PULSE

THE QUARTERLY PUBLICATION OF THE AMERICAN COLLEGE OF OSTEOPATHIC PEDIATRICIANS

SUMMER • 2015

Make Plans for the OMED 2015/ACOP Pediatric Track Conference in Orlando

Join us in Orlando! The American College of Osteopathic Pediatricians is joining OMED 2015 for an exciting CME program. Based on survey responses from past ACOP CME conference attendees and assessment of current pediatric topics to help pediatricians prepare for continuous maintenance of certification, the CME Committee will be offering a conference with the most current updates on nephrology, urology and gastroenterology. The first day of the conference will present perinatal/neonatal topics surrounding the late preterm infant. We will have a joint session with the American College of Allergy and Immunology to address immunodeficiencies, SCID neonatal screening and food allergies on Monday. We will be joining the ACOFP in a session sponsored by the AAOA on Thursday to address fever evaluation and antibiotic resistance.

28+ Category 1-A CME Credits

Family-centered medicine is of utmost importance to pediatric healthcare providers. It implies that the family is part of the healthcare team, recognizing that the family knows the child best and therefore, are experts in the needs of their child. This also allows for better communication between the family and the healthcare team, and ultimately better clinical outcomes for the child. The last day of our conference will present the theme of family-centered medicine and have an interactive session with a family that will outline the principles of family-centered medicine in action.

Take time to relax and enjoy all of great opportunities that OMED has to offer such as the AOA Opening Reception, the MVPs Cocktail/Pool Party and the Lunch and Learn sessions. Reconnect with former classmates and colleagues during the Alumni events.

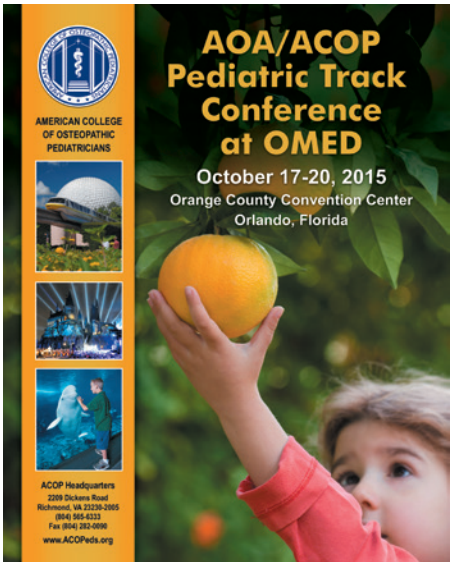
Orlando will offer a "magical" experience whether you visit one of the Disney theme parks, enjoy shopping in Downtown Disney, try a fabulous cuisine in one of the area's restaurants or have a fun evening in one the various night clubs.

Join us in Orlando for great education, reconnecting with former classmates and colleagues, enchantment and earning 28+ hours of pediatric CME.

Marta Diaz-Pupek, DO, FACOP
Program Chair
ACOP CME Committee Co-Chair

Visit **www.osteopathic.org** for registration information ,

Please be sure to register as Osteopathic Pediatricians in the "Specialty College Section."



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Kim Battle

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President's Message

Carl Backes, DO, FACOP, FAAP
ACOP President

Carl Backes, DO, FACOP, FAAP

It is with honor that I write my first message. Thank you for allowing me the privilege of serving as your president.

WOW! That's how I describe the ACOP's 75th Anniversary celebration. Our joint conference with the AAP section of the osteopathic pediatricians entitled "Doing Pediatric Education Together: Keeping Our Children Safe" was a smashing hit with a record 330 registrants.

First, the thank you's:

- To our ACOP staff, especially Stewart Hinckley, Kim Battle, Teri Allanson and the Ruggles Service Corporation support staff.
- To Edward E. Packer, DO, and Erik Langenau, DO, for co-chairing the program. They did a great job.
- To our CME committee co-chaired by Marta Diaz-Pupek, DO, and R.Edwin Spitzmiller, DO, for a fantastic program!
- To all who presented posters (a record 56) you all did a fantastic job—let's keep it up!
- To all ACOP board members for their support and their visions for the future.
- To all ACOP committee members and the chairs for their outstanding work using ACOP as our educational and political voice.
- To the chef, the band, and Westin Hotel for the dancing, food and the delightful 75th Anniversary Gala.
- To the Emeritus Honorees, for all invited and the eight attendees, we enjoyed honoring you and revisiting our past leadership. We hope you continue to stay involved with us.
- To Robert W. Hostoffer, DO, our recipient of the Harold H. Finkel, DO, and Arnold Melnick, DO, Community Pediatrician of the Year Award, for your contributions to our college, our profession, and the many patients you have helped.
- To Martin Finkel, DO, our Career Achievement Award recipient, for your contributions to our college, our profession, and the research you have done on abuse to help so many children and families.
- To Bret Nolan and Christine Beeson, our student representatives on the ACOP Board thank you for your effort to inform and engage more than 1900 students interested in an osteopathic pediatric career.
- To Scott Cyrus, DO, our outgoing President, for your leadership, innovative ideas, and guidance as we begin the single accreditation system.
- My last, but most certainly not least, thank you goes to "The Star" Arnold Melnick, DO, for your speech on pediatric osteopathic history. Your ten finger story had everyone on their feet. At ninety-five-years old, you exemplify who we were and where we are going. Your talk was a highlight of our conference as you were the Watson Memorial Lecturer for the third time.
- And finally, thank you, everyone, for allowing me to lead us forward. We must act as a team!

So what needs to be done?

- Continue to provide outstanding ACOP programs (with the AAP osteopathic section, AOA, or alone).
- Invite all DO pediatricians and maybe family physicians to our next convention in Orlando, Florida, on October 17-20, 2015, as a combined AOA/ACOP Pediatric Track and ACOP Spring Conference in Phoenix, Arizona, on April 14-17, 2016.
- Continue to have outstanding committee chairs and members necessary to allow us to be the voice of the pediatricians.
- Continue efforts to increase membership. We must encourage student members to

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MELNICK at Large

Home Schooling

By Arnold Melnick, DO, FACOP

Parents universally have their own "shorthand" for controlling, socializing and educating their offspring. Many of those come into common use and looked at carefully become humorous barbs-- but essentially a base for "home schooling." Here is a compilation from the Internet, with the "educational objective" of each:

My Mother and Father Taught Me...

RELIGION
"You better pray that will come out of the carpet."

TIME TRAVEL
"If you don't straighten up, I'm going to knock you into the middle of next week."

LOGIC
"Because I said so, that's why."

MORE LOGIC
"If you fall out of that swing and beak your neck, you're not going to the store with me."

FORESIGHT
"Make sure you wear clean underwear, in case you're in an accident."

IRONY
"Keep crying and I'll give you something to cry about."

OSMOSIS
"Shut your mouth and eat your supper."

CONTORTIONISM
"Just you look at that dirt on the back of your neck."

HYPOCRICY
"If I told you once, I told you a million times. Don't exaggerate."

BEHAVIOR MODIFICATION
"Stop acting like your father!"

ANTICIPATION
"Just wait until we get home."

MEDICAL SCIENCE
"If you don't stop crossing your eyes, they are going to get stuck that way."

ESP
"Put on your sweater; don't you think I know when you are cold?"

HUMOR
"When that lawn mower cuts off your toes, don't come running to me."

HOW TO BECOME AN ADULT
"If you don't eat your vegetables, you'll never grow up."

GENETICS
"You're just like your father."

MY ROOTS
"Shut that door behind you. Do you think you were born in a barn?

