Letter from the Chair
Christine Johnson, MD, FAAP

Greetings fellow Section Members! It is that time of year again where we plan for upcoming moves and transitions, new interns and residents and the selection board. We can continue to look to the American Academy of Pediatrics (AAP) and the Section on Uniformed Services as our Academic Home.

To that end, I hope you enjoy this Spring Newsletter. A big thanks to LCDR Shannon Marchegiani for taking over the role of Newsletter Editor. Hopefully you will get a sense from these articles, what great things our Army, Navy, Air Force and Public Health Service colleagues are doing all over the world.

I look forward to seeing you all at the 2015 AAP NCE in Washington DC, October 24-27, 2015 and specifically at our Second Annual USPS Lite, Section on Uniformed Services, educational session on Sunday October 25th. The section is excited to welcome several wonderful speakers, host the robust Scientific Awards Competition, and award the Outstanding Service Award, Dave Berry Award as well as the Chapter East and West Outstanding Pediatrician Awards at this wonderful venue. Please work with your Specialty Consultants / Leaders to request official approval to attend the meeting if possible.

Christine L. Johnson, MD, FAAP
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2015 Uniformed Services Section Election Results

Executive Committee Member – Army
Mark Burnett MD, FAAP
Keith Lemmon MD, FAAP

New Term Begins November 1, 2015

Thank You to the 2015 Nominations Committee
Jennifer Hepps, MD, FAAP
Witzard Seide, MD, FAAP
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Be Informed!!! Get Involved!!!

Join the Section on Uniformed Services LISTSERV® Today!

If you are interested in joining the Listserv, e-mail tcoletta@aap.org.
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Notification of desire for membership, subscription requests and address changes should be sent to:

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E-mail: membership@aap.org
Visit https://fs25.formsite.com/aapmembership/affiliate/secure_index.html for an application.

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American Academy of Pediatrics
Section on Uniformed Services
Welcome Our New SOUS Newsletter Editor

Shannon M. Marchegiani, MD, MS FAAP
LCDR MC USN
shannon.m.marchegiani.mil@mail.mil

LCDR Shannon M. Marchegiani is a Navy neonatologist at the Walter Reed National Military Medical Center, as well as an Assistant Professor of Pediatrics at the Uniformed Services University of the Health Sciences University and a Guest Researcher at the National Human Genome Research Institute at the National Institutes of Health. She is serving as the interim Associate Program Director for the National Capital Consortium Neonatal-Perinatal Medicine Fellowship.

LCDR Marchegiani was first commissioned as a 2nd Lieutenant in the United States Air Force Medical Corps in May 2001 upon acceptance to the Uniformed Services University of the Health Sciences (USUHS) for medical school training. Upon receiving her Medical Doctorate degree in 2005 from USUHS, she completed her pediatric residency training at Naval Medical Center Portsmouth in 2008. In 2006, during her residency, she transitioned services from Air Force to Navy with the completion of an interservice transfer initiated prior to medical school graduation. Selected for neonatology fellowship training with a deferred start, she served as a General Pediatrician from 2008-2009 at McDonald Army Medical Center in Fort Eustis, Virginia, where she instituted developmental and M-CHAT screening at well baby and well child visits. She subsequently completed training in the Neonatal-Perinatal Medicine Fellowship in the National Capital Consortium from 2009-2012, and in 2012 remained at Walter Reed National Military Medical Center as a staff neonatologist. She additionally continued to pursue her research interest in the study of rare Mendelian diseases through the NIH Undiagnosed Diseases Program and complete coursework relevant to medical genetics and inborn errors of metabolism. LCDR Marchegiani is a Fellow of the American Academy of Pediatrics and is board-certified in both General Pediatrics and Neonatal-Perinatal Medicine.

LCDR Marchegiani grew up initially as an Air Force “brat,” before her father transitioned to service as a C-130H pilot with Stratton Air National Guard in upstate New York in support of the National Science Foundation Antarctica mission. She received her Bachelor of Science Degree from Cornell University with a concentration in genetics and development and went on to receive a Master of Science degree in Biology from Purdue University. Before entering medical school, she worked as a research technician in the field of genetics at the Children’s Hospital of Philadelphia studying the rate of nondisjunction in mice with Robertsonian translocations and the use of micorarrays as a technology to identify novel imprinted genes. LCDR Marchegiani currently resides in Maryland with her husband, CDR(s) Michael R. Melia, an emergency medicine physician who serves as the EMS Medical Director for the National Capital Region, and their three children Ainsley, Michael and Elliott.

For more information or to join the section…visit our website at: http://www.aap.org/en-us/about-the-aap/Committees-Councils-Sections/Section-on-Uniformed-Services/Pages/default.aspx.
Air Force Consultant Update

So I have been in the chair now for about eight months. The learning curve has been quite steep so I appreciate everyone’s patience and guidance during this process. It is really cool to see the AFMS Pediatric organism from the 30,000 foot view. We have such a diverse and talented group all over the world doing some phenomenal medicine. Whether it is malaria research in Africa or leading MILVAX at the DHA, we are leading the way. I just want to touch on a few big rocks we have been working on over the last few months.

We are close to having a currency rotation set up with the University Medical Center Children’s Hospital in Las Vegas, Nevada. We are working feverishly to finish a curriculum (thanks Major Reyes) and get a training agreement finished to allow rotations to begin. I am really hoping to develop this into a robust training refresher for those who have expressed interest in maintaining their inpatient skills. This hospital has a burn unit, level one trauma center for children, NICU, PICU, and pediatric emergency department. More importantly, they have amazing staff that are highly interested in supporting the military by training us. Many of them are prior military themselves. If you have not yet contacted me about being added to the list, please email me. I already have close to the number that this program will support, so if you want one of the remaining slots, you must let me know soon.

I have been working with our HEDIS Cell here to modify our Childhood Immunization Metric. We will be tracking the HEDIS Combo 3 moving forward. This will let us compare AFMS performance to the information that is tracked by the Center for Disease Control (CDC) through their Nation Immunization Survey. You will now be able to compare your immunization rates to the state you belong to, or nationally if you are at an overseas location. Additionally, we have added individual immunization rates so you can determine which vaccinations your parents are refusing or missing most frequently. This should assist you in your campaign efforts for patient education. Finally, we are going to beta test a system that will allow ASIMS to communicate with Audio-Care to remind households with a patient who is due or overdue for an immunization. Continue to flow your ideas up and I will get them out to the field for best practices.

Going forward, we have projected ongoing needs for training developmental pediatricians and adolescent medicine physicians. These two career fields are key to training residents to successfully care for patients at small MTF’s where subspecialty care is located at a great distance to the base. These fields are very rewarding and assignment locations are typically at very desirable locations. If you have not considered these fields for training please feel free to contact Major Erik Flake (eric.flake@us.af.mil), program director at Madigan for developmental pediatric fellowship interest. Major Shana Hansen (shana.l.hansen.mil@mail.mil) is the program director at SAMMC for Adolescent Medicine and can give you information about the fellowship program.

That is all I have today. Please let me know if you are not getting my regular updates via email and I will ensure I update my contact list. It is truly an honor to serve you. Please utilize me if you have questions or concerns and I will be happy to help. As always, thanks so much for the hard work.

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Greetings, Uniformed Services Pediatricians! Summer is arriving here in Boston after a record-breaking winter. Despite the 9 feet of snow here, things have been busy for the Army’s pediatrics team.

For starters, COL Andy Doyle has stepped down as General Pediatrics (60P) Consultant after four years in the role. Thanks to Andy for all his hard work and mentorship, especially while serving in a variety of demanding operational assignments, including his current job as CSH commander. Best of success to him and his team during their current deployment, and safe return to all.

I’m honored and humbled to be joining a team of great consultants. COL Andre Fallot is the Pediatrics Subspecialty (60Q) Consultant, COL Jeff Greene is the Adolescent Medicine Consultant, and COL Dee Gries is the Neonatology Consultant. We work together closely, so feel free to contact any of us if you have ideas, questions, or concerns.

Army pediatricians have been busy throughout the operational force. During the past year, pediatricians have continued to deploy or serve unaccompanied tours overseas in Kuwait, Afghanistan, and various locations in the Pacific Region. LTC(P) Catherine Kimball-Eayrs noted that, at one point this year, about 6 to 8% of all Army staff pediatricians were deployed. In her location, pediatricians far outnumbered internists and family practitioners. Thanks again, to all of you who continue to demonstrate pediatricians’ versatility, dedication, and military relevance.

As we reach the end of another academic year, graduating residents are preparing for their initial assignments, and dozens of pediatricians are preparing for their next move to new staff assignments, sub-specialty training, or operational tours.

Whether you’re moving or not, it’s a good time of year to ensure your administrative records are up to date. Take some time to make sure your Officer Record Brief is up to date and shows your current job description. You might be surprised by the number of folks whose ORBs list them simply as “incoming personnel” long after they’ve arrived at a new duty station. Make sure all the other information on your ORB is up to date and that your personnel offices have submitted supporting documents to your official military personnel file (OMPF). Also, make sure your official photo is up to date, especially if you’ve received new awards or changed your name since the last one.

The recent Army TSG Consultants’ Symposium reiterated the fact that military schools continue to be important for promotion. If you’re a Captain out of residency, you should complete the Captains’ Career Course as soon as possible. Intermediate Level Education is becoming increasingly important for promotion to Colonel, and it is definitely a requirement for more and more board-selected senior medical positions. Since I know pediatricians can excel in any leadership role Army Medicine has to offer, I want to make sure we have as many ILE grads as possible.

Graduate medical education remains strong this year. We will have 23 new pediatrics interns this summer: eight at Madigan, seven at Tripler, four in San Antonio, and four at Walter Reed. We will also have 10 fellowship starts this summer: one in adolescent medicine, two in critical care, two in developmental behavioral pediatrics, one in endocrinology, one in gastroenterology, one in hematology-oncology, one in neonatology, and one in pulmonology.

Continued on page 7
As we begin next year’s GME cycle, I encourage you to start thinking about your plans. We’ll be sending out announcements detailing the application process and timelines. If you’d like to move to a new location or pursue an operational or administrative assignment, let Andre or me know so we can begin to plan, as well.

Lastly, as of this writing, we are putting together the conference approval packet for Army pediatricians to attend the AAP’s National Conference and Exhibition in Washington, DC from 24-27 October 2015. Thanks to Catherine Kimball-Eayrs and the Section on Uniformed Services team for the countless hours of work they’ve done to organize the SOUS program from 1000 to 1600 on Sunday, 25 October 2015. While there’s no central funding for this conference, it will be a fantastic event and a wonderful opportunity for Uniformed Services pediatricians to celebrate the work we do to care for our Service members and their families.

