



California Chapter 2, the Los Angeles County, Inland Empire
and Central Coast Chapter

“Trust Me, I’m a Pediatrician”

By Mary Doyle, MD, FAAP, President, AAP California Chapter 2

When did we pediatricians join the ranks of the mistrusted? Now, mind you, I don’t think we are quite at the level of our attorney or insurance company friends, at least not for the time being. And, it still isn’t quite as funny to substitute “pediatrician” for “lawyer” in the joke about the sharks that don’t attack the lawyer bobbing in the ocean out of professional courtesy, but we seem to be on that same downward path. There was a time when the words, “I’m a doctor,” were equivalent to, “trust me,” because for us, the right to utter those words was earned only after the completion of medical school, a residency, and board certification, and reflected clinical training and experience in making sound judgments and practicing medicine in the face of uncertainty. Unfortunately, as trust erodes, so goes the linchpin of what binds physicians and families. It has been well demonstrated in studies that trust in physicians is what makes patients and families willing to seek care, willing to follow our recommendations, and willing to allow us significant decisional authority.¹

How do we know this is happening? We know this erosion of trust is happening not because it is making headlines or being lectured about at grand rounds, but when Internet articles assume more authority than our judgment. We know this is happening when celebrity anecdotes speak louder than studies. It happens when politicians or narrow interest groups legislate what exams should take place in the newborn nursery or at school entry. It happens when pediatrics ceases to be the bridge between science and the care of children and when the pediatrician is no longer looked to as the professional charged with making good judgments synthesized from multiple considerations. It happens when the media or politicians attempt to bridge that gap or when parents and patients look to them to do so.

How did we get here? This part I am not so clear on and I don’t think there was any one event that pushed us closer to

But, viewing patient blogs to see what patients really think of us provides a few clues: the common thread seems to be a breakdown in communication. According to one site, we, speaking generically as physicians, don’t know how to say, “I don’t know,” or, “I’m sorry,” or are afraid to say either. We are accused of neglecting the latest research and of resisting education from our patients. Many think we don’t respect the family’s intelligence by not involving them sufficiently in the decision-making process, by not taking the time to explain how we arrived at our recommendations, or by dismissing research they have done on their own. Some feel we are not proactive enough about preventative health practices or that they have to suggest tests that need to be done for monitoring.²

Turning to the pediatric palliative care literature, studies support which aspects of physician communication are satisfying to children and their parents and which have the potential to either facilitate or obstruct care. Five domains stood out: relationship building, demonstration of effort and competence, information exchange, availability, and appropriate level of child and parent involvement.³ When the physician’s communication is not satisfying to the patient and his or her family, they look elsewhere to fill the gap. Unfortunately, there are a lot of “elsewheres”: celebrities, legislators, lawyers, the media, the Internet, to name a few. More unfortunately, those “elsewheres” breach our patient-family-physician relationship.

What to do or why do anything at all? The answer to the second question is obvious and I hope to make the answer to the first question obvious, as well. Do nothing and the most powerful and enjoyable aspect of being a pediatrician is lost: caring for children and their families as a professional privileged to influence decisions that truly affect lifelong health and well-being.

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Palm Springs, California

February 12 - 15, 2009

The Hilton Palm Springs Resort

ADVANCES IN PEDIATRICS

April 16 – 19, 2009

The Flamingo Hotel

Las Vegas, Nevada

Program information and registration flyers will be mailed 3 months prior to each meeting and will be available on the Chapter website at www.aapca2.org. For more detail, contact Kathleen Shematek at (213) 250-4876 or email kshematek@aap.net.

Committees and Task Forces 2008 – 2010

American Academy of Pediatrics, California Chapter 2 (Appointed positions, except Nominating Committee)

Committees and Task Forces are the lifeblood of a successful organization. They focus on specific areas of interest and thrive on the interest and dedication of its members in accomplishing its goals. Listed below are the current committees and task forces of AAP California Chapter 2.

CHAPTER 2 COMMITTEES	CHAIRPERSONS TELEPHONE / EMAIL
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• AIDS Committee	• vacant
• Breastfeeding Committee	• Touraj Shafai, MD 909/689-9220 shafaidocs@yahoo.com
• Bioethics Committee	• vacant
• CCS / Children With Disabilities Task Force	• Robert Jacobs, MD 323/669-2300 rjacobs@chla.usc.edu
• Child and Spousal Abuse Committee	• vacant
• Community Outreach Committee	• Elliott Weinstein, MD 909/621-0973 elstwein@charter.net
• Committee on Service, Education & Mentoring (CSE)	• Al Yusin, MD 323/226-5692 tmy222@aol.com
• Electronic Communications Committee	• Oved Fattal, MD 818/375-4457 ofattal@verizon.net
• Environmental Health Committee	• Cyrus Rangan, MD 213/240-7785
• Fetus and Newborn Committee	• George Franco, MD 310/459-7773
• Foster Care and Adoptions Committee	• Kerry English, MD 310/668-4872 kerrydoc@ca.rr.com
• Infectious Disease Committee	• Wilbert Mason, MD, 323/361-2509 wmason@chla.usc.edu
• Injury and Poison Prevention Committee	• vacant
• L. A. Care – Children's Health Committee	• Curren Warf, MD 323/660-2450 cwarf@chla.usc.edu
• Legislative Committee	• Damodara Rajasekhar, MD. drakasekhar@charter.net
• Membership Committee	• Wilbert Mason, MD, 323/361-2509 wmason@chla.usc.edu
• Nominating Committee	• Elliot Weinstein, MD 909/621-0973 elstwein@charter.net
• Pediatric Practice Committee	• Christopher Tolcher, MD 818/340-3822 ctolcher@sbcglobal.net

