This February, the Medical Student Subcommittee (MSSC) gathered in Chicago, IL together with the larger American Academy of Pediatrics (AAP) Section of Medical Students, Residents and Fellows in Training (SOMSRFT) to outline the long range plans for the future of the section. This was the first year that medical students were invited to the Long Range Planning Meeting (LRPM), signifying an important direction for medical students assuming an even greater and more active role in the AAP SOMSRFT.

The first task of the day was a strategic planning session to deliver the section’s mission, vision, and key values. An exciting discussion centered on how SOMSRFT can be leaders "here and now" in the AAP, rather than solely considered future leaders. SOMSRFT is the AAP’s largest section, and as such, will continue to seek an active voice within the AAP. The MSSC, in particular, will be actively advocating (Continued)
for an even greater voice for medical students interested in pediatrics. Medical students are in a unique position as they are early enough in their training to take action and be at the cusp of change. If medical students can be engaged and aware of the AAP from their entry to training, there will be a strong foundation for pediatrics moving forward.

With emphasis on lifelong advocacy, mentorship, and leadership, the MSSC has adopted as its mission: "To offer targeted programming and enthusiastic representation for medical student members within the section and in the AAP, to promote collaboration between medical students and other members/committees of SOMSRFT and the AAP through concentrated outreach efforts, and to utilize the resources of the AAP to empower medical students to advocate on behalf of children and adolescents."

In discussing its core values, SOMSRFT believes in empowering, enabling, and educating its members by providing the tools and resources to be effective leaders and agents for change now. As Lisa Costello, former MSSC Chair shared during this section, "There is no question that change will be made, but the question is what the change will be." At this LRPM, a list of priorities was created with many points targeted at increasing medical student involvement and roles within the AAP with an overwhelming showing of support from the pediatric resident and fellow members of SOMSRFT.

One way that medical students can increase their involvement in the AAP and SOMSRFT is by participating in advocacy projects. During LRPM, it was decided that the 2014-2015 SOMSRFT advocacy campaign would focus on childhood poverty. With more than 16 million children (22% of all children under 18) living in households with incomes at or below the 100% federal poverty threshold, the AAP SOMSRFT believes that this is an issue paramount to child health that deserves attention from pediatric leaders at the community, state, and national levels [1]. Medical student representatives brainstormed on campaign initiatives that will elicit interest from Pediatric Interest Groups and allow for both innovative and feasible advocacy projects at medical schools across the country. Medical students and residents are encouraged to work together because, as noted multiple times during the LRPM, medical students have the time, energy, and numbers to make substantial progress.

Moving forward, medical students can look forward to more benefits of membership within the AAP, more scholarship opportunities, mentorship opportunities, new resources for Pediatrics Interest Groups, and exciting programming at the AAP National Convention and Exhibition in San Diego, CA in October 2014.

Reference:
Pediatric Mental Health Services: A Global Need

Angela Martinez, M4, Boston University School of Medicine and Fellow for the Foundation for International Medical Relief of Children

Ana Maria* is a 15-year old girl living in rural Nicaragua. Her father sexually abused her, and she is now pregnant with his child. Without other options, she continues to live in the local village with her family, but no longer attends school. The nurse at the local health center suspects she might be depressed, and the physician also expresses concern. He tells me he is not trained to provide the counseling he believes Ana Maria needs, and the necessary psychiatric medications are not locally available.

Unfortunately, situations of limited mental health care are not uncommon. According to the World Health Organization (WHO), in low- and middle-income countries, 76 to 85% of people with severe mental health disorders receive no treatment for their disease [1]. In recent years there has been a movement to raise awareness on psychiatric disorders, resulting in higher-level policy changes. Most recently, in May 2013, 194 member nations signed the WHO’s Mental Health Action Plan: 2013-2020.

Nicaragua is one of those WHO member states, but it does not have formal legislation or policies on mental health. Instead, in 2005, it created a mental health plan, with hopes of integrating mental health into primary care settings. Unfortunately, nine years later, psychiatric care is still largely confined to the single psychiatric hospital and a handful of specialized clinics, all located near urban areas and not easily accessible to the thousands of children living in rural areas like Ana Maria.