WISDOM
"When you get to my age, you'll understand."

JUSTICE
"One day you'll have kids and I hope they turn out just like you."

Take another look. Anything familiar? Are you starting to see some truths coming through the humor? Or are they just too real to laugh?

Do you have some favorite anecdotes? Personal? Office? Are you willing to share them with me? I'd like to collect them and maybe share them with others. Please send them to ***melnick5050@comcast****. net and be sure to include your name and address (street or e-mail). They will be appreciated.*

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2015 ACOP-AAP CONFERENCE AWARDS

Harold H. Finkel, DO and Arnold Melnick, DO COMMUNITY PEDIATRICIAN OF THE YEAR

Robert W. Hostoffer, Jr., DO, FACOP

Dr. Robert Hostoffer, Jr., is presented with the Harold H. Finkel, DO, and Arnold Melnick, DO, Community Pediatrician of the Year Award by ACOP President Dr. Carl Backes.

CAREER ACHIEVEMENT AWARD

Martin A. Finkel, DO, FACOP, FAAP

Dr. Martin A. Finkel is shown offering thanks after receiving the Career Achievement Award.

STUDENT CLUB OF THE YEAR

Michigan State University College of Osteopathic Medicine Pediatrics Interest Group (PIGS)

Student Trustees Christine Beeson (far right) and Bret Nolan (middle right) present the Student Club of the Year Award to Tracy Nogle (far left) and Leanne Sancrainte (middle left) of the Michigan State University college of Osteopathic Medicine Pediatrics Interest Group (PIGS).

ACOP HONORS EMERITUS MEMBERS

The ACOP presented medals to Emeritus members (from left to right) Drs. Joseph A. Dieterle, Laura S. Stiles, Philip W. Eppley, II, Stanley E. Grogg, Arnold Melnick, Neil S. Levy, Louis J. Schaner and Malcolm S. Schwartz.

2015 ACOP - AAP CONFERENCE POSTER AWARDS

BEST POSTER – CASE STUDY

Effects of In Utero Exposure to Varying Dosages of Valproic Acid

[1]Sooriyakumar G, [2]Holmes, L
[1]University of New England College of Osteopathic Medicine, Providence, RI, United States; [2]Massachusets General Hospital for Children, Boston, MA, USA

Dr. Abe Bressler, Chair, ACOP Research Committee, presents the Best Poster Case Study to Gayathry Sooriyakumar.

BEST POSTER – INSTITUTIONAL

COMLEX vs. USMLE: Evaluating APPD Preferences and Position on Applicant Board Examinations

Metts J, Des Moines University, Des Moines, IA, US

Dr. J. Michael Metts accepts the Best Poster-Institutional Award from Dr. Abe Bressler, Chair, ACOP Research Committee.

BEST POSTER – RESEARCH

Lack of Efficacy of Antenatal Corticosteroids in IUGR Infants

[1]Locke R, [1]McLean K, [2]Goudar S, [1]Sloan N, [1]Jaeger F, [1]Mackley A, [1]Thomposon D, [1]Vellanki H, [1]Derman R, [1]Paul D
[1]Christiana Care Health System, Newark, DE, USA; [2]Jnmc, Belgaum, Karnataka, India

Dr. Robert Locke accepts the Best Poster Research Award from Dr. Abe Bressler, Chair, ACOP Research Committee.

BEST POSTER – STUDENT CLUB

American College of Osteopathic Pediatricians (ACOP) at Edward Via College of Osteopathic Medicine - Carolinas Campus

[1]Pronman L, [2]Przybylowski L, [2]Patel D, [2]Ivanoff E, [2]Santiago J, [3]Sahhar H
[1]Edward via College of Osteopathic Medicine - Carolinas Campus, Spartanburg, SC, USA; [2]VCOM- Carolinas Campus , Boiling Springs, SC, USA; [3]VCOM-CC, Spartanburg, SC, USA

Dr. Abe Bressler presents the Best Poster Student Club Award to representatives from Edward Via College of Osteopathic Medicine-Carolinas Campus.

2015 Watson Memorial Lecture

The ACOP Spring Meeting Keynote Speaker and recipient of the 2015 Watson Memorial Lecture was Arnold Melnick, DO, FACOP. Dr. Melnick surprised no one by "hitting it out of the park." Although there is no replacing Dr. Melnick's mesmerizing delivery, his unabridged lecture is a great read. (Editor's Note: If interested in learning more about improving your own public talks, a good start is Dr. Melnick's book, Professionally Speaking: Public Speaking for Health Professionals with a forward by C. Everett Koop.)

2015 Watson Memorial Lecture Presented by Arnold Melnick, DO, FACOP

By Arnold Melnick, DO, FACOP

This is 1946. This is the Waldorf-Astoria Hotel in New York. This is the Annual Meeting of the ACOP. This is Arnold Melnick, a lowly intern at Osteopathic Hospital of Philadelphia, with a burning desire to become a pediatrician, who chiseled two days off to try to learn some pediatrics at this meeting.

But wait a minute! I looked at all the ballrooms like this and couldn't find the ACOP. Finally, I found a small, side Conference Room with a small table in the corner. The 15 or so ACOP members around that table were the 1946 ACOP Annual Meeting.

Dr. Arnold Melnick presents the 2015 Watson Memorial Lecture in Fort Lauderdale.

I sat through an afternoon with no additional pediatric knowledge but with an improved understanding of the ACOP organization. As soon as the meeting ended, Helen Hampton, who was President, approached me with a pile of papers and asked, "Will you be good enough to review these tonight and give a brief summary at tomorrow's session?" So my brief discussion the next day on the brand new field of child development became only the second educational presentation at an ACOP Annual Meeting. That was 70 years ago and the start of a 70-year love affair between me and ACOP.

Seventy years ago, pediatricians usually limited their practices to infants under one year of age. The reason: infectious diseases overwhelmingly predominated their practices and there were no anti-infective medications or antibiotics. (That accounts for the famous picture of the doctor sitting by the bedside of a dying child, painted in 1887 by Sir Luke Fildes.) Actually he had little to fight the illness – except kindness, sympathy and support. Ultimately, as the specific drugs appeared in the 40s, the upper age of our practices rose to12 years (where it was when I entered practice), then to 16 and today it varies from 21 to 25.

Thanks! Today, I appreciate being invited to give the Watson Memorial Lecture and especially being the only person to give it three times. I know I have slowed down, but it didn't take me long to realize that I was not expected – being almost 95 and not having seen a patient in almost 40 years – to give the latest treatment of premature infants or discuss the newest cardiac drugs. I was invited because I am the only living member who has lived through 70 years of ACOP activity. So I'll try to give you my view of many salient happenings in those 70 years – and throw in a few comments on key things that I think took us from...

Rejection and Discrimination to Recognition and Acceptance

When I was in medical school in the 40s, we faced a deadly plague – called "the draft board." Medical students and graduates were all subject to being drafted into the medical branches of the armed forces. But DOs were declared "quacks" by the AMA, and the medical services (whose medical decisions understandably followed AMA standards) refused to grant us commissions in their medical corps. And that also meant that osteopathic students had no deferments and had to face draft board actions. I survived by virtue of a repeated 4-F classification (physically unfit for military service – vision).

However, the general policy brought agony to us and we chafed at the discrimination. But in retrospect, there was what I believe was a positive effect. Massive numbers of practicing MDs were drafted, leaving their neighborhoods bereft of adequate medical services. As a result, those "stranded patients" almost had to go to a DO. Many of those patients learned that DOs were "regular doctors" (so did their friends and neighbors) and many remained with the DOs after the war. This created a steady stream of thousands of patients for DOs and the pool of "osteopathic " patients grew exponentially, forming a basis for continued and increasing influence.