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• Program Committee (CME)	• Robert Adler, MD 323/669-4523 radler@chla.usc.edu
• Quality Improvement Committee	• Wilbert Mason, MD, 323/361-2509 wmason@chla.usc.edu
• Resident Advocacy Committee	• Eyal Ben-Isaac, MD 323/361-2110 ebenisaac@chla.usc.edu
• Scholarship Committee	• Edward Curry, MD 909/427-5477 Edward.s.curry@kp.org
• School Health Committee / Mental Health Task Force	• Michele Roland, MD 323/669-2153 mrolandk@chla.usc.edu
• Substance Abuse Committee	• Trisha Roth, MD 310/452-9782 trisharoth@aol.com
• Violence Prevention Committee	• Vacant
LIAISONS	
• CATCH Program	• Elisa Nicholas, MD 310/933-9430 enicholas@memorialcare.org • Alice Kuo, MD 310/794-2583 akuo@mednet.ucla.edu • Lisa Richey, MD 818/501-3125 lrcztheday@hotmail.com
• Children's Medical Services, DHS, State of California	• Susan Igdaloff, MD 213/897-3186 Susan.Igdaloff@dhcs.ca.gov
• District IX Pediatric Council Liaison	• Christopher Tolcher, MD 818/889-4831 ctolcher@sbcglobal.net
• EDHI (Early Hearing Detection)	• Shirley Russ, MD 310/453-9782 shirleyruss@aol.com
• Hospital Care	• vacant
• Public Relations Comm. (Media Resource Team)	• Howard Reinstein, MD 818/784-5437 rhinehow@aol.com
• PROS Liaison / Coordinator	• Heide Woo, MD 310/825-6208 hwoo@mednet.ucla.edu
• Residents' Liaison	• Caroline Castelforte, MD ccastelforte@chla.usc.edu
• EDSI (Early Disease Screening Initiative)	• Helen DuPlessis, MD, 562/755-1823 hduplessis@verizon.net
• Literacy Project	• Alice Kuo, MD, 310/825-8042 akuo@mednet.ucla.edu
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To combat this slow erosion of trust I am asking that you make California Chapter 2 of the American Academy of Pediatrics your local professional home, akin to the medical homes we provide our patients. Participate in what the Chapter is doing to maintain the integrity of pediatrics and ensure the best possible care for our patients and their families. By paying Chapter dues, you have already demonstrated a level of commitment that 570 of our local AAP Fellows have not made, those who have chosen to be a member of the AAP at the National level only. But, by participating in Chapter activities, we can do more. The activities already in progress include the following:

- 1) Quality initiatives that satisfy Maintenance of Certification requirements
- 2) CME programs that address clinical advances, pediatric practice management and the needs of pediatric residents in our area
- 3) Advocacy for programs vital to the economically disadvantaged children of California and for legislation that protects or improves the health of all children of California
- 4) Partnerships designed to include pediatric input into programs that serve families and children
- 5) Workgroups, committees, and liaisons addressing very

specific issues: breastfeeding, smoke-free environments, obesity, cultural competency, mentoring of young pediatricians, resident scholarship and adequate reimbursement for services

Though our AAP contacts in Sacramento and Washington, D.C. still insist that we pediatricians are viewed as “the good guys” when we go knocking on legislators’ doors, other sources seem to be telling us we need to communicate better about why we are the “good guys” and why our patients and families’ trust in us is still justified. California Chapter 2 of the American Academy of Pediatrics, as your local professional home, can help. Trust me, I’m a pediatrician. Trust me, I’m your new Chapter president.

References:

1. Trachtenberg F., et.al. “How patients’ trust relates to their involvement in medical care.” *Journal Family Practice*. 54(4). (2005). 3 August 2008. <<http://www.ncbi.nlm.nih.gov/pubmed/>>.
2. “Do you Trust your Doctor?” Weblog Entry. *Musings of a Distractible Mind*. 30 July 2008. *Physician’s Blog*. <<http://distractible.org/2008/07/30/do-you-trust-your-doctor/>>.
3. Hsiao, JL, et.al. “Parent and child perspectives on physician communication in pediatric palliative care.” *Palliat Support Care*. 5(4) (2007): 3 August 2008 <<http://www.ncbi.nlm.nih.gov/pubmed/>>.

