President's Message

Mastering the Art of Mentoring

“Above all do no harm” is probably one of the most recognized quotes from Hippocrates. Hippocrates was attempting to create a medical fraternity that was distinct from the charlatan medical providers of his day. Hippocrates had some clear principles that distinguished “the practitioners of the art” from other providers: keep all things in confidence, do not have sex with your patients, and do not take money to kill your patients. Hippocrates knew that if his medical fraternity was to grow and thrive, students needed to be taught “the art.” His writings include many references to the importance of teachers and their role in mentoring. The wisdom of Hippocrates is clear in his ethical principles, which are still followed today. His emphasis on the importance of mentoring students in the art of medicine is also just as valuable today as it was thousands of years ago.

The MCAAP wants to continue the Hippocratic tradition by mentoring our trainees in the art of pediatrics. In Massachusetts we are blessed with an incredible number of talented medical students, residents, and fellows in training interested in pediatrics. We are also lucky to have bright and enthusiastic pediatricians who can be teachers and mentors for these trainees. When we surveyed our trainees about what the MCAAP can do to advance their careers, finding mentors in the world of pediatrics was their highest priority. The MCAAP is a natural conduit to connect our members with the next generation of pediatricians, and we have begun a “chapter champions” initiative to link trainees with pediatricians across the Commonwealth.

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The Role of the Pediatrician: How Can We Prevent Gun Deaths in Children?

The tragedy that took place at Sandy Hook Elementary School in Newtown, Connecticut, was shocking and profoundly saddening to us all. This nightmare turned reality awake the nation and galvanized a much-needed discussion on firearms, mental health services, and child safety. The disturbing truth is that gun-related deaths among children and adolescents are by no means infrequent in our country. Gun-related injuries are the second most common cause of death in children and adolescents 1 to 18 years of age (the...
Recently, an article on drowning made a big splash. In it, a former Coast Guard rescue swimmer describes the so-called instinctive drowning response (IDR) and how to identify drowning victims in the water. Sounds basic, doesn’t it? Yet as a health care provider I found that my own notions of what drowning looks like were hopelessly off base. Despite having resuscitated many drowning victims, I have never seen anyone drown — I don’t think. In retrospect, I have been looking for all the wrong signs: flailing arms, gasping for breath, yelling or splashing to indicate distress. Yet the classic drowning victim shows none of these signs. In fact, what movies and television teach us about how drowning looks is about as realistic as old westerns are with regards to gunshot wounds. I would never expect a teen with abdominal trauma to give a short soliloquy about his life, bubble a bit of blood at the mouth, and then slump over peacefully after a touching, calm, and self-aware last sentence. So why was I expecting that a drowning victim would splash?

It turns out, the splashing and yelling that the media portrays as drowning is part of what experts call aquatic distress. Far from being comfortable or confident, a person in aquatic distress is usually in trouble and in need of help. But the crucial distinction is that they are maintaining voluntary movements and a patent airway. They should receive our help, but are not yet in grave danger.

**Warning Signs**

These signs may signal a potential drowning victim, according to Mario Vittone at Slate.com:

- Head low in the water, mouth at water level
- Head tilted back with mouth open
- Eyes glassy and empty, unable to focus
- Eyes closed
- Hair over forehead or eyes
- Not using legs — vertical
- Hyperventilating or gasping
- Trying to swim in a particular direction but not making headway
- Trying to roll over on the back
- Appear to be climbing an invisible ladder

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When I was first asked to take Tufts medical students into my practice, I was hesitant. I was worried that I didn’t have much to share with the students. They were masters of the latest technology and scientific knowledge, and I was a general pediatrician who played with kids all day. These young, bright medical students probably were more than a few chapters ahead of me in the latest EBM and biochemistry, but I had my many decades of knowledge of pediatrics to share with them. I was energized by the enthusiasm and interest of the students who came into my office. What I found was that while I was learning some basic science from them, they were enjoying learning basic pediatrics from me.