Enjoy the summer season. Remember, even as you’re counseling your patients on summer safety, to be safe yourselves and watch out for each other.

Very respectfully yours,

Tom Eccles, MD FAAP
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Deployment and Military Medical Home Resources

Families in the uniformed services often face challenges with regards to deployment situations. The Deployment and Military Medical Home Resources on AAP.ORG provides pediatricians, both military and civilian, and other care providers with tools to address these needs.

Learn about this at:
Hello everyone! I’ve been honored to serve as your Specialty Leader and have really enjoyed talking with so many of you over the last couple of months. I’ve been impressed by your ability to expertly care for military families in a wide variety of challenging environments. We currently have uniformed Navy pediatricians at over 20 locations around the globe who continue to carry out our primary mission of providing first rate, compassionate care to military children. Our training programs remain very strong, with 42 pediatric residents and 14 fellows currently in training in a wide variety of pediatric specialties. Many Navy Pediatricians continue to serve in Executive Medicine and Operational billets, while others are working hard on improving our ability to care for military children through their efforts on BUMED and DOD initiatives related to critical areas such as immunizations, newborn care, electronic health records and obesity. This is an impressive body of work!

The Comfort and Mercy Missions are now underway and Navy pediatricians are filling critical roles on each team. CAPT Tony Delgado, CDR Cole Bryan, LCDR Missy Buryk, LCDR Chris Foster and LT David Myles are all participating in Continuing Promise 15, the USNS Comfort’s 6-month humanitarian and civic assistance mission to the Caribbean and Central and South America. Navy pediatricians CDR Gregg Montalto, CDR Harlan Dorey, CDR Natalie Burman, LT Sharon Enujioke and LT Janelle Kringle are participating in Pacific Partnership 15. The USNS Mercy departs in May and will work with host nation partners in Southeast Asia and the Pacific Islands to deliver Public Health Outreach and Education, Subject Matter Expert Exchange, Primary Care and Surgical Interventions. Each team plans to send us updates along the way and we look forward to sharing their “Sea Stories” with the community. We expect similar opportunities in the future, so if you have a personal interest in Humanitarian Missions, please reach out to me and let me know.

The 1st Annual Errol Alden Pediatric Symposium was held in the DC area in March of 2015 and was a huge success! This unique symposium provided high quality CME and networking opportunities for the broad range of providers who care for military children. Attendees from surrounding MTFs included physicians, nurse practitioners and physician assistants from multiple disciplines. The meeting focused on improving care coordination in the region and included a “How can we serve you better” survey, updated descriptions of sub-specialty services offered at WRNMMC Bethesda, contact information for providers and Service Chiefs within each sub-specialty and clearly defined pathways for network MTF and civilian providers to use when referring patients, seeking advice or arranging admissions. I wanted to share this particular aspect of the symposium with our entire community, to highlight the benefits of creating a learning environment that allows primary care and specialty providers to learn together while building relationships. Navy Pediatrics was well represented on the planning committee by CDR Jill Emerick and LCDR Shannon Marchegiani and in the lecture hall by CDR Theophil Stokes, who led a small group discussion about, “Outpatient care of the NICU graduate.”

If you are interested in pursuing fellowship training in 2016, please contact me by mid-summer at the latest. I’m happy to talk to you about particular specialties, the general application process and community needs. We can also connect you with mentors and current fellows. I’ll also look forward to talking with those of you up for new assignments in the late summer and early fall. I’ll do my best to advocate with the detailer to get the right people in the right assignments. Lastly, I look forward to working with you as you progress through your careers; frankly it’s the best part of the job. I’ve truly been amazed with the talent Continued on page 9
in our community and will do all I can to help you succeed. You can reach me at 757-953-5159 or email at roger.s.akins.mil@mail.mil.

CDR Roger Scott Akins, DO, FAAP  
Developmental-Behavioral Pediatrician  
Specialty Leader, Navy Pediatrics  
Head, Neurodevelopmental Pediatrics, NMCP  
Chair, EFMP, East Coast Central Screening Committee  
Assistant Professor, Pediatrics, USUHS

Updated Message from the AAP Department of Membership

If your AAP membership expires soon, please watch your mail for your renewal invoice. You will receive an e-mail notifying you when your renewal invoice has been mailed. When you receive your invoice, please review it for accuracy. If you currently hold other AAP memberships, they will be on your renewal invoice in the following order:

• National membership
• Chapter Membership (Uniformed Services and State)  
• Section membership(s)  
• Council membership(s)

A couple of things to note:

1) The state chapter is added to all national renewal invoices regardless of current state chapter membership status.
2) Uniformed Services chapter membership is added to your invoice if you are currently a member or if you are associated with the military in the AAP database.
3) Chapter membership is not mandatory, though is strongly encouraged.
4) The Section on Uniformed Services does not charge dues. You can easily join the section online. Log on to the Member Center, in the Member Community section click the “Join a Section or Council” link.

Please Note:
Members can pay and/or edit their membership renewal invoice online at http://eweb.aap.org/myaccount. Log in with your AAP ID and password. Chapter, section, or council memberships can be removed from your invoice prior to entering credit card information. If you wish to change your member type or add additional chapter, section or council memberships please contact Member Services at 800-433-9016, ext 5897 or e-mail us at membership@aap.org.

Thank you for your continued membership and support of our mission.
Welcome Our New Navy Consultant

CDR Roger “Scott” Akins
Developmental and Behavioral Pediatrician
Naval Medical Center Portsmouth

CDR Akins is originally from Arizona. He attended Northern Arizona University and earned his Bachelor of Arts in Liberal Arts in 1993 and then his Doctorate of Osteopathic Medicine at Midwestern University in 1998. He completed his residency training and served as Chief Resident of Pediatrics at the Naval Medical Center in Portsmouth, Virginia. In 2001, CDR Akins reported as a pediatrician to the Naval Hospital in Jacksonville, Florida, where he was recognized as the Navy Young Pediatrician of the Year and received the Admiral Melvin Museles Award for Excellence in Medical Education. In 2004, he was named Head of Pediatrics. In 2007, he began a fellowship in Developmental and Behavioral Pediatrics at the U.C. Davis M.I.N.D. Institute.

Since 2010, CDR Akins has served as the Head of the Division of Neurodevelopmental Pediatrics at the Naval Medical Center Portsmouth. He leads a division of professionals that provide direct care to military children with neurodevelopmental disorders in Virginia and in remote OCONUS locations, travelling to Cuba, Italy and Spain. Under CDR Akins leadership, the Division of Neurodevelopmental Pediatrics has developed programs that utilize Community of Practice Models that improve care coordination between military treatment facilities, schools and civilian healthcare providers. In 2013, CDR Akins was named as the Specialty Leader for Navy Developmental Pediatrics and contributed to policy development for the treatment of military children with autism spectrum disorders. In 2014, his contributions to clinical and academic excellence were recognized with the NMCP Master Clinician Award. In 2015, he was selected as Navy Pediatrics Specialty Leader.

CDR Akins is an Assistant Professor of Pediatrics at USUHS. His primary research interest is in evaluating the effectiveness of a model of networked behavioral health services linking schools, primary care providers (PCPs) and subspecialty providers who care for school-age children in remote areas with limited access to pediatricians and pediatric mental health specialists. He has also presented findings related to service utilization in children with neurodevelopmental disorders, the use of complementary and alternative medicine (CAM) in families of children with autism, frequency of gastrointestinal symptoms in children with autism and the frequency and severity of migraine and other health problems that affect family members of children with fragile X Syndrome. He is currently Principal Investigator in a study of over 40k military children with neurodevelopmental disorders.

The Guide to Military Pediatrics is located on the Section on Uniformed Services web page.
INCREASING SUPPORT FOR MILITARY PEDIATRICIANS,
CHAPTER VACANCIES AND OYP NOMINATIONS

We are interested in increasing the support we can provide to military connected pediatricians and are in need of individuals who are interested in service at various capacities within the chapter. There will be a vacancy in the Executive Board in the position of Vice President as Dalila Lewis will be transitioning to the position of President this summer, and we also have a recent vacancy in the position of CATCH grant facilitator. Additionally, to improve communication and participation within the residency programs we would like to identify a resident and staff liaison at each of the military pediatric residency programs in our region. We invite all chapter members stationed in close proximity to the military pediatric residency programs (NMCP, NCC, and WPAFB) to consider volunteering in this capacity. Please e-mail the chapter Executive Director, Carolyn Famiglietti at carolyn.famiglietti@aap.org with interest in any of the above positions ASAP. If you have been nominated for another AAP award please know that you can apply to this one as well. We are hoping for a robust response as we know there are a lot of amazing young pediatricians and look forward to providing the awardee to this year’s OYP from each service at the new annual USPS lite during the NCE in Washington DC in October of 2015. Historically we have used chapter funds that come from your dues to allow these young physicians to travel and receive their award in person which will now occur at the national conference this fall. To apply, please e-mail a nomination letter and CV to carolyn.famiglietti@aap.org. We look forward to receiving your submissions!

As Chapter leaders we were excited to support the 1st Annual Errol R. Alden National Capital Region Pediatric Symposium held on March 21, 2015. We hope that some of you were able to attend and look forward to supporting other educational opportunities. You can read the event summary submitted by our member-at-large Dr. Daniel Kramer - See Page 14. We would also like to provide military specific MOC and are looking for individuals who are interested in assisting with this endeavor. Finally it is time to submit nominations from each of the services for the Outstanding Young Pediatrician Award. This is the opportunity to recognize your hardworking colleagues! Traditionally, this award is given to a relatively ‘young’ or junior staff pediatrician with emphasis on provider impact in the primary care or austere settings.

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

Please submit your idea or article to:
Shannon M. Marchegiani, MD, MS, FAAP
shannon.m.marchegiani.mil@mail.mil.
This afternoon I am sitting at the Camp Arifjan, Kuwait swimming pool looking out over all of the Soldiers, Sailors, Airmen, and Marines stationed here enjoying a nice break from their work week. I have to say that this deployment to Kuwait in support of Operation Inherent Resolve has been nothing like previous deployments that many of us have experienced in the last decade – thank goodness. In stark contrast to my current deployment, I am reflecting this month on the 70th anniversary of the Battle of Okinawa. On April 1st, 1945, my 19 year old grandfather, USMC Corporal John Lemmon went ashore on Okinawa for what was to become one of the costliest battles of World War II. On May 14th, 1945, he was shot in the knee with a machine gun bullet and received multiple shrapnel wounds. He was evacuated off of the island to the USS Mercy, a predecessor of the current USNS Mercy. When the Battle of Okinawa was finished 12,500 US Service Members had lost their lives and 38,000 were wounded during the six week battle. Just a few months later, on Sept 2, 1945 Japanese Imperial Forces would surrender to the Allied Forces aboard the USS Missouri in Tokyo Bay. As we appreciate the end of our major operations in the Middle East, let us never forget the contributions and sacrifices of those service members and their Families who have come before us.

