Message from the Chair

Rana Chakraborty MD, MSc, FAAP, FRCPCH, DPhil (Oxon)
SOIMG Chairperson

The Provisional Section is no more.... we are now a full Section!!

We are now the Section on International Medical Graduates at the American Academy of Pediatrics. Kudos to our membership, our executive committee and of course AAP Staff Katie Clark! This has been a long road, but I personally feel the timing of the development of the Section coincides for many IMGs across the U.S. with new and unexpected challenges. As a group caring for 25-30% of the Nation's children and adolescents, these challenges require advocacy and a voice for the children we serve at a State and individual level, and include supporting the Affordable Care Act (ACA), keeping Medicaid strong and renewing the Children's Health Insurance Program (CHIP).

One of my major concerns has been role of IMGs affected by the travel ban particularly pediatricians from Iraq, Iran, Syria, Yemen, Sudan, Libya and Somalia. There have been a number of anecdotal reports of how patient care has been affected, in areas that rely on IMGs. Please let us know and send us your stories on the plight of pediatricians affected by the current Administration's immigration policies. As an executive committee, we developed the resolution below in collaboration with the Section on International Child Health. Our resolution asked for advocacy to support children of migrants who are at risk or who have been deported. I am pleased to report that our resolution was

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voted as the second top resolution at the Annual Leadership Forum in March 2017. The message to all AAP members is to continue to advocate for all children and adolescents and their families, irrespective of their immigration status.

Resolution #LR5  (17) –2017 Annual Leadership Forum

TITLE: Advocate for and Support Children of Migrants

SPONSORED BY: Provisional Section for International Medical Graduates

DATE: February 28, 2017

DISPOSITION:

Whereas, over 7 million children with non-citizen parents reside in the US; and

Whereas, a significant proportion of such children are likely to have high levels of toxic stress and adverse childhood experiences exacerbated by the climate of fear generated by the current administration's immigration policies; and

Whereas, the mission of the AAP is to “support the optimal physical, mental, and social health and well-being for all infants, children, adolescents, and young adults”, therefore be it

RESOLVED, that the Academy continue to be strongly engaged in dialogue, organizational partnerships, and activities to prepare the pediatric workforce to advocate for and to support children of immigrants.

FISCAL NOTE: None

REFER TO: 2017 Annual Leadership Forum

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Reason for Late Submission

1. We undertook a strategic review of the Provisional Section for International Medical Graduates and Section on International Child Health advocacy priorities following the US Presidential election and following the strong enforcement of immigration policy, which we are now witnessing across the U.S. These are the main reasons why we are submitting this resolution after the Nov 15th deadline.

2. The current administration has just this month released memos authorizing federal authorities to deport undocumented immigrants more aggressively and announced plans to hire 10,000 immigration and customs agents and increase the number of detention facilities, thereby intensifying the need for greater protection of American children of migrants [1]. We believe that the current anti-immigrant climate necessitates that pediatricians advocate for children of immigrants immediately rather than waiting until the next Annual Leadership Forum.

3. Expenditure of funds is not anticipated

BACKGROUN INFORMATION: Background Information from the Author

Across the U.S. an alarming number of children are being separated from their parents following deportation of their guardians by Immigration and Customs Enforcement. Anti-immigrant sentiment, actively promoted by the current U.S. administration, has generated a climate of fear among many migrant families.

This fear is now manifesting in the adverse psychological, emotional and physical well-being of many migrant families and their children in the form of high levels of toxic stress and adverse childhood experience [2].

Children of migrant families in the U.S. are denied or remain hidden from basic healthcare and educational facilities, which directly impacts on their survival and development. These children are often also denied the right to an identity and the protections afforded by permanent residency or citizenship. These children are also vulnerable to ongoing exposure to food insecurity and living below the federal poverty level. The climate of fear and uncertainty has bought on mental health issues in children of migrants in the absence of appropriate health services or advocacy.