There are a myriad of barriers to proper mental health care for Nicaraguan children. Similar to other developing nations, Nicaragua commits only 0.8% of its total health budget to mental health. 91% of this amount goes to the psychiatric hospital and clinics, a funding level contradictory to both the WHO resolution and the adopted national plan, which dictate a resource allocation strategy that would devote a larger percentage of funding to incorporation of mental health services in rural primary care settings. On the provider level, Nicaraguan medical schools commit approximately 2% of pedagogical time to mental health, with minimal to no further training in the primary care career path. The lack of emphasis on mental health in Nicaraguan medical school has led to a dearth in graduating psychiatric providers; there is an average of 2 psychologists and 1.5 psychiatrists per 100,000 individuals [2]. In addition to these concerning numbers, providers face the problems of limited access to psychotropic medications, lack of community awareness, and stigma towards psychiatric conditions. (Continued)
These latter two factors in particular often lead to human rights violations, such as involuntary hospitalization with abusive use of seclusion and restraint, and marginalization from society [3].

Pediatric mental health services are even further behind, despite suicide being a leading cause of death among young people and the fact that half of mental health disorders manifest in childhood [1]. Having worked in rural Nicaragua for the past few months, I have had the opportunity to speak with many local providers and teachers about mental health. It quickly became obvious that the need for child psychologists and psychiatrists is omnipresent. Teachers often recount stories of children affected by physical abuse, poverty, and divorce. These factors contribute to poor school attendance and performance, and physicians also express concerns about teen pregnancies and substance use. In a country where the majority of the population is below 25 years old, one can imagine how these factors can add to the personal distress of children, like Ana Maria, and also to economic loss at a national level.

Mental health disorders affect children’s development and skill acquisition, but effective early recognition and treatment can have a significant impact in reducing both morbidity and mortality caused by psychiatric conditions. Since appropriately trained primary care providers can successfully perform these tasks, global policies have shifted a focus to integrating mental health into primary care [3]. Although little has been done to correct the fragmented care in Nicaragua, the presence of a strong primary health care structure presents opportunities for diminishing the burden of psychiatric illnesses.

My work in Nicaragua has focused on bringing in a pediatric psychologist to work alongside the primary care providers in five rural communities. The additional training and support for local doctors should improve early recognition and intervention, as well as increase access to and coordination of pediatric mental healthcare. Moreover, inclusion of mental health services in local health posts decreases the economic burden and stigma of traveling to specialized centers, keeping families together and enhancing social support systems for patients [4]. Despite the many challenges, my hope is that with the increased interest in mental health and presence of new technologies, such as tele-psychiatry consultations, we can successfully begin to narrow the psychiatric treatment gap in low- and middle-income countries.

The objectives of the WHO’s Mental Health Action Plan: 2013-2020 span beyond primary care including policy changes, access to pharmaceuticals, and increased research. We should prepare for a long road with many unexpected problems ahead, but should also be encouraged by the growing interest in mental health issues among providers worldwide. One day, with leadership and support from primary care physicians, children like Ana Maria could receive holistic care addressing mental and physical health needs, family conflicts, and social stressors.

*Alias used to protect child privacy

References:
Fostering Interest in Child Health: UIC Pediatric Career Development Track

Megha Shankar, M2; Monica Samelson, M2; Sara Boblick Smith, MD; Deanna Behrens, MD; Jonathan Miller, MD
University of Illinois at Chicago
College of Medicine

According to the American Academy of Pediatrics’ recent Pediatrician Workforce Statement, in the United States, the current pediatric workforce does not adequately provide primary care for inner-city pediatric populations like that of Chicago [1]. University of Illinois at Chicago (UIC) College of Medicine has a talented and diverse student population in the heart of Chicago and therefore is well poised to address this problem. Although UIC is the largest medical school in the state of Illinois, from 2006-2011 only 9.4% of our students chose fields relating to pediatrics, and of these, only nine students total matched into residencies at UIC. The Pediatrics Career Development Track (CADET) program was launched in 2012 by general pediatrician Dr. Jonathan Miller with goals of introducing students to pediatrics earlier in their careers and fostering relationships between students and pediatric residents and faculty. This strategy addresses the growing needs of children in our community and aims to attract high quality students into pediatrics and into the UIC Pediatric Residency Program specifically. Now led by intensivist Dr. Deanna Behrens and hospitalist Dr. Sara Boblick Smith, the CADET program offers a graduated experience for students as they progress through training. The hypothesis is that early exposure to pediatric mentors, experiences, and patient care will influence passionate and committed students to pursue a career in pediatrics [2].