In Memoriam: AAP CA Chapter 2 Says Goodbye to Dr. Joan Hodgman

It is with great sadness that Chapter 2 says goodbye to our esteemed colleague and honorable Chapter member, Dr. Joan Hodgman, who passed away from ALS on 8/10/08. Dr. Hodgman served as our Chapter’s president from 1990-92 and continued to participate in Chapter activities until shortly before her death. To honor her memory and remind us of what an inspiration she was to us all, we are reprinting an autobiographical article she wrote for the National AAP Senior Section. Dr. Hodgman certainly will be missed, but her spirit, wisdom, and clinical acumen live on in all of pediatrics and in those fortunate enough to have known her.

-Mary Doyle, M.D

January 2008

Joan Hodgman, MD, FAAP
AAP Section for Senior Members
Executive Committee Member

“I am a true westerner. I was born in Portland, Oregon on Labor Day in 1923. My mother, perinatal before her time, had gone from Medford where my parents were living, to friends in Portland to get a real obstetrician to deliver her. I even had a pediatrician. We moved to Reno, Nevada and to Oakland, California following my father’s construction business. When I was four, we moved to Southern California and I have been here ever since. I went to South Pasadena High School, where I met my husband, Amos Schwartz. He sat behind me in Miss Foote’s Public Speaking Class and took me to the Junior Prom.

He had just been elected as our senior class president so he was a “catch”. He waited for me while I messed around and we married after we had been out of high school ten years. I was an art major in high school; but in my senior year I switched to premed. I have given my determination to go into medicine a great deal of thought and I still don’t know where it came from.

I am the only physician in my family going back several generations. When I was a girl, women were supposed to be nurses not doctors. I knew if I wanted to be accepted to medical school I would need good grades so I studied for them and managed an A average in college at Stanford. I was still not admitted to Stanford medical school. Stanford at the time had no quota for women, but

never took more than two in a class. I’ve never been unhappy with Stanford because they did me a big favor. I went up the peninsula and applied to UCSF which at the time was a much better medical school. I was admitted promptly and enjoyed my schooling there. Since being admitted to medical school, I have never been personally very aware of prejudice against women. I stayed at UCSF Hospital for a year of post-graduate training before coming home to Los Angeles.

World War II was over by then and the veterans were coming home, I was fortunate to get a resident position in Pediatrics at Los Angeles County University of Southern California Medical Center. When I was in medical school, newborns were not given medical care.

They were given nursing care and if they survived they were discharged to a doctor. The only normal newborn I saw during all of medical school was the infant I delivered when I was an OB. Infants weighing less than one kilo were expected to die. When I was a resident, Lou Diamond of Harvard developed the exchange transfusion for rh disease, which accounted for one third of the deaths in newborns at the time, and published the procedure in one of the journals in 1978. Dr. Robert Clelland, who was the Head Physician for Pediatrics and I as Chief Resident read the article and tried it out. Fortunately, the newborn infant did very well. That was my initiation into newborn care.

When I finished my residency, I opened my own office, which was entirely possible at the time. Amos and I had been married while I was a resident and he was in USC Medical School. He was actually my student on Pediatrics which was considered an acid test. House calls were common at the time, and usually came in the evening. What did the new Pediatrician have to offer but availability, so when the phone rang, I went. My husband was doing his surgical residency and needed to be at the hospital for early surgery. I was spending my evenings making house calls and I knew what my husband sounded like on the telephone but I was having trouble recognizing him.

After two years I decided that I didn't need to work less hard but I needed more control of my time. The job as Head Physician in Pediatrics was open and I applied for it and was chosen over seven other applicants. I was the only full time member of the Pediatric faculty at LAC USC Medical Center. The remainder were practicing Pediatricians who donated time for rounds with the residents.

They were excellent physicians and devoted to teaching, but there was no academic aspect to the program. Two years after I had started it was decided to add another Head Physician. The service was to be divided into the wards and the clinics and nursery. I had first choice and was going to choose the wards as the most important part of the service, but shortly before I had to decide I realized I would miss the babies in the nursery. So I chose the clinics and nursery. Among the first things I did was get rid of the clinics and then I could concentrate on the nursery.

The gods were riding on my shoulders and I have never looked back. Our hospital was delivering between 15,000 and 18,000 babies per year at the time. We did not yet have an NICU but we did have a premature ward. We were the only hospital in town that admitted outside babies to its nurseries. The Health Department had evaluated all hospitals with delivery services and had established whether they could keep small babies or send them to us. We had microchemistries, Gordon Armstrong incubators and x-ray machines that could give a clear picture of the lungs even if the baby was breathing 80-100 times a minute. We did not have ventilators as yet. In the 60's we tried to establish a NICU. We would clean out a nursery for the purpose and come back the next morning to find it full of babies. Not surprising when you consider that 18,000 births equates to 50 deliveries per day.