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Resolution #LR5 (17) –2017 Annual Leadership Forum
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At this time of crisis, the Academy should continue to play a leading role in advocacy to prepare the pediatric workforce for the protection and rights of children living in migrant households especially children whose parents have been forcibly removed by U.S. immigration.


On a personal level, my thoughts and prayers go out to Dr. Tracy Sin-Yee Tam and to all staff and families affected by the attack at Bronx-Lebanon hospital on Friday 30th June, 2017. I was a pediatric intern and resident from 1993-1996 at that great hospital, and know the pivotal role Bronx-Lebanon has had in the careers of countless generations of IMGs and the lives of the patients the hospital so diligently serves. It comes as no surprise that providers rushed towards gunfire to risk their lives instead of fleeing (see https://www.nytimes.com/2017/07/04/nyregion/bronx-lebanon-hospital-neighborhood.html).

Have an enjoyable and safe summer.
Best wishes,

Rana Chakraborty MD, MSc, FAAP, FRCPCH, DPhil (Oxon)
Professor of Pediatrics
Division of Infectious Diseases
Emory University School of Medicine
Letter from the Editor

Maheswari Ekambaram, MBBS, FAAP
SOIMG news Editor

Welcome to the Summer edition of the SOIMG newsletter!

Greetings, Members of SOIMG (Section of International Medical Graduates)! Yes, we are a full section now with 946 members as of July 1, 2017. We would like to extend a warm welcome to the International Medical Graduates (IMGs) who started their pediatric residency this year. Pediatrics remains one of the top 3 choices for IMGs. In the 2017 Match, about 17% of positions in Pediatrics were filled by IMGs. This year's match day was wrought with added stress for some IMGs especially those hailing from 6 countries (Iran, Libya, Somalia, Sudan, Syria, and Yemen) named in the travel ban. The Supreme court has now identified individuals who are exempt from the ban. These include individuals who can demonstrate a “credible claim of a bona fide relationship” with a person or entity in the United States. Physicians traveling to the United States with a contract to engage in a program of graduate medical education (GME) would fall under this exception. An additional difficulty for this year's IMGs was the suspension of premium processing for H1B visas which could have delayed start dates. As a community of IMGs, we face many hurdles and come out resilient. For many of you, this resilience was tested at very beginning of your careers. Remember that you are a valuable part of the pediatric workforce and contribute to its diversity. The Academy welcomes and supports you.

Many IMGs work in underserved areas providing care to the nation's most vulnerable children. Currently, over 40% of children in US have Medicaid insurance. It is critical that these children maintain their Medicaid insurance and eligibility for Medicaid insurance is expanded to include more children. With strong advocacy by the academy and pediatricians our voices were heard and no harm was done to health insurance for children… yet. Our work is not over. Children's Health Insurance Program (CHIP) Continued on Page 6

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is up for renewal soon. This is the time for renewed advocacy efforts to make sure children have access to high quality affordable healthcare. Put your advocacy hats on! Know who your legislators are (You can find numbers for your senators here: https://www.senate.gov/senators/contact/) and call to express your opinion. For those social media advocates and tweetiatricians, consider sharing messages to urge the Congress to keep Medicaid and CHIP strong (use #keepkidscovered)

Lastly, join us for a section reception at the AAP National Conference & Exhibition (2017), on September 17th in Chicago. We would like to meet you all and hear your suggestions on our section.

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Helping Neonates Around The World

By Kartikeya Makker, MD FAAP

It is estimated that about 90% newborns make the transition to extra uterine life without any intervention. However, the remaining 10 percent need some degree of support to achieve cardiopulmonary stability. Around 3-6% need assisted positive pressure ventilation, and <1% require advanced resuscitation (intubation, compressions and medicines). The burden of perinatal mortality and morbidity is estimated to be highest in low income countries where many deliveries still happen outside a health care facility.

