did not contain many provisions which the Legislative Conference fought for. This bill included language allowing white potatoes in WIC and also scaled back some whole grain and sodium standards for school meals. However, next year the Healthy Hunger-Free Kids Act is up for reauthorization where many of these issues will likely come up once again and where continued support and advocacy is needed!

So what can you do now? Check out [http://federaladvocacy.aap.org](http://federaladvocacy.aap.org) and remain up-to-date on the latest information on child nutrition resources. You can write a letter to the editor of the local paper in your home city about the importance of healthy nutrition. Or you can send a letter to your representatives on a state or national level asking them to please support healthy nutrition for kids. And, as always, nothing is more effective than speaking to your patients and their families about the importance of healthy eating. We all need to keep working together to ensure that our nation’s children have access to healthy meals all day long no matter where they are!

**Paediatrics versus Pediatrics: Practicing Pediatrics in Canada**

Nicholas Monfries, MS2, University of Calgary Faculty of Medicine

Greetings from your friendly neighbor north of the 49th parallel! With so much discussion about the healthcare industry lately, I thought I’d offer a primer on the Pediatric discipline in Canada. *Pediatrics* and *Paediatrics*, as it is spelled in Canada, may be spelled differently, but, in fact, the definition is largely the same and refers to the branch of medicine concerned with the care of children. However, it is in the application and utilization of paediatric expertise wherein differences arise between the U.S. and Canada. *(continued)*

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Photo: Alberta Children’s Hospital. The paediatric academic medical centre that serves Calgary, southern Alberta and southeast British Columbia. The hospital has 133 inpatient beds, as well as numerous paediatric subspecialty clinics. The Paediatric ER at Alberta Children’s Hospital receives over 60,000 visits per year. Photo credit: Nicholas Monfries.
While most people know about the difference in the delivery of services, whereby Canada incorporates a single-payer, universal healthcare system, many people are unfamiliar with other aspects unique to the Canadian system. These differences include the structure of residency training, nature of primary care practice, and the number of paediatricians in practice.

Residency Training

In Canada, medical students are matched to residency positions through a centralized matching system known as the Canadian Resident Matching Service (CaRMS), which is similar to the NRMP. Once matched to Paediatrics, each resident must complete 3 years of core paediatric training. After their third year in core Paediatrics, residents have the option to pursue subspecialty training for an additional 2-3 years or have the option to pursue dedicated general/community paediatric training for one additional year. Regardless of the route a resident takes, all paediatric residents can take the general paediatrics licensing exam during their 4th year, and upon successful completion, may practice as a general paediatrician. Therefore, while general pediatrics training in the U.S. is three years, in Canada it is four years.

Primary Care Practice

Though there is regional variation in the practice profiles of general paediatricians across Canada, a majority of general paediatricians have consultant-level practices and do not provide primary care services. In fact, compared to the United States, where a majority of children see a paediatrician for primary care, it is estimated that only 30-40% of children in Canada see a paediatrician for primary care needs. Instead, a majority of children in Canada are seen by a family physician and are only referred to a general paediatrician for complex chronic disease management or for specialized assessment regarding specific health and/or developmental concerns. Therefore, in some parts of Canada, assessments such as well-baby and well-child checks are largely the responsibility of family physicians. In fact, in order to gain sufficient skills in managing paediatric patients, Canadian family physicians can pursue an additional year of residency training in Child and Adolescent Health.

Number of Paediatricians

When comparing the United States and Canada there is a striking difference in the number of paediatricians (general paediatricians and non-surgical pediatric specialists) practicing in both countries. According to the professional organizations in each country, there are over 90,000 pediatric-focused physicians practicing in the United States, which includes pediatric surgical specialists, pediatric subspecialists and approximately 58,700 practicing general paediatricians3. For comparison purposes, that equates to almost 19 general paediatricians/100,000 population4. This discrepancy is likely due to a multitude of factors, including differences in the function of the family practitioner in Canada and the U.S.