I believe this was a major tactical error on the part of the AMA – they literally chased patients to osteopathic physicians – unconsciously, of course. Thereby, we developed a larger cadre of osteopathic supporters than any advertising or publicity could possibly have created. So much so, that DOs accidentally reaped a huge impetus in public recognition and acceptance.

Pediatric Training

At the time of my internship, there were only two osteopathic residencies in Pediatrics and they were in California. So when I finished my internship, I went into what was then called General

Practice. That was the route all previous DO pediatricians had taken. I also did what they did – I arranged to study Pediatrics at the feet of practicing pediatricians. This time, however, three of us exerted pressure on PCO and on Dr. Bill Spaeth (Department Chair) to set up a preceptor-type training program for us. The other two candidates were Otto Kurschner, a classmate of mine, and Thomas Santucci – that's Tom, Senior – all friends and colleagues. ALL BECAME CHIEFS!!!

Our program was the start of long-term training programs for the College and proved to be a forerunner of many other pediatrics training programs in our profession, set up by the previously trained pediatricians.

Our routine was to work under Bill, Jim Purse and Harry Breitman in the twice-weekly Pediatrics Clinic, with occasional lectures thrown in, plus hospital rounds almost daily – sometimes there were as many as six pediatric patients in the pediatric wards. And we were involved with examination and care of all infants in the Nursery. After five years, we also earned the degree Master of Science in Pediatrics from the College, plus becoming eligibile for ACOP certification, both of which all three of us achieved.

Meanwhile, I was in private practice, limiting myself after my first year to Pediatrics. Let me tell you about "practice". First, "doctors" at that time essentially consisted of "neighborhood physicians" and "specialists." When I started, the neighborhood physicians or "general practitioners" usually opened offices in their homes and serviced overwhelmingly that particular locale. "Specialists" were either located at the local area hospital or occasionally had a centrally-located office.

In the 40s, a routine office visit cost $2, with an occasional additional charge of $1 for injections, such as vaccines – and we only had DPT and DT vaccines to offer. House calls – the now almost-forgotten time when doctors packed their "doctor bags" with all their equipment, and went to the patient's home because the patient was too sick to get to the office. The charge: $3 – and let me tell you – that extra few dollars a week for house calls were very helpful to physicians' incomes.

Lest you wonder about just $2 for an office visit, allow me to paint you a picture of what things were like back then: Large Hershey bar... 5 cents, Good steak dinner... $2.50 to $3.00, Daily newspaper... 3 cents, Postage for a simple letter... 2 cents, Average middle-class (row) home... $4,500, Average new car... $1,200 AND gasoline was just 15 cents a gallon.

Plus consider these facts:

- There were only eight or nine TV stations in the entire U.S.
- No credit cards, no computers
- Some outdoor plumbing was still around
- Cell phones were only in the comic strips
- And, for doctors:
- Most doctors (non-specialists) held "office hours" – no appointments – so "walk-ins" were the mode of operating offices
- There were no antibiotics or anti-infectives – thus the bedside doctor
- As for medications: Your PDR today contains more than 3,500 pages of drugs. My 1947 PDR was a "massive" 380 pages
- My annual tuition at Temple University (1937-42) was $200, but when I went to PCO a couple of years later, it was $400 a year.
- So, a $2 office visit was right in line with the 1940s.

Prominent Events

Let me try to delineate some of what I consider 10 of the high-points of ACOP's progress – adding occasionally some important steps to our wide acceptance:

1. Over the early 40s, we had a couple of irregular ACOP newsletters, minor in the scheme of things, but we had no official publications. They were simply eight mimeographed pages about twice a year. (Does anyone remember mimeograph?) Within a couple of years of joining, I began to edit and publish *The Bulletin of Pediatrics* on a regular basis – several times a year, but still mimeographed. For a few years, Ross Laboratories took over the task of the actual publishing and mailing. Our publication grew in the 1990s, under AOA Management, into a printed bulletin and was re-named PULSE. This newsletter continued on a regular basis to improve until today – in its excellent form – under the editorship of Rob Locke.

2. The degree Fellow of the American College of Osteopathic Pediatricians began as a sort of reward for each ACOP President, as they didn't receive even expenses during their terms. This distinction became a significant permanent badge of honor. Eventually, it was expanded to serve as a distinguished service award without so naming it. In this new century, we converted to what most organizations had done – made it a sign of specialty certification. All previous holders' awards were renamed Distinguished Service Awards.

3. Dr. William Spaeth, then a Past-President of ACOP, recognized early on that, because of our small number of members and who were spread all over the country, there should be regional divisions of the ACOP, labeled according to geography. As there were clusters of ACOP members – small clusters – in the Philadelphia, Los Angeles and Chicago areas, the initial recommendation was to establish the Eastern Association of Osteopathic Pediatricians, the Mid-Western Association of Osteopathic Pediatricians and the Western Association of Osteopathic Pediatricians. This made it easier, with our limited membership, to hold educational sessions for the pediatricians in those areas – a rare opportunity in those days.

As I recall, the Eastern Association held three meetings a year, with programs tailored to the members' desires and needs. They were well attended, offering more education than would have been available in just one national meeting. And we had great opportunities to learn, and even a chance for some of the younger members to become officers. The Western group had always had meetings with educational sessions – even before ACOP was founded – and I presume they continued with their programs.

This went on for about five years. Lest anyone feel that this was a minor thing, remember that back then, DOs could not attend any outside specialty lectures because of discrimination – and this was a boon educationally to our specialists.

4. Around the same time, the AOA began running specialty *Supplements* to its *Journal* and invited ACOP to participate – one of the first. I was appointed Editor and continued to serve in that capacity for the life of *Supplements* – about five years. This was another recognition of ACOP by AOA as the true representative of the pediatric specialty – important because over time, we in ACOP had felt that such recognition was not forthcoming. Plus, it gave a number of our leading members an opportunity to be published in a legitimate medical publication.

5. Somewhere in the 30s or 40s, the Kansas City College of Osteopathic Medicine and the Jackson County Osteopathic Asso-

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Watson Memorial Lecture

Continued from page 7

ciation began co-sponsoring what was known as the Annual Child Health Conference. It grew in size and importance through the years. Its purpose was to provide consultative services for the many rural DOs in surrounding areas and offering some pediatric training to their students and to "local" DOs. Remember that in those days, most MD specialists would not consult with DOs – the AMA had officially declared that "voluntary association with DOs was contrary to the AMA Code of Ethics" – a ruling that persisted for many years. There were no pediatricians at KCCOM, so the practitioners were stymied. It was most successful and went on for years. DOs would come from 300-400 miles away with their problem patient(s) to consult with the guest pediatricians at the Conference. Other DOs would come just to learn as cases were examined and to listen to the guest lecturers. Another example of the profession's creating education for itself – a necessity.

In 1953, ACOP became associated with the Conference, convening its first annual Conference on Pediatric Education there. ACOP had been moving in the direction of studying pediatric facilities and pediatric education in the profession, and this was a convenient and worthwhile place to begin. In 1954, for example, representatives of five of the six osteopathic colleges and 11 major osteopathic teaching hospitals took part in the CPE.