The CADET program allows pre-clinical students to thoroughly explore the field of pediatrics outside of the regular curriculum in order to determine if the field is a good “fit” for them. Pre-clinical students who apply for the CADET program with an interest in pediatrics, along with other specialties, find valuable, personalized career advice through the program. For example, after attending a workshop on career options in pediatrics, Megha Shankar discovered that she could combine her multiple medical interests in a fellowship in Pediatric Obstetrics and Gynecology. Workshops like these open students’ eyes to the breadth of potential paths in pediatrics during an impressionable stage in medical education. While shadowing Dr. Miller in the newborn nursery, students learn important differences between the adult and newborn physical exam, while applying knowledge from lecture material, such as the Babinski reflex. Students learn to appreciate cultural patterns in breastfeeding and the challenges of patient education in a pediatrics setting. This spring, the program will collaborate with the UIC Art School to teach CADETs and pediatric residents the power of observation through art and apply this skill to patient interactions. These experiences work synergistically with curricular requirements to enhance medical education (Continued)

Photo: Children’s Health Working Groups discuss pediatric cases
and nurture students’ interest in working with children.

The CADET program is also strategically integrated into the UIC College of Medicine curriculum. In the first and second year, students are paired with individual faculty mentors in general pediatrics and subspecialties and meet in weekly small group sessions. The Children’s Health Working Groups for M1s and M2s are designed to bring pediatrics-interested students together, and in doing so powerful communities are formed. Every week, students research and discuss topics as diverse and compelling as the anti-vaccination movement, the differing regulations regarding scientific research in pediatrics, and the challenges in determining how to best care for undocumented children. Beyond these discussions, group members share personal experiences, participate in role-play scenarios, and seek advice from a faculty advisors and M4 tutors. These activities help students to navigate complex topics important for the care of children; they also help students to hone the tools of compassion, communication and understanding necessary to become successful physicians in the field of pediatrics.

As students progress through the third and fourth year of medical school, they will have the opportunity to interact with and receive mentorship from pediatric residents and faculty mentors, to attend pediatrics-focused workshops, shadow pediatric faculty and residents, and to engage in pediatrics research. Through curricular and extracurricular experiences, the CADET program puts students on the right track to kindle an interest in pediatrics and, in the long run, enhance pediatric care [3].

This year, a record number of UIC College of Medicine graduating students applied to programs in pediatric related residencies, including ten to Med-Peds and eighteen to the UIC Pediatric Residency Program. Though there are likely multiple factors contributing to this increase, the CADET program has increased the visibility of pediatrics as a whole in the medical student population. As more CADETs graduate, students will mature into mentorship roles themselves, providing guidance to the next generation of pediatric trainees. The program gives students the guidance they need to find a place in the pediatric medical world and ultimately to provide service to a vulnerable and underserved population. Eventually, the program will be expanded to the other University of Illinois campuses and other medical schools in the Chicago area. The CADET program will continue to provide exposure, scholarship, and mentorship within the pediatric realm to medical students in order to increase the interest in pediatrics at UIC – and hopefully the future will see programs extending beyond our campus continuing to train CADETs, our future pediatricians, to meet the needs of children.

References:
The Boston University Down Syndrome (BUDS) Program: Learning Through Friendship

Kristen Hart, M3, Erin Krizman, M4, Joshua August, M4, Boston University School of Medicine

Despite personal and parent indication that individuals with Down syndrome lead happy, fulfilling lives [1, 2], it has been shown that physicians’ negative perceptions of Down syndrome affect treatment recommendations, and in some instances have led to the suggestion of abortion when a prenatal diagnosis has been made [3]. The Boston University Down Syndrome (BUDS) Program was implemented by medical students at Boston University in 2011 as a service-learning elective model to address the educational deficiencies in preparing students to care for patients with Down syndrome and other developmental disabilities.

In the BUDS Program, medical students are paired with a teen or young adult with Down syndrome who, along with his or her family members, function as teachers to educate the medical students about living with Down syndrome. The pairs meet every month to participate in social activities, visit museums, attend sporting events, and spend time with family and friends. During this time, medical students have the opportunity to forge a strong relationship with their peers with Down syndrome and their families. This offers students the opportunity to learn about living with Down syndrome first hand, understand the unique medical and social needs of this population, and develop confidence and strong communication skills for working with patients with developmental disabilities. The relationship the student forms with the partner and his or her family offers students the opportunity to learn about the family’s experiences with physicians working with their child with Down syndrome. Parents generously share stories about the first time they learned their child had Down syndrome, how their impressions of having a child with Down syndrome have changed, and their visions for their child’s future.