India is the largest contributor to the 3.1 million neonatal deaths and 2.6 million stillbirths that occur globally annually. Hypoxic events at time of birth account for ~717 000 intrapartum deaths each year and a morbidity burden of 42 million disability adjusted life years. Prevention and effective response to these events can avert many of these losses and are essential to achieving Millennium Development Goal (MDG) 4 (to reduce, by two-thirds the mortality in children < 5 years old between 1990 and 2015). With a neonatal mortality rate of 34 per1000 live births and a declining but still high stillbirth rate of 27 per 1000 births, India is not yet on target to achieving this goal.

To address this problem of perinatal asphyxia, the American Academy of Pediatrics and American Heart Association developed the Neonatal Resuscitation Program (NRP), which has been highly successful, with >3 million health care providers completing the course in the United States alone. Additionally, more than 130 countries, from both the developed and developing world, have adopted the NRP curriculum.

However there have been reservations on the application of NRP to resource poor settings. Some initiatives aiming to achieve a similar success reported disappointing results probably because of differences in the environment, cultural practices and preferences, personnel and equipment associated with childbirth in the resource limited countries. In these countries, majority of the births take place at home or in regional clinics where traditional midwives and attendants with absolutely no training at all are present.

As a medical student doing rotations in rural India, it was heart breaking to see the lack of neonatal resuscitation services. Even if resuscitation was attempted, the lack of follow up care and transport

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for further management (for e.g. cooling for asphyxiated babies) and cost involved in all these steps was a major limiting factor.

To assist developing countries with the uphill task of scaling up resuscitation training, Helping Babies Breathe (HBB), a graphically based curriculum was designed by the AAP and launched in 2010. The HBB program targets health care providers in developing countries with a combination of best practices, simplified protocols, and teaching techniques. HBB promotes multidisciplinary teams of physicians, nurses, and midwives, including auxiliary nurse midwives (ANMs), as master trainers and instructors. The HBB curriculum stressed the importance of assessing and supporting respiration in the first minute of life called “The Golden Minute”.

Two published reports have assessed the efficacy of HBB in resource poor settings. In the report from India there was a 48% reduction in “fresh stillbirths” (FSBs), which have been speculated to include a substantial number of potentially viable infants who would not have previously been offered resuscitation. A limitation to be noted is that > 90% of the attendants who administered bag and mask ventilation in both the pre- and post-training periods were physicians and not the allied health care workers who attend most of these deliveries in real life settings. In the HBB efficacy study from Tanzania in the 2 years after intervention, there was a 24% reduction in FSBs and a 47% reduction in early neonatal mortality, defined as death within the first 24 hours.

These studies provide important insights and possible future directions for this initiative. The observed decrease in early neonatal mortality in the Tanzanian study, where education was focused on the traditional birth attendants rather than physicians, suggests that the HBB program may result in a substantial improvement when implemented in large populations and aimed at non-physician primary birth attendants.

If the Tanzanian experience can be replicated in rural and traditional birthing settings, where training is more cultural than evidence based, the impact on FSBs and neonatal mortality rate would likely be even greater than observed in these hospital-based studies.

With the HBB being now ~6 years in action those in position should make the effort to implement this proven initiative. The Vermont Oxford Network (VON) has been partnering with AAP and offer a HBB master trainer course at their Annual Quality Congress to further this important cause. VON has been involved extensively in Ethiopia to improve their neonatal resuscitation practices and have trained 3 neonatologists to continue the good work.

I believe as International Medical Graduates we have the unique experience of understanding the ground reality outside of USA and have received training in both resource poor and state of the art resuscitation settings. The onus is on us to further this initiative and bring about a positive change in neonatal mortality rates.

