



# Section on Anesthesiology & Pain Medicine NEWSLETTER

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN®



FALL 2022

<https://tinyurl.com/anesthesia-pain>

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## Chairperson's Report

Mary Landrigan-Ossar, MD, PhD, FAAP, FASA



Mary Landrigan-Ossar

Happy Fall to everyone! Academics, parents, and pediatric specialists greet this season as the real start of the new year. Historically the start of school meant that we could count on a bit of a lull in pediatric operative cases, but it does not seem that we have yet returned to the usual ebbs and flows of the hospital year. Hospital operations in most parts of the country have been affected by ongoing challenges with respiratory illnesses, hospital bed capacity, and staffing. Through all of this I remain heartened by the dedication of everyone in our healthcare teams to the care of our young patients, and I am hopeful for the days and years ahead.

It's been an active several months for the Section on Anesthesiology and Pain Medicine. Just this week, our Section sponsored the publication of a *Focus on Subspecialties* article in *AAP News*, titled "Behind the Ether Screen: Pediatrician's Role in Peri-Operative Preparation" by our very own Dr. Jessica Berger. Please see page 5 for a re-print of Dr. Berger's piece. Section members have also recently started work on the revision of two statements, one titled "Recognition and Management of Iatrogenically Induced Opioid Dependence and Withdrawal in Children," authored jointly with the AAP Committee on Drugs and to be led by Dr. Adam Adler, and a revision of the statement on "Critical Elements for the Pediatric Perioperative Anesthesia Environment" to be led by Dr. Justin Long. In cooperation with the Section on Cardiology and Cardiac Surgery, the SOA continues work as co-author of a new clinical report on "Preoperative Clearance in the Pediatric Patient with Congenital Heart Disease Undergoing Non-Cardiac Surgery"; we expect the report to be published in the near future so keep an eye out for news on that. We have multiple statements in progress as well, including a revision of the statement on "The Assessment and Management of Acute Pain in Infants, Children, and Adolescents"; a statement on "Care of Pediatric Patients with Chronic Pain"; and a revision of the statement on "The Pediatrician's Role in the Evaluation and Preparation of Pediatric Patients Undergoing Anesthesia" – to be authored for the first time jointly with the Committee on Practice and Ambulatory Medicine (COPAM). In cooperation with the Section on Oral Health, the Section also has a clinical report in progress on "Oral Healthcare for Children with Developmental Disabilities". These statements are one of the major outputs of the Section; if any members have a suggestion for a new statement please reach out to propose it.

On a larger scale, the AAP has continued to advocate for the health and safety of children and pediatric specialists. On October 8<sup>th</sup> the AAP released a newly updated policy statement and technical report on firearms safety. As many of you are aware, gun violence is now the leading cause of death in children, and as the largest voice for pediatric health advocacy in the country, the AAP is stepping up to try and help reverse that trend. Threats of violence against pediatricians and pediatric subspecialists have become a frightening new reality for many of us. In response, the AAP, the American Medical Association (AMA) and the Children's Hospital Association (CHA) have united in support of physicians and hospitals who have been threatened and attacked in recent months. The groups sent a [letter](#) urging the Department of Justice to investigate the increasing threats of violence against physicians, hospitals and families of children for providing and seeking [evidence-based gender-affirming care](#). The organizations also call on technology platforms to do more to stop the rhetoric that often incites threats or acts of violence and

*(Continued on page 2)*

## Chairperson's Report

(Continued from page 1)

has led to harassment campaigns across the country, much of it directed at children's hospitals and the physicians and staff who work there. In addition, last month the AAP announced that it will launch a new Center of Excellence on Social Media and Youth Mental Health, a feat that will be made possible by a \$10 million grant from the U.S. Department of Health and Human Services (HHS), through the Substance Abuse and Mental Health Services Administration (SAMHSA). You can find more on each of the initiatives mentioned above in the newsletter pages to come. Also, the AAP [News Room](#) is a great place to learn about how the Academy is tackling important issues facing US children and children across the world on a daily basis.

We are delighted to celebrate the recipient of our 2023 Robert M. Smith Award, Dr. Navil Sethna. On a personal note, Dr. Sethna was one of my attendings when I was a pediatric anesthesia fellow. His example of clinical excellence combined with deep-

rooted compassion for his patients set an example for me that I've endeavored to live up to in my practice. Please see page 2 for a tribute to Dr. Sethna and his amazing career; we look forward to celebrating his award at our joint meeting with SPA in Austin this coming March.

If you are traveling to the SPA meeting in New Orleans this week, I look forward to seeing you there. The return of in-person meetings has been a wonderful thing, although I certainly understand that there are people who still do not feel it's appropriate for them to travel at this time. To our friends who will not be in New Orleans, stay in touch by email, or on Twitter (my kid says I'm too old for Instagram or any other social media). Our Section will have a booth in the exhibit hall at the meeting, and I will be spending some time there so please stop by and say hello. As always, we hope to find ways to involve more of our members in the work of the Section and are open to hearing any ideas for new initiatives.

## Tribute to Navil Sethna, MB, ChB, FAAP 2023 AAP Robert M. Smith Award

Constance S. Houck, MD, MPH, FAAP, Mary Landrigan-Ossar, MD, PhD, FAAP, and Christine Greco, MD, FAAP

We are extremely excited to provide this tribute to our friend and colleague, Navil Sethna, MB, ChB, FAAP, the 2023 Robert M. Smith awardee. Navil is a long time AAP Section on Anesthesiology and Pain Medicine member and an internationally known expert in pediatric pain medicine. He has been a leader in all aspects of pediatric acute and chronic pain management for more than 35 years and has served as a mentor to a generation of physicians in pediatric pain management.

Navil was born in Baghdad, Iraq, where he attended medical school at the Medical College of Baghdad. After the rise of Sadaam Hussein, his family moved to the United Arab Emirates where he trained in emergency medicine and surgery. He subsequently moved to the U.S. in 1979 and, after completing a year of surgical training at Brookdale Hospital in Brooklyn, NY, realized that a career in anesthesiology was his true calling. He went on to complete his anesthesiology residency in Brooklyn and then came to Boston Children's Hospital (BCH) in 1982 to do a Fellowship in Pediatric Anesthesiology. After joining the staff at BCH in 1983, it was clear to all that Navil could do anything he set his mind to. He became an invaluable member of the Department and was especially known for his expertise in caring for the most complex patients. He was a founding member of the Spine Surgery Multidisciplinary Perioperative Team for Patients with Neuromuscular Disorders as well as the Anesthesia Liver Transplantation Team. His work with complex patients prompted his interest in regional anesthesia and a search for better ways to treat perioperative pain in children. This led him to a collaboration with Dr. Charles Berde to create the Pain Treatment Service at Boston Children's Hospital in 1986, one of the first comprehensive pediatric pain services in the U.S.



Navil Sethna,  
MB, ChB, FAAP

In order to further educate himself in the science of pain medicine, Navil subsequently took a 15-month sabbatical in 1994 to work with Mitchell Max at the National Institutes of Health in Bethesda, Maryland, where he was involved in some of the landmark research on pain mechanisms at the National Institute of Dental Medicine. After returning to BCH, he used the insights he gained to advance both the clinical and research aspects of the Chronic Pain Clinic. He also went on to develop the foundations for the BCH Headache Clinic and the Pediatric Pain Rehabilitation Center, where he currently serves as the Clinical Director. He is considered the leading expert in most areas of pediatric pain medicine, including Complex Regional Pain Syndromes, quantitative sensory testing, and pain rehabilitation. Over the years, Navil has made countless scientific contributions to the field of pediatric anesthesiology and pain medicine which have shaped the way we care for patients.