Working closely with trainees can bring us all back to the magical moments when we first fell in love with pediatrics. Students bring back that sense of wonder and excitement that may have been buried inside each of us from years of practice, or perhaps just a few months with an EMR. No matter how interesting something may be, it is human nature for things we do routinely to seem mundane. Recently I had a student in the office when our triage nurse stepped into my office. “Another Tasmanian Toddler Takedown coming in” she said. That was our code for an older brother who yanks the arm of a younger sibling and subluxes the radial head. In my 30 years of practice I have reduced hundreds of nursemaid’s elbows. Number 503 did not seem like a big deal to me, but when it was over and the toddler raised his arm to get a sticker, the medical student looked at me like I had just raised Lazarus. When I handed him a paper copy of an article explaining the anatomy, he looked at it like one looks at an ancient relic, with a slight quizzical gaze and a concern that he might damage such an ancient parchment. By the end of the morning he had figured out how to turn the pages without clicking on them, and he left my office pulling and pronating his own hand. I chalked that up as a successful session; I had not been peed on once by a newborn, and I had planted the seeds of pediatrics in another medical student.

I even for one brief second seemed as cool as those specialists with their 3-D hologram scopes.

Phronesis was Aristotle’s term for practical wisdom. Pediatricians in practice gain phronesis over the multiple interactions between patients and families. Pediatricians do not need to be concerned that they have nothing to teach these new students who are wired to the Internet and have the latest Journal article at their fingertips. The students are looking to learn from our abundance of accumulated wisdom. They want to learn the tricks of the trade, from how to get a good belly exam out of a squirmy toddler to how to talk to a teen about their depression or their sexual preference. Our trainees want to work with and learn from a wide range of pediatricians and pediatric specialists, not just those high in the ivory academic towers of Boston. The MCAAP is looking to recruit our members into a group of wise pediatricians who will shape and shepherd this next generation of physicians.

In the fall of 2013 the MCAAP will be holding a conference for medical students, residents, and fellows in training. We are looking for young pediatricians to help us teach our trainees how to successfully transition from residency into practice. We are looking for residency directors to speak to our medical students about choosing a residency, and fellowship directors to speak to our residents considering fellowship training. Above all, we want pediatricians of all stripes who would be interested in becoming mentors to the students, residents, and fellows. All of us have wisdom to share, and we have an interested audience looking to learn.

Even though the scientific and technical aspects of medicine have advanced light years since the time of Hippocrates, the need to teach and to mentor the next generation of physicians and pediatricians remains the same as in ancient times. We will use our modern techniques of websites, emails, and Facebook pages to connect individuals, but it will be that old-school mentoring that will make a real connection. Cathleen Haggerty will be gathering contact information for mentors that we will use to connect with medical students and trainees.

Hippocrates said, “Medicine is the most distinguished of all the arts.” What he could not foresee was that pediatrics was going to be the most fun and rewarding of the medical arts. That is a modern wisdom that lives in the hearts of all pediatricians. I invite you to share that wisdom and your love of pediatrics. I can promise you that it will be a rewarding experience for mentor and trainee alike. I hope you will join us and become one of our chapter champion mentors. If you are interested, please contact Cathleen at Cathleen.Haggerty@mcaap.org.

— John O’Reilly, MD, FAAP
The Role of the Pediatrician: How Can We Prevent Gun Deaths in Children?  
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first is motor vehicle accidents). According to recent CDC census data, in one year alone, there were 1,553 gun-related homicides in this age group, 493 gun-related suicides, and 121 gun-related accidental deaths. Sadly, 68 percent of all homicides and 40 percent of all suicides among these young people involved guns."

At hospitals and clinics across the country, we care for children who have lost siblings in shootings, teens with gunshot wounds in the trauma bays, and young families who live in neighborhoods where it is not safe to play outside. Every year, more children and adolescents are killed by guns than by cancer, infections, or heart disease, and therefore gun violence is, without question, a paramount issue for pediatricians.

**Firearms Policy Update**

The issue of pediatricians’ role in preventing gun deaths was brought into the spotlight in 2011, when Florida passed legislation that forbade physicians from asking families about guns in the home. However, a permanent injunction against the law was issued, and Governor Rick Scott subsequently appealed the ruling.