It is hard to believe the last two years have gone by so quickly, but this is my last newsletter as the USW President. I would like to thank all of the members of the Chapter for your outstanding support and contributions to the Chapter over the last two years. On the first of May you will have received a ballot form to select a new Chapter Vice President and 2 Members at Large. On July 1st MAJ Amy Thompson will assume the Chapter Presidency along with the newly elected VP. I have every confidence in MAJ Thompson’s abilities to lead the Chapter into the future successfully. In fact we had a chance to cross over for about two weeks at Camp Buehring, Kuwait in February as she was leaving the theater as the Brigade Surgeon for the 1st Brigade of the 1rst Infantry Division and I was working temporarily at Camp B with the 21st Combat Support Hospital. We shared several meals and coffee shop meetings over two weeks planning Amy’s transition to the Chapter Presidency and brainstorming for the future. Amy’s husband, MAJ Josh Thompson, remains active as our Chapter webmaster. He has done a fantastic job of giving our web presence a needed facelift and keeping information current. I know you are being left in very capable hands.

In preparation for this quarter’s newsletter, I looked back over the last two years’ newsletters and chapter executive committee meeting notes. It is truly amazing how much we have accomplished as a Chapter on behalf of military kids and their Pediatricians. As I took office in the summer of 2013 we were all facing the first and “hopefully only” sequester and government shut down. This ended up playing a remarkably important role in providing some direction for the Chapter. With funding from the military virtually dried up for professional development and trainee travel, the Chapter saw an opportunity to step in and utilize its resources to support opportunities in these areas for members. In 2013 and 2014 the Chapter provided complete financial sponsorship and individual mentorship to a resident/fellow trainee from each of the Pediatrics Training Programs in the West Chapter to attend the annual AAP NCE in Orlando 2013/San Diego 2014. We also took advantage of the Chapter’s financial health to double our Executive Director’s salary. Elina works very hard for the Chapter and was long overdue for a raise. In Feb 2014 the chapter executive committee gathered in San Antonio with our District VIII Vice Chairperson and staff from the

Continued on page 13
AAP to develop a strategic plan for the Chapter. The strategic plan along with the chapter’s annual reports can be viewed at any time on the Chapter Website at www.uschapterwest.org/. The Chapter remains in good financial health with a balanced budget. Through the great work of Dr. Norm Waecker, in the last 2 years the Chapter established an endowment to begin planning for long term financial security. We appreciate his foresight and vision in this area. We also owe Dr. Waecker a great debt of gratitude for his work in setting up and administering the Chapter Grant management program. Over the last two years, the Chapter has received and executed three CATCH School Based Health Center grants totaling $34,000, two major HPV vaccine and adolescent wellness grants totaling $40,000 and a handful of other grants. The Chapter updated its vital Military Youth Medical Home and Deployment Support Website in 2013 - http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Pages/Deployment-and-Military.aspx

Your Chapter leaders represented military kids and pediatrician issues to the National AAP leadership at the Annual Leadership Forums in Schaumburg, IL at the 2013 and 2014 meetings, the District Meetings in Scottsdale and Boston, and at the AAP National Convention and Exhibit in Orlando and San Diego. We recognized a Pediatrician of the Year from each service as well as awarded multiple special achievement awards to Chapter members who have distinguished themselves on behalf of military kids and pediatricians. The Chapter also waded into the social media realm by starting a US West Chapter Facebook Group and starting a Twitter account @AAP_USW.

I am so proud to have gotten the chance to work with all of the great people on the executive committee over the last 2 years. Amy is ready to take over. Thornton Mu and Renee Matos have brought outstanding creativity and contributions to the Chapter as the Members at Large and have motivated the San Antonio Residents through a great AAP at lunch initiative that they have set up. Jay Dintaman has kept us financially savvy and sound as the Chapter Treasurer. Dr. Norm Waecker has provided fiscal leadership and guidance to the Chapter as noted above and served as our “corporate memory” having been involved in chapter leadership for many years. Finally, Elina Ly has kept us connected with the AAP, kept us all in touch, and kept us on track with our schedules, meetings and reports. Without this great team, the Chapter would be merely a shadow of what it has ultimately grown into over the last several years. I am sincerely grateful to all of the executive committee members and to the entire Chapter for helping to make my time with the Chapter meaningful and memorable.

As we look toward our future, let us never forget where we came from and all of those who have paved our way. It is a place of highest honor to have been a part of one of the AAP Chapters charged with advocating for our critical profession and the deserving military children to whom we have committed our professional lives.

A rare opportunity. Seven Army Pediatricians gather at Camp Buehring, Kuwait in Feb 2015. Who’s taking care of all of the military kids back home? From Left to Right: LTC Soo Kim-Daleo, LTC Timm Vedder, COL Mark Burnett, CPT Liz Simmons, LTC Keith Lemmon, CPT Bob Kelly, and MAJ Shaprina Williams. MAJ Amy Thompson had left just the day prior and LTC Catherine Kimball-Eayrs and MAJ Tony Recpero arrived in theater shortly after this picture was taken. — at Camp Buehring, Kuwait
1st Annual Errol R. Alden National Capital Region Pediatric Symposium

Daniel Kramer, MD
Chapter East, Member at Large

The “1st Annual Errol R. Alden National Capital Region Pediatric Symposium” was held at Walter Reed Bethesda on March 21, 2015 honoring Dr. Errol R. Alden, MD FAAP. Dr. Alden was honored for his long term Service to the Nation as a former military Pediatrician who obtained the rank of COL, MC, USA at retirement and went on to become the Executive Director and the CEO of the American Academy of Pediatrics. Dr. Alden was formerly the Chairperson and Professor of the Department of Pediatrics of the Uniform Services University of the Health Sciences and the Chief, Department of Pediatrics, Walter Reed Army Medical Center. The symposium was organized by the Department of Pediatrics of the Uniform Services University of the Health Sciences and the Department of Pediatrics of the Walter Reed National Military Medical Center at Bethesda. It was also sponsored by the Uniformed Services East Chapter. Dr. Katona, who is chairman of Pediatrics at USUHS, gave a moving history of Dr. Alden, having known him as a contemporary, along with his many achievements.

The symposium was held on a Saturday and included lectures in the morning by COL Tom Burklow, MC, USA from Pediatric Cardiology on “Cardiology Pearls for the Participation Sports Physical,” LTC(P) Brent Lechner, MC, USA Pediatric Nephrology on “Pediatric Hypertension,” and MAJ Brian Green, MC, USA from Pediatric Dermatology on Dermatology “Tips and Tricks.” The afternoon session allowed for small group sessions that included academic leaders Steve Min, LTC, MC, USA from Pediatric Gastroenterology, CDR Theophil Stokes, MC, USN from Neonatology, LTC Jean Burr, MC, USA and COL Jeff Hutchinson, MC, USA from Adolescent Medicine, LTC David Dennison, MC, USA from Pediatric Neurology, COL Mike Rajnik, MC, USAF from Infectious Disease and LTC Karen S. Vogt, MC, USA from Pediatric Endocrinology.

The symposium attracted primary care providers from the various military clinics and hospitals in the NCR. Since funding has been cut for training and meetings, the Uniformed Services East Chapter teamed up with the Department of Pediatrics to try a pilot program aimed at primary care providers to be done locally with local experts. The Department recognized that their constituency included not only General Pediatricians but also Family Practice physicians, Nurse Practitioners, Nurses and Physician Assistants. Participants received CME category 1 credits for six hours, ability to network and meet the consultants they refer patients to and were given a Staff Directory to contact WRNMMC Staff in a more immediate manner.

COL Margret Marino, MC, USA, Chief of Pediatrics, made it quite clear in her introduction that the primary care provider was the key to access for patients to the Children’s Center at Walter Reed Bethesda. She also stressed that we are one team and that our collaborative effort will result will in use of the MTF to its maximum potential by capturing patients and encouraging them to use resources within the MTF. This will serve to enhance the teaching programs at USUHS and WRNMMC by ensuring an ample patient supply. Essentially, this can become a model for other teaching MTFs to enhance their referrals by improving their brand recognition in their area of responsibility.

Continued on page 15
All in all the day was quite successful and achieved its purpose. Dr. Alden was impressed by the excellence of the presentations. The participants were excited about the chance to connect with the experts as were the experts with them. Many thanks to the Planning committee Jill Emerick, CDR, MC, USN, Shannon Marchegiani, LCDR, MC, USN, Thomas Newton, COL, USAF, MC, and Carolyn Sullivan, COL(ret), MC, USA.
HOTWASH - An Update on Maintenance of Certification (MOC) 
Part 4
Laura L. Place (Col, USAF, MC), Chief of the Medical Staff, Luke AFB

Who: Pediatricians needing Maintenance of Certification (MOC) Part 4 Credit (Performance in Practice)

What: The American Board of Pediatrics (ABP) just recently announced expanded options to obtain Part 4 credit. One of these options includes receiving 40 points of credit for having established a Patient Centered Medical Home that is certified by the National Center for Quality Assurance (NCQA). It requires “meaningful participation” by the physician in order to claim the Part 4 credit. There is no fee associated with the application.

Other new options include “Create Your Own QI Project” which allows for credit to be earned on Quality Improvement (QI) projects that pediatricians have already completed, as well as “Organizational QI Program Development” which is applicable for those pediatricians in leadership positions who direct quality initiatives in their facility. To learn more visit:

https://www.abp.org/content/how-to-earn-credit#confirm

When: Effective 18 May 2015

How: Log-in to the Maintenance of Certification Activity Manager (MOCAM) at this link:

https://abp.mocactivitymanager.org/individuals/ncqa/

First time users must register. The application process is very quick. Required information includes: ABP number, uploaded copy of your facility’s NCQA certificate, and a brief paragraph summarizing your participation in the project. Applicants will be notified within 2 weeks of their approval.

Several Air Force pediatricians have already received credit notifications for using this pathway. I found this option to be very beneficial as it was free, quick (less than 20 minutes), and provided full QI credit. Please let me know if you have any questions about the pathway or application (laura.place@us.af.mil).