Navil has been a longstanding and supportive member of the AAP Section on Anesthesiology and Pain Medicine. He represented the Massachusetts chapter of the AAP as part of the legislative subcommittee on pain management. He was also a lead author on a joint statement of the Section on Anesthesiology and Pain Medicine and the Committee on Fetus and Newborn entitled *Prevention and Management of Procedural Pain in the Neonate: An Update*.

Navil is a true renaissance man and an incredible leader in the field of pediatric pain medicine. His efforts have changed the lives of not only the many patients he has cared for over the years but also those of us who have had the pleasure to work closely with him. Navil has taught innumerable trainees how to care for the sickest and most complex patients, both in and out of the operating room, and he continues to be the expert who is always willing to share his knowledge and advice. He is incredibly conscientious and passionate about what he does. He is always kind, considerate and thoughtful, even when he disagrees with your viewpoint. He is an incredible storyteller, and we always look forward to hearing his stories. Congratulations on your achievements, Navil, and thank you for your contributions and friendship.



## Seen in *Pediatrics*, *Hospital Pediatrics*, *AAP Grand Rounds*, and *AAP News*



### Pediatric Anesthesia/Critical Care

[Is General Anesthesia in Childhood Safe?](#) – October 2022

[Say 'NO' to Nitric Oxide During Heart Surgery](#) – October 2022

[Reducing Pre-Procedural Fasting Times in Hospitalized Children](#) – July 2022

[Reducing Pediatric Unplanned Extubation Across Multiple ICUs Using Quality Improvement](#) – May 2022

[Guidance for Structuring a Pediatric Intermediate Care Unit](#) – May 2022

[Propofol Induced Procedural Excitation Rather Than Sedation in an Adolescent Patient](#) – February 2022

[Development of an Integrative Medicine Perioperative Program to Address Stressors Amongst Adolescents Undergoing Orthopedic Surgery: A Pilot Study](#) – February 2022

### Pediatric Pain Management/Opioids/ Substance Use Disorder

[Impact of the 2017 FDA Drug Safety Communication on Codeine and Tramadol Dispensing to Children](#) – October 2022

[Implementation of an Opioid Weaning Protocol at a Tertiary Care Children's Hospital](#) – October 2022

[Improving Substance Use Prevention, Assessment, and Treatment Financing to Enhance Equity and Improve Outcomes Among Children, Adolescents, and Young Adults](#) – July 2022

[Recommended Terminology for Substance Use Disorders in the Care of Children, Adolescents, Young Adults, and Families](#) - June 2022

[Inequities in Pain Assessment and Care of Hospitalized Children With Limited English Proficiency](#) – May 2022

[Trends in Routine Opioid Dispensing After Common Pediatric Surgeries in the United States: 2014–2019](#) – April 2022

[Implementation of Enhanced Recovery Protocols Reduces Opioid Use in Pediatric Laparoscopic Cholecystectomy Surgery](#) – February 2022

[The Use of Validated Pain and Sedation Scales in the Pediatric Intensive Care Unit](#) – February 2022

### Equity, Diversity, and Inclusion

[Trends in the Diversity of Pediatric Faculty: 2000–2020](#) – September 2022

[Creating Work and Learning Environments Free of Gender-Based Harassment in Pediatric Health Care](#) – September 2022

[See It To Be It: Diversity and Inclusion in Academic Pediatrics Starts at the Top](#) – September 2022

### Pediatric Palliative Care

[Balancing Protection and Progress in Pediatric Palliative Care Research: Stakeholder Perspectives](#) – October 2022

[Palliative Care Programs in Children's Hospitals](#) – October 2022

[The Have and Have Nots: Characteristics of Hospitals With a Pediatric Palliative Care Program](#) – October 2022

[Guidance for Pediatric End-of-Life Care](#) – May 2022

### Pediatric Foreign Body Ingestions

[Warning Labels and High-Powered Magnet Exposures](#) – October 2022

[Pediatric Battery-Related Emergency Department Visits in the United States: 2010–2019](#) – September 2022

[Vascular Complications in Children Following Button Battery Ingestions: A Systematic Review](#) – August 2022

### Pediatric Trauma

[AAP Policy Statement: American Academy of Pediatrics Recommendations for the Prevention of Pediatric ATV-Related Deaths and Injuries](#) – October 2022

[AAP Technical Report: A Comprehensive Report on All-Terrain Vehicles and Youth: Continuing Challenges for Injury Prevention](#) – October 2022

### Pediatric Surgical Care/Emergency Care

[AAP Policy Statement: Optimizing Pediatric Patient Safety in the Emergency Care Setting](#) – October 2022

[AAP Technical Report: Optimizing Pediatric Patient Safety in the Emergency Care Setting](#) – October 2022

[Nonoperative Management of Uncomplicated Appendicitis](#) – May 2022

[Weighing the Risks and Benefits of Nonoperative Management of Appendicitis](#) – May 2022

### Pediatric Liver Transplantation

[From Survival to Survivorship in Pediatric Liver Transplantation](#) – September 2022

[Prognosis of Children Undergoing Liver Transplantation: A 30-Year European Study](#) – September 2022

### Health Care Benefits

[Scope of Health Care Benefits for Neonates, Infants, Children, Adolescents, and Young Adults Through Age 26](#) – September 2022



American Academy of Pediatrics  
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SPA-AAP **PEDIATRIC ANESTHESIOLOGY** 2023

**SAVE THE DATE**  
March 31–April 2, 2023  
JW Marriott ★ Austin, TX

## Call for Nominations for Open Positions AAP Section on Anesthesiology & Pain Medicine Executive Committee



Nomination Form Available [HERE](#)

We are currently calling for nominations for two (2) open positions on the AAP Section on Anesthesiology and Pain Medicine (SOA) Executive Committee (EXCOM). With Dr. Stephen Hays completing six years of service as an Executive Committee member in 2023, one position is opening. In addition, we anticipate an opening to arise with the transition of one of our current EXCOM members to the position of Chairperson-Elect next year.

The term of the new Executive Committee members will begin November 1, 2023. The term for each position is three years (and renewable one time for an additional three years).

The role and responsibilities of Section Executive Committee members are described at <http://downloads.aap.org/DOSP/ECMDescription.pdf>. Please note that the Section Executive Committee meets twice annually, once in conjunction with the SPA/AAP annual meeting in the spring and again at the SPA meeting in the fall.

Any interested candidate is asked to self-nominate. Every candidate must be up to date with their national AAP membership and be a member of the Section. Candidate information will be shared with the Section Nominations Committee, who will weigh in on the nominations received and make a decision on ballot selections in early January. The election will take place in March.

Thank you for considering this call for nominations. Please contact Section Manager, Jen Riefe, at [jriefe@aap.org](mailto:jriefe@aap.org) should you have questions about the nominations process.

**All submissions must be received by December 15, 2022.**



## New AAP Advocacy Reports Highlight Federal & State Advocacy

Be sure to check out the **Academy's fall 2022 advocacy report**, which provides an in-depth look at advocacy activities at the federal and state level impacting child health. [Read the report here.](#)

Also, don't miss the updated AAP [Academic and Subspecialty Advocacy Report](#), which reflects the work done recently on behalf of AAP subspecialty members. This includes extensive work to address both urgent and long-term needs of pediatric subspecialists.

Another good read is the [AAP News Washington Report](#), which highlights several COVID-19 advocacy victories over the Academy's two years of advocating during the pandemic and what they mean for children, families and pediatric medical professionals.

American Academy of Pediatrics  
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RESEARCH IN HEALTH EQUITY  
THE SUBSPECIALIST'S ROLE

## WEBINAR

Hosted by the Section on  
Cardiology & Cardiac Surgery -  
Trainees Committee  
*Moderated by Laura Lowrey, MD*



**Keila Lopez,  
MD, MPH**



Thursday  
27 October  
**Time**  
6:00 pm  
Central

REGISTRATION IS  
REQUIRED FOR THIS  
WEBINAR.