Key pediatricians at the Conference over the course of years were Leo Wagner and F. Munro Purse, both of Philadelphia, subsequently joined by a number or other osteopathic pediatricians from around the country. Attendance in some years reached 1,000 doctors, but eventually it folded as KCCOM developed its own faculty of pediatricians. It was a noteworthy run, both for offering great pediatric care for problem patients in the mid-west and providing many educational opportunities for the DOs. Many students and young DOs either added to their pediatric knowledge or were stimulated to choose Pediatrics as a specialty. It was a grand landmark in Osteopathic Pediatrics!

6. Over the years, many of our wives accompanied their husbands to our meetings, and sometimes had their own activities – mainly socializing and sight-seeing. In 1957, ACOP officially established an Auxiliary. Their annual dues were just $2. A splendid experiment that went on for only five years, then disappeared. There have been no attempts to revive it.

7. Over the years 1940 and 1950, there had been numerous talks, conferences, suggestions and complaints between the California Osteopathic Association and the California Medical Association regarding status of recognition. Primarily, the COA wanted to achieve equality of status, while CMS wanted to get rid of "those osteopaths" In May, 1961, both sides agreed upon "The Merger." The terms essentially were: DOs were to obtain an MD degree and license on payment of $65, and the College of Osteopathic Physicians and Surgeons was to be renamed the California College of Medicine (and grant MD degrees only). The DOs who joined CMA were assigned to a single geographical district, regardless of where they practiced. It has been estimated that about 2000 DOs chose to join the CMA, leaving behind a small coterie of DOs.

These loyal DOs formed the Osteopathic Physicians and Surgeons of California, which has grown in size and strength and now represents that state. Eventually, the ban on osteopathic physicians was voided by the state Supreme Court – and California continues to grow as an osteopathic state, even having two new osteopathic colleges – Touro and Western University.

"The Merger" created some division of opinion in the other states, with a minority seemingly wanting to mirror California. But a large majority of the osteopathic profession resisted and they prevailed. I believe strongly that the hoopla of the merger and subsequent events contributed to the strength and growth of the osteopathic profession, instead of weakening us.

For a full description of the entire merger situation, read Norman Gevitz' wonderful history of our profession, *The DOs:Osteopathic Medicine in America* or Robert Bomboy's *The Golden Anniversary History of the ACOP*.

8. No discussion of highlights would be complete without a word about the Annual Meeting of 1990 – the 50th anniversary of ACOP. It was held in St. Thomas, under the presidency of Mike Ryan. It not only featured an outstanding program and a wonderful vacation spot, it produced the landmark *50th Anniversary History* by Robert Bomboy – the first published history in the life of ACOP.

9. Over many preceding years, both the ACOP and the American College of Osteopathic Obstetricians and Gynecologists independently wanted out of meeting at AOA's annual meeting, and even had some discussions with each other regarding a joint meeting. It came to fruition in 1959 when the two met together, with an attendance of 175 physicians and 50 spouses, and a splendid program, featuring, even at this early date, several nationally-known MD speakers. Harold Finkel, who had become a specialist in convention exhibits, taught the ACOOG about the potential revenues -- and the joint meeting ran successfully for about five years. Another step in our growth!

10. In the 1970s, the ACOP realized that it could not continue using only volunteer physician-officers to manage ACOP. So, we hired Esther Martin, quite experienced in organizational management, as our first Executive Secretary. From that point on, we continued with professional management, much to our benefit. Esther Martin was succeeded by Theresa Goeke, then David Kushner, and then we came under the care of AOA management. They produced our first printed newsletter – named PULSE – and on a regular schedule. For several years now, we have successfully had Ruggles Corporation as our management company, with Stewart Hinckley as our Executive Director – with mutual benefit.

As I end my 70 years of ACOP observation, I must add two additional progress notes of importance. First, this meeting – a combination of educational programs of ACOP and AAP – is certainly a great forward step. And forthcoming soon, the new ACGME, combining graduate education efforts of both professions, holds hope of great progress for DOs and MDs alike.

There it is. Ten salient features that I feel were significant points in the 70 years that I have observed – and been active in – ACOP. There are many, many more people and events that could have been recalled and may be important or significant to other members. But these are mine.

I would be pleased to answer questions or hear your comments at the end of my lecture.

I have taught public speaking periodically throughout my career, One thing I always emphasized, "Don't end your talk with a mumbled 'thank you' and sit down. If you want to thank the audience, make it meaningful."

So, thank you for inviting this old man for a final crack at an ACOP program. And thank you for honoring me three times as the Watson Memorial Lecturer. And thank you for being willing to listen to this old man's overview of the last 70 years of ACOP. And above all, I thank you because all this makes me feel young again! ACOP, I love you!

Osteopathic Education

The Unique Need for Physician Parent Groups

By Tami Hendriksz, DO, FACOP

The joy, pride, and excitement that accompanies parenting is often wrought with challenges, self-doubt and questions. To help alleviate this, many parents find it helpful to join parenting groups for support, comradery, and socialization. All parents (regardless of whether they work outside of the home or stay home to raise the children) have some common ground, and can find support in these parenting groups.

Unfortunately, social media has highlighted the "Mommy Wars," in which parents who stay at home and parents who work express their preferences of their lifestyles in superior and condescending manners. This can isolate these two groups and leave each feeling less worthy and defensive. Physician parents have a unique challenge when it comes to parenting groups. Many physician parents feel conflicted when instead of simply receiving support as a fellow parent; they become the "medical expert" of the group. They may also be faced with group members who forcefully challenge scientific and medical information.

Additionally, the job of a physician is unique in a number of ways. The hours, the level of responsibility, the stressors, the on-call nature, the prerequisite level of education and training, and the direct impact on the health and well-being of others can make it challenging for physicians to relate easily to other professionals, let alone other parents. For this reason there are groups now developing to address the unique population of physician parents. Earlier this year, a Facebook Group called the Physician Moms Group was started. It is a private group with membership restricted to direct invitation. The need for such a group quickly became apparent based on its rapid popularity. Within a few months, the membership has grown to over 18,000 physician moms.

The group members come from every medical specialty; some work full-time, part-time, or are not currently practicing medicine. There are residents, fellows, attendings, and retirees. The breadth of the posts is as diverse and fascinating as the members of the group. From how to deal with student loans to the best make-up and clothing brands to consults on difficult patients/challenging cases to funny stories and pictures of their children to support for working mom guilt to career advice–the topics are endless and many group members comment on how easily they lose hours reading through the group's posts.

Parenting is challenging. Being a physician is challenging. Finding a group of similar people who combine both of those challenges is refreshing, fulfilling, and sanity-saving.

Tami Hendriksz can be found on twitter @drhendriksz. Send her a tweet about your most difficult patients, your most rewarding patients, why you love pediatrics, or anything.

Support Our Students
Donate to the PRES FUND

Please consider making a donation to the ACOP Pediatric Research & Education for Students (PRES) Fund. The purpose of the fund is to provide a formal mechanism to support student research.

The ACOP has always been committed to its students and student clubs by keeping dues and registration fees at an absolute minimum. Once the corpus of the new fund reaches its target, the ACOP will institute an application and award system to fund students' research. All board members have already contributed to the fund and it is hoped that there will be a very high participation rate from the members at large no matter what the amounts.

The American College of Osteopathic Pediatricians is a 501(c)6 organization. Donations to the PRES Fund may be tax deductible as allowed by law and will be acknowledged by the ACOP. Why wait? Make your donation today.

Visit www.acopeds.org TO DONATE NOW!