Letters to the Editor

Have a concern about a feature or story that appeared in a past edition of the Uniformed Services Newsletter? Just want to comment on something related to uniformed services? We have a new feature, “Letters to the Editor.”

Please send any comments or concerns to Shannon Marchegiani, MD, MS FAAP shannon.m.marchegiani.mil@mail.mil or Tracey Coletta tcoletta@aap.org. We will publish the letters and do our best to respond to your concerns.
Leaders as Clowns, Sans Nose
Dr. George Patrin, Singing Clown, Advocate

Those in privileged leadership positions, no matter the organization or occupation, should be clowns every day. I refer to taking on social clown personas – being people who remain light-hearted and positive, with no reservations or shyness about being of service to all we meet, doing whatever we can to bring joy and diffuse stress, if for only a moment, out of genuine concern for others, and especially for those in our sphere of responsibility and care.

Adopting this attitude change would be a huge service to employees, colleagues, and acquaintances and make one a truly transformational leader. Does this require a red nose, you may ask? Initially, yes, the artificiality of the red nose breaks down needless barriers, ones we imagine are there, and also the barriers that those we interact with put in place to protect themselves….from us. With the nose on, we can be bold in our interactions as the nose is an obvious public statement that the person someone is dealing with at the moment isn’t really me, but a ‘clown me.’ The nose clearly allows one to “make a fool of oneself” in public, which takes immense courage, actually. Think on it as one on the other side – if the boss is willing to do this, perhaps I can take a few risks to improve the workplace and so our product, too. The ‘magic’ of the nose is that it transforms our behavior and sends an immediate unspoken message that the interaction between us is not to be ‘business as usual,’ but a time of removed barriers, improved communication, personal interaction, and right now. The nose insists on attention and reaction, it demands it… for us, without ‘us’ having to ask for it. And the nose works in every language, not surprisingly. This is only known, unfortunately, by those who have put one on, and gone out in public. So go ahead, do it, put one on tomorrow, before you go out the door. Those you meet will certainly know you are “up to something.” Out in public, especially with people you don’t already have a relationship with, the nose will immediately establish a connection, it ‘opens the door,’ gives permission to interact. The nose removes barriers because people want to let their guard down, laugh, smile and wonder, when a red nose appears. It’s genetic in all of mankind, the emergence of the ever-present inner child. A sincere clown triggers trust between people, even hope, because people want to be loved. Given the power of the nose, the best leaders should clown a good amount of the day, get over themselves, do whatever is necessary to be of service to others, bringing joy and hope into the workplace. It’s good for moral. Clowns can do anything; there are no expectations, except maybe, for surprise. Sit unexpectedly still, suddenly laugh, cry, look with amazement into the eyes of another; it’s all good, and right, and true, coming from a clown. Perhaps most importantly, in our culture, people aren’t supposed to, are not allowed to, touch. Clowns however, are expected to try to get away with it. Clowns are expected to give a humble and sincere hug whenever possible, and truth be known, the longer the better. The beginning and end of every meeting should be a (group) hug, as long as the moment will allow, one of genuine appreciation and humble concern for the hugee(s). Far too often, touch is only for a fleeting moment, through a hand shake or placement of the hand on a shoulder or arm. We don’t plan for, or allow for, genuine non-sexual touch in our daily encounters, unfortunately. We are too rushed. The nose breaks the routine and allows for lingering, thus breaking the routine, just for a moment. We know there is great value in providing momentary comfort, a connection, even if with only the eyes, as a release from stress and daily care. If we do this consciously, with genuine concern and unconditional love for one another, even though fleeting, moving on to another moment with another person, we leave the former recipient forever...
Leaders as Clowns, San Nose . . . Continued from page 17

changed, to wonder if they’ll (hopefully) see that caring clown again, anticipating even a longer moment and connection the next time. Leaders can and should leave behind a trail of wondrous smiles and ‘hopes’ at day’s end. True, in so doing we leave behind a piece of ourselves… if we do it right. Eventually, in time, we can be brave enough to do all this without the nose, but retain the persona. Leave all we meet with a token of our affection, given without expectation other than to draw out the child within, and an unspoken pledge of continued support for the grown-up caretaker of that child spirit in the future. Yes, leaders should be clowns in public, with or without the nose. The world would be a better place. Don’t bother to send in the clowns…they’re here. Send me.

For Veterans…

COL (Ret) George Patrin, Pediatrician, recently returned from a second International Community Clowning Trip with Dr. Patch Adams of the Gesundheit! Foundation (recall the movie Patch about his medical school experiences). Dr. Patrin’s first trip with Patch was to Russia in Nov 2012 to visit orphanages, senior homes, and hospitals. During this trip Dr Patrin, surrounded by the love and friendship of a troop of International clown mates, had an unexpected improvement in PTSD symptoms and depression resulting from his 23 years of active Army service and two deployments to combat zones, complicated by the suicide death of his 20 year old son in 2009. While psychotherapy, support groups, and men’s grief therapy were helpful, this two week experience so changed him, that his wife and family, especially his 1 1/2 year old granddaughter, noticed a remarkable change in his affect and spirit on his return. George spoke with Patch Adams, resolved to work with Patch’s Gesundheit! and George’s non-profit, Serendipity Alliance, to conduct a future clown trip with Veterans to determine if this effect was universal. Over the past two years they have written a research protocol with the Chicago VA PTSD Program to arrange for Veterans currently in therapy for any number of conditions - PTSD, TBI, depression, addictions, anxiety and/or suicidal ideation - to go to Guatemala the week of October 10-18, 2015 and participate in humanitarian clowning. The recent trip March 7-14, 2015 was the traditional Spring Break trip to Guatemala for Gesundheit!. (See The Gesundheit Institute, gesundheitinstitute@patchadams.org) This group was made up of citizens of the US (TX, CA, WA, and VA), Mexico, Bolivia, Panama, and Canada. Guatemala is an ideal clowning location as the country has an established humanitarian clowning program (called Fabricas) and the hotel is a private bed and breakfast where the troupe can decompress each evening and explore how the day’s visits are affecting each person’s emotional state. Prior clowning experience is NOT required, or expected on any Gesundheit! Humanitarian Community Clowning Trip. Wearing a red nose, called “Nasal Diplomacy” by Patch, breaks down barriers allowing for real, sincere, human connection unlike any other ‘volunteer’ experience (see Dr. Patrin’s SOUS article – ‘Leaders as Clowns, sans nose’). We believe this immersion experience will transform every Veteran leading to a decreased need for ongoing ‘standard’ therapy in the future. Providers knowing of or caring for Veterans who might benefit from this groundbreaking Gesundheit! research trip can contact George at patrin.george@gmail.com. This first trip can take only 10 Vets. A waiting list will be started for future trips should this prototype pilot have the results expected.

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Have you ever seen or experienced something that was so powerful it redirected your course in life? That happened to me this fall. I was just trying to survive the onslaught of flu season in a busy general pediatrics clinic while balancing the stressors of being a single mom. Often I struggled just to get through the day, on the verge of depression. Focusing on technological advances in medicine was never on my radar. Honestly, in the past, medical technology rather scared me; new advances seemed to be exclusive or implausible and something only surgeons or academics would need. Sure, I would get a little thrill about a new lighted ear curette or a giraffe shaped reflex hammer, and our practice made the painful transition to electronic medical records with the rest of the nation, but that was the extent of my focus on technology.

Then, the Cleveland Clinic Top 10 medical advances for 2015 showed up on my screen. “The New Art of Blood Collection and Diagnosis,” #3 on the list, caught my eye. It described new way to draw blood, virtually painless and enabling labs to be run off just 1-2 drops of blood at a fraction of the cost of traditional labs. After watching a TED Talk with Elizabeth Holmes and her company Theranos, discussing this new way to perform labs based on nanotechnology and microfluidics, something clicked in my neural synapses, transforming my thinking. I realized that I never even contemplated that there could be a different way to draw blood. I always accepted the status quo: blood test = painful needle stick + a good-sized tube of blood removed. This was a new and exciting concept—the possibility of a PAINLESS blood draw and needing only minute amounts of blood. Now here was a great reason to embrace technology! As a recent literature review in *Surgical Neurology International* highlighted, there are brain changes in infants undergoing painful procedures that were previously unappreciated, which makes anything that decreases the pain from frequent blood draws, not to mention the amount of blood needed, very welcome. I remember in residency the NICU babies needed transfusions just because we removed so much blood for monitoring. Other benefits might be decreasing costs associated with blood draws, preventing the need for PICC lines in chronically ill and cancer patients, lowering rates of hospital acquired infections, streamlining the newborn screening process and speeding up identification of infections. Even though not much is known about how Theranos works and published data are limited, to me, the beauty is in the idea. This novel, out-of-box thinking has compelled me to learn about and advocate for new technologies that can better children’s, and perhaps, all of our lives.

Several other technologies that minimize pain and the amount of blood needed with procedures are on the horizon. I’m excited that microfluidics is being applied to newborn screening. A company called Baebies is using this “lab-on-a-chip” technology to create new screens for lysosomal storage disorders and the pilot study examining this technology in newborn screening was just published in *The Journal of Pediatrics*.
in January 2015. Baebies is also creating portable devices that have global potential. The results can be obtained quickly with a tiny amount of blood at reduced cost and essentially run at the bedside. Wouldn’t it be great to know if a newborn had galactosemia before leaving the hospital so that the formula change and education could occur immediately rather than risk having the patient fall through the cracks or trying to track down the family 5 days later? Other types of painless blood draws on the horizon include the Seventh Sense Biosystems device called TAP and another product, Hemolink, from the company Tasso, has a blood drawing device that seems to have gained its inspiration from the leech. It draws and stores blood into a little container, with hopes that eventually this will be able to be done at home and sent to a lab via the mail once some storage hurdles are overcome. This technology again has global implications and shifts healthcare from being performed in the hospital to the communities, which may ultimately help save costs and engage patients to take ownership of their health.

Not only is the possibility of painless blood draws on the horizon, but also painless vaccines! Researchers like Dr. Mark Prausnitz of Georgia Tech and many others are working on microneedles, tiny patches that can deliver vaccines and other medicines. The global capacity of these technologies is mind boggling to me. Some of the microneedles are dissolvable, don’t require refrigeration and eliminate needle stick injuries. Just think about how the ability to vaccinate in remote areas could change global health and at the same time, save the environment from dangerous needle waste. Microneedles for TB tests are being made as well. This is revolutionary! Can you imagine how the practice of pediatrics would change?