[SIGN UP HERE](#)

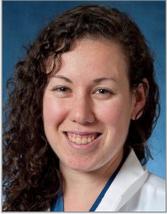
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Medicine, Section of  
Pediatric Cardiology  
Attending Physician,  
Pediatric Cardiology  
Texas Children's Hospital  
Associate Professor,  
Pediatrics, Baylor College  
of Medicine

LIVE WEBINAR

# AAP News™

## Behind the Ether Screen: Pediatrician's Role in Peri-Operative Preparation

by Jessica A. Berger, MD, MHS, FAAP



Jessica A. Berger, MD, MHS, FAAP

Pediatric anesthesiologists play an integral role in the care of children, yet the nuances of pediatric anesthesiology are not well-known by providers who spend most of their practice outside the operating room, procedure suites, or radiology. With insight into what pediatric anesthesiologists do, pediatricians can assess when their patients need anesthesia for procedures and imaging and can be informed participants in peri-operative preparation.

Anesthesiologists combine enteral, intravenous, and inhalational agents to induce and maintain a target level of sedation or general anesthesia, achieve immobility when needed, provide analgesia for painful procedures, and mitigate the physiologic stress response to surgery. Some anesthetics can be completed with a “natural airway,” which refers to spontaneous ventilation with a nasal cannula or blow-by supplemental oxygen. Other procedures require endotracheal intubation and mechanical ventilation. An anesthesiologist crafts the technique by considering the procedure or imaging study, the patient’s medical

history and comorbidities, and the setting. Remote and ambulatory locations tend to have fewer resources readily available in case of emergencies, which may change how an anesthesiologist will practice.

The safe practice of anesthesia depends on peri-operative patient “clearance,” a common reason for visits to the pediatrician’s office. Though “pre-operative clearance” is used to describe the process, “peri-operative preparation” is a better name for what should be a collaborative team-based approach among pediatricians, anesthesiologists, and surgeons (or proceduralists) to ensure that patients are medically optimized, that anesthesia carries an acceptable risk-benefit profile, and that the procedure is being performed at the optimal time and in the optimal setting for the patient. Thinking of it as “preparation” rather than “clearance” reframes the process so that even patients who are not at their baseline due to illness or injury are as well-prepared as they can be. A good example of this is a previously healthy infant with severe electrolyte derangements due to pyloric stenosis who must be resuscitated prior to pyloromyotomy.

There is more to peri-operative preparation than assignments of American Society of Anesthesiology physical status and Mallampati scores. Peri-operative preparation is about risk stratification. One way to begin is to consider whether the patient and the procedure are high-risk or low-risk. Patients who are high-risk may follow multiple sub-specialists or rely on devices such as tracheostomy tubes or ventilators. Other high-risk patients include those with comorbidities that impact daily life or are potentially life-threatening if poorly managed peri-operatively. Examples include, but are not limited to congenital heart disease, sickle cell disease, diabetes mellitus, cystic fibrosis, intrinsic coagulopathies, or inborn errors of metabolism. For patients who are high-risk, even procedures which are typically short, low-risk, and/or minimally invasive require significant planning. By identifying these patients early, a collaborative team of primary care pediatricians and pediatric subspecialists can enact plans for peri-operative care. High-risk procedures involving the airway, the brain, and the heart or major blood vessels always require planning, even for patients who are generally healthy.

In the community, many patients see their pediatrician for a pre-operative visit. It is useful to have a systematic approach to the history and physical which focuses on identifying risk factors for anesthesia. A pediatrician may uncover by interview alone a risk for malignant hyperthermia or bleeding disorder. Questions about recent upper respiratory infections along with a physical exam can determine the risk of airway complications such as laryngospasm. Pediatricians who are concerned about any aspect of the history or physical exam should feel comfortable reaching out to the child’s surgeon who can route questions to the anesthesia team or refer for an anesthesia consult if such a service exists at that institution. It is useful for community-based pediatricians to familiarize themselves with the anesthesia services at their nearby hospitals and surgery centers.

In the hospital, inpatients are assessed by a member of the anesthesiology team. To best serve these patients, attending physicians and trainees should understand their institution’s anesthesia evaluation process and consult early if a patient will need surgery or imaging with anesthesia. Early conversations with an anesthesiologist will ensure that the procedure is scheduled for a safe time and location, that appropriate labs are drawn (but superfluous phlebotomy is minimized), that proper blood products are available, NPO instructions are accurate, and ICU beds are available. Procedures are less likely to be delayed with sufficient planning.

By understanding what takes place on the anesthesia side of the drapes and what goes into peri-operative planning, pediatricians should feel empowered to advocate for their patients and play an active role on the peri-operative team.

## Spotlight on EDI - Equity, Diversity & Inclusion

### American Academy of Pediatrics Calls for Elimination of Race-Based Medicine

*The effects of racism are interwoven in U.S. healthcare systems and structures, from practice and teaching of medicine to disease management*

In a powerful new call to action, the American Academy of Pediatrics demands critical self-evaluation and fundamental changes in the practice of medicine to end long-standing inequities in health care.

In a new policy statement, “Eliminating Race-Based Medicine,” pre-published online May 2, 2022, in *Pediatrics*, the AAP observes that race is a historically derived social construct that has no place as a biologic proxy. Over the years, the medical field has inaccurately applied race correction or race adjustment factors in its work, resulting in differential approaches to disease management and disparate clinical outcomes.

“Before we can legitimately address systemic and structural inequities in health care we must first recognize that they exist and are a byproduct of deeply ingrained societal racism,” said Chair of the AAP Board Committee on Equity, Joseph L. Wright, MD, MPH, lead author of the policy statement and Chief Health Equity Officer of the University of Maryland Medical System.

“The American Academy of Pediatrics is taking an important step toward dismantling race-based medicine. This effort calls for acknowledging the impact that differential lived experiences have on individual and population health outcomes through a race-conscious health equity lens rather than through approaches that have inappropriately identified skin color as an independent risk-adjusting variable,” Dr. Wright said. “Social determinants of health need to be carefully considered in the development of care delivery strategies including factors embedded in broad categories such as access, the physical environmental and community supports. Evidence informed incorporation of these factors is vital in all areas of medicine.”

The policy statement reflects on the vigorous debate on the role of race and racism in medicine, and how perceptions of physiologic differences based solely on racial phenotypes have long been intertwined in the practice and teaching of medicine. The statement includes examples of race-based clinical algorithms or practice guidelines that are undergoing reexamination and reconsideration within pediatrics and across other medical specialties.

“Eliminating race-based medicine is necessary; it is challenging; and it is long overdue,” AAP President Moira Szilagyi, MD, PhD, FAAP, said. “AAP is mindful that this work will make some uncomfortable, not only because it requires systemic change, but how we must approach this work as individuals. We welcome this challenge – and the discomfort that comes with it – and are encouraged by the steps that AAP has already taken.”

The AAP recommends:

- All professional organizations and medical specialty societies should identify and critically examine organizational policies and practice guidelines that may incorporate race or ethnicity as independent variables or modifying factors. The Academy will advocate through its elected and appointed leadership across the health care landscape for the elimination of race-based medicine in any form.
- The AAP will leverage its relationships with medical schools, academic health systems, schools of medicine and accrediting bodies to ensure health equity curricular content, including a specific focus on the elimination of race-based medicine. It will seek to proactively reframe appropriate social determinant of health measures.
- The Academy will critically examine, deconstruct, retire, if necessary, and revise all practice guidelines and/or policies that include race assignment as a part of clinical decision-making.
- The Academy will leverage its Words Matter document,, to ensure that all authors, editors, presenters, media spokespersons, and other content contributors recognize race as a social construct only and desist from any use, or its reference, as a biologic proxy.

“The evolution of modern medicine has produced incredible advancements and accomplishments in health care,” Dr. Wright said. “But we must acknowledge and address the stark inequities that persist in leaving vulnerable populations behind. We are better than this. Now is the time for change.”