In 1968 we moved to another hospital on the same grounds and finally had room to start our NICU. It was the first one in Los Angeles. We had Fellows in training although there was as yet no national Fellowship program. Paul Werhle joined our faculty as Chairman of Pediatrics in the late 1960's and brought an academic background.

I sat at his feet and learned a bunch about presenting abstracts, clinical research and running a division. Neonatal care blossomed into a Division of Pediatrics with ever-smaller infants being cared for. Feizal Waffarn, one of our junior faculty at the time and I started our Bioethics committee in the 1970's during the Baby Doe controversy. Our administration could not tell us not to hold meetings but they did ask us to keep the committee under wraps. I believe their reluctance stemmed from their worry about headlines in the LA Times about minority babies being done in at the County Hospital. Interestingly, in 2005 when JACOH evaluated our hospital, they were very interested in patient advocacy. Our administration was able to claim that we had had a bioethics committee since 1975.

My husband and I had two daughters. I just made it under being an elderly primipara of 30 at the time. The second was born a year and a half later. I have four grandchildren; three boys aged 24, 20 and 20, cousins not twins, and finally an eleven-year-old granddaughter. My husband developed a lymphosarcoma and died at the age of 47 in 1970. They say only the good die young and he was very good. I have now been a widow almost twice as long as we were married.

Technology in newborn care advanced rapidly. We added ventilator care, efficient incubators, blood gas determinations and routine monitoring of the infants. We also became proficient at clinical research. I now have a 36 page CV with 130 peer reviewed articles and almost twice as many abstracts presented at research meetings. Also, there are a number of other articles and book chapters including one book entitled SIDS with co-author, Toke Hoppenbrouwers.

I have had the opportunity to travel to other units worldwide and in at least two, Cali, Columbia and Poland I have been a factor in the improvement of their newborn care. I went through the levels of academic status, starting with instructor as a resident and ending with Professor of Pediatrics in 1969. When I retired recently I became Emerita Professor.

I have had a number of awards of which I am proud but will only list two here. I was selected in 1976 as the Los Angeles Times Woman of the Year in Science. Then, my most prestigious award was the Apgar Award given by the Perinatal Section in 1999 at the NCE in Washington, DC. I stepped down from Chairman of the Division of Neonatology a number of

years ago, but continued to take my scheduled rotation on rounds and teaching. A few years ago I gave up rounds in the NICU because it was too demanding. I miss not being responsible for the NICU as that is where I worked with the residents and fellows and got to know them. Recently I have spent most of my time with medical students, teaching and sponsoring them in clinical research projects. At the present time, I am involved in writing four papers for eventual publication in peer reviewed journals and I had two abstracts in the last Western Society for Pediatric Research. Not too bad for an old lady.

I have been active in the AAP as President of Chapter 2 and Alternate

Chair of District IX. I have belonged to national committees, especially Committees on Women's affairs when that was necessary some years ago. Now, I am Editor of the Senior Bulletin of the Section for Senior Members. I have been president of all the local organizations to which I belong including the Los Angeles Pediatric Society, Salerni Collegium, a support group for the medical students at USC and the Southwestern Pediatric Society. I am a founding member of the California Association of Neonatologists and a member of the board. On January 1, 2008, I retired from LACUSC and received a nice parting gift. It was a very attractive chair with the medical school logo on the back, my name, "In Recognition for Dedicated Service", and the years 1948-2008. Wow!"

AMERICAN ACADEMY OF PEDIATRICS DISTRICT IX AWARDS, JULY 2008

Award of Chapter Excellence: California Chapter 2

Special Achievement Award: Mary Doyle, MD, California Chapter 2, for her leadership as District Treasurer in establishing an effective Finance Committee and revising district financial policies

Section On Young Physicians (SOYP) - Resources For Young Physicians

YoungPeds Network	http://www.aap.org/ypn
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SOYP E-newsletter	www.aap.org/ypn/yp/aap)yp/newsletters.html
YP Recruitment and Retention Grants – up to \$3000 for new chapter	events focused on getting young physicians involved with AAP
YP Liaison Positions: AMA-YPS, PREP, AAP Grand Rounds, Committee	on Membership, Committee on Pediatric Workforce, Committee on CME, NCE Planning Committee, PMO Workgroup
AAP California (District IX) Representative	Christina S.L. Vo, MD, csvo@aap.net , 925-438-1100 (office)
AAP California Chapter 2 Representative	Caroline Castleforte, MD, ccastleforte@chla.usc.edu

Remember To VOTE!

NATIONAL AAP PRESIDENT-ELECT CANDIDATES FOR 2008

Election Ballot Deadline October 1, 2008

Colleen A. Kraft, MD, FAAP Richmond, VA

Colleen A. Kraft, M.D., F AAP is the President of the Virginia Chapter of the American Academy of Pediatrics. In her private practice with Pediatric and Adolescent Health Partners in Richmond, Virginia she develops innovative ways to address morbidities new to the practice of pediatrics. In her previous practice, she served as Managing Partner. She also teaches in the Division of Community Pediatrics at Virginia Commonwealth University, and is Medical Director of Medical Home Plus, Inc., a non-profit that complements the Medical Home by connecting families and physicians with community resources.