The stress and anxiety caused by vaccines and blood draws is not to be underestimated. Not a day goes by when a child in the clinic does not well up in tears (scream, hide under the table, or even faint) at the thought of getting a shot or blood draw. Every parent and child I talk with about these new technologies say “Please, hurry!” All the nurses I discussed this with love it too. So many groups of people would benefit—neonates, those with cancer and autism, diabetics, needle phobes, those with poor venous access, the geriatric population. Why stop there? Why not painless insulin, allergy shots, IVIG and chemotherapy? What about a redesign for the IV? There are great opportunities for the healthcare field to become more patient-centered. If technologies to ease blood draws, limit sample volume, and aid vaccine delivery are in development, I think we should question what else remains to be done before they can be used? How can we help get them approved?

Wouldn’t it also be great to focus on PAIN PREVENTION rather than pain management? The Institute of Medicine’s “Relieving pain in America: a blueprint for transforming prevention, care, education and research 2011,” states that “At all levels, focus should be on prevention,” but to meet this mandate it will require a cultural transformation. The draft of the National Pain Strategy just released recommends a focus on pain prevention as well. I think hospitals, in general, are paying attention to children’s pain with many procedures are performed with sedation; but what about in the outpatient world? With obesity and lipid guidelines, many more kids are getting blood draws. More and more vaccines are being added to the schedule. In another TED talk, Dr. Amy Baxter describes how there is an increase in needle phobia over the years that may be related to higher numbers of vaccines. It appears that kids who are more needle phobic are less likely to get their HPV vaccines, and as adults, less likely to get the flu shot. Needle pain needs to be taken seriously. Dr. Amy Baxter became an entrepreneur and invented the Buzzy4shots, a FDA approved device sold online that is evidenced based to help relieve pain with injections. I purchased one to try for

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our clinic and found it really does help kids in the school-age group. Synera topical lidocaine and tetracaine patches could be another option for children getting needle sticks. Distraction such as blowing bubbles, humor, and oral sugar solutions have also been shown to decrease the pain with shots. I discovered there is actually an evidence-based guideline for handling pain with vaccinations (see citation below). For babies, breastfeeding during painful procedures has been shown to decrease crying and pain indicators. I admit I haven’t done all I should to reduce pain with procedures, but want to improve. We are working at our hospital to draw up plans to have infants breastfeed during painful procedures such as newborn screens and hepatitis B vaccination. Even just critically assessing whether a lab test is truly needed could help save a child from undergoing a painful needle stick. On my journey of discovery, I joined Twitter along the way. Twitter was scary to me at first because I didn’t understand it, but it has been a wonderful experience. It opened up a new world of information and exploration of ideas that I otherwise never would have been exposed to. Atul Gwande’s book, Better: a Surgeon’s notes on performance, and Tedmed/Ted Talks have been a great source of inspiration. I have been able to connect with those advocating for children’s well-being, their education, and healthy communities. Most importantly over the last few months, I have regained joy in medicine and in life. I have rekindled my love of reading and learning. I am now recharged to help improve the care I deliver and take on the responsibility to improve healthcare for future generations. Drake said “Sometimes it’s the journey that teaches you a lot about your destination.” Who knows, maybe the entrepreneurial spirit will hit me as well?

http://health.clevelandclinic.org/2014/10/top-10-medical-innovations-for-2015/#mg_ld_43138


Seventh Sense Biosystems TAP http://www.7sbio.com/products/tap-products.html


microneedles, https://www.youtube.com/watch?v=gnRS7EXmXAo


http://nationalpainreport.com/the-national-pain-strategy-is-released-8825894.html

Buzzy4shots http://buzzy4shots.com  http://buzzy4shots.com/


pain with vaccinations http://www.cmaj.ca/content/182/18/E843.full

http://apps.who.int/rhl/newborn/cd004950_agarwalr_com/en/


A Deployed Pediatrician in Bagram

Eddie Uy, Lt Col, USAF, MC
Lackland AFB and SAMMC GME Pediatric staff
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This is Eddie Uy, M.D., Lt Col, USAF, MC, GME Pediatric staff of Lackland AFB and San Antonio Military Medical Center (SAMMC). This is a brief summary of my experience as a deployed pediatrician in Bagram; both thoughts I had and cases experienced.

• It was an honor to be deployed and serve our country in Bagram, Afghanistan the recent past 6 months from October 2014 through April 2015.

• I am fortunate to be tasked to deploy. It is a lifetime experience.

• I dedicated my service to my Pediatric patients and to morally support the staff in our hospital in Bagram.

• I took care of the medical aspect of the Pediatric surgical patients with our neurosurgeon, ENT surgeon, orthopedic surgeon, and our eye surgeon.

• I am the only pediatrician in our hospital, and have to take care of the medical issues of our pediatric patients 24 hours a day.

• I enjoyed my deployment. It is an eye opening experience to see the adult trauma and injury cases that we have for the past 5 and ½ months. I saw and learned from several trauma cases, and from my pediatric surgical humanitarian cases that were then operated on in our hospital.

• It is amazing of what our hospital team can do.

• Our hospital treats any injuries or trauma whether they are Americans, NATO members or Afghan policemen, soldiers, civilians and even our Afghan enemies.

• Some of the trauma patients are so fortunate to survive without many handicaps or complications, despite the mechanism of their injuries.

  ◦ For example there is one patient who was shot on his face sideways, and this caused him to only have a lacerated wound on one side of his facial muscle. Our great ENT surgeon was able to repair the laceration and fortunately [the patient] did not have any facial nerve damage.

  ◦ There is another patient who was shot on his neck and part of his larynx was injured. It was repaired

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A Deployed Pediatrician in Bagram  
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surgically by the ENT doctor and the trauma surgeon who checked for possible esophageal injury. After the initial surgical repair, he was transferred to the US for definitive treatment. He recovered well, after 1 month of further treatment and recuperation in the hospital.

◦ There is another patient who was hit with a bullet on his one eye. The bullet just hit superficially his cornea. He is vision was not affected.

• Some are much less fortunate; bullets penetrating body armor and entering the lower spinal cord area, paralyzing from the waist down or amputees. We have

• We have a few cases of gunshot wounds on the extremities. These wounds with shrapnel have to be cleaned, called “washout,” or debridement and irrigation, with 2 liters of N.S.S. in the operating room, every 1 to 2 days, until the wound is clean.

• It is amazing of what our hospital team can do.

• We have several humanitarian pediatric cases that the surgeons of different specialties operated on with good outcome. We have three infants ranging from 6 months to 9 months with hydrocephalus secondary to congenital lumbar myelomeningocele, treated by Dr. Major C.J. Berg. The new procedure is done on them is called a “3rd ventricle ventriculostomy,” and two of them were successful with regards to their hydrocephalus. One of them will need a V-P shunt. The latter was referred to another facility in the area, for the V-P shunt.

• We have a case of suprasellar intraventricular low-grade polycystic astrocytoma that was surgically removed completely. The patient was anticipated to develop Diabetes Insipidus after the operation and she did develop DI on the first day after operation. She needed DDAVP and had to be monitored closely 4 times a day initially to check her serum electrolytes and urine. There are some labs that we cannot do in our facility. We have to improvise our laboratory monitoring. This patient was then switched to oral desmopressin upon discharge and then referred and transferred to a German facility for further rehabilitation.

• We have 1 case of brain dura repair and patch for leptomeningeal cyst secondary to an open fracture from a fall off a roof. Most of the houses in Afghanistan are on the slope of a hill, so the incidence of children falling down form the roof is relatively high.

• Burns

• Another common accident is skin burn from a fire, since the Afghan has a common fire pit for several families in their living area. The young children are often unattended and their clothes will accidentally be caught in a fire causing a severe burn. But some of the burn scars of the Afghan children are secondary to old blast injuries.

• The ENT surgeon, Dr. Major Brent Feldt from Travis, did two pediatric cases of scar revision on the neck

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due to contractures secondary to skin burns affecting the neck and mouth opening.

• We have a case of an 18 month old boy with contractures of his hands secondary to skin burn scar. Our hand orthopedic surgeon, Dr. Major Évan Jones, and general orthopedic surgeon, Dr. Major William Howarth, repaired this case.

• The results are amazing.

• We have two cases of cleft lip repair done by the ENT surgeon.

• We have few pediatric cases of chronic skin infections with draining wounds, secondary to trauma that were debrided and treated with antibiotics for 6 weeks as outpatient for the bone infection.

• There are few cases of old fractures with deformities that were ORIG (Open reduction and internal fixation) by our 2 orthopedic surgeons.

• There is another girl with optic nerve glioma, operated by Dr. Major Brett Davies of Lackland AFB. This patient has severe proptosis and Neurofibromatosis Type 1; Her left eye with the tumor is protruding 1 inch out of horizontally out of her eye socket. The tumor on her unilateral blind eye was surgically removed. She was then given an eye prosthetic.

• Her face and eye look so good with the prosthesis.

• We have few cases of tonsillectomies for very enlarged tonsils causing snoring and frequent recurrent tonsillitis.

• My usual routine for work is making rounds 3 to 4 times in 24 hours for my Pediatric patients, and having to answer any issue even at night. I have to check in on my pediatric patients, early in the morning at around 0530 before the rounds, then rounds at 0700 am for the ICU patients and at 0800 for non ICU patients.

• My cases are fewer than my adult counterparts, but I am one the only non-surgical physician who will be called 24 hours a day for any issues of pediatric patients in our hospital. They are all my patients since I am the only Pediatrician.

  ◦ In the first few months, I will be called several times in 24 hours for any issue that the pediatric patients may have.

• At first, almost all the nurses and the 4N’s (military medical technicians) are very uncomfortable with the pediatric patients, since almost all of them are trained with adult patients and did not have much experience with pediatric patients. But after 3 months of exposure to our Pediatric patients, my guidance and the guidance of two senior nurses and two pediatric nurses, the rest of the nurses and the medical technicians became comfortable with the pediatric patients in our hospital.

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A Deployed Pediatrician in Bagram  

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• I also supported a lot of people in our hospital, by talking to them and encouraging them with positive attitudes and advice.

• The great moral support, positive advice and encouragement that I gave to all my co-workers, including the nurses, 4N’s and the other enlisted folks in the hospital, are my great service that I did for our country, in this deployment.

• A lot of our people appreciate me for doing this. They call me “great mentor and adviser”. I usually do not want to tell people the good things that I did.