So, is there a difference between Paediatrics in Canada and Pediatrics in the United States? The answer is yes; there are some differences. But, ultimately, when it comes to the core function of the specialty - the care and treatment of children – both countries are very similar, despite their differences in spelling.

References

Pediatrics Bioethics Committees: What Do They Do?

Melissa Stone, MS4, University of Miami Miller School of Medicine

The beginning of medical ethics can be traced back to Hippocrates, who famously wrote in an oath now recited at white coat ceremonies across the globe, “I will take care that they suffer no hurt or damage.” Hippocrates is telling us that we should not impose unnecessary, painful procedures on our patients. However, with emerging medical advances, this concept is more relevant than ever before. Within medicine, this notion is most salient when it comes to the care of our smallest patients.

Many pediatric patients cannot verbalize their wants and needs and if they can, they lack the capacity to make decisions about their medical care. As pediatricians, we must act in our patients’ best interests. In difficult situations, pediatricians will often look to the AAP, which has outlined policies on topics ranging from HIV disclosure in adolescents, to parents pursuing complementary and alternative medicine for chronic illnesses, to parents withholding fluids and nutrition in children with a painful, terminal disease. However, these guidelines do not cover every ethical situation that might occur.

When the guidelines are unclear or conflicts regarding treatment decisions arise, medical teams and families look towards Pediatric Bioethics Committees for guidance. At many hospitals, these committees can be consulted. In the same way you would page Pediatric Gastroenterology for guidance on a patient’s total parental nutrition, you can page your hospital’s Bioethics Committee for a consult on an ethical concern.

Most hospital ethics committees formed in the 1980s. In 1984, the AAP issued a statement supporting the notion of “infant bioethics committees.” During this time period, with the advent of increasingly sophisticated neonatal intensive care units, infants were being born at earlier gestational ages, which led to an increase in ethical issues and difficult decision making surrounding the first few days of life. Infant bioethics committees, composed of physicians and lay people, were formed to assist medical teams and families during difficult times.

The modern day Pediatric Bioethics Committees vary from hospital to hospital. They can range from a two person team responsible for handling all cases and seeking others’ opinions as needed to teams as large as 30 people, comprised of physicians, hospital administrators, nurses, chaplains, lawyers, medical/nursing students, and community members meeting regularly to discuss cases. The culture of Pediatric Bioethics Committees also varies from hospital to hospital as some hospitals have a vibrant consulting community while others have a few pediatricians versed in the function and value of the Bioethics Committee.

When an ethics consult is placed, the Bioethics Committee investigates. Through chart review and speaking with the patient, family, and medical team, the Committee comes to a consensus on the medical facts and conflicts at hand. Then, the Committee meets independently to discuss the case, forming a conclusion about the most ethically appropriate actions. The philosophy behind a Bioethics Committees is that when a group of reasonable people with different professions from various backgrounds reach an educated conclusion, that conclusion is likely ethically appropriate. (continued)
However, ethics is not black and white, but rather a spectrum of grey. Consequently, the Committee will often reach several ethically appropriate conclusions. Additionally, as with any consult, the primary team has the final say and the conclusions from the ethics consult are merely recommendations.

As a future pediatrician, what does all this mean to you? Get involved with the Pediatric Bioethics Committee at your hospital! Ask to attend the next meeting and remember the value of this important resource the next time your team is in an ethically difficult situation.

Aversive Thumb Sucking Therapy: A Denatonium Benzoate Chemical Burn Case Report

Aarusha Jana Das MS3, Asif Khan MS3, Jon A. Courand, MD, FAAP
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Thumb sucking is a common reason parents bring their infants and children to pediatricians for treatment. We present a case report of an infant who suffered a severe chemical burn due to the use of a denatonium benzoate based nail polish as aversive treatment. From the recommendation of the pediatrician to treat this infant’s thumb sucking, to the utilization of denatonium benzoate as aversive therapy, we review the steps that led to this unfortunate injury and how it could have been prevented.