Born in Akron, Ohio, Dr. Kraft was in an inaugural Head Start class in 1965. She received her B.A. from Virginia Tech, her M.D. from the Medical College of Virginia, and completed pediatric training at the Medical College of Virginia Hospitals. For the past 20 years, she has taught medical students and residents in classroom and clinical settings here and abroad.

As President of the Virginia Chapter, Dr. Kraft is often quoted in media and print about the excellent return on

public investments in children's health. She is well known to the Governor's staff, State and Federal legislators, insurance companies as well as Medicaid and health department officials. Dr. Kraft has spoken nationally and internationally on numerous pediatric topics, serves on the Executive Committee of the Council on Community Pediatrics, and writes for the Section on International Child Health Newsletter.

Dr. Kraft enjoys music and travel with her three children, ages 22, 20, and 18.

Judith S. Palfrey, MD, FAAP Boston, MA

Judy Palfrey is a general pediatrician and child advocate. She has developed widely accepted medical home approaches that address health inequities and provide guidance for practices and school systems on the comprehensive care for children with special health care needs. She has advocated for SCHIP, improved school health services and payment to pediatricians for developmental screening and coordination of care.

She has served as AAP Section Chair of Developmental and Behavioral Pediatrics, President of the APA, Di

rector of Building Bright Futures, and National Program Director of the Dyson Community Pediatrics Initiative.

Born in El Paso, Texas, Judy grew up in Baltimore, Maryland. After receiving her BA from Harvard and MD from Columbia, she trained at Jacobi Hospital in New York. She joined Children's Hospital, Boston, serving as General Pediatrics Division Chief (1986-2008). She fostered the division's growth to 90 faculty members, 25 fellows, nearly 100,000 annual patient visits. She has written five books including *Community Child Health* and *Child Health in America*, over 100 articles and chapters dealing with improving child health systems. She has mentored hundreds of medical students, residents, and fellows.

Judy is the T. Berry Brazelton Professor of Pediatrics, Harvard Medical School. She directs the Children's International Pediatric Center, Children's Hospital, Boston. She is Master of Adams House at Harvard College along with her husband, Sean, who is the former President of the Massachusetts Chapter of the AAP. They have three children and two grandchildren. Judy enjoys messing around in boats, clamming and tennis.

MORE TIME, MORE JOY, LESS HASSLE

Michael Gollub, MD, FAAP, and Glenn Schlundt, MD, FAAP

As a group, pediatricians are busy practitioners who are frequently disinclined to involve themselves in the business aspects of medicine. Most simply presume that the harder they work the better they will do. Most expect that insurance payments will cover the costs of overhead and supplies, such as vaccines. Some are apprehensive that there are business aspects of running a practice (or working for one), that they don't know, but are unsure how to learn about a health services system that is increasingly, if unnecessarily, complicated.

In an April 16, 2008 editorial in the LA Times, Albert Fuchs, MD, commented: "Even the best medical schools give short thrift to practice management. So a doctor can emerge as a skilled diagnostician without a clue how to run a business that serves consumers. In fact, many physicians find it distasteful to think of medicine as a business at all."

Managing our practices well and surviving happily require that we think of medicine as a business. We have a greater chance of continuing as excellent physicians if we become more efficient and effective in practice management. We will then also achieve the ancillary goals of more free time, more joy and less hassle in our professional lives, and better overall quality of life in general.

One way to develop some business savvy, we believe, is the AAP Section of Administration and Practice Management (SOAPM).

SOAPM provides a twice a year newsletter and a very active listserv on which pediatricians discuss the problems that con-

front us and offer practical suggestions and improvements. Some of the topics covered recently include offering services that ethically produce more income; contracting hassles and means of improvement in our insurance company contracts as well as our entitlement to reasonable payment for services we provide; issues dealing with the "Anti-vaxers" and approaches to dealing with patients who refuse vaccines; problems with insurance company reimbursement for newer, more expensive vaccines and our need to get adequately repaid for the expense of paying for and providing the vaccines; coding and charging for numerous issues we might not have considered such as developmental screening and review of records of adopted or prospective adopted patients; efficient means of patient scheduling; and EHR topics.

We have also been effective in giving effective feedback to National AAP and letting it know how the AAP can and should work with us to improve our practice lives so we can give better care to our patients. Our voice is heard and improvements have been made.

We have both found membership in SOAPM educational and worthwhile, especially with regard to the section's listserv, in which many current administrative and clinical topics are discussed. Both younger physicians just starting out and more seasoned physicians with substantial administrative experience stand to benefit by learning how well-run practices across the country approach and solve problems that face many practices.