In October 2012, just two months before the shooting in Newtown, the American Academy of Pediatrics (AAP) issued a policy statement on firearm-related injuries. The policy statement recommends that pediatricians incorporate questions about the availability of firearms in their assessments of home safety during clinical interviews. It also recommends that pediatricians urge parents who own guns to use safe storage methods in order to prevent children from accessing them.

The AAP’s policy statement calls on pediatricians to act as leaders in advocacy efforts in order to “continue to advocate for the strongest possible legislative and regulatory approaches to prevent firearm injuries and deaths.”

After the tragedy in Newtown, pediatrician leaders participated in the development of the President’s Plan to Protect Our Children and Our Communities by Reducing Gun Violence, which focuses on “making schools safer, increasing access to mental health services, closing background check loopholes, banning military-style assault weapons and high-capacity magazines, and taking other common-sense steps to reduce gun violence.”

In 1996, research on gun-related injuries was effectively stifled when the National Rifle Association successfully lobbied to incorporate a statement into public law stipulating “that none of the funds made available for injury prevention and control at the [CDC] may be used to advocate or promote gun control.” In January 2013, President Obama took a major step in re-vitalizing research on firearms safety when he signed a Presidential Memorandum directing the CDC to research the causes and prevention of gun violence.

The AAP has taken on a robust federal advocacy approach to keep children safe from gun violence, with an emphasis on improving mental health access, enacting gun safety policies, encouraging federal gun safety research and reducing children’s exposure to violence.

**Interview with Dr. Sean Palfrey**

In “Preventing Gun Deaths in Children,” a Perspective article published in the *New England Journal of Medicine* in December 2012, Dr. Sean Palfrey, a practicing pediatrician and professor of pediatrics and public health at Boston University/Boston Medical Center, and his wife, Dr. Judith S. Palfrey, a pediatrician at Boston Children’s Hospital and past president of the AAP, asked the essential question: “How can we prevent gun injuries?”

This question has become a priority for pediatricians and child advocates across the country. We had the opportunity to sit down with Dr. Sean Palfrey to discuss the article “Preventing Gun Deaths in Children” and what medical students, residents, and pediatricians can do to advocate for children and families in terms of gun violence and firearm safety.

Q: What inspired you and your wife to write this piece in NEJM?

S.P.: We were shocked by what happened at Sandy Hook. As pediatricians caring for an inner-city population, it reminded us of a patient of Judy’s, a 12-year-old boy who had been killed on the way to the grocery store with his mother after being caught in the crossfire of a gun battle. These kinds of experiences give pediatricians a voice in legislative advocacy. Because we are on the ground, we can say, ‘This is what we see day to day. We see this and live with it, and we are shocked and saddened.’

Q: What is the most important role for pediatricians in regards to child safety and guns?

S.P.: Don’t fear to ask. People are often grateful that they are asked because they understand that we care about the child’s life. Find the right words to ask about risk factors, such as drugs, alcohol, and abuse in the home. At a legislative level, [we need] to protect our legal right to ask.

Q: In your experience as a clinician, what are the best ways and questions to approach the gun and safety issues with families?

S.P.: It is very effective to incorporate these questions into anticipatory guidance about the child’s development. For example, for the parent of a child turning 2, you can counsel them by saying: ‘Your child’s almost 2 years old, and soon they’re going to be curious, active, and getting into everything in the house. Are there locks on the cabinets in the home? Are the family’s medication bottles kept in a safe, locked place? Are there things like guns in the home? If so, are they kept loaded, or is the ammunition stored separately? Guns should be routinely included in conversations about home safety.

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Q: In light of these tragedies, do you think that it is pediatricians’ duty now to take this issue up outside the medical setting?
S.P.: Our posture is to ask, talk, listen, counsel, and advise. Advising can include attending town meetings, sitting on town councils, or meeting with parents on school committees. There are some with a narrow view of what it means to be a physician, limiting the role of the physician to just those seven minutes with a patient. Others, oftentimes in rural and inner-city populations, take into account all the aspects that factor into health and expand the definition of ‘physician.’

Q: What do you think is the best way for medical students, residents, and pediatricians to advance this issue both inside and outside the medical setting?
S.P.: Legislators are actually waiting to hear from their constituents — they want to hear from the people who vote in their districts and who have opinions on current issues. Scheduling visits, making phone calls, and writing letters are all effective ways to have your voice heard. One phone call to talk about one issue can make a big difference.