• I also gave a very extensive lecture power point entitled “Intussusceptions in Children,” for our Medical staff Grand Rounds in Bagram.

• I am also the head of the expectant team for the mass casualty of our hospital. Being the leader, my presence and judgments play an important role for the expectant team.

• There are two events, where we have dead casualties that I have to be in charge of. We have to follow the custom for the Afghan or Muslim traditions in cleaning their bodies and wrapping them with a clean white sheet with no blood staining the sheets, covering their bodies.

• This is the brief summary of my experience as a deployed Pediatrician, in Bagram.

I hope my fellow pediatricians will be motivated and be inspired with my experience in this deployment.

Dr. Uy with 8 year old female optic glioma patient and family member.

AAP 2015 National Conference and Exhibition
October 24-27, 2015
Washington, DC
Two pints and three hours with Jay Kerecman

Interview by Shannon M. Marchegiani, MD, MS, FAAP

Jay D. Kerecman, MD MSc, (Col, USAF, MC), neonatologist, started out as a late preterm infant born into the family of a career Air Force fighter pilot in Sacramento, CA at Mather AFB. Following childhood as a military brat, he attended Cornell University on an AFROTC scholarship and graduated with a BA in Biology before matriculating at the Uniformed Services University of the Health Sciences for medical school. He completed his Pediatric Residency training at Keesler AFB in Biloxi, MS. Following residency, he completed his Neonatology Fellowship at Wilford Hall USAF Medical Center in San Antonio, Texas, remaining there as staff before returning to Keesler. He went on to serve in Okinawa, Japan as a Medical Director and Flight Commander, before again returning to the NICU at Wilford Hall, where he additionally chaired the Scholarly Oversight Committee for the Neonatal fellowship and pursued a Master of Science Degree in Clinical Investigations. In 2009, he was selected as the Program Director for the Neonatal-Perinatal Medicine Fellowship of the National Capital Consortium in Bethesda, MD. He finished his active duty career serving in that role and as the Neonatology Consultant to the Air Force Surgeon General. Dr. Kerecman will be retiring from the Air Force to Maine in June 2015 with his wife, Linda, and their children, Sarah, Carolyn, Natalie, & Daniel.

On a perfect May evening in Bethesda, I had the rare opportunity to sit down with my mentor and former program director, Jay D. Kerecman, MD MSc (Col, USAF, MC), and discuss something other than call schedules or ACGME milestones. Retiring from the Air Force after 24 years on active duty this June, Jay graciously granted me the chance to interview him with a collection of questions submitted by his current and former fellows, his neonatology colleagues, a former residency classmate, his residency program director, and even his eldest daughters. And so with the din of Rock Bottom Brewery in the background and a few pints between us, we began.

Which superpower, flight or invisibility, would you choose and why?

JDK: Who asked that question? Invisibility. Because you can sit in the corner and watch what’s going on without anyone knowing you are there.

What is your favorite vacation spot or ideal vacation?

JDK: Juneau, Alaska. My best friend from the Air Force growing up now lives there. We met in Germany in the 6th grade. Every summer in college and for part of med school we would drive from the east coast all night to Colorado or Wyoming and go four-wheeling and backpacking for a few weeks. But Alaska is by far my favorite place to do outdoors things.

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What did you like best about training at Keesler or what is a favorite memory from Keesler?

JDK: There were no fellows and the staff did not stay in house so we got to do a lot.

Can you describe in detail Colonel Kotchmar’s ‘levels of upset’ and the corresponding facial expressions?

JDK: [laughs] Who asked that? He actually only had one face. He curled his lip, and the more he curled his lip, the more upset he was. The irony was he had a doormat in front of his desk that had a happy face on it that said, “SMILE” on it, and when you were getting chewed out you spent the whole time looking at it. Of course I can’t think of a time I didn’t deserve the dressing down I was getting. Dr. Kotchmar [Col (ret), USAF, MC] was exacting and big on accountability and truly had an impact on me in my early years. The corollary to that was it wasn’t George [Col. Kotchmar] you were afraid of upsetting. It was Gary Crouch [Col (ret), USAF, MC].

[Colonel (ret) Gary Crouch was the Pediatrics Residency Program Director at Keesler AFB from 1997-1999. Per report, he was rarely upset or raised his voice, so when he was upset…]

Dr. Kotchmar had a rule for Morning Report. The interns had to be showered and in uniform for Morning Report. If they weren’t, the PGY3 got chewed out, so they [the interns] had to have all their work done in time to make it to their shower. Either this, or my fighter pilot father, is where I got my hang-up about starting on time (much to the chagrin of my fellows).

What made you choose neonatology?

JDK: So it was the tail end of my third year [of medical school] and I had not really enjoyed anything I had done all year long, so I thought I was destined to be a radiologist. I did a Peds rotation at Malcolm Grow, at the time they had a nursery there, and they had about five things roll through there that week that shouldn’t have been there including a diaphragmatic hernia and maybe like a 28 week preemie. Bob DiGironomo, [Col (ret), USAF, MC], who is now a good friend of mine, was a staff pediatrician at Andrews then, and we just had the best week and I knew exactly then that was what I wanted to do. That was the environment I liked and the type of medicine I liked. And when I did my sub-internship experience at NNMC with Jerri, that was further reinforced [staff neonatologist Jerri Curtis (CAPT (ret) MC USN) ].

You know, it’s funny too, because when I went on to start fellowship, Bob was still a fellow, so we were actually fellows together.

What job would you have chosen if you had not become a neonatologist?

JDK: An allergist. Or maybe an ophthalmologist.

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What about if not in medicine?

JDK: A pilot. Or maybe a forest ranger. Christine Erdie [Col, USAF, MC] could tell you a story about when we were interns in the middle of the night, in the middle of the year, and I said, “That’s it. I am going to quit and go to forestry school.”

Why were you going to quit?

JDK: Because I was tired of being an intern.

Who were some of your mentors and what did each of them teach you?

JDK: Who asked that? Interesting. Who were my mentors? For Gen Peds, my biggest non-neonatology mentor was probably Gary Crouch, and that is because of his dedication to patients and to education.

For Neonatology, my biggest mentors were Brad Yoder [Col (ret), USAF, MC] and Don McCurnin [Col (ret), USAF, MC], and again it was that combination of expertise and sense of duty that I learned from them. The other thing that I learned from both of them was that when you are training people you have to give them space. Don used to call it “stick time.” You have to give them stick time. You knew they were going to make some mistakes, but if you didn’t give them that, you were doing them a disservice. Your job was to make sure the mistakes weren’t so bad so as to compromise the patient.

Why specifically to you hate HFJV (high frequency jet ventilation), a.k.a. The Jet?

JDK: [Laughs] Because I trained at Wilford Hall. No, I don’t hate the Jet. I just don’t understand it. I probably never saw a Jet until my third year of fellowship and that was at an outside institution.

When did you first know you wanted to go into education or want to become a program director?

JDK: When I was a Medical Director and Flight Commander in Okinawa. Because I left resident teaching at Keesler to go do that. And even though it was in its own way very meaningful, I realized that it wasn’t me or wasn’t a good fit for me.

Don McCurnin would tell you that I actually spent my entire last year of fellowship trying to get the Air Force to send me get a PhD in [Molecular and] Cell Biology at USUHS. We had a lot of conversations about that. He actually tried [on my behalf]. But I think that probably would have been a mistake. I remember emailing, asking if there were active duty students in the program, and there were, but you had to get your service to let you go. And when I went to fellowship, I had no desire to do research, but within a year and a half, it was all I wanted to do. In fact, it drove my family nuts, because I used to care for the baboons in the NICU at the primate research center. The project…I had a couple different things going on…but one of my projects involved literally going to the baboon NICU every day. It was kind of on the way between my house and Wilford Hall, but even on the weekends when I was off I would have to run out there. It used to drive Linda just nuts. “Oh the damn monkeys again.” And I would say, “Well, it’s only for 15 minutes. It’s right up the road.”

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And so I had some amazing opportunities in and after fellowship, and for a while all I really wanted was to be a researcher. But the needs of the Air Force pulled me away from that and in the end, I think that helped me realize my underlying passion for education.

**What was a difficulty you faced (a patient case, parent interaction, or personal challenge) and how did you overcome it?**

JDK: Hmm.
SMM: We can come back to this one.
JDK: Yeah, let’s come back to it.

**Are you aware that your low, quiet serious voice is more terrifying than Voldemort?**

JDK: [Laughs] Was that my daughter?
SMM: No, but your daughters really loved that question.
JDK: I bet they did, because in my household we are very enamoured with Meyers-Briggs. So the hobby is looking up your “type,” and seeing what characters are associated with you, and so there is Darth Vader, Voldemort…and somebody else. So that’s me.
SMM: So you are Voldemort?
JDK: Yes. So am I aware? Not consciously. But I will tell you that the more angry or upset that I am, the quieter I am. I do know that.

**Do you realize how intimidating your silent listening is? And referencing that question, “How do you obtain that skill?”**

JDK: Uh…. Well the funny story you could tell about that is I am very comfortable with silence. My family is not a “talkie” family. I don’t mean my immediate family, but my Mom and my Dad and my sister; we are not a talking family. My Dad…I still remember the time he came home from a mission and he had had an “inflight” and had almost had to bail. We were just sitting around after school and he walked in, he sat down in the chair and pulled out some sort of tape recorder and just played what had happened. And it all ended okay. And then he got up, walked away, and went to bed. That’s my Dad.

And so… so I’m very comfortable with silence. Rob Sayers [Col (ret) USAF, MC], he’s probably still a member of the Section, Developmental Pediatrician, though he’s retired now. When I was a resident, he was developmental faculty, and when I was at Keesler as Staff, he was the Department Chair. And he was the kind of guy that, even with his patients, he would get so much information just by being quiet. And it really struck me and I just would watch him. He wouldn’t say anything. And they wouldn’t say anything. And he would sit there. And as a student you would be really uncomfortable, but it wasn’t your place. But then suddenly the most interesting things would come out. And so I think that that molded me. There was a time when I was staff… I was a neonatologist, and he called me and he said, “I need to meet with you, I need to talk to you,” and so I went to his office and I came in and sat down. He’s at his desk. I’m in the chair. He doesn’t say anything. I don’t say anything. He doesn’t say anything. I don’t say anything. And this probably

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went on for five minutes. Finally he says, “Okay, I give. You win. You’re more comfortable with silence than I am. “And then we had a conversation but I was so proud of myself at that moment.