CALL FOR ABSTRACTS

AOA/ACOP Pediatric Track Conference at OMED
October 17-20, 2015
Orlando, Florida

Submission Deadline: July 27, 2015

eJOURNAL of the American College of Osteopathic Pediatricians

Visit www.acopeds.org for the latest issue of *eJACOP*

President Backes' Acceptance Lecture

Editor's Note: In accepting the Presidency of the ACOP, Carl Backes, DO, FACOP, gave a stirring speech reflecting upon his faith, vision, hope and love for the ACOP.

FAITH...HOPE...LOVE

By Carl R. Backes, DO
President, ACOP

Dr. Carl R. Backes took the gavel as the new ACOP President at the spring conference in Fort Lauderdale.

FAITH

1. Faith that the AOA, AACOM, and ACGME signing of a Memorandum of Understanding which creates a single accreditation system (SAS) for graduate medical education is necessary![1]
   - Access to ACGME training program (2013-2014 over 5000 DOs graduated – 48% entered an AOA accredited program and 45% entered into an ACGME accredited training program)
   - Eliminate duplication of programs
   - Osteopathic medicine visibility increased
   - Unified voice on GME access and funding issues
   - Aligned competency standards
   - Consistent GME training
2. Faith that the ACGME will create osteopathic tracks with osteopathically-focused learning environments. I am the Pediatric Review Committee member on the ACGME Committee and I will strive to continue the osteopathic role in SAS medical education.
3. Faith that all applicants to osteopathic colleges realize that we have a distinctive philosophy in primary healthcare and it is the best one. We use our hands and our hearts when we treat our patients and we are the fastest growing profession in the US. We do something right!
   - First year enrollees in osteopathic schools (2001 – 3,043; 2014 - 6,636)
   - Expanded colleges of osteopathic medicine (2012 to 2014 – 19→42, colleges and branch campuses)
   - 2013 – first year allopathic enrollment = 20,055; first year osteopathic enrollment = 6,786; Total = student enrollment 26,841… a quarter of medical students are DOs
4. Faith that our osteopathic colleges will, with AOA research funding, support osteopathic basic science and clinical research allowing accepted publications in reference journals. We must become more evidence-based led by osteopathic colleges' OMM departments.
5. Faith that we take the time to be politically involved – local, state, and national – in osteopathic organizations. We must be one force to allow a satisfactorily agreed upon single accreditation system by 2020. The ACOP is stronger when we are all together!
6. Faith that our students of osteopathic colleges successfully match for residencies.[2] In 2014 NRMP, 611 osteopathic participants were initially unmatched (AACOM). With a growing number of osteopathic students, will students have trouble matching with allopathic programs?
7. Faith that the states support Medicaid expansion to provide care for those in need by using state directed needs and political objectives (federal waivers, QHP's, medical home models, or premium assistance to personal health savings accounts).
8. Faith that the repeal of Medicare's SGR (sustainable growth rate) stabilizes physician payment rates and reauthorizes funding for children's health, teaching health centers, and the National Health Services Corps.[3]

HOPE

1. Hope that the ACOP and all our osteopathic specialty colleges continue to grow stronger and larger. The ACOP, with the AAP osteopathic branch, are the voice of osteopathic pediatric healthcare today.
2. Hope that we, as osteopathic pediatricians, are involved in the politics of pediatric medicine.
3. Hope that we continue to use our OMM skills in practice and properly use reimbursement codes for payment for our care of children.
4. Hope that we continue to be pediatric student mentors and pediatric resident trainers. Without practicing and teaching the osteopathic approach to children, we will not be distinctively different, but we are.
5. Hope that our educating skills provide feedback to our osteopathic trainees as we transfer our model of education - The CAST model.[4]
   C – Continue to do these things (maintain the positive)
   A –Alter these behaviors (address things that are not yet strengths but could be)
   S – Stop (discontinue the activities that do not add value or are erroneously applied)
   T – Try this approach next time (offer a new skill to apply and practice)
6. Hope that we (the ACOP) promote osteopathic curriculum tracks our osteopathic focused program in hospitals training D.O.s which will benefit both allopathic and osteopathic physicians.
7. Hope that as DO mentors in pediatrics, we will use OMT and demonstrate our positive experiences with students and

residents allowing them to incorporate OMT in their future mdical home.[2]

8. Hope that we accept the Blue Ribbon Commission (BRC) recommendations to align osteopathic medical education with innovative health care delivery.[5]
   - Increase focus on the new competencies
   - Transition education to a competency based system
   - Remove educational insufficiencies
   - Link osteopathic predoctoral educational and osteopathic GME continuum longitudinally
9. Hope that we, the ACOP and all its members, must be thoughtful osteopathic pediatric leaders. We must act as a team now!!

LOVE

1. Love my family, my wife, three children, five grandchildren, two daughters-in-law, and one son-in-law – five of them in medicine. Medicine as a profession is an honor!
2. Love my profession.
   - A 40-year osteopathic pediatrician and pediatric trainer in Columbus
   - A 34-year osteopathic neonatologist in Columbus
   - A third generation pediatrician with over 40,000 charts
3. Love my osteopathic degree. I was raised on a farm in St. Cloud, Minnesota. I went to a one room country school for the first six grades. My mom was my teacher those first six years, but taught school for 50 years. My dad was a dairy farmer. In college, I went to an osteopathic doctor in Fargo, North Dakota and she helped me to be accepted as a student at KCOM. As an intern at Saginaw Osteopathic Hospital, I wanted to be a surgeon. It was then that I met my mentor, John Milionis, DO (ACOP Past President). He led me to the love of caring for children! He also suggested I be a pediatric resident and train at Doctors Hospital which I did with Ben Cohen, DO, and Dwain Harper, DO (both Past Presidents of ACOP).

   I have been a political advocate as Past President of the CAOM and the OOA, a regional Dean and Professor of Pediatrics for OUHCOM, and now the incoming ACOP President. I have been a pediatric resident and neonatal fellowship trainer. I have an interest in evidence-based research in the care of the osteopathic pediatric patient. I love my DO degree and will fight that every DO student, resident, fellow, and doctor with a DO degree should stand tall. We are the ones!

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President's Message

Continued from page 2

continue as resident and fellow members and then become pediatrician members of the ACOP.

- Propose a postgraduate research award for a competitive opportunity to present at our ACOP conferences.
- Continue efforts towards a single accreditation system (SAS). As the pediatric osteopathic RC member on the pediatric ACGME committee, I anticipate approval of our pediatric AOA approved programs at the upcoming ACGME meeting in May.
- Continue the growth of our student PRES fund to support our student membership: a grant written by student members Bret Nolan and Christine Beeson was well received by our Board with anticipated approval in October.
- Continue plans for the ACOP to join the AOF to support the Outstanding Pediatric Resident of the Year Award. We approved both the concept and our initial share of this year's monetary award and we will finalize this support in October.
- Continue efforts to develop osteopathic training sites. Our GME committee with Robert W. Hostoffer, DO, has worked tirelessly to open new pediatric osteopathic training programs in Coney Island in New York, Detroit Children's Hospital, Cape Fear Hospital in North Carolina. We also anticipate reopening the pediatric osteopathic program at Rainbow Hospital in Cleveland. Thank you, Bob, for leading this effort!
- Continue efforts to seek AOA assistance in helping us encourage pediatric dual programs to stay as they are. AOA members Catherine Gilligan, RN, CPA, MM and Joseph A. Giamo, DO, and trustee, attended our board and GME meetings. A letter was sent to AOA president Robert Juhasz, DO, requesting his support.
- Continue effort to expand GME committee's role, exemplified with a name change to Osteopathic Pediatric Development Committee.
- Continue efforts to develop rural track pediatric training programs. Led by Robert W. Hostoffer, DO, and myself, this effort will allow a rural community hospital and children's hospital to share equally in pediatric resident training. Our osteopathic pediatric rural track program has obtained AOA approval and was presented at the ACGME pediatric meeting this May.
- Continue efforts to assure all pediatric training programs have either an osteopathic focused program or an osteopathic track program. The Doctors Hospital, Ohio Health, and Nationwide Children's Hospital are a "model" track programs with the accepted publication of our program in the June issue of the JAOA.
- Anticipate the launch of our new ACOP website by June, 2015. We thank Stewart and his staff for making us increasingly visible.