Q: In regards to the specific measures outlined in your NEJM piece, are there any that you think best lend themselves to physician advocacy in conversations with families and/or in the legislature?
S.P.: The response is threefold:

a) Defending the right to ask about guns in the home and the right to collect data on these issues. The collection of this kind of data comes very naturally out of our role and the conversations we have with families. We want answers to be tallied and the conversations we have with families comes with immeasurable joys, but outcomes can be lethal if fear and anger become stimulants and shooting becomes reflexive.

b) Counseling families about limiting screen time and limiting the amount of violence viewed by children. In movies and video games children learn to shoot enemies and animals. The games seem so harmless, but can become lethal if

Q: As a practicing primary care pediatrician in an academic setting, what are your thoughts on pediatric residents training on guns/safety?
S.P.: There is certainly a place for it. The question is where to put it in the curriculum. Should it be taught to students and/or residents? And should it be required or elective? The most important aspect of this training would be practice with wording. The way our electronic medical record is set up now, the question of ‘guns in the home?’ comes up as part of a checklist on safety, which may or may not be an effective method of asking when pressed for time. However, real, live, practiced questions, incorporated into a conversation about ways to safeguard the home can allow physicians discuss these topics in a low key and non-judgmental way.

Students and residents should be encouraged by school and residency programs to take on advocacy initiatives, to connect students to those in the field so that they can follow through with these initiatives, and maybe even make it their life’s work.

We would like to sincerely thank Dr. Palfrey for the interview and encourage all medical students, residents, and pediatricians to become involved through your school and/or local AAP chapter if you are interested in pursuing issues around gun violence and firearm safety.

A career in caring for children and families comes with immeasurable joys and complex challenges. A pediatrician’s close relationship with families allows them a unique perspective on the wonders of youth and, sometimes, the horrors of heartbreak. It is a physician’s responsibility to use this perspective in order to counsel families and to advocate for change on a broader scale for the benefit of children. — Kristin Schwarz, M3, Boston University School of Medicine, and Christian Pulcini, M3, Tufts University School of Medicine

References

‡The President’s Plan to Protect Our Children and Our Communities by Reducing Gun Violence. February 2013, whitehouse.gov/sites/default/files/docs/wh_now_is_the_time_full.pdf.
7References

Send your email address to chaggerty@mcaap.org for instant notification of issues important to the MCAAP membership.
From the Massachusetts Department of Public Health (MDPH): Immunization Exemptions on the Rise

The MDPH Immunization Program has been reviewing exemption rates by county among kindergarten students in Massachusetts. This data is collected through the annual Kindergarten Immunization Survey sent to all schools in the Commonwealth. The rate of students claiming a medical or religious exemption to one or more required vaccines has been gradually increasing in recent years, with the most current data (from the 2012–13 school year) indicating a 1.5 percent exemption rate for all kindergarten students in Massachusetts. This is an increase of 0.4 percentage points since 2010.

The exemption rate exceeded 4 percent for kindergarten students in three counties this school year, leaving many children at risk for vaccine-preventable diseases. Specifically, schools in Franklin County reported 6 percent of all kindergarten students with an exemption to one or more vaccines.

Religious and Medical Exemptions to Immunizations among Kindergarten Students, 2012–13

<table>
<thead>
<tr>
<th>COUNTY</th>
<th>TOTAL EXEMPTION RATE (%)</th>
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<tr>
<td>Berkshire</td>
<td>3.2</td>
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<tr>
<td>Bristol</td>
<td>1.1</td>
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<tr>
<td>Cape Cod counties (Barnstable, Dukes, and Nantucket)</td>
<td>4.5</td>
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<tr>
<td>Essex</td>
<td>1.3</td>
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<tr>
<td>Franklin</td>
<td>6.0</td>
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<td>Hampden</td>
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<tr>
<td>Hampshire</td>
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<tr>
<td>Middlesex</td>
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<tr>
<td>Norfolk</td>
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<tr>
<td>Plymouth</td>
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<tr>
<td>Suffolk</td>
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<td>Worcester</td>
<td>1.4</td>
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<tr>
<td>MA State Total</td>
<td>1.5</td>
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The Immunization Program visited schools reporting the highest exemption rates in Massachusetts in 2012 and 2013. These visits were an opportunity to provide school nurses with information and resources to assist with conversations they may have with vaccine-hesitant parents. MDPH also continues these efforts with pediatricians, strongly encouraging them to lay the foundation for immunizations and engage parents at their practices.