Case Report

A previously healthy 10-month-old male, with no prior past medical or surgical history, was admitted to our hospital inpatient pediatric service with a cellulitis infection on his left thumb superimposed on a prior chemical burn. Five days prior, the mother of the child had applied an over the counter nail-biting deterrent to the infant’s nail and thumb based upon the suggestion of her physician. Despite instructions that stated the polish be added to the nail, the mother applied the polish to the entire digit to stop her son from sucking his thumb. A caustic component of the nail ointment (denatonium benzoate) caused the infant such irritation that he started chewing his thumb, thus creating a nidus for the subsequent cellulitis. The next day, the patient’s thumb was erythematous and edematous. Two days later, the skin on the infant’s thumb started to desquamate. This caused the mother to seek medical attention from her primary care physician. The infant was immediately referred to an outside hospital facility before finally arriving at our institution for further care and management.

When the infant arrived at our institution he was admitted to the pediatric floor for continued medical care. He arrived in no apparent distress, hemodynamically stable, and comfortable.

Transition to oral pain medication (acetaminophen 15mg/kg/dose q4h prn) from the previous facility had been successful in controlling the infant’s pain. Examination of the infant revealed no other injuries aside from the documented chemical burn on his left thumb. No constitutional symptoms were exhibited.
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The thumb itself was noted to have a 5 mm eschar at the tip along with erythema and superficial sloughing of the skin to the mid-portion of the digit (Fig. 1). Edema and erythema was also noted at the proximal thumb and thenar eminence with minimal tenderness to palpation. There was no involvement or spreading to the base of the hand or the wrist. Due to the location and nature of the chemical burn, our institution’s plastic surgery team was consulted to evaluate the infant. Recognizing the cellulitis superimposed on the chemical burn, the recommendation from the plastic surgery team was to start empiric treatment of the skin infection with intravenous ampicillin/sulbactam (Unasyn) and topical bacitracin/silver sulfadiazine accompanied by close observation and monitoring of the chemical burn.

After 24hrs of antibiotic treatment the infant’s cellulitis appeared markedly improved (Fig. 2). Furthermore, his desquamation ceased and appeared to be resolving. The infant’s rapid improvement negated the need for operative debridement or incision and drainage of the thumb. The recommendation from plastic surgery was to continue care and treatment in the outpatient setting with follow-up for possible surgical intervention or reconstruction if needed. A referral to Child Protective Services for assessment of the infant’s social situation was made. With follow-up appointments scheduled, precautions administered, and medications prescribed (5 day regimen of Augmentin), the infant was discharged from our facility to the care of his mother.

**Discussion**

Thumb sucking is a common and innocuous behavior of infancy and early childhood that is estimated to occur in 23% to 46% of children aged 1 to 4 years old. As an adaptive behavior, thumb sucking is used by infants to occupy themselves between feedings and holdings, while also teaching infants to soothe themselves. It is only after the age of four that thumb sucking begins to lose much of its adaptive benefits and poses mild to moderate health risks. By the age of four, only an estimated 12% of children continue digit sucking. Thumb sucking that continues beyond the age of four places the child at greater risk for dental malocclusion, digital deformities, and speech difficulties. In addition, a child can also encounter emotional problems from the negative social stigma associated with thumb sucking that can contribute to ridicule from peers.

Knowing the indications to start therapy in a child with a thumb sucking habit is important for pediatricians to prevent unnecessary treatment and avoid needless risks. General pediatric guidelines and literature recommend that treatment for thumb sucking is not needed before the age of four. Even in children older than four, if the habit is infrequent, not causing difficulties with dentition or interfering with social development, therapy is not necessitated. The most frequent indication for intervention is the presence of a dental problem due to thumb sucking, for which a dental consultation should be obtained. Less common indications for interventions are alopecia due to hair-pulling covarying with thumb sucking or digital deformity due to intense thumb sucking. In the presented case, it is quite obvious that the infant did not meet any of the indications for treatment. Furthermore, at only 10 months old, the infant was well below the threshold to start considering intervention. Adherence to the guidelines on thumb sucking could have easily prevented this infant’s unfortunate injury.