(Continued)
The medical students and the faculty advisor, a developmental pediatrician, reflect on the students’ diverse experiences and review relevant journal articles at monthly group meetings to supplement the students’ individual experiences with academic discussion. This setting allows students to compare experiences, elicit suggestions from their peers regarding challenges that they have faced, and share important lessons they have learned in the program. The students complete a final project reflecting on their experience in the program and how it has affected their development as a future physician.

The BUDS Program is in its third year, with over twenty pairs having participated. The response to the program thus far has been overwhelmingly positive, from both students and participants with Down syndrome. Students and parents have commented:

“My partner told me, ‘We’re going to be buddies forever,’ and I responded, ‘Yes we are.’ And I meant it. I certainly plan on continuing to see [my partner]. Coming into the BUDS program, I expected to have a good time. I expected to learn a lot, both from [my partner] and his family. I was not, however, prepared for how much acceptance he and his family had for me. I was welcomed in, and I benefitted much from their kindness and openness. This was definitely not just a learning experience, as I have truly made a lifelong friend.”

-Second Year Medical Student

“Participating in the BUDS program has been the highlight of my medical school experience and definitely the most influential volunteer activity that I have been involved in. My partner is self-sufficient, intelligent, and responsible, which has allowed us to develop a relationship that is truly between two peers.”

-First Year Medical Student

“What we have appreciated about BUDS most, together, has been how naturally this BUDS friend has shared [my son’s] life and interests. [My son’s] partner has shown curiosity about what [my son] likes, what his living situation is, and he has shared activities that [my son] enjoys. A huge strength has been that it allows a friendship that is as independent as possible from parental supervision.”

-Parent of BUDS Program Participant

Individuals with Down syndrome have more unmet medical needs than most other patients with special health care needs [4]. The cause of this disparity begins with inadequate education of future physicians during their medical school years. Students have limited opportunities to foster the ability to communicate with patients with Down syndrome. Additionally, many adult providers lack experience with this population; yet, individuals with Down syndrome receive care from nearly all medical specialties due to its many co-morbidities. (Continued)
This prevents these physicians from understanding the medical and psychosocial challenges that individuals with Down syndrome face. The BUDS Program addresses this educational gap. Students who complete the Program are equipped with the skills to effectively communicate with individuals with Down syndrome, the empathy to understand their unique issues, and confidence in their ability to effectively care for these patients and their families. The program aims to expand its educational initiatives to other medical schools to address the national deficiency in preparing future physicians of all specialties to care for individuals with developmental disabilities.

The BUDS Program has received the generous support of a grant from the Schwartz Center for Compassionate Healthcare. The Program would not be successful without the support of Dr. Barry Zuckerman, Dr. Jack Maypole, the Boston University School of Medicine Office of Enrichment, Office of Student Affairs, and Office of Alumni Affairs, and most especially, all of the individuals and families that have participated.

References:
Protecting Children: Subspecialty Spotlight on Child Abuse Pediatrics

Melissa Stone, M3, University of Miami Miller School of Medicine

In 2013, more than six million children in the United States were reported as suspected victims of abuse or neglect [1]. Child abuse includes a number of forms of severe maltreatment, including physical abuse, physical neglect, verbal abuse, emotional abuse, and sexual abuse [2]. Children are a special population deserving protection and child abuse pediatricians help our society do exactly that.

Each state has its own system for the reporting and investigation of child abuse. However, in all states, medical personnel are required to report cases in which there is reasonable suspicion of child abuse. The police may be involved in acute cases of sexual abuse or severe physical abuse; however, Child Protective Services (CPS) is principally responsible to investigate cases reported to state Abuse Hotlines. In Florida, the Department of Children and Families (DCF) is the CPS state agency. When DCF accepts a case, it can be classified as “immediate” and a DCF Child Protective Investigator (CPI) must make face-to-face contact with the child within three hours. In all other cases, the CPI must make face-to-face contact within twenty-four hours. DCF then determines which cases are referred to the Child Protection Team (CPT) for that district. In Florida, the CPT also reviews all the cases accepted by the Abuse Hotline and can mandate certain cases be referred to the CPT.