There have been multiple vaccine-preventable disease outbreaks in the United States in recent years, and the risks from immunization exemptions are well documented. In 2011, 196 measles cases in U.S. citizens were reported to the CDC. Of the 196 cases, 166 were unvaccinated or had unknown vaccination status. Of these unvaccinated individuals, 50 were not vaccinated due to a religious or philosophical exemption. Utah had two measles outbreaks in 2011 in which 69 percent of the cases were unvaccinated due to personal belief exemptions. Twenty-three (23) percent of the Utah cases acquired measles infection during school.

Washington State declared a pertussis epidemic in 2012 in response to the 1,300 percent increase in pertussis cases from 2011 to 2012. Of the 1,000 children in Washington with pertussis ages 3 months to 10 years of age, 76 percent were considered up-to-date with the childhood DTaP series; 43 percent of children ages 11 to 12 years of age and 77 percent of children ages 13 to 19 years of age had a documented dose of Tdap vaccine. In Massachusetts, the number of pertussis cases more than doubled from 273 in 2011 to 653 in 2012. However, this increase in cases in Massachusetts does not appear to be due to exemptions at this time.

Vaccine-preventable diseases still represent a real threat to the health of the public, and it is extremely important that children are vaccinated according to CDC’s Recommended Immunization Schedule. Current research suggests that parents’ decisions whether to vaccinate or not can be heavily influenced by their health care providers. In short, parents are more likely to vaccinate their children when their pediatrician recommends they do so. While it may be challenging, it is crucial that health care providers communicate effectively and honestly with parents to increase immunization rates in their practices.

For information supporting this evidence, please see the journal articles below. Also included are several other resources that MDPH finds helpful for having vaccine conversations with parents. For any questions regarding immunization exemptions in
Massachusetts, call the MDPH Immunization Program at (617) 983-6800 and ask to speak to an immunization epidemiologist or nurse. — Nicole Pulcini, MPH, MDPH Immunization Program

Journal Articles:


References


Interim Recommendations: Prevention and Control of Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices (ACIP), 2013

The CDC has published interim recommendations for the use of influenza vaccines. The interim recommendations were approved by the ACIP on February 21, 2013, and are available at cdc.gov/flu/professionals/acip/2013-interim-recommendations.htm. The interim recommendations include notes on vaccine abbreviations, vaccine recommendations, and a table of available influenza vaccine products for 2013–2014 that can be found at cdc.gov/flu/professionals/acip/2013-interim-recommendations.htm?5f Missouri=03 and-Safety.aspx

An expanded 2013 ACIP influenza vaccination recommendation statement will be published in Morbidity and Mortality Weekly Report (MMWR) prior to the start of the 2013–2014 influenza season. Providers should consult the expanded 2013 ACIP influenza vaccination statement when it becomes available for updated information.

Tips and Time-savers for Talking with Parents about HPV Vaccine

CDC has a wonderful pre-teens and teens website at cdc.gov/vaccines/who/teens/index.html that includes immunization resources for providers, parents, pre-teens, and teens.
Q&A: Two Professions, One Oral Health Message — Refer by Age 1

Dr. Rashmi Shah is a practicing pediatric dentist in Brockton, Massachusetts, and Dr. Heena Banker is a pediatrician in Waltham, Massachusetts. The sisters, who grew up in Mumbai, India, and attended Bombay University, were taught early on in their careers to look at a patient’s oral health as part of their systemic health. Dr. Banker continued her education at University of Chicago (pediatric residency), and Dr. Shah attended Boston University (pediatric dentistry) and Tufts University (DMD). Both sisters are active in their professions. Dr. Shah is currently a NERB examiner, attends the Massachusetts Dental Society’s Executive MBA Program and sat on the Massachusetts Board of Registry in Dentistry for 10 years. Dr. Banker is involved with various committees at Children’s Hospital, Boston. In their personal lives, Dr. Banker is an accomplished skydiver and a trapeze artist. Dr. Shah is a champion in her gym division for cross-fit training.