Have an idea or topic to discuss?
Join the Section on International Medical Graduates Listserv by contacting kclark@aap.org
Pediatric cardiology is a diverse field that spans vastly different landscapes in the developing and the developed world. In today's world with increasing focus on equitable healthcare and global health, many trainees, including those in pediatric cardiology, are interested in bridging these differences during their education. This may be attained through formal rotations at global health sites, where the trainee has a chance to work with patients and resources under guidance of a local faculty. During residency, I had worked at the Kamuzu Central Hospital (KCH) in Malawi during my global health rotation. Through my clinical duties and my experience teaching cardiology to the local students, I noticed the need for cardiology clinical skills and teaching in Malawi. Further, with my background of medical school training in India, I was especially interested in equipping myself with the skills and knowledge to be a global pediatric cardiologist. So, as soon as I started my fellowship, we started the planning for a pediatric cardiology rotation at KCH. With the support of our fellowship director AGC as well as mentoring faculty AES from Texas Children's Hospital (TCH) and a local KCH faculty, we planned the rotation to be timed around the halfway mark of my second year. This allowed me to acquire the knowledge and echocardiography skills to be a useful worker as well as educator. We also planned a clinical observational study to describe the spectrum of inpatient cardiac disease at a tertiary hospital in sub-Saharan Africa, and obtained Institutional Review Board approval from both KCH as well as TCH.

The rotation was a great learning experience for both myself as well as the local personnel. Under TCH faculty supervision, I carried out all the pediatric cardiology consults during the month, and performed all the pediatric echocardiograms. I taught the pediatric cardiology curriculum to the medical students and medical officers, and also went over the operation of the EKG machine to empower them to use it more often. Due to the wide variety of pathology seen in the hospital, we were able to illustrate the different presentations of acyanotic and cyanotic heart disease, as well as the medical management strategies. Previously echocardiograms were being done by the radiology technicians who might not be familiar with congenital heart disease. For instance, many patients with atrioventricular septal defects and left-sided atrioventricular valve regurgitation, or those with dilated cardiomyopathy and central mitral regurgitation had been misdiagnosed as rheumatic heart disease with mitral regurgitation. We went over echocardiography techniques with two of the medical officers to help pass on the skills. We also went over methods to transmit images to us if needed to discuss patients.

When I started teaching, I realized the knowledge gaps often stemmed from the lack of management options. It is difficult to be inspired to learn about diseases that may not be amenable to surgical correction within the home country. However, we discussed the importance of differentiating and triaging diseases appropriately, as the correct identification and management of heart failure and rheumatic heart disease can change the outcomes for many children with cardiac disease. Local engagement was paramount, as we shared the data of our findings with the Department of Pediatrics and got a very enthusiastic response and interest in future endeavors. It also helped initiate the spirit of scientific approach and quality improvement which is critical to allow these programs to make optimum use of their resources.
ABOUT THE AUTHORS:
KP graduated from the All India Institute of Medical Sciences (AIIMS), New Delhi, India, prior to pursuing residency at the Cincinnati Children's Hospital Medical Center. She is currently a pediatric cardiology fellow at Texas Children's Hospital.

AES is an Assistant Professor of Pediatrics in Cardiology at Texas Children's Hospital. She completed her pediatrics and pediatric cardiology training at Children's National Medical Center.

AGC is an Assistant Professor of Pediatrics in Cardiology at Texas Children's Hospital, and program director of pediatric cardiology fellowship. After completing his medical school training at the Universidad Francisco Marroquin in Guatemala, he pursued further training in pediatrics at the University of Illinois at Chicago/UIIC Children's Hospital, pediatric cardiology at the Rainbow Babies and Children's Hospital and cardiac critical care the Arkansas Children's respectively.

Did You Know...?

The Academy Travel Office is here to serve your travel needs
Monday thru Friday from 8:00 am till 4:30 pm CST.
Receive air discounts to AAP meetings and car discounts through Avis and Hertz.
We also offer reservations through Concur on line, for those who prefer to book their own travel.
If taking a vacation is what you are looking for
then contact Elizabeth Harrison for air, cruises or land packages.
Our toll free number is 888-227-1772.