When recommending therapy for thumb sucking, aversive treatments are considered second-line therapy and should not be utilized unless all primary behavioral options have been exhausted. The first line of therapy that should be suggested to parents wanting to address a thumb sucking child is to use positive reinforcement. Positively encouraging a child when they are not sucking their digit leads to a fundamental change in behavior and a reinterpretation of the action itself.
Examples of positive reinforcement include praise or rewards (e.g. stickers on a calendar) each time the infant goes through a period without thumb sucking. Second-line therapies that go beyond cognitive behavior include the use of a sock or adhesive strip that remind the child not to put their digits in their mouth. When recommending aversive therapy, pediatricians should avoid suggesting compounds that include denatonium benzoate as the aversive component, due to its caustic property. So even if the infant’s pediatrician, in our case report, felt it appropriate to begin thumb sucking treatment, it would have been better to recommend positive reinforcement techniques rather than jumping ahead to aversive options.

Because denatonium benzoate is primarily added to solutions as a deterrent, rarely are the caustic skin properties highlighted or warned about when added to topical products. Albeit the caustic side-effects rarely occurs in topical application, when they do occur they are so significant that awareness and early detection are important.

The OTC product used by the mother of the infant presented in this case report is a nail polish marketed as a quick and efficacious nail-biting deterrent. The directions of the nail polish state that the product be applied in two coats to the nail daily for at least three months. The documented warnings included with the product highlight its flammability and toxicity with ingestion. Listed in the ingredients is denatonium benzoate, the bitter tasting aversive compound by which the nail polish acts as a deterrent.

Although denatonium benzoate is listed in the ingredients, the packaging of the product fails to caution about the caustic properties of denatonium benzoate. Including a notation about this adverse property could warn parents and lead to more cautious use of the product. Had a clear warning been included with the product, the mother in our case (continued)

Denatonium benzoate (Benzylidethyl (2:6-xylycarbamoyl methyl) ammonium benzoate; C28H34N2O3) is a bittering agent that is promoted as an aversive agent and utilized in numerous substances. Soluble in alcohols, ethylene glycol, and water, denatonium benzoate is added to many household, automotive, and cosmetic products to prevent ingestion. It is also used as an active ingredient in nail-biting and thumb sucking deterrents, despite the Food and Drug Administration (FDA) citing a lack of efficacy data for its use. Furthermore, the FDA has clearly stated that “any OTC drug product containing ingredients (denatonium benzoate) offered for use as a nail-biting or thumb sucking deterrent cannot be generally recognized as safe and effective.” This is echoed by the material safety data sheet for the compound, which identifies it as “hazardous in case of skin contact (irritant) and very hazardous in case of ingestion.”
report would have been more aware about the caustic property and would have likely been more responsive at the earliest signs of a chemical burn and would have sought medical attention earlier. Medical attention prior to the desquamation could have prevented the superimposed cellulitis that opportunistically followed the chemical burn.

In addition to a better warning label, clearer directions on how to apply the product could have prevented its erroneous use and the adverse reaction seen in this case report. The mother of the child made the assumption that applying the nail polish to the entire thumb, rather than just the nail, would be more effective. Unfortunately, the application of denatonium benzoate to the infant’s skin led to the chemical burn, something that could have been avoided if the mother had only applied it to the nail. Since the directions included with the product do not explicitly state to limit the nail polish to the nail itself, it is easy to misinterpret the directions and apply the nail polish to the entire digit, thereby increasing the risk for a chemical burn.

Fortunately, the infant’s rapid response to antibiotics and appropriate burn treatment prevented the need for surgical intervention of the digit. Better education of the therapeutic options for thumb sucking, along with clearer instructions and warnings on the aversive nail polish could have prevented this injury.

Conflicts of interest: None of the authors have any conflicts of interest, financial or otherwise.