In Florida, the CPT is statutorily mandated and is lead by a Medical Director who is a board-certified pediatrician. Recently, a new pediatric subspecialty has been recognized, child abuse pediatrics. To be eligible for board certification in child abuse pediatrics, one must complete a standard pediatrics residency as well as complete a thirty-two accredited fellowship in the United States. Although new fellowship programs are emerging each year, there remains a shortage of child abuse pediatricians. As child abuse pediatrics is a new field, many of the current Medical Directors have been grandfathered into the certification without a formal fellowship program.

In a recent conversation with Walter Lambert, M.D., Medical Director of the University of Miami’s CPT with over twenty-five years of experience in the field, he discussed that the differences between legally sanctioned physical punishment and child abuse are often difficult to discern. Child abuse pediatrics is a unique field in that much of its practices are not based on evidence-based medicine. While the idea of performing a placebo-controlled, double-blind trial of how much force it takes to cause a bruise on a child’s buttock with the palm of one’s hand is certainly ridiculous, child abuse pediatricians must determine which bruises are indicative of child abuse. In particular a thorough, head-to-toe physical exam is vital for each visit. A deep understanding of the religious and cultural practices of the area is also important. These pediatricians then use previous clinical expertise and extensive history gathering to discern the typical from the pathological. (Continued)
Further complicating these issues is the debate over corporal punishment and the hotly debated line between this type of punishment and physical abuse. Domestic corporal punishment, the use of physical force for the purpose of correction or control of behavior from parent/guardian to child, remains legal in the United States. In 1998, the American Academy of Pediatrics issued Guidance for Effective Discipline that highlighted both the ineffectiveness of spanking as a method of behavior modification and the deleterious impact of corporal punishment on child socio-emotional development, recommending that practitioners promote alternative methods of behavior modification for children [3]. Although bans on corporal punishment have been proposed in several states, they have failed to secure passage. This leads child abuse pediatricians into the difficult problem of discerning what might be a case of legal physical punishment from a case of child abuse.

Child abuse pediatrics is also unique in that these pediatricians must manage a complex network of lawyers, police officers, and social workers for each case. Child abuse pediatricians are often subpoenaed for legal proceedings, going to court for depositions or testifying several times each week. Though child abuse pediatricians often feel pressure from many sides with competing agendas, the pediatricians must keep in mind that their primary responsibility is the child’s mental and physical health. Dr. Lambert strongly believes that for these pediatricians, “We are the first step of therapy and often the most effective thing anyone can do for these children is telling them that their body is okay.” Child abuse pediatrics is a field where a pediatrician can make an immediate, life-altering impact on their patients merely through the first encounter alone.

Unfortunately, a large number of the cases investigated by child abuse pediatricians involve sexual abuse, and seasoned experts often find that these cases are the most emotionally challenging in the field. Dr. Lambert states, “Obviously sexual abuse cases are disgusting, but the medical examiner’s role is crucial in obtaining a detailed history from the child as well as reassuring the child about their body. The very idea of sexual abuse is disgusting and to cope, when I go home, I separate myself emotionally from the case; I compartmentalize in order to continue my normal life.” Sexual abuse cases are also challenging due to a lack of physical evidence. The vast majority of these cases will have completely normal exams but that does not mean abuse did not occur. According to Dr. Lambert, “Convincing others that a normal vaginal exam is normal can be one of my greatest obstacles.”

In addition to case investigations, many child abuse pediatricians have other clinical, research, or academic responsibilities. Some of these pediatricians have failure to thrive, foster care, political asylum, or child abuse follow-up clinics. In some states, there are mandated CPTs for each county and it is possible for these pediatricians to live in a rural area. Most often, however, CPTs are associated with a large, academic center. Subsequently, many participate in clinical research, often (Continued)
studying the psychosocial factors involved with cases, and have teaching responsibilities for medical students as well as residents. Some also work in child abuse pediatrics part-time, and spend the rest of their time working as a primary care pediatrician. As a new field, child abuse is rapidly expanding and subsequently provides some flexibility in career paths.

To gain more exposure to the field of child abuse pediatrics, go online and contact a child abuse specialist in your area. Also, many medical schools offer an elective in child abuse where medical students and residents have the opportunity to participate in case investigations and observe interactions with law enforcement and lawyers.

All pediatricians, regardless of the field in which they practice, will encounter children suffering from abuse or neglect, yet only a small proportion of pediatricians will specialize in this. Regardless of the pediatric field in which you pursue, awareness is vital as we all will be the first line in protecting these children from harm.

*Melissa Stone would like to thank Dr. Walter Lambert for his time in sharing his knowledge of child abuse pediatrics and teaching her about the field.*

References:

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