Q: At what age do you refer children to a dentist and why?

Dr. Banker: I refer patients to a dentist by age 1 so they can reinforce our messages about encouraging the discontinuation of the baby bottle, assessing dental alignment, and applying fluoride varnish. Dentists also emphasize the importance of parents’ brushing their child’s teeth, which young children cannot do without adult assistance. It is important that parents be given this information as soon as the teeth start erupting, which is well before a child’s first birthday.

Q: Describe what you do during your well-child visits regarding oral health.

Dr. Banker: I created an oral health template for our Electronic Health Record system. The template contains dental questions specific for each age range. For example, at age 1 the question that automatically pops up is: Does the child have a dental home? (Note: Dr. Banker has become a leader in templates for her health care group at Children’s Hospital.)

Q: What do you look for during your oral health exam?

Dr. Banker: I use the model of “look and refer” all children to a dental home. I look at the front teeth for the initial assessment at this age range. Dark staining could be an example of dental decay. If the front teeth are broken or cavitated, then children are automatically in the high-risk category and need to be seen as soon as possible by a dental provider. But all children should have a dental home by age 1.

Q: What is the most important message you consult with Dr. Shah, a pediatric dentist?

Dr. Banker: Toothache triage! For example, I had a patient with infection in his teeth. It was a shame for him to be in such pain. He was unable to qualify for treatment under general anesthesia through his insurance. I called Dr. Shah and Dr. Shah did the surgical case for free. She went out of her way to accommodate the patient and treat the patient ASAP. This is just one example of how patients have benefited from a relationship between medical and dental providers.

Q: What is the number one reason you refer children to a dentist?

Dr. Banker: Children in all socioeconomic levels and ethnic groups are facing this problem. Whether they are cared for by parents, grandparents, nannies, or other caregivers, there are a lot of children with dental decay today.

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Dr. Banker: Children in all socioeconomic levels and ethnic groups are facing this problem. Whether they are cared for by parents, grandparents, nannies, or other caregivers, there are a lot of children with dental decay today.

Q: Do you see early childhood caries (ECC) in children across all socioeconomic groups or only in children from low-income families?

Dr. Banker: Children in all socioeconomic levels and ethnic groups are facing this problem. Whether they are cared for by parents, grandparents, nannies, or other caregivers, there are a lot of children with dental decay today.

Q: Do you have children who end up in the OR for treatment of gross decay who could have been treated as an outpatient had they been referred at a younger age before the disease worsened?

Dr. Shah: Lots of kids end up with cavities prior to age 3. If caught early, it is less likely to be a traumatic experience. With proper oral hygiene instruction and parental involvement at a young age, this disease is preventable. Early intervention can also decrease the progression of the disease for children who already have dental decay.

Q: Why is it important for pediatricians to refer children at age 1?

Dr. Shah: Dental decay is the number one chronic disease infecting children today. It is five times more common than asthma and seven times more common than hay fever. Yet, dental decay is totally preventable. And visits to the dentist can be fun! Children routinely come to the office for field trips where they play with the air and water syringes and have a social visit.

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By contrast, a true drowning victim loses voluntary control of limbs and vocalization as soon as water triggers constriction of the larynx. The resulting cascade of autonomic nervous activity leads to “external, unlearned, instinctive drowning movements that are easily recognizable by trained rescue crews,” according to Francesco A. Pia, PhD, the first descriptor of IDR. The problem is that to a novice like me these autonomic responses can make drowning victims look calm, relaxed, and quiet as they bob in the waves. (See “The Instinctive Drowning Response” and “Warning Signs.”) Many people never experience aquatic distress but move straight to the IDR instead. Once the IDR has begun, victims typically have just 20 to 60 seconds until they submerge for the final time — and in the case of children and other vulnerable populations, perhaps even less.