So I just think I’m a listener, I think you learn a lot by listening. Sometimes by making someone sort of struggle through something in their head, they come to the right conclusion. I remember the episode with Marie [Strait, LT MC USN] and the kid with the pneumothorax in the middle of the night and I don’t think I said a word. She called me with the kid with the pneumo, she knew she needed to evacuate it, she hadn’t yet, she was running it through in her head about not evacuating it, she talked for about ten minutes and by the time she got to the end of her conversation she said, “you know what, I realize I need to be evacuating this,” and so rather than me just telling her that she came to it.

**Describe your most memorable patient or patient care moment.**

JDK: My most memorable patient care moment was actually Baby Ava. I still get a little bit emotional about that. In fact, when I was talking to the students the other day and we were talking about viability and gestational age and uncertainty, I actually had to pull back a little bit because I could feel myself getting a little bit upset talking about her. Because she was the epitome of the kid that, you know, I would have written off. That was going to die. In fact, I told them [the parents] before she was born she was probably going to die. I told them after she was born she was probably going to die. Kristina Herriott [CPT/ANC] takes great joy every day when I walk into the unit she in showing me another video of Ava walking or talking or whatever else. It was really touching actually, around the time Ava was supposed to go home, Ava’s parents actually asked Kristina to text me because they wanted me to come and hold her. Because I was the doctor who said she probably wasn’t going to make it. And they were so happy that she was going to make it. I take care of a lot of 23 and 24 weekers, a lot of sick babies, but for some reason, that one just got to me.

**What is the best piece of advice you could give to a graduating fellow?**

JDK: You don’t know everything but you know how to get the information that you need. And you know that you have people you can call. You shouldn’t hesitate to call on your colleagues. There is no pride in doing it on your own. Neonatal intensive care is very much a team sport.

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What is the best piece of advice you could give to a new fellowship program director?

JDK: The best thing that a fellowship director can do is to provide top cover and resources and get out of the way. Let people find their potential. You have to set an example, but it is so different from residency where [they] really might need to be micromanaged. Fellows need space to develop and explore, and to come to conclusions themselves.

What job would you have chosen to do if you had not become a neonatologist?

JDK: A pilot. Except that I am not tactical enough. Or a forest ranger. And then I’d be poor. I actually went to college for a pilot track and didn’t decide I wanted to apply to medical school until the end of my junior year.

SMM: What made you switch?
JDK: Knowing yourself? Does that make sense? Thinking about what I wanted to be doing in ten to fifteen years versus two years, because if I had done what I wanted to do in two years, I would have gone to flight school. That’s really what I wanted to do.

Why Maine?

JDK: Because it is the Alaska I’ll never have. Someone in Bangor did ask me why I wanted to come to the “edge of civilization.” I guess that has a strange appeal to me.

Was there a career path, area of interest, or job you wanted to pursue during your military medical career but for whatever reason, you didn’t get the opportunity to? Do you have any regrets about that? Did something else fulfill that interest or goal for you and what was it?

JDK: So in medical school I did toy with the idea of doing Aerospace Medicine, because I thought that it was this ideal combination of my interests. But I think that I decided that if I was going to practice medicine, I wanted to care for more than just a mostly well or healthy population. Does that make sense?

But I always wanted to take and experience the flight medicine course. At USUHS they wouldn’t let me. And in residency, they wouldn’t let me. So the year after fellowship, I stayed in San Antonio to be faculty and I knew it was the last time I’d ever have the chance to do it, so I took the twelve weeks and took the course. You weren’t supposed to have any other clinical duties while you were doing it, but I said, “Listen, I won’t tell them [the flight medicine course], I’ll do my service other times, I’ll take my calls regular, if you just let me do the class,” and they said sure. It was a blast. It really was. The centrifuge and the chamber and the rides and everything. I loved it.

The thing that I found was that, in San Antonio in particular that year, and also especially in Okinawa on all the air transports that I did, that really that was the ideal combination of my interests. And that just reminded me of one of the most difficult patient experiences I ever faced.

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So in fellowship we did these ECMO transports, and those are the sickest patients I’ve ever cared for, probably, but we always had this team of twelve to fifteen people, so you were never alone. You always had a lot of experience and back up. But when I was in Japan, it was a thirteen-hour flight from say Tokyo to the States, the West Coast, and it was one doctor. You had a couple of nurses. So there was an American baby with Transposition in a Japanese hospital and they had done a Rashkind [atrial septostomy] but it was too small and the Japanese didn’t want to do anymore. They said they had done all they could do and we needed to get the baby to the States. And oh, by the way, it was when my three other partners had all gone to take their boards, and we had someone come in to backfill, so it was me that went on the transport. So we had to go to the Japanese hospital, evaluate the baby, talk to the cardiologist back in the States. We came to the conclusion that the baby was sick and our best chance was to get him to a cardiac center, but we decided that San Antonio was too far, and we needed to try to get to the West Coast. So we found a center that said they could take him if we could get him there. The hardest call was whether to do it or not. Having never seen the patient and knowing we only had a couple of hour window to evaluate the patient because the aircrew would lose their time. We didn’t have a lot of time to screw around. They already had a very limited flight time window without having to stop somewhere and so we knew we couldn’t stop somewhere along the way. So it was myself, we had two nurses, we had a med tech that functioned as the RT. It had already been a 16-hour day for our team when we got to Tokyo; crew rest rules did not apply to the neonatal team. The baby was sick. He was on pressors. He was intubated. Anyway, to make a long story short, exactly at about the midpoint across the ocean, he went into a pulmonary hypertensive crisis. We didn’t have nitric. We didn’t have much Prostin. We had limited gas. We had the pressors we had. We couldn’t communicate. It was cold. It was loud. It was dark. I remember wearing a headlamp, writing on a clipboard what I wanted the nurses to do because they couldn’t hear what I was saying and we had to decide whether to turn back or keep going, because we still had another 6 or 7 hours either way. We got on the SAT phone. We talked to the cardiac center and we decided to go. We talked to the parents, because they were on the flight. That was the other thing. The parents were right there. And we literally hand bagged that kid into the unit and he went on to get his switch the next day and he did okay. But I think I still have PTSD from that transport.

SMM: Wow.

JDK: And you had no books. You couldn’t look up on the Internet. You couldn’t phone a friend. You couldn’t do anything. You just had to rely on what you knew. And I’m not saying I did it well, but I’ve never been so glad to roll into a unit with a kid.

What was the best part about being stationed in Okinawa?

JDK: The best part about being stationed in Okinawa was also the worst part; that I lived exactly across the street from work. So my family could come to the unit or I could go home for lunch; even when I was on service. It was a really nice community. You would see your patients’ families all the time out on base. But the nicest thing was being so close to work and being able to pop in and out whenever, and so my family remembers that part. The part that I didn’t like was that was the short notice changes, like that transport I was just talking about, I had six hours notice and I was gone for five days.

The other part I liked about living in Okinawa was that I felt like the patients I cared for…well, in Bethesda, if the patients I care for don’t get cared for by me, they’ll get cared for, right? They can go to wherever. But

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a lot of times over there, we were it. If we didn’t care for those patients, they weren’t going to get cared for. So we had a 14-bed unit, but if we had 22 patients, we had 22 patients. So that mission was really unique.

What is the most useful medical pearl you have ever heard?

JDK: The key to success in mechanical ventilation is recruitment.

What was the most rewarding part of your career in the military and why?

JDK: Service to military families. The epitome is taking care of the baby whose Dad is deployed to Afghanistan and knowing he can feel just a little bit better about the situation. Because I can’t imagine having a preemie and not being there.

What are the last three books you read?

JDK: Who asked that? A biography of Townes Vanzandt, the Texas folk singer, Born to Run, which is a book about the barefoot running tribe and, Wild. I probably should have said Anna Karenina.

Did you always plan on being a lifer and staying in for 20 years? What influenced your decision?

JDK: I’ve never not had an ID card. I grew up in the military. I was in ROTC. The honest truth is I had an ROTC scholarship and I added seven years on it for USUHS. So I owed 11 years by the time I graduated fellowship. But I knew the life, knew what I was getting into.

What did you learn about yourself while interviewing for civilian positions? What do you wish you had known or done before you started interviewing?

JDK: What I learned about myself was that geography was more important than I realized. So if you had asked me in July or August of last year, when I wasn’t sure I was going to be retiring, but I was considering, I would have said, “Well, I have friends in the Southeast,” and there were people who said they wanted to hire me…. academic places and there were a few places where I maybe could have been a program director. So I started trawling the job boards, this is kind of when I was [back-filling] in Okinawa, and this job came across in Montana. I was intrigued. I looked at this place. I looked at this hospital. I was right in the middle of this place in my life where all I was doing was taking care of patients. I would go in in the morning and see patients and I was enjoying it. And the idea of being there when my kids went to school in the morning…and then the idea of living in the mountains. I was surprised. So I told Linda about it. I thought she’d say, “No way,” but she was actually more excited about it than I was. That one didn’t pan out for whatever reason, but it made me start to look at other things and I think that it made me realize that I wasn’t willing to go just anywhere. If someone in the military wants to be a commander, they go where they are needed, because they want to be a commander. And I realized I was at the point in my life where I wasn’t there any more. It was a lot more important to me where I went to settle down.

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To answer the question, what do I wish I knew? I wish I knew more about negotiating. But everybody does. Even right now, I am still negotiating the contract. Two people told me to hire a lawyer. I probably wouldn’t have. But I’m glad that I did actually. Because I don’t know enough about that side of medicine and he has pointed out some very interesting things actually.

What do you think is the most important thing a program director or mentor can offer a struggling learner? How about an over-achiever?

JDK: So a struggling learner needs to know that everybody struggles with something. It may be professional, it may be personal, but everybody is fighting a battle.

SMM: What was yours?

JDK: Mostly work-family balance, if I’m being honest.

SMM: What about for the over-achiever?

JDK: They are struggling with something too. You have to find it out. And I think it comes back to listening. It is not something I’m always very good at, because I don’t pick up on emotional things very well. That’s what my family would tell you. That I have the sensitivity of a rock and that I will not notice something going on if there are multiple layers to it. If there is a definitive problem to fix, I’m great, but if it is something in the middle that is not ready for a solution, but just needs to be talked about as a problem, that is my failing.

What is the best and worst part of being a program director? What part of the job is your absolute favorite part? What is your least?

JDK: My least favorite part is the regulatory stuff. ACGME. I think it’s swung far too far the other way. The best part? The best part is an obvious answer. The best part is the fellows. The best part is each individual and watching them come in the first day and watching the person that they are when they leave. Absolutely.