Membership in SOAPM is \$30/year, and well worth the cost. To join, fill out the application from <http://www.aap.org/moc/memberservices/sectionform.cfm>

Negotiating With Insurers: Is "Win-Win" the Correct Approach? SOAPM News- Spring 2008

An editorial by Herschel R. Lessin MD, FAAP

I think that we would all agree that most pediatricians are nice people. We tend to avoid conflict and usually try to do the fair and right thing in our business dealings. However, the question arises—Is this a useful approach when dealing with insurance company issues? The classic book, *Getting to Yes*, by Fisher and Ury, from Harvard, details this approach to negotiation. The goal is to put yourself in your opponent's shoes and give them

something that they want in return for something you want (this is highly simplified for this discussion). By doing so, everyone can "win," and it will be easier to get from NO to YES. By using this technique, negotiation can be brought to a successful conclusion quickly, with both sides feeling satisfied and seeing the value that the other side brings to the table. For most situations, this is the best way to negotiate, particularly when you value a relationship with your opponent.

Unfortunately, this seems to be the only technique people remember about this valuable book. There is another chapter devoted to identifying the type of negotiation in which you are actually involved. The win-win scenario is only valid at times when both parties value the other and want to have an ongoing and useful relationship. The corporate culture of a business is the basis for much of its negotiating style. Some insurers are indeed interested in win-win relationships.

New WIC Foods are Good News, but Pose Challenges for Staff and Physicians

Pediatricians, frustrated by the lack of consistency between American Academy of Pediatrics (AAP) nutrition recommendations and the foods given to their patients by the Women, Infants and Children (WIC) Program, will be pleased to learn that—starting in mid to late 2009—infants in WIC will no longer receive fruit juice, but instead will receive baby food fruits and vegetables starting at six months, matching revised guidelines to be issued by the AAP in July 2008.

A Long Time Coming

These significant revisions are the result of over fifteen years' effort by the WIC community to convince the U.S. Department of Agriculture (USDA) to bring WIC foods in line with U.S. Dietary Guidelines. In 2003, USDA commissioned the Institutes of Medicine (IOM) to conduct a review of WIC foods to conduct an evaluation of the diets of the WIC population and to make specific recommendations for changes based on these findings. The Committee to Review the WIC Food Packages consisted of recognized technical experts in pediatric and obstetrical nutrition from around the country who volunteered their time to the study. The resulting reports were objective, independent and based on current scientific evidence, public comment and rigorous peer review. The National Academy Library released the publication, WIC Food Packages: Time for a Change in December 2005.

Important parameters for these recommendations included: the changes must be cost-neutral, workable for nationwide distribution and store check-out, consider potential administrative burden, by suitable for a variety of cultures and consider the role of the WIC program in providing supplemental food, breastfeeding support and nutrition education.

Nutrition Priorities for the WIC Infant and Child Population

Based on its study of current dietary intakes, the IOM Committee developed criteria for their recommendations. WIC foods should:

- reduce the prevalence of inadequate and excessive nutrient intakes in participants;
- contribute to an overall dietary pattern consistent with the U.S. Dietary Guidelines for individuals 2 years of age and older and with established dietary recommendations for infants and children under 2 years, including support for breastfeeding; and
- be widely available, commonly consumed and provide for cultural preferences.

IOM Recommendations for Infants and Children

The resulting revised foods lists for infants and children will be welcome by pediatricians; some new requirements for “documentation by a medical professional” may cause concern as well:

- To encourage breastfeeding, formula in the first month is discouraged for breastfeeding dyads, less formula overall is in the package for partially breastfeeding dyads and the “market value” of the package for exclusively breastfeeding dyads is greatly increased;
- Juice is eliminated for the infant category, replaced with baby food fruits and vegetables starting at six months of age; fully breastfeeding infants also receive baby food meats;
- The amount of juice is limited to 4 oz per day for children, down from 8 oz;
- Fruits and vegetables are provided as a “cash-value voucher” worth \$6 per month;
- Cheese and milk amounts are reduced and milk must be low fat starting at two years;
- Half the cereal options provided must be whole grain;
- Soy and tofu are available as cultural options at State discretion but, for children, must be accompanied by documentation of approval by the medical care provider;
- The regular food package for infants and children may be provided in addition to exempt formulas, but again, only with documentation from the medical care provider.

Implementation in Phases

California WIC has held meetings over the past few months to gather input from a wide variety of interested parties in order to shape the policy decisions regarding food types, amounts and other policies prior to implementation. For input from the medical community, program staff has met with Medi-Cal Managed Care Medical Directors and is planning a series of conference calls over the summer. If you are interested in participating in one or more of these conference opportunities, or to learn more about the upcoming changes to WIC foods, please contact Michele van Eyken, RD, MPH, the Deputy Chief of the California WIC Program at 916-928-8806 or by e-mail at Michele.van.Eyken@cdph.ca.gov.