It's been a WOW way to start, so let's keep it going!

SHARE YOUR STORY AND INSIGHT

An upcoming issue of the PULSE will focus on pediatric military medicine. If you have a special story, expertise or insight that you would like to share, please contact Robert Locke, DO, MPH, PULSE Editor at **rlocke@christianacare.org** or **acopublications@gmail.com**.

Member Spotlight: Adam Czynski, DO

Column Editor – Katherine Locke

Editor Comment: Adam Czynski, DO, is an attending neonatologist at Loma Linda University Children's Hospital and expert on disaster planning.

Q: Tell us a little bit about the disaster planning work you do at Loma Linda University Children's Hospital. Are you part of a team? Do you meet regularly? How often do you run simulations?

At Loma Linda Children's Hospital, we have a disaster team that includes NICU, PICU, and Environmental Health and Safety staff. The team focuses on developing plans to help protect our patients and staff during a disaster. Our goal is to create plans that will minimize the disasters impact on health care delivery. To accomplish this, we had a very broad definition of what is an actual disaster. We decided a disaster was any event that depleted us of resources, exceeded our current resources, or directly interrupted patient care. We created this definition because if we only focused on earthquakes, fires, floods, or large scale events, we would miss the disasters that occur frequently. Disasters such as lose of power, loss of medical air, short staffing, violent patient/family encounters, or patient surge. The aforementioned disasters occur at a greater frequency than large-scale disasters and have a greater potential to disrupt patient care.

Plan development is a big part of our team but a good plan is worthless if it can't be executed. To drill on our disaster plans, we use the Medical Simulation Center at Loma Linda to conduct training. Every quarter we conduct a hospital-wide disaster drill focusing on a large-scale event that has unit-based consequences.

Q: When did you become interested in disaster planning? Did you take classes or workshops?

I have always had an interest in emergency response and preparedness. When I was younger, I served as a volunteer firefighter in our town. I stayed with the fire department until I started medical school. My experience in the fire department has helped with leading our NICU disaster preparedness. If a person is interested in disaster preparedness, there are many different opportunities to learn the necessary background information. The Federal Emergency Management Agency offers free online class across all areas of hospital preparedness. To get exposure, I would recommend taking IS-100, IS-200, and IS-700. These courses will introduce the National Incident Command System to healthcare providers to provide a better understanding of disaster response.

Q: What's the number one area where you see hospitals (including intensive care units) fail to adequately prepare?

The number one area where hospitals and units fail to prepare is in the basics. Disaster preparedness and training is too often an afterthought. Heavy patient loads make it challenging for staff to take a few hours out of the day for a drill. In addition, the hospital personnel able to attend drills are most likely not the people who will be present for a disaster. When we sit down to write our plans, we focus on inclusive plans that hopefully provide guidance through an event, but we also create job action cards that provide the bare essentials for staff so they can safely perform through the disaster. When you make job action cards, you have to envision that the float nurse who has never worked on your unit can still function or that the weekend night housekeeper can still safely contribute to the disaster response effort.

Though the scale of disasters may be classified as large or small, most disasters encountered by hospitals and units are routine. Very few are catastrophes. But even a routine disaster can become a catastrophe when it displays some novel or new element. A fire in a patient room that requires an evacuation should be considered a routine disaster, but if the staff is not trained on how to evacuate patients, the lack of education becomes the novel element and this routine disaster can quickly become a catastrophe.

Q: In the wake of disasters, there's often a media buzz about how to avoid or better prepare for similar disasters. For instance, lessons from Hurricane Katrina helped prepare disaster management of all types for Hurricane Sandy. Does that translate into hospital training? How can doctors and administrators seize the moment in the wake of a disaster to better prepare for future ones?

Every disaster provides multiple learning opportunities to improve the response effort and to improve resilience during the subsequent event. But many lessons can be applied across all platforms, not just hospitals. Lessons from Katrina applied to Sandy focused on repositioning assets. Get supplies and resources to positions before the storm so they could be deployed quicker during the response. This was demonstrated by the NICU at NYU where they not only repositioning resources to bring to the NICU, but were pre-identifying NICU beds where they could transfer their patients if they had to evacuate. They had also learned to move necessary transport equipment to the ground floor prior to losing power.

Hurricanes present a unique characteristic in that they can be anticipated, but disasters like tornados or earthquakes make repositioning a challenge, so one must depend on training and disaster plans.

Also, any time a disaster strikes, grant funding and government sponsored funds quickly become available. To really take advantage of these funding streams, you need to be able to demonstrate a current vulnerability, identify a capability that strengthens this vulnerability, and have a plan to implement the new capability. Places to look for funding are FEMA, Department of Homeland Security, and local county Hospital Preparedness Programs

Q: An active shooter is a dynamic, unforeseen crisis that could strike hospitals at any time. Are there preventive measures that can be used to prevent or minimize harm?

Active shooters are events that are almost impossible to anticipate. A lot of funding and research has gone into projects attempting to predict which individuals will be active shooters. A crime is considered an Active Shooter when there is an individual actively involved in killing or shooting individuals. Most active shooter events end with the shooters taling their own lives, running, or surrendering. A majority of active shooter events end with the shooter taking their own lives. The average time of an active shooter event is five minutes, with an average police response time of 18 minutes. This shifts the responsibility of personal safety back on the individual who is entrapped in the shooting. There is no single measure of prevention in stopping an active shooter. However, having locks on doors, video cameras, security at exits and entrances will help deter

the shooter. Stop-gap measures are ineffective. Personal awareness and pre-planning are the best preventative measures a person can take. The Department of Homeland Security recommends one of three actions: Run, Hide, or Fight.

When our Disaster Team runs an active shooter simulation, we ask the group one question, "Can you kill another person?" This is an important question because when an individual chooses to be an active shooter, they have already declared their intentions. You have to be able to match their intentions, if threatened. We ask our question because it helps people find the strength to run. During an active shooter event, if you do not run or escape, then by default you must hide. If you hide, you have to be prepared to be found and if found, you must be prepared to fight to the death. The shooter has already declared his willingness to kill and you must be able to defend your own life with the same commitment. During our simulations, participants almost always, in pre-simulation questionioning, indicate they will run. Yet during the simulation, almost everyone hides. Through medical simulation, we try to help participants find the personal strength to run (if capable) and if they are not able to run, then to hide in a defendable location. We don't encourage and in fact dissuade, people from looking, for an active shooter. Looking to be a hero during an active shooter incident is a fastest way to becoming a memory.

Q: How do you balance your work as an attending neonatologist with your work with disaster planning for the children's hospital? In what ways do these intersect?