Misrecognition of the instinctive drowning response may explain some of the more sobering water safety facts. About 5,000 children are hospitalized after drowning or near-drowning each year. Of these, 15 percent will die and another 20 percent or more will suffer serious brain injury. Children under 5 years of age are at especially high risk, with drowning as the leading cause of death for children 1 to 4 years of age. Perhaps most terrifying is the fact that in studies, 70 percent of preschoolers who drown are in the care of one or both parents at the time of the drowning and 75 percent are missing from sight for five minutes or less. Although there may be some reporting bias to these numbers, an inability to recognize drowning also delays appropriate reaction to and triage of drownings, especially in the early stages. Certainly, this inability to recognize drowning victims may explain why in many cases where drownings are caught on camera, adults are often playing and splashing just feet from the victim, unaware that anything has gone wrong.

So how can we educate parents about IDR and the signs of drowning? Review the warning signs with families during an office visit, have a handout that describes the IDR, or share the articles and videos listed below. For those with a social media presence, it may be helpful to provide a visual aid by sharing a recent Today Show piece on the same topic. Most of all, tell parents the headline of the recent article by Mario Vittone at Slate.com: “Drowning Doesn’t Look Like Drowning” — it is quiet or silent. Tell parents to actively watch children in the water, and if there is any doubt, ask if they are ok. Kids should know that if they don’t respond to this query, mom or dad will assume that they are in trouble and be coming over to save them. Hopefully, with these tips and a few others, we can reduce the number of Massachusetts children who drown or nearly drown this summer.

— Anne H. Light, MD, FAAP

References
5 “Moms: Would You Be Able to Spot Someone Drowning?” video.tvguide.com/TODAY+show/Would+you+be+able+to+spot+someone+drowning/20057123primary+%primaryvalue+NBC%20TODAY%20Show.

Information for Families

“Drowning Doesn’t Look Like Drowning” By Mario Vittone, Slate.com slate.com/articles/health_and_science/family/2013/06/rescuing_drowning_children_how_to_know_when_someone_is_in_trouble_in_the.html

“What Does Drowning Look Like” By Brian Scott k2radio.com/what-does-drowning-look-like


“Moms: Would You Be Able to Spot Someone Drowning?” video.tvguide.com/TODAY+show/Would+you+be+able+to+spot+someone+drowning/20057123primary+%primaryvalue+NBC%20TODAY%20Show

The Instinctive Drowning Response

As described by Francesco A. Pia, PhD, in On Scene: The Journal of U.S. Coast Guard Search and Rescue:

1. Except in rare circumstances, drowning people are physiologically unable to call out for help. The respiratory system was designed for breathing. Speech is the secondary, or overlaid, function. Breathing must be fulfilled, before speech occurs.

2. Drowning people’s mouths alternately sink below and reappear above the surface of the water. The mouths of drowning people are not above the surface of the water long enough for them to exhale, inhale, and call out for help. When the drowning people’s mouths are above the surface, they exhale and inhale quickly as their mouths start to sink below the surface of the water.

3. Drowning people cannot wave for help. People instinctively force their arms laterally and press down on the water’s surface. Pressing down on the surface of the water permits drowning people to leverage their bodies so they can lift their mouths out of the water to breathe.

4. Throughout the instinctive drowning response, drowning people cannot voluntarily control their arm movements. Physiologically, drowning people who are struggling on the surface of the water cannot stop drowning and perform voluntary movements such as waving for help, moving toward a rescuer, or reaching out for a piece of rescue equipment.

5. From beginning to end of the instinctive drowning response people’s bodies remain upright in the water, with no evidence of a supporting kick. Unless rescued by a trained lifeguard, these drowning people can only struggle on the surface of the water from 20 to 60 seconds before submersion occurs.
MassHealth Reaches out to Its Members; Pediatricians Can Reach out to MassHealth when Oral Health Access is an Issue

MassHealth works hard to educate its members about the importance of good oral health. Outreach initiatives (such as fluoride varnish training sessions and member fairs where oral health information and toothbrushes are distributed) help members understand their benefits and learn how to obtain assistance in times of need.

New members receive a welcome packet with information describing the benefits included in the MassHealth Dental Program. On their birthday they receive a reminder about the importance of good oral health, and if they forget to show up for an appointment, they are urged to reschedule one. If members neglect to schedule an appointment for a year, they receive a letter letting them know they are overdue.