### AAP Releases New Bright Futures Resources on Health Equity

#### Bright Futures: Health Equity Resources for Health Care Professionals

This new compendium of health equity resources includes tips and tools to prepare pediatric health care professionals to address the impact of racism, bias, and discrimination on the health and well-being of their patients and families. Pediatric health care professionals can use these resources in their practice/professional setting, for use in training, and for their own professional learning. These resources are designed to be used together, as a series, or as individual resources, based on the needs of the pediatric health care professional.

For more detailed information, please refer to the [Introduction: How to Use These Resources](#) document.



**Bright Futures™**  
prevention and health promotion for infants,  
children, adolescents, and their families™

### Bright Futures: Health Equity Resources for Pediatric Health Care Professionals



Learn to effectively address negative health impacts of racism, bias, and discrimination on patients and families.

**1** Frequently Asked Questions: Addressing the Impact of Racism

**2** Why Conversations About Race Matter—Effects of Conversation on Patient Care Tip Sheet

**3** Resource Repository

**4** Resource Repository for Parents and Children

Download these new resources today!

# AAP News™

## Firearm injury prevention: AAP updates guidance with multiple ways to reduce harm

Lois K. Lee, M.D., M.P.H., FACEP, FAAP

*A 16-year-old with a history of depression tells you he has thoughts of suicide but does not have a specific plan.*

*Parents bring a 4-year-old child with an 8-year-old sibling to a well-child visit.*

Both scenarios offer opportunities for pediatricians to provide anticipatory guidance on decreasing access to firearms, which now are the leading cause of death for U.S. children and youths ages 0-24.

The updated AAP policy statement *Firearm-Related Injuries and Deaths in Children and Youth: Injury Prevention and Harm Reduction* and accompanying technical report provide guidance, updated information and resources for pediatricians. They also provide evidence on the importance of safe storage of firearms, anticipatory guidance, lethal means counseling, violence intervention programs and legislation.

The documents, from the AAP Council on Injury, Violence, and Poison Prevention, are available at <https://doi.org/10.1542/peds.2022-060070> and <https://doi.org/10.1542/peds.2022-060071>. They will be published in the December issue of *Pediatrics*.

### Scope of the problem

In 2020, use of firearms resulted in 10,197 deaths among those from birth to age 24 years, and they are the leading cause of pediatric deaths, including for homicides and suicides. There also are disparities when considering the race, ethnicity, sex and socioeconomic status of victims.

Among pediatric firearm deaths, homicides account for 58%, suicides 37%, unintentional shootings 2% and legal intervention

(i.e., by law enforcement) 1%. School and mass shootings account for less than 1% of pediatric firearm deaths.

Increased access to firearms at both the household and state level are associated with increased firearm deaths in the pediatric population. Providing barriers to firearm access can help. Interventions at the primary care, emergency department, psychiatric, hospital and community levels can decrease the likelihood that at-risk individuals will harm themselves or others. Stronger legislation also is associated with decreases in firearm deaths.

### Counseling families

Firearm-related injury prevention anticipatory guidance, coupled with provision of safety equipment (e.g., trigger locks, gun locks, gun safes), improves firearm safe storage. If families keep firearms in the home, they should be counseled to store them unloaded, with the firearm and ammunition locked separately where children can't access them.

One method to decrease a child's unauthorized access to a firearm while allowing fast access by an authorized adult is to use the authorized user's fingerprint to open trigger locks and gun safes.

Firearms have the highest lethality of any means of suicide with a greater than 90% fatality rate. Given this high rate and the impulsivity associated with suicidal ideation, removing firearm access from at-risk individuals is essential to decrease suicide



## Practice **safer storage** in your household by storing your firearm:

**Unloaded**



**Separately from ammunition**



**Locked up, away, and out of sight**



#SaferStorage

**T4CIP**  
TRAINEES FOR CHILD INJURY PREVENTION

(Continued on page 8)

## Firearm Injury Prevention

(Continued from page 7)

risk. It is important to counsel families about removing firearms and other lethal means of self-harm, including medications and poisons. Families can be advised on keeping firearms temporarily in someone else's home or at a firearm dealer, gun club/shooting range or with the local police.

Some states have extreme risk protection order (ERPO) laws (<https://americanhealth.jhu.edu/implementERPO>) that allow a family, clinician (depending on the state) or law enforcement to ask a judge to temporarily prohibit an at-risk individual from possessing or purchasing a firearm.

### Legislation

Stronger state firearm injury prevention laws are associated with lower firearm fatality rates. Child access prevention (CAP) laws, for example, hold gunowners liable for how firearms are stored when children are in the home.

The Bipartisan Safer Communities Act, passed by Congress in June 2022 after the shooting deaths at Robb Elementary School in Uvalde, Texas, is the first federal firearm-related legislation passed in over 25 years. However, continued advocacy will be needed for additional firearm laws, including those addressing universal background checks, assault weapons bans, safer storage and ERPO.

### Recommendations for pediatricians

- Provide anticipatory guidance to families about the importance and effectiveness of barriers to prevent access to firearms in the home.
- Encourage parents and caregivers to ask about firearms and

their storage where the child may spend time, including relatives' and friends' homes.

- Discuss risks and removal of firearm access for those at risk for suicide and homicide.
- Know state CAP and ERPO laws.
- Learn about hospital- and community-based violence intervention and prevention programs.

Pediatricians interested in advocacy related to decreasing pediatric firearm injuries and deaths can contact their AAP chapter or firearm injury prevention advocacy organizations (see resources).

Dr. Lee is a lead author of the policy statement and technical report. She is chair of the AAP Council on Injury, Violence and Poison Prevention and a liaison from the Society for Pediatric Research to the AAP Committee on Federal Government Affairs and Committee on Pediatric Research.

### Resources

- [AAP Gun Safety and Injury Prevention page](#)
- AAP PediaLink courses on [storing firearms](#) and [counseling on reducing access to lethal means to prevent suicide](#)
- [Information for parents from HealthyChildren.org on gun safety](#)
- [Asking Saves Kids](#)
- [Everytown for Gun Safety](#)
- [Moms Demand Action](#)
- [March For Our Lives](#)

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## Welcome New Members!

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## AAP In the News

### Leading Health Care Organizations Urge Action to Protect Physicians, Hospitals, Patients and Families from Violence

**Groups call on Department of Justice investigation, technology platforms to address harassment and threats of violence against physicians and hospitals**

October 3, 2022

Today, the American Academy of Pediatrics (AAP), American Medical Association (AMA) and Children’s Hospital Association (CHA) unite in support of physicians and hospitals who have been threatened and attacked in recent months.

The groups sent a [letter](#) to Attorney General Merrick Garland urging the Department of Justice to investigate the increasing threats of violence against physicians, hospitals and families of children for providing and seeking [evidence-based gender-affirming care](#). The organizations also call on technology platforms to do more to stop the rhetoric that often incites threats or acts of violence and has led to harassment campaigns across the country, much of it directed at children’s hospitals and the physicians and staff who work there.

“Whether it’s newborns receiving intensive care, children getting cancer treatments or families accessing compassionate care for their transgender adolescents, all patients seeking treatment deserve to get the care they need without fear for their personal safety,” said AAP President Moira Szilagyi, MD, PhD, FAAP. “We cannot stand by as threats of violence against our members and their patients proliferate with little consequence. We call on the Department of Justice to investigate these attacks and social media platforms to reduce the spread of the misinformation enabling them.”

The AAP and AMA collectively represent more than 270,000 physicians and medical students and CHA represents more than 220 children’s hospitals across the country. The groups wrote to Attorney General Garland urging “swift action to investigate and prosecute all organizations, individuals, and entities responsible.”