As an attending neonatologist, my unit-based focus on disaster preparedness compliments the greater children's hospital preparedness program. The team I work with is a multidisciplinary team that pulls from different departments within the hospital. This diverse group of people makes unit-based planning and the bigger children's hospital planning come together nicely. But my neonatology work on BPD, NEC, and prematurity and disaster preparedness focuses on unexpected critical events. What brings the two together for me are the mental models I use. The same mental models I use to help guide my medical decision making guide my disaster planning. Whether you have an unexpected extracorporeal membrane oxygenation (ECMO) patient, 24-weeker, or a disaster; the preparations we make ahead of time and the mental models we use to hopefully guide our are decisions towards the best possible outcome.

Chickungunya: A Caution for the Travel Season

By Jessica Mondani, DO

Education on the risk of acquiring the Chikungunya virus has been routinely given to travelers visiting countries in Africa, Asia, Europe, and the Indian and Pacific Oceans. Within the past year, cases of local transmission have been increased in the Caribbean countries and territories, Puerto Rico, US Virgin Islands, and Florida. Travelers to these areas do not always seek the advice of a travel clinic specialist, as they are common vacation destinations and historically thought to be low risk for transmission of diseases. Primary care physicians should be aware of these new risks and need to be able to provide education or referral to a specialist. Clinicians also need to consider Chickungunya in the differential diagnosia of the returning traveler with febrile illness.

Chikungunya is a virus that is transmitted through mosquito bites. It is most often spread to people by Aedes aegypti and Aedes albopictus mosquitoes. Mosquitoes become infected when they feed on a person currently infected with the virus. These mosquitoes are aggressive daytime biters. As with most viruses, there is no specific treatment, so the best protection from the virus is to use preventative measures, which include:

- Use air conditioning or window/door screens to keep mosquitoes out or sleep under a mosquito bed net
- Help reduce the number of mosquitoes in the area by removing standing water
- When weather permits, wear long-sleeved shirts and long pants
- Use insect repellents

Once infected with chikungunya virus, 72-97% of people become symptomatic. The incubation period is 3–7 days (range, 1–12 days). Primary symptoms include acute onset of fever and polyarthralgia. Joint symptoms are usually bilateral and

symmetric. Other nonspecific symptoms can mimic Dengue (transmitted by the same mosquitoes and can cause co-infection) or other common viruses and may include headache, myalgia, arthritis, conjunctivitis, nausea/vomiting, or maculopapular rash. Laboratory findings are notable for lymphopenia, thrombocytopenia, elevated creatinine, and elevated hepatic transaminases. Acute symptoms typically resolve within a week to ten days. Populations more at risk for severe disease include neonates exposed intrapartum near the end of pregnancy, older adults (> 65 years), and persons with underlying medical conditions. While mortality is rare, it is most likely to occur in older adults.

Chickungunya is expected to continue to spread due to factors such as low immunity, a highly mobile population, and ease of transmission. While it was initially thought the spread would be limited to the areas with more tropical-like climate the Aedes albopictus, mosquitoes can live in more temperate climates. Scientists predict Chickungunya could spread as far north as southern New England. Just one more virus on the ever-expanding list for a potential vaccine.

Celebrating 1940 - 2015 75 Years!

TALES FROM ADOLESCENT MEDICINE

Creating an Adolescent Friendly Office

By Jessica S. Castonguay, DO, MPH

A mother recently brought her mid-adolescent daughter into my office for a visit about irregular menses. There was nothing particularly special about the visit medically, however the mother and daughter were arguing when I entered the room. I assumed they were arguing about data packages or curfews. As I introduced myself, the patient took my hand and asked why we had Disney Junior on in the waiting room if we were an office dedicated to teenagers. Her mother immediately told me that she had asked that her daughter not say anything about it, that it was not a big deal.

But it is a big deal. Adolescence is a time when young men and women develop habits that can affect them throughout their lifetime. Their physician's office should be a place that they can come with any concern, be heard, and feel comfortable doing so. In 2012, the World Health Organization published guidelines for developing standards for adolescent friendly healthcare. Such healthcare must be accessible, acceptable, equitable, appropriate, and effective.

Accessible

"Adolescents are able to obtain the health services that are available."

While pediatric residency programs generally have an adolescent provider available, this is limited by proximity to a training site. Teens who do not drive or do not have access to a car may have trouble attending appointments more than a few blocks away.

Accessibility also refers to how we communicate with our teen patients. While I am still happy to call and make an appointment with my physician, today's teens may prefer electronic communication. This may turn out to be a positive result of patient portals for teens.

Acceptable

"Adolescents are willing to obtain the health services that are available."

Teens need to be comfortable to continue to come for visits. This is what my office violated with the Disney Junior snafu. We inadvertently made the patient feel like she was in the wrong place. A separate section of chairs at the end of your waiting room with some teen appropriate reading material may be all you need.

It is also important to have staff that interact with teens and are not put off by teen concerns such as menstrual concerns and depression. If a teens feel that a staff member is condescending, they will not return.

Equitable

"All adolescents, not just selected groups, are able to obtain the health services that are available."

Pediatricians can be somewhat uncomfortable managing traditional teen concerns that seem much more adult than their age would suggest. That's okay! If you asked me about circumcision care right now, I'd be uncomfortable discussing that! But, I'd know whom to ask. The key knows whom to curbside or where to refer your teens when their problems feel a little out of your league.

Appropriate

"The right health services (i.e. the ones they need) are provided to them."

Teens are a healthy population. The majority of their concerns come from risky activities like unprotected sex and drinking or questions they have about sexuality or mood. Teens may feel uncomfortable discussing these topics in front of their parents, so it is important to have times alone with your teen patients. Check with your state about confidentiality laws in your area. If you don't ask about sexual activity or depression, your patient is unlikely to volunteer that information. If you don't know, then you can't provide appropriate services.

Effective

"The right health services are provided in the right way, and make a positive contribution to their health."

If you ask questions, as discussed above, then you can provide effective services. This could be as simple as counseling the overweight patient on healthy snacks and frequent exercise with referral to a registered dietitian if needed. The trick is meeting patients where they are. Let them participate in developing the plan as much as they can. If adolescents feels that they were a part of the process, rather than subjected to it, they are more likely to follow through.

Is there something small you can change in your office to make it more adolescent friendly? I am starting with turning the channel.

All introductory quotations are from "Making Health Services Adolescent Friendly/Developing National Quality Standards for Adolescent Friendly Health Services," World Health Organization, 2012, ***http://apps.who.int/iris/bitstream/10665/75217/1/9789241503594_eng.pdf***

PULSE will soon be Mobile Friendly!

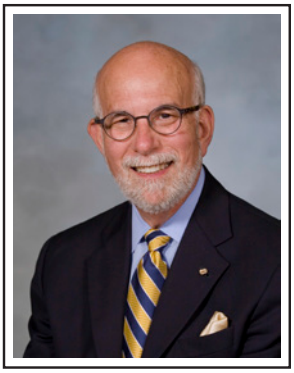
Starting with the next issue, the PULSE Newsletter is going to be mobile friendly. Although the PULSE will no longer be available in print, the PULSE will be flexibly formatted and easily read across all of your devices (computer, tablet, smart phone). All designed to quicken your PULSE!

iPerch

Reflections by Past Presidents of the ACOP

Edited by Steven Snyder, DO, FACOP

By Martin A. Finkel, DO, FACOP
Past President, 1997-1998



Martin A. Finkel, DO, FACOP
ACOP President
1995-1996

It's hard to believe it has been 18 years since I had the honor of being the president of the ACOP. As with all presidents, I had a learning curve and relied on my predecessors to help direct me in making decisions that were in the best interest of the ACOP. I can't help but reflect on the amazing growth of the college and how that growth was built on a solid foundation by those who preceded me and those who followed. As each and every president who begins their term, there is a desire to make a sustainable mark that adds value to the organization. No doubt I had anticipatory anxiety about taking the reins of leadership and for good reason. But I knew my father, Harold H. Finkel, DO, a former president, and Arnold Melnick, DO, and an ACOP icon, were looking over my shoulders and would not hesitate to provide advice.