References:


Conclusion

This case presentation highlights two issues of concern: the appropriate management of thumb sucking in infants and children, and the use of denatonium benzoate and similar compounds as bittering agents in nail biting and thumb sucking deterrents. In the case presented, the chemical burn due to denatonium benzoate was further complicated by subsequent cellulitis of the digit.
The Making of a Successful Pediatric Interest Group

Mark Greenstein, MD, University of Connecticut School of Medicine

There are things that one does that develop over time. It can be instructive to look back and try to untangle how a process, procedure or idea emerged. Where did it come from? What were the influences on it? I was led to reexamine my work as a pediatrics interest group advisor when I was asked to write about Pediatric Scholars or Peds Scholars for short, the student-led pediatric interest group at the University of Connecticut School of Medicine.

It has been 20 years since I was first invited to take part in Peds Scholars. One of the students invited me as a guest speaker since I am trained in both Clinical Genetics and Developmental-Behavioral Pediatrics. I supported a student’s talk and spoke about developmental issues in children with Down Syndrome. The evening was lovely, if sparsely attended, and included about five students, the host, and myself. My inviter and all those involved had done a great job. However, after a pleasant night, I wondered why so few people had come. My inviter told me that poor attendance was not uncommon at these kinds of events, which relied upon word of mouth to get interested third and fourth year students to attend.

As time passed, I was once again invited to help out; this time working with a student who presented about dermatologic findings in children. Again, it was a lovely night, with very few students in attendance.

When the advisor retired, I was given a chance to lead the group for one year, since no senior faculty were interested in the position. I immediately decided to make several changes at once. First, I opened the group up to students from all four years, instead of just third and fourth years. I created post cards with blank spots for the day, date and time. On the first night of the season, students addressed these post cards to themselves filling in dates and times. One week before each meeting, these postcards were mailed out to the students. During this first year we had more students and more presentations than ever before!

Each year I begin with introductions; attendance is comprised of first year students checking things out for the first time to fourth year students still unsure of what they want to do to veteran members who have never missed a meeting. I talk a bit about my own path and decisions. I also talk a bit about the history of the Harriet Lane Handbook. On this first night, fourth year students are asked to sign up for dates throughout year that they would like to present. During the years before PowerPoint, I borrowed a slide projector and an overhead projector for these sessions which were all held at my home to remain informal.

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What else do we do? Towards the end of the year we host a research night where students can present their fourth year “selective” project to an audience of peers and faculty. This is always a fun night. From these presentations, our department chooses the winner(s) of our Linda Ives Award In Research in Pediatrics.

Throughout the years we have added several new meetings based on the needs of our students. Just a few years ago we added in what we call “Fours to Threes”, a night when fourth year students, having just completed their interviews and rankings, meet with third year students to give their thoughts and advice on fourth year and help demystify the Match. For years I have hosted our annual Pot Luck Supper, inviting faculty from each division making sure that we have a broad representation of life choices and cultures. This allows the fourth years to talk to faculty about the rank lists and about other programs. Last year, based on a student request, we added a few meetings on bereavement which have been very well received.

I would be remiss if I did not mention food and snacks. Each year I mull gallons of apple cider which perfumes the house all winter. When the weather is warm, I freeze some cider and float it in a punch bowl with chilled cider. The dining room table is always covered with snacks ranging from Girl Scout cookies to candies to chips to nuts to gluten free food to sugar free food to vegan snacks and fruits and veggies.

Above all else, these meetings show a real sense of camaraderie and support between all members of all classes. In the end, I know that not everyone is going to ultimately pursue pediatrics, but everyone knows they are welcome to join us for some fun, learning, and laughter.

Council of Pediatric Subspecialties: A Great Resource for Students

Chirag Parikh, MS3, New York Institute of Technology College of Osteopathic Medicine

Though it is early in our medical training, many of us considering a future in pediatrics may also have an idea of a subspecialty we wish to pursue. An excellent resource to help students explore pediatric subspecialties is the Council of Pediatric Subspecialties (CoPS). This organization was formed with the mission of uniting pediatric subspecialties so that they may work together to best promote child health.