Highlights of The WIC Food Package – Final Interim Rule Published December 6, 2007

Effective Date: February 4, 2008

State agencies must implement by: October 1, 2009

Interim rule comment period ends: February 1, 2010 (“pilot” until final rule is published)

Cost Neutral: USDA estimates that the revisions to the WIC food packages will be cost-neutral.

No additional funds will be provided to implement this rule.

USDA Requires States to Implement These Changes

Addition of New Food Types

- ⊕ Fruit – any variety of fresh, whole or cut, without added sugar, for women and children
- ⊕ Vegetables – any variety (but no white potatoes) of fresh, whole or cut, for women and children
- ⊕ Whole wheat bread (may include whole wheat buns and rolls) for women and children
- ⊕ Baby foods – jarred infant fruits & vegetables; jarred infant meat (fully breastfed infants only)
- ⊕ Breakfast Cereals (at least half of State’s authorized breakfast cereals must meet whole grain requirement)
- ⊕ New fish options for women fully breastfeeding (states must authorized two types)

Food Delivery Systems

- ⊕ Vendors must stock at least two varieties of fruits, two varieties of vegetables, and at least one whole grain cereal authorized by the State

New Milk Requirement

- ⊕ Only infants 12-23 months will receive whole milk. All others will be issued reduced-fat, low-fat or non-fat milk.

Fruit & Vegetable Cash-Value Check

- ⊕ Children and Women are to receive dollar-amount fruit and vegetable check:

- Children \$6
- Pregnant, partially breastfeeding and postpartum women \$8
- Women fully breastfeeding \$10
- Women fully breastfeeding more than one infant \$15.

- ⊕ Monthly value of the fruit/vegetable cash-value voucher will be adjusted annually for inflation

- ⊕ Not allowed: white potatoes, herbs or spices, edible blossoms of flowers, fruit leathers/roll-ups

Reduction/Elimination of Current Food Types

- ⊕ Quantities of milk, cheese, eggs, and juice will be reduced for women and children
- ⊕ Juice will be eliminated from the infant’s package
- ⊕ Infant formula amounts will be reduced for partially breastfeeding infants and for all formula-fed infants starting at six months of age

States May Opt to Implement These Changes

New substitutions for current and new foods

- ⊕ Processed (canned, frozen, dried) fruits and vegetables without added sugar as a substitute for fresh fruits and vegetables



- ⊕ Bananas for up to 16 oz. infant fruit (1 lb. bananas = 8 oz. infant food)
- ⊕ Soy beverage and tofu as substitutes for milk
- ⊕ Brown rice, bulgur (cracked wheat), oatmeal, whole-grain barley, soft corn or whole wheat tortillas as a substitute for whole grain bread
- ⊕ Canned salmon, sardines or mackerel (specific types) as a substitute for tuna
- ⊕ Canned beans as a substitute for dried beans

Food Delivery Systems and the Fruit & Veggie Cash Value Check

- ⊕ State Agencies may allow participants to pay the difference when the purchase of authorized fruits and vegetables exceeds the value of the cash-value check
- ⊕ State Agencies may allow farmers at farmers’ markets and roadside stands to accept cash-value checks for fruits and vegetables

They are impressed by the value you bring to the table and, if you can convince them that it is worth it, they will agree to higher payments. However, within the insurance industry, some companies have no such cultural bias. Their negotiating style is what Fisher and Ury called the "street fight." In a street-fight negotiation, there is no interest whatsoever in an ongoing relationship. There is no interest in a give and take of value. This type of negotiation is better characterized as a "win-lose" negotiation.

Historically, we pediatricians have approached all of our negotiations with payers as win-win propositions. The problem with our insurance relationships is that we are actually in a street fight negotiation and fail to realize it.

When a street fighter confronts a win-win pediatric negotiator, the street fighter will always prevail because the pediatrician thinks that the payer is actually interested in having the opponent come away satisfied. The street fighters will prevail because the pediatrician thinks that the payer sees value in an ongoing relationship. Pediatricians will make a reasonable proposal, which will then be used as a "ceiling" by the street fighter. We will offer concessions that are taken, but where nothing is offered in return. They win. We lose. In a street fight, the only currency is power and the resolve to do what is necessary and/or walk away. Those items are notoriously lacking when pediatricians negotiate with payers. When you deal with bullies, being reasonable is viewed not as a virtue, but as a fatal

weakness. The bully always will continue to press for more, while giving nothing of value in return. It is far past time for all of us pediatricians to take a street fight mentality with payers who take such an attitude with us. It is time to draw some lines in the sand, which we will not cross. Payers listen far better when they realize that you are tough, that you mean business, and that you will do whatever is necessary to get what you want. The best negotiations often happen AFTER the letter of withdrawal from the plan.

When you enter into negotiation with payers, the first thing to do is to identify the type of negotiation with which that you are involved. The next thing to do is act accordingly. Sadly, when it comes to some in the insurance industry, nice guys often do indeed finish last.