As I laid out my agenda for the college, it became immediately apparent that there was much to do and only a year to accomplish all I had envisioned. I was excited for the opportunity to operationalize a number of initiatives, but anxious they couldn't be fully implemented in such a short time period. I believed that past and future presidents had similar frustrations and I proposed the presidential term be extended to two full years providing additional time for each new president not only to develop new initiatives, but also see them fully implemented. The idea received traction and we proceeded with the necessary bylaws changes to extend the presidential term to two years.

The ACOP struggled a bit with differentiating our organizational image from the elephant in the room, the AAP. I felt we needed to develop a marketing campaign to reflect what we do as DO pediatricians that made a difference in the care of children. So I proposed the ACOP byline, "Caring for America's Children." Maybe a bit pretentious at the time, it was adopted by the college and it remains on our stationary today. In some ways it's now a much more justifiable byline considering the mushrooming of our ranks and the growth of the college.

Our colleges' Departments of Pediatrics were quite variable in their available resources to meet the educational and curricular challenges. Departmental chairs had no formal mechanism to share resources, exchange ideas and support each other ultimately to enhance the quality of our student and resident education. I proposed that we create a "Council of Departmental Chairs" that would provide a forum for meaningful exchange and mutual benefit. Chairs embraced this idea in spite of the challenges of communicating in the pre-internet, routine e-mail correspondence era. So, through conference calls and annual meetings, we exchanged ideas and increased camaraderie amongst colleagues. Unfortunately, we were only able to sustain this initiative for several years. In recent years, a version of this Council has reemerged.

I enjoyed my year as President and the honor of working with wonderful officers and a membership comprised of my colleagues but which made me feel a part of a unique family. Attending a CME program every now and then provides each of us with not only a quality education but strengthens our bonds as osteopathic pediatricians. I am proud to be a member of the ACOP family and hope each of our members recognizes and is enriched by our heritage and our ability to maintain our exceptional identity as an organization committed to "Caring for America's Children!"

Summer Time Water Safety

It is summertime and no better time to remind parents about kids and water safety.

Industrial agriculture uses 342 gallons to make one hamburger and two gallons to grow a single walnut, but only a few inches water creates a drowning hazard or an infectious disease risk. Drowning is the second leading cause of accidental death in 5-24 year olds. Temperatures easily tolerated by adults can quickly cause hypothermia in infants. Pools or natural water (lakes, streams, ocean) that are below 85°F can quickly lead to an infant becoming hypothermic. Internationally, waterborne illness contributes four billion cases of infectious diarrhea and two million death/year (or 5,000 deaths/day). The majority of these deaths occur in children less than five.

Good general information for parents about U.S. water safety can be found at:

http://kidshealth.org/parent/firstaid_safe/outdoor/water_safety.html

Welcome New Members!

Fellow

Lisa Ferreira, DO ..... Jupiter, FL
Tamika Bush, DO ..... Greensboro, NC
Jennifer A. Ligon, DO, FACOP ..... Evans, GA
James Henley, DO ..... Tulsa, OK

General

Izola B. David, DO ..... Bala Cynwyd, PA

Intern

Adil Manzoor, DO ..... Newark, NJ
Roger Nakata, DO ..... Brooklyn, NY
Allegra Paolillo, DO ..... Pompano Beach, FL
Amy L. Maggard, DO ..... Albany, OH
Alana M. Hahn, DO ..... Evansville, IN
Meaghan N. Raney, DO ..... Jefferson City, MO
Maxie E. Davie, MS, DO ..... Shreveport, LA

Pediatric Student Club

Madeline Mineo ..... Brooklyn, NY
Jamie L. Pruitt ..... Alden, NY
Meghan C. O'Rourke ..... Feasterville-Trevose, PA
Soha F. Iqbal ..... Lewisburg, WV
William H. Dempsey ..... Lewisburg, WV
Jerry P. Henderson ..... Lewisburg, WV
Courtney M. Savilla ..... Lewisburg, WV
Kelsey R. Gay ..... Lewisburg, WV
Lindsey M. Gordon ..... Lewisburg, WV
Alexandria S. Huy ..... Lewisburg, WV
Mudita K. Patel ..... Lewisburg, WV
Rayan S. El-Zein ..... Lewisburg, WV
Heidi E. Henson ..... Lewisburg, WV
Courtney E. Cotter ..... Lewisburg, WV
Alyssa M. Beda ..... Lewisburg, WV
Delaney A. Keane ..... Lewisburg, WV
Anne L. Taylor ..... Lewisburg, WV
Dianna Tomblin ..... Lewisburg, WV
Maria C. Komer ..... Lewisburg, WV
Lauren N. Wackerman ..... Lewisburg, WV
Erin McMahon ..... Lewisburg, WV
Sylvia J. Pawlowska ..... Lewisburg, WV
Petagay A. Ricketts ..... Roanoke, WV
Erica M. White ..... Ronceverte, WV
Rebekkah R. Brown ..... Cross Lanes, WV
Janine N. Sponaugle ..... Cedarville, WV
Danielle M. Ballard ..... Suwanee, GA
Sarah S. Coyle ..... Suwanee, GA
Keri L. Seamon ..... Suwanee, GA
Philippus R. Uys ..... Lawrenceville, GA
Katherine E. Pottinger ..... Lawrenceville, GA
Samantha J. Mandel ..... Lawrenceville, GA
Rebecca M. Lynch ..... Lawrenceville, GA
Bijal R. Patel ..... Duluth, GA
Rebecca C. Alms ..... Duluth, GA
Ethan F. Wohl ..... Lagrange, GA
Siri L. Chirumamilla ..... Atlanta, GA
Minjoo Kim ..... Brandon, FL
Christina M. Rinaldi ..... Sanibel, FL
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Sara M. Basedow ..... Irontan, OH
Julie M. Passage ..... Grosse Pointe, MI
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Kathryn E. Nelson ..... Aurora, CO
Daniel K. Clark ..... Aurora, CO
Elaine S. Buckholtz ..... Aurora, CO
Janice Chan ..... Englewood, CO
Katherine G. Rose ..... Englewood, CO
Jane C. Wieler ..... Englewood, CO
Taylor J. Hudson ..... Englewood, CO
Jamie S. Twiggs ..... Englewood, CO
Sindi Diko ..... Englewood, CO
Marina Mesiha ..... Highlands Ranch, CO
Bryce L. Harmon ..... Parker, CO
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Joanna N. Israel ..... Glendale, AZ
Ritambhara Wadhwa ..... Glendale, AZ
Alexander R. Peck ..... Glendale, AZ
Marianne H. Gelter ..... Glendale, AZ
Katie D. Norris ..... Avondale, AZ
Amanda Gittelman ..... La Quinta, CA
Randi E. Schutz ..... Lake Forest, CA
Paulina C. Altshuler ..... Danville, CA
Hong Diem Le ..... Vallejo, CA
Robin So ..... Vallejo, CA
Paul A. Copperman ..... Yakima, WA
James D. Calamia ..... Yakima, WA

Membership Questions?

Contact Greg Leasure, greg@societyhq.com or (804) 565-6305