I had the privilege of interviewing Dr. Richard Mink, the past chair of CoPS, where I learned more about his involvement in CoPS as well as its creation. Dr. Mink’s involvement began in 2007, when he was the Critical Care Representative for CoPS. His initial interest stemmed from the desire to improve the way subspecialty training was structured. Essentially, regulations for fellowship training were not as strong as those for residency training, and at the time there was no organization working to address this and other similar issues. For example, program directors for residency programs are required to have a specific amount of experience and training to take on this position, but there is no such requirement for pediatric subspecialty fellowship directors. In addition, residents face certain difficulties when transitioning to fellowships. A prime example is the contracts, where residency contracts often end on June 30th and fellowship contracts begin on July 1st. With little to no time in between, transitioning can be difficult especially if a fellow must move to a new city or state.

What were the initial goals of CoPs?

According to Dr. Mink, this program was started in 2006 and grew out of frustrations with the Match system for pediatric subspecialties. Prior to the organization’s efforts, a Match system did not exist for pediatric subspecialties in the way it did for residencies and there was no official group that managed fellowships or addressed related problems.

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What are the most important achievements CoPS has made?
The application process is considered one of the biggest achievements of CoPS. Until 2006, fellowship programs did not use the Electronic Residency Application Service, ERAS, which is used for Match. Therefore, getting all pediatric subspecialties onto this system was one major hurdle that was overcome.

What are the future goals of CoPS?
The next goal, according to Dr. Mink, is to set up a unified start date later than July 1st. This would allow an appropriate amount of time for matched fellows to get situated and prepare for their new position. There are currently action teams looking at these issues, and a recommendation has been put forth for a new start date of July 7th.

Other plans include projects examining fellowship readiness, efforts to make a group of career advisors available for trainees, and the compilation of recommendations for which rotations residents should complete.

How can medical students use CoPS?
Dr. Mink encourages students to explore the CoPS website, www.pedsubs.org, where they can access a wealth of information about each pediatric subspecialty. This website can help aspiring pediatricians make informed decisions about what specialty they may choose to pursue. Each specialty is described in detail, with answers to questions about how to apply, lifestyle, compensation, career opportunities, board certifications and more! This resource is updated every 2 years and is an excellent resource for students looking to get a better idea of what a certain subspecialty entails.

CoPS is a wonderful organization and a great resource for medical students to use to further explore possible careers in the future once residency is completed. Dr. Mink’s suggestion to explore the website further had me reading through specialties I have never considered! CoPS is a very elaborate resource for students and residents alike and should be accessed by all future subspecialists!

Submit at Article to the AAP Medical Student News!

✧ Requesting submissions for March’s Advocacy-themed issue and June’s Mental Health-themed issue!

Questions, comments?
Email us at:
aapmedstudentnews@gmail.com
A Farewell from the Medical Student Subcommittee Chair

Christian Pulcini, MD, Medical Student Subcommittee Chair and PGY1, Children’s Hospital of Pittsburgh

It has been a true honor to serve as Chair of the Medical Student Subcommittee (MSSC). In my time as Chair, I have seen the medical student membership in the AAP increase from 800 to 1800, leadership positions for medical students double, and most importantly, medical students become national members of the AAP.

Since becoming Chair, I have graduated medical school and have begun my internship in pediatrics. As much as I wanted to continue to Chair the MSSC, I felt strongly that it should be a medical student leading this dedicated group of medical students, and I hope this tradition continues in the future. Therefore, on January 1st, 2015 I will be stepping down from this position. Shannon Brockman, 4th year medical student at University of Florida, is the wonderful leader who has been elected to take the group forward. Shannon will become Chair at a very exciting time in AAP history. The MSSC will be doubling in size, as we will be adding an Assistant District Representative in every district to help in the expanded responsibilities of the MSSC as a whole. We will also soon be rolling out our new PedsConnect on-line resource, a comprehensive advising resource for medical students formed through a partnership with the AAP and the Counsel on Medical Student Education and Pediatrics (COMSEP). It is exciting times for medical students and the AAP!