“Individuals in all workplaces have the right to a safe environment, out of harm’s way and free of intimidation or reprisal,” said AMA President Jack Resneck Jr., MD. “As physicians, we condemn groups that promote hate-motivated intolerance and toxic misinformation that can lead to grave real-world violence and extremism and jeopardize patients’ health outcomes. The AMA will continue to work with federal, state and local law enforcement officials to develop and implement strategies that protect hard-working, law-abiding physicians and other health care workers from senseless acts of violence, abuse and intimidation.”

In addition to the letter to the Department of Justice, the groups call on Twitter, TikTok and Meta, which owns Facebook and Instagram, to do more to prevent coordinated campaigns of disinformation. The organizations ask the platforms to take bolder action when false information is shared about specific institutions and physicians. They also urge social media companies to enforce safety and hateful conduct policies to stop the endangerment of patients, families, physicians and health care staff.

“We are committed to providing safe, supportive and inclusive health care environments for each and every child and family, and the clinicians and staff who are dedicated to caring for children,” said CHA President Amy Wimpey Knight. “Threats and acts of violence are not a solution, nor a substitute, for civil dialogue about issues of a child or teen’s health and wellbeing. At CHA, we are

committed to working across sectors to prevent misleading and inflammatory comments that result in threats to those caring for patients.”

The groups wrote in their letter to Attorney General Garland, “Our organizations are dedicated to the health and well-being of all children and adolescents. We are committed to the full spectrum of patient care—from prevention to critical care. We stand with the physicians, nurses, mental health specialists, and other health care professionals who provide evidence-based health care, including gender-affirming care, to children and adolescents.”

### AAP Statement on Supreme Court Decision in *Dobbs v. Jackson Women’s Health Organization*

June 24, 2022

**By: Moira Szilagyi, MD, PhD, FAAP, President, American Academy of Pediatrics**

“Today’s Supreme Court decision to overturn *Roe v. Wade* means that the once Constitutionally protected right to access an abortion is no longer guaranteed nationwide. This decision carries grave consequences for our adolescent patients, who already face many more barriers than adults in accessing comprehensive reproductive healthcare services and abortion care.

“The American Academy of Pediatrics (AAP) this morning [reaffirmed](#) our longstanding policy supporting adolescents’ right to access comprehensive, evidence-based reproductive healthcare services, including abortion. Today’s ruling means that in many places in the United States, this evidence-based care will be difficult or impossible to access, threatening the health and safety of our patients and jeopardizing the patient-physician relationship.

“In the wake of this ruling, the AAP will continue to support our chapters as states consider policies affecting access to abortion care, and pediatricians will continue to support our patients.”

### AAP Statement on FDA’s Removal of JUUL Products from the Market

June 23, 2022

**By: Moira Szilagyi, MD, PhD, FAAP, President, American Academy of Pediatrics**

“Today’s decision from the U.S. Food and Drug Administration (FDA) to remove all JUUL products from the market represents a major victory for public health. Ever since JUUL products came on the market, they have been appealing to and addicting youth, and pediatricians have been urging FDA to act.

“JUUL has had an outsize role in contributing to the public health epidemic of youth e-cigarette use and today’s action is one essential step to reverse this damage and ensure a tobacco-free future for this generation of young people.

“We also support FDA’s decision to remove JUUL’s menthol products from the market. Menthol-flavored e-cigarettes, with their cooling mint flavor, are no different from other flavors that are used in tobacco products to lure and addict young people. To date, the FDA has not ruled on applications for any other menthol e-cigarette products, and this decision is a step in the right direction.

“It is time for FDA to finish this process and remove all flavored e-cigarette products, including menthol, from the market once and for all. We cannot wait any longer to do what is right to protect the health of children and teens across the country.”

## AAP to Launch New Center of Excellence on Social Media and Youth Mental Health

*Funding from the U.S. Department of Health and Human Services will allow AAP to create a healthier digital ecosystem for children and youth*

The American Academy of Pediatrics was [recently awarded](#) \$10 million (\$2 million/year, renewable up to five years) from the U.S. Department of Health and Human Services (HHS), through the Substance Abuse and Mental Health Services Administration (SAMHSA). The funding will enable AAP to establish a National Center of Excellence on Social Media and Mental Wellness, which the AAP has named Center of Excellence: Creating a Healthy Digital Ecosystem for Children and Youth.

The center will serve as a centralized, trusted source for evidence-based education and technical assistance to support the mental health of children and adolescents as they navigate social media.

“We are thrilled to have been selected to lead and sustain vital work in an emerging field whose relevance has grown, especially over the past few years,” said AAP CEO Mark Del Monte, JD. “With our deep expertise in both mental health and in digital technology, and with the growing crisis in child and adolescent mental health continuing to be an area of organizational focus, there could not be a more important time for AAP to help confront these challenges and use our voice to make needed change for children and adolescents.”

AAP brings a unique developmental perspective to this work: Social media engagement starts in early childhood and continues through adolescence, where algorithms and marketing-driven incentives shape the content youth consume and share, impacting their online experience and mental health.

Accordingly, the center will be led by Medical Directors Megan Moreno, MD, MEd, MPH, FAAP, whose work focuses on adolescents, and Jenny Radesky, MD, FAAP, whose work focuses on younger children. Dr. Radesky and Dr. Moreno were co-authors of the Academy’s current policy statements on media use by children and adolescents.

“As an adolescent medicine physician and researcher, I’ve focused my research career on the intersection of adolescent health and digital media,” said Dr. Moreno. “I am passionate about leveraging research findings for real-life impact for teens and their families, so I am excited to be part of this incredible team to provide families with evidence-based tools to navigate digital media.”

Dr. Moreno is Principal Investigator of the Social Media and Adolescent Health Research Team (SMAHRT); her research focuses on the intersection of technology and adolescent health. SMAHRT has contributed the largest body of evidence in the area of adolescent health and social media to date.

Dr. Radesky is incoming chair of the AAP Council on Communications and Media (COCM) and brings more than a decade of experience as a practicing pediatrician and academic researcher with expertise in child development and behavior, parenting, and media use in younger children.

“Healthy relationships with technology start in early childhood. I am grateful for this opportunity to provide resources that help families choose the digital experiences that are worth their children’s time and attention, raise kids who are critical thinkers about technology, and build social-emotional skills that will transcend online and offline spaces,” Dr. Radesky said.

Growing evidence has established both risks and benefits to social media use. Imbalances in these risks and benefits can harm mental health, exacerbate existing health disparities, and compound systemic inequities for youth.



The center’s goals are to:

1. Improve pediatric mental wellbeing by reducing the risks and leveraging the benefits of social media;
2. Build the capacity of individuals who work with youth to mitigate social media’s impact on mental wellbeing and promote healthy social media use, and
3. Synthesize and promote the evidence base and best practices for healthy social media use via communication, guidance, and other resources.

In addition to the medical directors, the center will be guided by a cross-sectoral Technical Expert Panel comprising educators, clinicians, youth, parent and community representatives, researchers, and industry representatives, and a diverse Youth Advisory Panel whose members will partner in the creation of content and activities.

The center will disseminate evidence around the risks and benefits of social media use and expand and translate the growing field of research around actionable solutions to protect youth mental health online, including family media plans, privacy protections, open communication with trusted adults, and mental health supports.

“Pediatricians have been alarmed for some time by the growing mental health crisis impacting children and adolescents, and we have much to understand about the role of social media in children’s healthy development,” said AAP President Moira Szilagyi, MD, PhD, FAAP. “This work will allow AAP to do what we do best: convene diverse experts, steep ourselves in the research, and work relentlessly, with children and adolescents at the center, until we can create a healthy digital ecosystem that supports and prioritizes their needs.”