Intervention is a MassHealth member’s “one stop” for assistance. Members have intervention specialists available to them five days a week to address complaints and other important issues. If intervention is needed, the representatives will reach out to the member within 24 hours.

If physicians are having trouble with oral health access or other issues for patients with MassHealth, physicians can contact the intervention specialist by emailing MassHealth a request to reach out to the member.

Customer care staff, available Monday through Friday from 8:00 a.m. to 6:00 p.m., can be reached at (800) 207-5019 or via email at masshealth-dental.net. On the site, members have access to the member manual, forms, a find-a-dentist feature, and more.

MassHealth and DentaQuest work together to ensure members a responsive level of service. If you have any questions about the outreach initiatives described in this article please contact Tracy Chase, executive director of the MassHealth Dental Program at DentaQuest, at (617) 886-1310.

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Please remember to double check that your ad is the correct size and contains the most up-to-date information.
As summer quickly approaches in New England, our waiting rooms will soon be filled with children and families getting ready for kindergarten. A recent study in *Pediatrics* reminds us that the work to get ready for kindergarten must begin years before that if we are to succeed.

Researchers in Rhode Island looked at kindergarten reading readiness test scores for children attending public kindergarten and linked these to state health department records of blood lead testing by using individual identifiers. The study population (N = 3406) was 59% Hispanic. For each child, the geometric mean blood lead level (BLL) was estimated by using all previously reported BLLs. Analyses were adjusted for gender, age, year enrolled, race, child language, and free/reduced lunch status as a measure of socioeconomic status.

The median geometric mean BLL was 4.2 µg/dL; 20 percent of children had at least 1 venous BLL ≥10 µg/dL. Compared with children with BLLs <5 µg/dL, the adjusted prevalence ratios (95 percent confidence interval [CI]) for failing to achieve the national benchmark for reading readiness were 1.21 (1.19 to 1.23) and 1.56 (1.51 to 1.60) for children with BLLs of 5 to 9 and ≥10 µg/dL, respectively. On average, reading readiness scores on the Phonological Awareness Literacy Screening-Kindergarten (PALS-K) decreased by 4.5 (95 percent CI: −2.9 to −6.2) and 10.0 (95 percent CI: −7.0 to −13.3) points for children with BLLs of 5 to 9 and ≥10 µg/dL, respectively, compared with BLLs <5 µg/dL. These results are similar to results in MA where in 2009, 4.7 percent of children less than 5 years of age had a BLL ≥10 µg/dL.

In October 2012 the CDC began using a reference level of 5 µg/dL to identify children with blood lead levels that are much higher than most children’s levels. The CDC is no longer using the term “level of concern” and is instead using the reference value to identify children who have been exposed to lead and who require case management. This new level is based on the U.S. population of children from 1 to 5 years of age who are in the highest 2.5 percent of children when tested for lead in their blood. The CDC will update the reference value every four years using the two most recent NHANES surveys.

What is both compelling and concerning in this study is that BLLs well below 10 µg/dL were associated with lower reading readiness at kindergarten entry. The high prevalence of elevated BLLs in New England means we all need to pay attention to the impact lead may have on early literacy not only as we are screening for school readiness but in what we do both regarding lead and early literacy. We must do all we can to limit environmental exposure to lead, and in addition, do all we can to improve children’s early literacy skills. On this front the evidence is strong for the power of reading aloud to children.” Let’s work together to get less lead in their blood and more books in their hands! — Marilyn Augustyn, MD, FAAP

For more information about Reach Out and Read and early literacy, email Massachusetts Program Director Alison Corning-Clarke at alison.clarke@reachoutandread.org or Massachusetts Coalition Medical Director Marilyn Augustyn at augustyn@bu.edu.

References

2. http://matracking.ehs.state.ma.us/Health_Data/Childhood_Blood_Lead_Levels.htm
3. cdc.gov/nceh/lead/ACCLPP/blood_lead_levels.htm
JOB CORNER

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Jolia Georges
Director of Physician Recruitment
jgeorges@capecodhealth.org
(508) 862-5481

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