I want to close by sharing a vision statement for medical students in the AAP. On the plane ride home from the AAP SOMSRFT Long Range Planning Meeting in February 2014, I was so impressed by the medical students and residents I met, that I sketched out a vision statement on a piece of scrap paper. This vision addressed three opportunities for medical students involved with the AAP. I wanted medical students to remain 1) Informed: as depicted by medical students sitting at the table where important decision-making is occurring, 2) Engaged: as depicted by horizontal lines signifying medical students being horizontally integrated (as opposed to vertically or hierarchically integrated) in the multiple facets of the AAP, 3) Empowered: as depicted by medical students contributing actively to the overall mission of the AAP.

I hope you can also share in my vision as current medical students and as you progress further in your training.

Thank you all for your membership in the AAP and your continued dedication to children.

For Kids,

Christian D. Pulcini, MD, MEd, MPH PGY1, Children’s Hospital of Pittsburgh of UPMC

Photo: Actual copy of MSSC vision statement drawn by by Christian Pulcini.
A Message from the Outgoing Editor of AAP Medical Student News

Kristin Schwarz, MD
Editor of the AAP Medical Student News
PGY1, Boston Combined Residence Program in Pediatrics- Urban Health and Advocacy Track

Dear Readers,

As my two year term as the Editor of AAP Medical Student News draws to a close, I would like to thank all the readers who stayed up to date with our quarterly publication, as well as the authors who shared their unique stories with our readership. I would also like to thank the AAP Section On Medical Students, Residents, and Fellowship Trainees (SOMSRFT) Medical Student Subcommittee, who has provided ongoing excellent leadership for the medical student members of the AAP.

Over the past two years, thanks to the great enthusiasm and hard work of the AAP SOMSRFT Medical Student Subcommittee, I have seen extraordinary growth in the medical student presence and voice in the AAP, as the medical student member base has expanded from 800 to 1,800 members. With this increase in student membership has come an opportunity to share unique perspectives, opinions, and experiences in pediatrics with other students across the country. It has been a true joy to support our authors, budding pediatricians, in bringing important issues and new perspectives to light through their writing.

I encourage you to keep up to date with the AAP’s medical student activities through AAP Medical Student News, and to consider submitting your own work. I also encourage you to check out the AAP Section on Medical Students, Residents, and Fellowship Trainees’ NEW Monthly Feature column in Pediatrics, for which I have the great privilege of serving as Deputy Editor. This new column will debut in January 2015.

On a personal note, during this two year term I have also progressed through training in my third year of medical school into my intern year. Through this transition into residency, I have been grateful to be a member of the AAP community- as the AAP has continuously served to enrich my perspective on the field of pediatric medicine.

The incoming editor, Aylin Sert, a third year medical student at University of Massachusetts Medical School, is incredibly passionate about both pediatrics and journalism, and will surely continue to ensure an excellent quality AAP student publication. I wish the best of luck to all and, again, thank you for reading.

For Kids,

Kristin Schwarz, MD
PGY1, Boston Combined Residency Program in Pediatrics
Urban Health & Advocacy Track
Boston Children’s Hospital | Boston Medical Center
Congratulations!
To the newest members of the Medical Student Subcommittee!

2015 Assistant District Representatives:

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Genevieve Guyol, Boston University School of Medicine

District II
Jonathan Witonsky, Albert Einstein School of Medicine

District: III
Joshua Davis, Sidney Kimmel Medical College / Thomas Jefferson University

District IV
Sarah Maxwell, Medical University of South Carolina

District V
Rachel Nash, Oakland University William Beaumont School of Medicine

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Nisha Wadhwa, University of Chicago, Pritzker School of Medicine

District VII
Mina Tahai, University of Mississippi School of Medicine

District VIII
Natalie Strokes, ATSU School of Osteopathic Medicine

District IX
Jennifer Han, University of California Riverside School of Medicine

District X
Sara Kim, Florida International University Herbert Wertheim School of Medicine
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