Visit the section website for more resources
at [aap.org/soimg](http://aap.org/soimg)

or

Update your contact information
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Here you can edit your address, specialties and interests
AAP President-Elect Candidates:

“The strategic plan includes goals to enrich communications pathways and platforms to prioritize bi-directional communication between and among the Academy’s leadership and constituent bodies (e.g. chapters, sections, councils, committees).”

What does the Academy need to do to make this happen for sections?”

Dr. Michael Weiss of Coto De Caza, CA

The AAP Five-Year Strategic Plan clearly outlines the priorities focused on enhanced communication: Goal 2: Enrichment of Member Value and Engagement, Goal 3: Nurturing Physician Leadership Development, Goal 4: Enhancing AAP-Chapter Relationships, and Goal 5, the foundation and gating item for the other goals: Fostering Better Communication.

With over 50 AAP Sections representing more than 36,000 pediatric sub-specialists who practice in small and large community-based practices, academic institutions, and multi-specialty groups, effective communication with AAP leadership can be a daunting task. The obvious diversity dictates that one size does NOT fit all for this constituency.

Sub-specialists are further challenged by the fact that they often must belong to a wide variety of organizations to assure they receive appropriate CME opportunities and maintain the ability to network with other experts in their respective fields. Given these competing priorities, the AAP must communicate around a value proposition that fulfills the sub-specialists academic, business, and personal needs.

I would suggest that inviting Section representatives to attend District and Chapter meetings, where AAP leaders are present, would facilitate front-line communication benefitting both the sub-specialists and the general pediatricians. Additionally, joint primary care and sub-specialty presentations at NCE and other large meetings would be a way to engage Section members in bi-directional clinical discussions which would foster a better understanding of the specific issues faced by our sub-specialty colleagues.

Relationships trump communication methodology every day and any opportunity we have to foster the face-to-face interaction between our general pediatricians and sub-specialists should be capitalized upon.
AAP President-Elect Candidates:

“The strategic plan includes goals to enrich communications pathways and platforms to prioritize bi-directional communication between and among the Academy’s leadership and constituent bodies (e.g. chapters, sections, councils, committees).”

What does the Academy need to do to make this happen for sections?”

Dr. Kyle Yasuda of Seattle, WA

To develop an effective communication system, we must understand the needs of Subspecialty and Issue-centered Sections. All Sections depend on timely communications to advocate for children and families and to develop appropriate educational and policy products. Some Sections have need for rapid responses to unforeseen developments. Foundational to improving AAP communication is the expeditious completion of its Digital Transformation.

Digital Transformation is the retooling of our organization to become truly member centric. It is the systems and processes that can make the Section member experience as seamless and valuable as possible. It is more than a new website or social media portal. One aspect of the digital platform is to assist each Section to provide timely communications. It must be modifiable to enable Sections to set their own priorities and provide a means for instant messaging.

For the AAP leadership to be more responsive to its Sections, we need to have informal communications on a regular basis. Whether through social media, chat room, or virtual town hall, the connection between Section members with key Academy contacts can improve. The digital platform should also facilitate communications between Sections and other elements of the Academy to enable members to share resources and areas of expertise.

Digital Transformation is the first step in creating an AAP virtual world where Section members can participate in the communities we choose, have information we desire provided in real time, and connect easily with other Sections and our AAP family.
Next SOIMG Newsletter Article Request:

It is with great pleasure that we serve as your editors for the newsletter of the AAP Section on International Medical Graduates. We are requesting articles representing health topics, pediatric research, medical education, personal stories or related topics of interest for our section. Articles submitted may be edited for formatting purposes.

**Deadline for the winter/spring submission is January 5, 2018**

Please feel free to contact us below if you have suggestions or comments.

Thank you,
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Get Involved……..

**AAP Member Stories**- Check out how members are engaging with the AAP and what inspires them to stay involved. Visit our [AAP Get Involved](#) page and click on the “Member Experiences Gallery” in the upper right to see their stories. And while you are there... **share your own!** We'd love to hear from you.