## Blueprint for Change for a System of Services for Children and Youth with Special Health Care Needs (CYSHCN)

The Health Resources and Services Administration's Maternal and Child Health Bureau (MCHB) recently released a [Blueprint for Change: A National Framework for a System of Services for Children and Youth with Special Health Care Needs](#). The document serves as a national agenda and framework to advance the system that serves children and youth with special health care needs (CYSHCN) to improve their lives and well-being.

### Elements of the Blueprint

The *Blueprint for Change* is a framework described in a series of articles that comprise a supplement in *Pediatrics*. Together, they describe:

- The sizable, diverse population of CYSHCN
- The public health role in building a well-functioning system of services
- A rationale, guiding assumptions, principles, and strategies to achieve the vision
- The critical areas of equity, quality of life, access to services, and financing of services

**This [special supplement](#) in *Pediatrics* is freely available and includes the [Blueprint/introduction](#) followed by seven articles:**

*Introducing the Blueprint for Change: A National Framework for a System of Services for Children and Youth with Special Health Care Needs*

- *Guiding Principles for a System of Services for Children and Youth with Special Health Care Needs (CYSHCN) and their Families*
- *Children and Youth with Special Health Care Needs: A Profile*
- *Progress, Persistence, and Hope: Building a System of Services for CYSHCN and their Families*
- *Health Equity for Children and Youth with Special Health Care Needs: A Vision for the Future*
- *Quality of Life and Well-Being for Children and Youth with Special Health Care Needs and their Families: A Vision for the Future*
- *Access to Services for Children and Youth with Special Health Care Needs and their Families: Concepts and Considerations for an Integrated Systems Redesign*
- *Financing Care for CYSHCN in the Next Decade: Reducing Burden, Advancing Equity, and Transforming Systems*

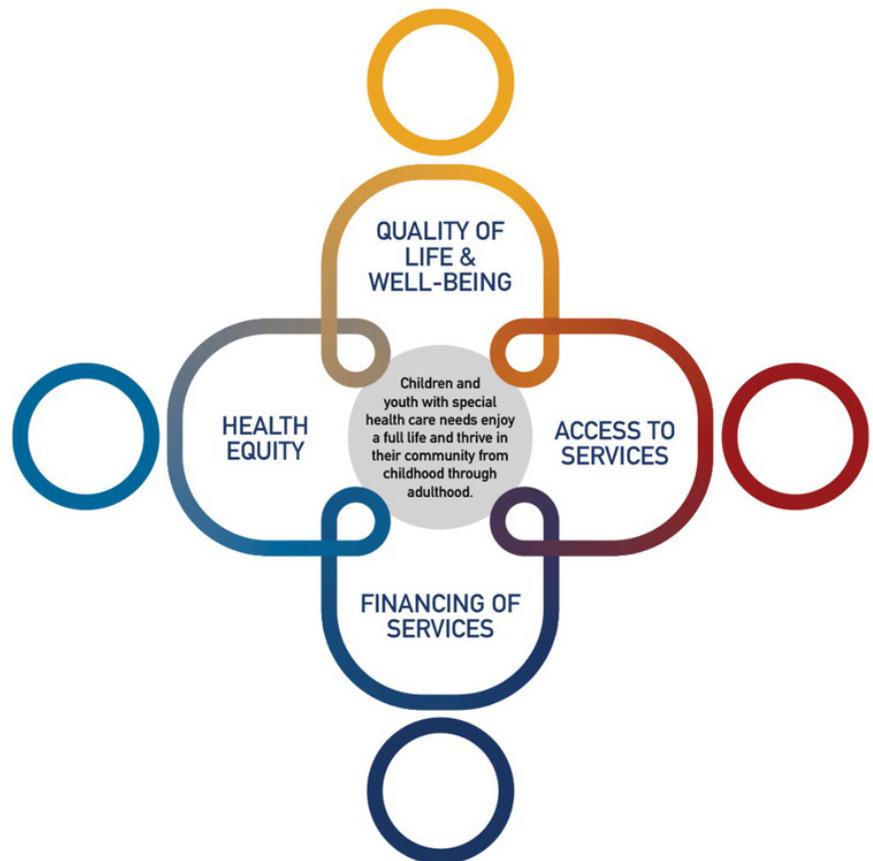
### How You Can Help

Advancing the system for CYSHCN requires leadership, partnership, will, opportunity, persistence, and stakeholders coming together to achieve the vision presented in the *Blueprint for Change*.

Whether you are:

- Self-advocates, youth, family members, and family-led organizations
- Healthcare professionals at the community-level
- Public health professionals and leaders
- National organizations
- State and local organizations
- Academic institutions that support training for healthcare professionals and other allied professions
- Researchers
- Federal agencies

You can read the *Blueprint* and adopt it. Use it as a lens through which you take action. Advocate, inform, share, train, plan, educate others, allocate resources, and coordinate activities that help build a better healthcare system for CYSHCN.



### Calling for newsletter articles!

For our next SOA newsletter, the Spring 2023 edition

Please send proposals to Debnath Chatterjee, Newsletter Editor at [Debnath.Chatterjee@childrenscolorado.org](mailto:Debnath.Chatterjee@childrenscolorado.org) by February 15, 2023





## The Great Investigator Gap in Sponsored Pediatric Clinical Trials

Gina Calarco MPH, BSN, CCRC

Sr Director Strategy & Planning

LabCorp, Rare Diseases, Advanced Therapies, and Pediatrics Team

Email: [gina.calarco@labcorp.com](mailto:gina.calarco@labcorp.com)

The landscape of industry (pharmaceutical or device) sponsored clinical trials in pediatric populations has made enormous gains since regulatory mandates first were introduced in the 1990's. However, the ability to recruit patients into these trials has faced significant challenges thus dampening the progress. A major issue for recruitment is related to the finite number of pediatric research sites interested and capable of conducting these regulatory mandated trials.

In the US the FDA pediatric regulations have been outlined within the Pediatric Research Equity Act (PREA).<sup>1</sup> This legislation has the aim to progress knowledge and data impacting pediatric clinical care through incentives and mandates for conducting pediatric clinical trials following approval of an IND in an adult population. Since this legislation was first introduced in the 1990's, mandates have expanded into pediatric oncology (FDA Reauthorization Act of 2017 (FDARA)<sup>2</sup> and device work (2007 Pediatric Medical Device Safety and Improvement Act).<sup>3</sup> This has led to more pediatric clinical trials and data which offer insights and care decision support resulting in a positive impact to pediatric medicine and patients.

Various researchers have published on the challenges related to recruitment for pediatric clinical trial work. Per a 2018 publication from Hwang et al, nearly 2/3 of pediatric IND trials between 2007 and 2014 were discontinued or had not reached enrollment targets within 6 years of starting.<sup>4</sup> This poses a significant hardship for sponsors, investigators, and most importantly the patients and families participating or looking to the research community and IND/device trials to develop new care options.

Publications and reported metrics have noted several reasons for not meeting enrollment goals.<sup>5</sup> While it is true that pediatric, indication specific populations are limited and even considered rare by some; the 2020 US census showed approximately 22% of the population was less than 18 years of age.<sup>6</sup> This offers perspective to set our expectations and grow our potential to improve how we conduct and meet the recruitment for PREA mandated trials. We will always experience a more limited and shifting pool of pediatric patients but there is the opportunity to expand access to clinical trial work to reach more of the pediatric population.

Having worked in the pediatric clinical trial space for over 15 years, at both a site and now from a contract research organization (CRO) perspective, there is a supply and demand issue at play that is greatly impacting the ability of these trials to enroll and produce meaningful data and expanded choices for pediatric medicine. While there has been needed and successful growth of pediatric investigational new drug trials (demand), there has not been the same growth in developing new investigators and sites with access to a more diverse and broader pediatric population (supply).