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Quality Corner - Infection Control and MDROs in Ambulatory Pediatrics

Wilbert Mason, MD, FAAP

Antimicrobial resistance is increasing in the U.S. and world-wide⁽¹⁾. Over the last 15-20 years there has been a dramatic increase in prevalence of non-susceptible pneumococci, vancomycin-resistant enterococci (VRE) and methicillin-resistant *Staphylococcus aureus* (MRSA). Resistance among Gram-negative organisms has also emerged including extended-spectrum beta-lactamase (ESBL) producing *E. coli* and *Klebsiella*, multiply resistant *Pseudomonas aeruginosa* and *Acinetobacter* species that are resistant to all commonly used antimicrobials. These bacteria are not resistant to a single agent as suggested by some of their names (e.g. MRSA and VRE) but to multiple antimicrobials or even classes of antimicrobials. These are known as multidrug-resistant organisms (MDRO). These organisms have frequently emerged from healthcare settings and hospitals are often reservoirs of these organisms in the community.

The impact of MDROs has been substantial. Morbidity and mortality associated with infections with these microbes are high. In 2005, there were 18,650 in-hospital deaths subsequent to MRSA infections in the U.S.⁽²⁾. Increased morbidity and mortality has been documented in outbreaks of ESBL-producing *Klebsiella* in intensive care units⁽³⁾. MDRO infections are associated with greater costs to the healthcare system than those due to more susceptible organisms. For example, it has been estimated that the excess cost

attributable to an infection due to MRSA ranges from \$3000 to \$35,000 as compared to costs associated with an infection due to susceptible *S. aureus*. As a result, it has been estimated that in 2005, MRSA infections cost the healthcare system (patients and hospitals) between \$830 million to \$9.7 billion in direct costs.⁽⁴⁾

Because of the rapid emergence of antimicrobial resistance and spread throughout the community, the Institute of Medicine has identified MDROs as a public health priority and has recommended wide ranging efforts to combat the threat posed by these organisms⁽¹⁾. In addition, the Centers for Disease Control and Prevention (CDC) published guidelines to guide hospitals in their efforts to control infections due to MDROs⁽⁵⁾.

Contact Isolation Precautions are recommended of control spread of MDROs in hospital settings but how should general pediatricians address infection control in the ambulatory setting when treating patients who are known or suspected to be colonized or infected with an MDRO?

The CDC guidelines and the AAP Red Book⁽⁶⁾ suggest that Standard Precautions are appropriate for routine care of patients in the ambulatory setting. Standard Precautions include the following practices:

continued from page 11

☀ Appropriate Hand hygiene-use alcohol gel or hand washing BEFORE AND AFTER each patient contact and after touching body secretions or blood whether or not gloves are worn. If hands are visibly soiled hand washing is indicated and it is preferred when caring for patients known or suspected to be infected with *C. difficile*.

☀ Gloves and nonsterile gowns should be worn for contact with uncontrolled secretions, pressure sores or draining wounds, incontinent stools, and ostomy tubes and bags.

☀ Masks, eye protection, and face shields should be used during patient care activities and procedures likely to result in splashes or sprays of blood or body fluids.

Since some MDROs, such as MRSA, are extremely common in the community at the present time and many children are asymptotically colonized careful attention to Standard Precautions can prevent transmission of these organisms to patients in your practice.

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SCHOLARSHIP COMMITTEE AWARDS 2008 EDWARD S. CURRY, MD

The American Academy of Pediatrics, California Chapter 2, is pleased to announce that three outstanding San Luis Obispo County High School graduates received the 2008 Medicine Biological Sciences Scholarships. These students were honored at a ceremony held at San Luis Obispo, California on Saturday, July 12, 2008.

The scholarship winners are Cassie Jackson, who ranked 11th in her class at Nipomo High School Senior class of 291 students with a 4.0 grade point average. Cassie was the recipient of a \$1,000 scholarship. She plans to attend Dartmouth University with a goal of becoming physician.

Steven Manier graduated from Atascadero High School with a 4.0 grade point average. Steven is the recipient of a \$750 scholarship. Steven plans to attend Cal Poly San Luis with goal of become an Orthopedic Surgeon.

Onyinye Oriji graduated from Nipomo High School with a 3.52 grade point average. Onyinye is the recipient of a \$750 scholarship. Onyinye plans to attend University of San Francisco with a goal of becoming a physician.



L to R: Cassie Jackson, E. Curry MD, Steven Manier

The Medicine Biological Sciences Scholarship of the AAP, California Chapter 2, was established in 1995 from an endowment set aside to fund a continuing annual scholarship for promising high school seniors with the desire to pursue fields of medicine and biological sciences. Since 1995 American Academy of Pediatrics has awarded over 80 scholarships. The scholarship is limited to students in seven Southern California Counties (Los Angeles, Kern, San Bernardino, San Luis Obispo, Santa Barbara, Riverside and Ventura) and selection rotates annually between the regions. This program has been recognized by the national American Academy of Pediatrics with a special commendation as the first scholarship program organized by a chapter.

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