Have you ever received a bottle of rum from Mo [Mohamed Luqman, former NNMC NICU RN], and if so, what was the reason or significance?

JDK: Yes. I think he felt bad for me having to be a fellow all night [sub]. Either that or he thinks I’m a drinker, which may or may not be true.

What is your best advice for balancing career and family life and being successful at both?

JDK: You can’t. You can’t make everybody happy and you have to be willing to admit when you haven’t been living up to your priorities. I think sometimes the people that you care about the most get hurt the easiest, because not consciously, they are the easiest to hurt. Because you know they’ll still be there.

I’m a really poor example of how to do this well.

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**What do you do to recharge and stay consistent as a physician, mentor or leader?**

JDK: Going away sometimes. Traveling, getting outdoors. Sometimes going away helps me come back and be a better parent, physician, leader, whatever.

If you think back to high school or college and what you thought you were going to do, or wanted to do with your life, what surprises you the most? If “High School Jay” met “Current Jay” what would surprise him?

JDK: High school Jay was clueless. High School Jay would not have seen Jay as a Colonel. Of course, LtCol Jay would not have seen that either. I would not have seen myself a neonatologist. I’m not sure I even knew what that was until three years into medical school.

I actually applied to the Cornell School of Engineering and then changed to Arts and Sciences. This is a good story. So I had to take one more class, I needed one more class in the fall of my senior year of high school, and I thought, “Science is easy and I haven’t taken Bio since 9th grade, so I’ll take a Bio class.” And I loved it. So much so that I changed my major. The problem was both the Air Force and Navy had given me ROTC scholarships for mechanical engineering. Which I would have failed at miserably, because all my friends were engineers and I saw what they did. So I called these places on the phone and I played them off each other. I called the Navy and I said, “So I know you gave me a scholarship in mechanical engineering, but I really want to do Biology,” and I did the same thing to the Air Force. And I guess my record was good enough because they both said I could major in whatever I wanted. And I said, “Anything? What if I want to major in Hotel Management?” And they said, “Anything.” So that is why I majored in Bio. Which is good because I would have failed at engineering. I used to watch them do their problem sets and they would say, “well this will work if we just add a factor of 1.3,” and I’d say, “But where did that come from?” and they’d say, “We don’t know. But it works.”

**What font do you use for PowerPoint presentations?**

JDK: You know the answer to that. So, non-print font. Arial is the best font. Or Calibri. Because you read them faster. There is evidence that it takes longer to read a print font like Times New Roman. Who asked that question?

SMM: Me.

**What is your work philosophy?**

JDK: So I really appreciate actually, what I learned in Japan. No matter what your job is, you should try to do it well. I learned that by watching the people in Japan. You would have a street sweeper. And you know what? That was their job and they were going to be the best street sweeper that there was, because that was what they did. And so I think that the way that I apply that is, I know some people get really hung up on prestige…”Well, I want to be a doctor or I want to be a lawyer,” but I have a lot more respect for people who take whatever they are doing or what they want to do and work hard at it.

SMM: Your daughter asked that question.

JDK: Sarah?

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How did you discover coffee roasting? Why are you no longer allowed to roast coffee beans in the kitchen?

JDK: [Laughs] So I am a little bit cheap. About some things. So there was this new coffee roaster that opened up in Frederick [MD], and there was all this hype about fresh roasted coffee. And so I thought, I have to try this. And I was really skeptical. I bought a bag and I ground it and it was phenomenal. It was this really different experience. And meanwhile I had been thinking about brewing beer but I knew I probably didn’t have the patience to brew beer, and it was probably bad for my liver. So I got to reading about coffee roasting and I realized it is a half hour and it is over. It’s good or it’s bad and it’s done. It’s not like three days. The other thing that I really like about it is that there are rules to a certain point, but at some point you have to throw them out the window and just watch, look, listen and smell. And it is really good for me to do that. It is a little bit “seat of the pants,” and I’m not a seat of the pants person.

SMM: And why are you no longer allowed in the kitchen?

JDK: I’m not allowed in the kitchen because I had this episode where I let a roast go a little bit too long trying to get it perfect and it smoked the entire first floor. Natalie already complains anytime I roast coffee, but she was just about apoplectic about it, and none of the rest of the family was really happy about it either. So anyway, after that I went to Home Depot, I bought high heat duct tubing. I hooked it up to the vent. I got a box fan. I put the box fan in the window. I rigged a coat hanger to the box fan so that the vent blows into the fan and blows the coffee gas out the window. But now they laugh at me because of my contraption. Someone once said you once planned on being a forest ranger when you retired from medicine. Is that still the plan? Or what do you plan to do with your life when you leave or retire from medicine now?

JDK: Be outdoors.

What will you do with all your free time?

JDK: Theoretically, I am enrolling in the Berkley School of Music online guitar courses. And a push myself goal is to play guitar in front of an audience. Oh and also to torture my kids before school and have breakfast with them. And I’m pretty sure the novelty will wear off quickly for them. But in all seriousness, I am looking forward to making up for some lost time with my family and the outdoors; kayaking, hiking, Nordic skiing.

What will you miss the most about being a Program Director?

JDK: The fellows. Sitting in the unit on a Saturday morning after rounds and just talking with them.

What was the best thing a fellow ever said to you?

JDK: Well, one of the best things a fellow ever said to me was the story that I told you [about Marie Strait], where she said, “Oh wait, you didn’t say a word, but I totally see what I need to do.” And I think that exact

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The AAP Section on Uniformed Services would like to thank Mead Johnson Nutrition for their support of COMPRA.

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scenario played out with more than one person in different ways. Because I think the essence is not telling people what to do but getting them to realize it for themselves.
SMM: That’s great, Jay.
JDK: I don’t know. There might be some eye rolling. (Grins)

Over the course of your career, what has most influenced how you care for patients or practice the “art of medicine”?

JDK: There are so many things. But I would certainly want to thank my wife and my children for their patience, sacrifice, resilience and service. In the support they provided me, they have had a hand in every patient that I’ve cared for.

AAP Military Members Not Charged Higher Fee for NCE after September 12 Cut-Off Date

The AAP will not charge the higher NCE fee after the September 12, 2015 early registration cut off to any member to indicates MILITARY on the check off box on the NCE registration form.

The AAP recognizes that uniformed services members may encounter delays in receiving approval to attend the conference and the AAP does not want to penalize our members for these potential delays.

If you have any questions about permission to attend NCE or the meeting itself, please contact jburke@aap.org.

Safe travels!
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<td><strong>How will you as President help the Academy to provide tools to chapters and local members to promote community investment in children?</strong></td>
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**Lynda Young, MD, FAAP**

First, the unified voice of many is louder than many single voices. Building membership in our chapters increases the impact of the voice of advocacy for children. As President, I would encourage efforts to increase our membership at the local level, particularly through the use of social media and other electronic outlets. Secondly, many physicians and chapters are committed to advocacy but may not know where to begin. We need to make available the “playbooks” on relevant initiatives, like immunization, gun control, health coverage. Such playbooks can detail who to call, how to build collaboration, what the resources are - along with fact sheets and talking points. Thirdly, we need to implement a mechanism to share success stories. I propose that our Academy develop its own version of “Pinterest”. Pinterest is a free website, widely used for people to share ideas. Our members could post stories of successful promotion of investment in children on such an Academy website – for example, a post “Our Chapter was successful in getting legislation restricting access to tobacco products for children and here’s how we did it.” In this way, best practices across the country can be shared for our members to adopt and adapt for their own localities. The use of social media like this creates the opportunity to learn from others, as well as to engage and energize our members.

**Fernando Stein, MD, FAAP**

How will you as President help the Academy to provide tools to chapters and local members to promote community investment in children?

The formation of imaginative partnerships with commerce, industry, foundations and non-governmental organizations can be fostered and facilitated by the AAP. Individual members and Chapters should be able to partner with the national structure of the AAP to achieve this goal. A variety of services exist within the AAP that are available but not currently easily accessible to the members and Chapters.

Promotion of investment in children begins with the illustration of their needs and the eventual embracing of them by their community. Pediatricians have traditionally been the advocates for children and have the logical opportunity to speak to the needs of children. It is one of my central agenda items to facilitate leadership training and access to Academy services for all members.

The Academy has a Chapter Relations Division in place. I will make better known the skills available in the AAP Staff to help Chapters solve various problems. The AAP should establish a formalized consulting service that is widely publicized and readily accessible to the individual members and chapters. An effective method to support “Best Practices in Chapter Management Concepts” will be to make this service robust in its charge and responsibilities.

For the AAP to adequately represent the reality of its membership, it must gather information about members’ needs, attitudes and opinions. I will work to better manage and strategically utilize the AAP’s data and data systems so that current, reliable, and easily accessible information can be leveraged on pediatricians’ behalf.
AAP Section on Uniformed Services Agenda
A Section Program for Section Members (“H” Program) for
The 2015 NCE USPS LITE
Renaissance, Grand Ballroom Central Salon
Sunday, October 25
10 AM – 4 PM

10 – 10:10 AM  Welcome and Overview of the Section (10 minutes)
CAPT Christine Leigh Johnson, MD, FAAP

10:10 – 10:40 PM  Outstanding Service and Dave Berry Awards (30 minutes)

10:40 – 11:30 AM  Odgen Bruton Lectureship (50 minutes)
Early Feeding Issues  SPEAKER: Catherine Watson Genna, BS, IBCLC

11:30 – 12:20 PM  Top 5 Pediatric Dermatology Complaints and the Newest
Treatments (50 minutes)  SPEAKER: Brian Green, DO, FAAD

12:20 – 12:30 PM  Get boxed lunch (10 minutes)

12:30 – 1:20 PM  Food Allergies: When to Test, How to Document, When to Use
Epi (50 minutes)  SPEAKER: Satyen Gada, MD

1:20 – 2:10 PM  The Role of Pediatrics in a Down-Sized Military (50 minutes)
SPEAKER: Mark Thompson, MD, FAAP

2:10 – 2:30 PM  Formal Recognition of Errol Alden, MD, FAAP (20 minutes)

2:30 – 3:00 PM  Top Oral Podium Presentations (30 minutes; 10 minutes each)
for Bruton, Margileth and Johnson SAC awards
2:30 – 2:40 = Ogden Bruton Top Research Abstract
2:40 – 2:50 = Andrew Margileth Top Research Abstract
2:50 – 3:00 = Howard Johnson Top Research Abstract

3:00 – 4:00 PM  Uniformed Services Alumni Reception (60 minutes)
Chapter Awards, Review of Scientific Award Posters, Time with Specialty Advisors