The large academic pediatric centers are arguably the best centers for complex indications or advanced therapies where multiple sub-specialists and diagnostic capabilities are required. However, problems arise due to a funnel effect limiting the number of trials an investigator can support both from a recruitment/patient pool perspective but also a resource perspective. Factors affecting the resource funnel include clinical care and academic responsibilities and access to trial coordinators. Many of these centers are also involved with government and consortium work which may be prioritized creating further barriers to successful recruitment and completion of industry sponsored trials. When these known centers are unable to recruit or reject a study due to resourcing,

competition, or lack of patient population the trial often has to extend timelines (at best) or abandon the trial (worst case), as there are only a finite number of experienced sites and investigators with no good mechanism in place to develop new sites and investigators. This leaves valuable research questions unanswered and data unpublished, the exact opposite intention of the regulations.

Within the industry sponsored clinical trial space, CROs and sponsor companies often seek participation from the same investigators and sites, predominantly large academic pediatric centers in urban areas. As noted, these centers house diverse sub-specialty pediatricians, diagnostic capabilities, research experience, and access to known pediatric patient populations. While these centers have conducted quality clinical trial work for decades, and will remain a key entity for research projects, they cannot fill the overwhelming need for pediatric patient enrollment in the expanding clinical trial space. This begs the question for how to increase access to and improve the diversity of pediatric patients recruited into clinical trials while also helping to fix the supply and demand issue currently being experienced.

The pandemic has further exacerbated issues in conducting pediatric clinical trials as we have seen impacts on human resources at the known sites across all research roles, from loss/aging/retirement of pediatrician researchers, nurse study coordinators, administrative or support staff, and the institutional review boards. Even prior to the pandemic, one article noted the impending problem of aging medical researchers and a lack of younger investigators.<sup>7</sup> This leaves us with an even greater risk of delaying or stalling out important work to further advance pediatric clinical care. Those of us working in this space cannot expect the human resource and recruitment problem to fix itself.

A solution, to help address this supply and demand issue affecting recruitment, is to educate, encourage and support more sites and clinicians to become investigators and opt into sponsored clinical trial work. The urban corridor houses a finite amount of the pediatric population, leaving a portion hidden from or inaccessible to clinical trial work simply due to their location and/or utilization of an academic or known pediatric research center. There remains a subset of mandated clinical trial work that could be conducted outside of the large, known research centers and the urban corridor. Finding hospitals and clinics with pediatricians and support from their administration to learn and invest resources towards regulatory mandated, industry sponsored research has been difficult, but is a viable mechanism to help this supply and demand issue.

There is no doubt that key stakeholders, including clinicians, pharmaceutical companies, and CROs, need to work together to help develop the next generation of investigators. There is a need for a shift in how clinical research is factored into the clinical care of pediatric patients. We need more pediatric investigators and sites to offer and conduct clinical trials to build knowledge and access more treatment options proven through good research. This includes private practices and general pediatrician clinics, local/smaller community or non-academic hospitals with pediatricians or pediatric units, as well as partnerships with Integrated Research Organizations (IROs).

The first step is educating clinicians. Programs that support and educate on government regulations and industry sponsored clinical trial work during residency and fellowship training can help enable and build a new generation of researchers. Additionally, CROs and pharmaceutical or device companies are needed to support selection

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## The Great Investigator Gap

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of green sites and investigators recognizing that this involves some risk and added support is required to mitigate this risk. Advanced planning is required for this, and collaboration needs to occur well before a clinical trial begins. Clinical trials should be a conversation that is normalized and apart of clinical care but we first must empower and educate pediatricians to feel confident about participation for themselves and their patients. Structures and tools that support new pediatrician investigators may also come in the form of partnerships with larger academic centers, CROs, or IROs that provide smaller hospitals or private clinics access to education, mentoring, and create a pathway to enter and thrive within the industry sponsored clinical trial space.

We have a clear gap where there is a large amount of pediatric clinical trial work to be done and very finite resources to successfully recruit, collect data, and effect pediatric labeling or the sharing of results, so critical to scientific progress. There is a true need to build a new generation of pediatric investigators and sites that capture a more diverse patient pool and allow for trials to successfully enroll in reasonable timelines to impact clinical care.

This article is a call to action to our members to message, encourage, mentor, and promote the important need

for new pediatric investigators. Consider what you can do at your own hospital, clinic, or company as a mentor to help develop future researchers and sites. Although the pandemic has had many negative impacts to our lives one major success story is the work researchers have done. Our communities are aware of and talking about industry sponsored clinical trials more than ever and now is the right time to encourage the next generation of investigators. The intention is that this article generates further discussion and willingness of how each of us can assist development of sites and investigators to ensure new medicines and innovations are properly and efficiently researched in pediatric patients.

Reprinted with permission from the Spring 2022 newsletter of the AAP Section on Advances in Therapeutics and Technology

## Ethical and Societal Issues Concerning COVID-19 Vaccine for Children

Naomi Lavalent, MD, MA, FAAP, Chairperson AAP Committee on Bioethics

In October, I had the privilege of presenting to the AAP Section on Senior Members at the National Conference & Exhibition (NCE) about some of the important ethical dimensions of COVID-19 vaccination for children. I talked about the approximately 5.5 million American children with reported COVID infection. Today that number is nearly 6.9 million.<sup>1</sup> Sadly the increase in partially and fully vaccinated 12 to 17 year-olds has been modest - 50% of children in this age range are fully vaccinated now, versus 43% at the time of the NCE.<sup>2</sup> In better news, at the time of my presentation there was no vaccine available to younger children, and today, 3.6 million children aged 5 to 11 have received a first dose, after the emergency use authorization was granted on October 29<sup>th</sup>.<sup>3</sup>

Emergency use authorization falls under the umbrella of “pre-approval access” – under an EUA, the FDA must conclude that a product “may be” effective and that its known and potential benefits outweigh known and potential risks. For the COVID-19 vaccine, the US government purchased vaccine doses directly from the manufacturers, and distributed that supply to states, which in turn distributed it to institutions. What’s important to understand about this is that when we prescribe and administer vaccine under an EUA, we are making a *clinical* decision – this is not research. I based my content on a terrific paper by Holly

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Fernandez Lynch and colleagues on the ethical nuances of prescribing under an EUA, particularly in times of scarcity.<sup>4</sup>

The concept of “access vs. perception” is central in medical research ethics and is well demonstrated in much of the fear and frustration clinicians, patients, and parents have experienced during this pandemic. On the one hand we worried about the

(Continued on page 14)



## Ethical and Societal Issues Concerning COVID-19 Vaccine for Children

(Continued from page 13)

potential ramifications of a vaccine being rushed to market before we were certain that it was safe. This was an early concern of mine, fueled by the moniker “Operation Warp Speed”. (In hindsight that term was apt, but at the time it made me nervous.) On the other hand, as pediatric cases skyrocketed, we wondered, “What’s taking so long?” This urgency was beautifully captured in the “Are we there yet?” video released by the AAP after the EUA came through.<sup>5</sup> This tension between the notions that research is a fundamental good from which we all benefit and should embrace with enthusiasm, and that research is a fundamentally risky endeavor that should be approached with a healthy dose of skepticism, is one that we must all grapple with. Dreadful examples of exploitation, racism, classism, and coercion stain our path to modern medical innovation, and the bitter memory of some of these atrocities has been highly salient during this pandemic. In my presentation, I talked about some of the novel and interesting approaches that community and scientific leaders of color took to ensure that the vaccine trials would reflect America’s diversity without unjustly burdening vulnerable or historically disadvantaged groups with the inherent risks of research. The balance of research built on scientific and moral integrity has been artfully distilled down to the idea that these groups should be protected by research, not *from* it.<sup>6</sup>

The key premise that led to the stepwise approach to vaccine approval to progressively younger age groups - “age de-escalation” - is well-established in vaccine research.<sup>7</sup> There is a strong scientific basis for this approach, and exceptions require scientific justification. Of course, we don’t *have* to do it that way - see the terrific paper by Kevin Mintz and colleagues that systematically unpacks the advantages and disadvantages of including children earlier or later in the vaccine trial pathway - the authors consider risks and benefits to study participants, to child health broadly, and the impact on public trust in research.<sup>8</sup>

Vaccine issues reflect and even amplify important child health concepts. First, the toll of the pandemic on our education system has demonstrated the urgency of recognizing that child health and child education cannot ever be fully disentangled. The impact of the pandemic and the potential to modulate that impact by way of vaccination is poignantly illustrated by the price our children paid for the public health strategy of social distancing. Second, as we lament that nearly six months after the EUA was granted for older

children only half of them are fully vaccinated, we must reckon with a deep cultural divide in our society between those that feel great urgency to see our children vaccinated and those that are desperate not to have vaccination thrust upon them.

The pandemic has impacted almost every aspect of our personal and professional lives - that’s as true for bioethicists as anyone else. Any talk I give about it requires extensive revision from the previous iteration, as the state of knowledge, clinical realities, and surrounding context change. The need to quickly pivot to an immediate crisis or controversy is common in bioethics, but no other issue has had been so impactful on my work, or one that has required such frequent recalibration. The opportunity to share my work with this Section motivated me to keep learning about the history, principles, and philosophy of public health ethics in crisis - thanks for keeping me on my toes.

*\* The views represented in this piece are my own, and do not reflect an official position by the AAP Committee on Bioethics*

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Rochester, MN

**Nina Deutsch, MD**  
Liaison, Society for Pediatric Anesthesia (SPA)

**Adam C. Adler, MD, MS, FAAP**  
Liaison, AAP Committee on Drugs (COD)

**Sulpicio Soriano II, MD**  
Liaison, American Society of Anesthesiologists (ASA) Committee on Pediatric Anesthesia (COPA)

### Staff

**Jennifer Riefe, MEd**  
Section Manager  
[jriefe@aap.org](mailto:jriefe@aap.org)

## SPOTLIGHT ON PAIN

Featuring a Question of the Month from SPPM

Julie Good MD, FAAP; Rita Agarwal MD, FAAP

### Pain Management in a Teenager with Malignant Bowel Obstruction and Advanced Cancer

18 y.o man with incurable, recurrent metastatic Ewing Sarcoma presents acutely with severe abdominal pain. His abdomen is distended, and a mini laparotomy reveals diffuse intraabdominal metastasis and inoperable multi-location bowel obstruction. At a post-operative care discussion, he and his family express a primary goal of better pain control, and the patient further states he wants to be more alert. The patient is currently on Hydromorphone PCA 500 mCg per hour basal rate, 300 mCg demand dose with 8-minute lockout, Celebrex 200 mg po bid, gabapentin 1200 mg po tid and acetaminophen 650 mg po every 6 hours. The worst pain is in his bilateral lower abdominal and pelvic area which he rates as 8/10. He is DNAR/DNI and is unable to move much due to pain. He can't sit up in bed, nor can he comfortably lie on his side. His INR is 1.4

The patient, family and oncologists are requesting a regional technique to help manage his pain.

All of the following interventions should be considered EXCEPT

#### Answer Options:

- A. An epidural under deep sedation /general anesthesia
- B. Adjust or rotate opioids and adjuvant medications
- C. Intrathecal morphine catheter
- D. Refuse a regional technique because of increased INR and aspiration risk

*Find answer and discussion on page 16*



### IN CASE YOU MISSED IT... AAP PODCAST: “PEDIATRICS ON CALL”



“Pediatrics on Call” is the AAP’s podcast, exploring the latest news and innovations in children’s health, discussing the science behind child health recommendations, and

providing a forum to hear first-hand from leading experts in child and adolescent medicine. Each 30-minute, weekly episode features interviews about new research and hot topics in the field of pediatrics.

Some recent episodes of interest include:

#### Eliminating Race-based Medicine, Trends in Handgun Carriage

[Episode 113](#) 05/17/2022

In this episode Joseph Wright, MD, MPH, FAAP, at-large member of the AAP Board of Directors, joins the podcast to discuss a new policy statement on eliminating race as a biological proxy in medicine. Hosts David Hill, MD, FAAP, and Joanna Parga-Belinkie, MD, FAAP, also talk with Naoka Carey, JD, EdM, about trends in adolescent handgun carriage.

#### End-of-life Care, Family Advisors in Medical Practices

[Episode 117](#) 06/14/2022

In this episode Jenni Linebarger, MD, MPH, FAAP, FAAHPM, Chair of the AAP Section on Hospice and Palliative Medicine, goes through the new clinical report on guidance

for end-of-life care. Hosts David Hill, MD, FAAP, and Joanna Parga-Belinkie, MD, FAAP, also talk with Suzanne McClintick, MD, and Darci Brosnan about the role family advisors play in medical practices.

#### Pediatrics Research Roundup, Destigmatizing Substance Use Disorder

[Episode 120](#) 07/05/2022

In this episode Alex R. Kemper, MD, MPH, MS, FAAP, deputy editor of Pediatrics, shares a research roundup from the July issue of the journal. Hosts David Hill, MD, FAAP, and Joanna Parga-Belinkie, MD, FAAP, also talk with Rachel Alinsky, MD, MPH, FAAP, about a new policy statement on recommended terminology for substance use disorders.

#### Preventing Child Sexual Abuse in Health Care, Diversity Trends in Pediatric Faculty

[Episode 128](#) 09/13/2022

In this episode Antoinette L. Laskey, MD, MPH, MBA, FAAP, explains guidance in the new policy statement, Protecting Children From Sexual Abuse by Health Care Professionals and in the Health Care Setting. Hosts David Hill, MD, FAAP, and Joanna Parga-Belinkie, MD, FAAP, also talk to Emma Omoruyi, MD, MPH, FAAP, about trends in the diversity of pediatric faculty in academic medicine.

New episodes are released on Tuesdays. See all episodes at [www.aap.org/podcast](http://www.aap.org/podcast).

## SPPM Question of the Month

(Continued from page 15)

### Pain Management in a Teenager with Malignant Bowel Obstruction and Advanced Cancer

#### Answer: D

**Discussion:** End of life care should focus on patient goals for comfort and quality of life, while minimizing the risk of iatrogenic harm. The patient's goals for pain management, and concerns about side effects for current and possible analgesic therapy options should be explored. A patient's prognosis is important in guiding clinicians, since options that would not be considered early in the disease trajectory can be considered as illness advances.

Regional techniques including epidural or intrathecal catheter may improve analgesia and facilitate a patient's goal to maintain or improve alertness. Substantially lower doses of opioids, with or without local anesthesia can decrease sedative and other side effects of systemic opioids and significantly improve analgesia. The risks of placing the catheter and maintaining the infusion must be carefully balanced with these potential benefits. There are several case reports and case series demonstrating efficacy. In children and adults who cannot participate in positioning, the catheter often will need to be placed under anesthesia or sedation. The risks of the anesthetic or sedation will also need to be considered. Techniques of opioid rotation, adding stimulants to improve wakefulness, or adjusting adjuvant medications directed at pain and other side effects may also be considered based on the goals of care. Literature is limited and often each case needs to be individually considered.

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The banner features a dark blue background with a glowing globe at the bottom. At the top center is the SPPM logo, which includes a red figure holding a star, the text 'SOCIETY FOR PEDIATRIC PAIN MEDICINE', and 'Better Care for Children in Pain'. Below the logo, the text 'SPPM 2022 GLOBAL VIRTUAL CONFERENCE' is written in large, bold, white letters. Underneath, the date 'Saturday, November 5, 2022' is displayed. The tagline 'A Continuum of Acute and Chronic Pain' is written in a white, italicized font. At the bottom, the website 'SPPMglobal.org' and the hashtags '#SPPMglobal' and '#PedsPain' are listed in white.