Farewell from the Current Chair
Catherine Kimball-Eayrs, MD, FAAP, IBCLC
COL MC USA
Outgoing Chairperson, Section on Uniformed Services

Friends,

Over the last 12 years, it has been my absolute privilege to serve on the SOUS Executive Committee and, in particular, to serve as your Section Chair for the last four years. So often, in talking both with those in uniform and GS civilians, the most positive aspects of working in the MHS are the people we work with and the patients we serve. Each and every one of you embodies the spirit that is Military and PHS Medicine and it has been a true honor to serve you.

There have been many ups and downs over the last few years, such as transition from a stand-alone USPS to a section meeting embedded in the NCE meeting, and most recently a change to a virtual format these past two years. Yet our SOUS, and the AAP, continue to adapt and thrive, continually ensuring our mission does not fail.

You are in such great hands with our incoming SOUS Chair, Dr. (Col) Courtney Judd and the continued support of our amazing AAP staff member, Ms. Jackie Burke. I can’t wait to see where the next adventure takes us.

One team, one fight.

CKE
Catherine A. Kimball-Eayrs, MD, FAAP, IBCLC
ckimballeayrs@gmail.com

Though constantly changing, there are resources for pediatricians working with COVID-19 patients and families.

For more information, please see AAP Advocacy Report: COVID-19 Response and the AAP website on COVID-19.
Inside this issue:

<table>
<thead>
<tr>
<th>Section</th>
<th>Pages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Letter From the Chair</td>
<td>1</td>
</tr>
<tr>
<td>Fairwell from the Outgoing Chair</td>
<td>1</td>
</tr>
<tr>
<td>Greetings from the Incoming Chair</td>
<td>4</td>
</tr>
<tr>
<td>Section on Uniformed Services</td>
<td>3</td>
</tr>
<tr>
<td>Executive Committee Roster</td>
<td></td>
</tr>
<tr>
<td>For more information or to join the section</td>
<td>4</td>
</tr>
<tr>
<td>AAP and 23 Other Medical Organizations Oppose Reduction of Military Medical End Strength</td>
<td>5-7</td>
</tr>
<tr>
<td>Air Force Consultant Update</td>
<td>7-8</td>
</tr>
<tr>
<td>Army Consultant Update</td>
<td>8</td>
</tr>
<tr>
<td>Navy Specialty Advisor Update</td>
<td>9</td>
</tr>
<tr>
<td>Public Health Service Update</td>
<td>9-10</td>
</tr>
<tr>
<td>Section on Pediatric Trainees Liaison to the Section on Uniformed Services Update</td>
<td>11</td>
</tr>
<tr>
<td>Uniformed Services &amp; the AAP Mentorship Program</td>
<td>12-13</td>
</tr>
<tr>
<td>Uniformed Services University of the Health Sciences Pediatric Update on Student Curriculum and Faculty Appointments &amp; Promotion</td>
<td>14-15</td>
</tr>
<tr>
<td>USU Bushmaster Update</td>
<td>16</td>
</tr>
<tr>
<td>USU AAP Highlight!</td>
<td>17</td>
</tr>
<tr>
<td>Uniformed Services Chapter East (USCE) Update</td>
<td>18</td>
</tr>
<tr>
<td>Uniformed Services Chapter West Update</td>
<td>18</td>
</tr>
<tr>
<td>We welcome contributions to the newsletter</td>
<td>18</td>
</tr>
<tr>
<td>Tools (Original Art)</td>
<td>19</td>
</tr>
<tr>
<td>Myocarditis and COVID-19</td>
<td>20-21</td>
</tr>
<tr>
<td>The Utility of Deploying a Pediatrician</td>
<td>22-23</td>
</tr>
<tr>
<td>Be Informed!!! Get Involved!!!</td>
<td>23</td>
</tr>
<tr>
<td>10 Gender Affirming Healthcare Facts for Active Duty Pediatricians</td>
<td>24-25</td>
</tr>
<tr>
<td>Awards and Highlights from the Virtual AAP NCE SOUS Meeting 2021</td>
<td>26-28</td>
</tr>
<tr>
<td>AAP SOUS Scientific Award Winners</td>
<td>29-30</td>
</tr>
<tr>
<td>Conference on Military Perinatal Research</td>
<td></td>
</tr>
<tr>
<td>COMPRA Update – 2021</td>
<td>31</td>
</tr>
<tr>
<td>Mead Johnson Nutrition Thank You</td>
<td>31</td>
</tr>
<tr>
<td>Save The Date: Call for Abstracts-NCE 2022</td>
<td>32</td>
</tr>
<tr>
<td>Taking the Role of Primary Care Manager to New Heights</td>
<td>33-34</td>
</tr>
<tr>
<td>The Power of Parents in Pediatric Obesity</td>
<td>35-36</td>
</tr>
<tr>
<td>Updated Message from the AAP Department of Membership</td>
<td>36</td>
</tr>
<tr>
<td>Mission Essential: Refugee Mission Reflection</td>
<td>37-40</td>
</tr>
<tr>
<td>Bald Eagle in Flight (Original Photography)</td>
<td>41</td>
</tr>
<tr>
<td>Yellow-rumped (Audubon) Warbler (Original Photography)</td>
<td>41</td>
</tr>
<tr>
<td>Resources and Support for Military Pediatricians via DoD’s OneSource</td>
<td>42-43</td>
</tr>
<tr>
<td>Military Residencies: Hard Work and Hard Play making residents happy every day!</td>
<td>44-46</td>
</tr>
<tr>
<td>Living Longer: An Enjoyable and Healthy 2022</td>
<td>47</td>
</tr>
<tr>
<td>Editor’s Note:</td>
<td>48</td>
</tr>
<tr>
<td>10 Gender Affirming Healthcare Facts for Active Duty Pediatricians</td>
<td>24-25</td>
</tr>
</tbody>
</table>
Section on Uniformed Services
Executive Committee Roster

Col Courtney Judd, MD, MPH, FAAP
Chairperson – Air Force
courtney.a.judd.mil@mail.mil

COL Catherine Kimball-Eayrs, MD, IBCLC, FAAP
Immediate Past Chairperson
Pediatric Specialty Advisor - Army
ckimballeayrs@gmail.com

Col Eric M. Flake
Executive Committee Member – Air Force
Pediatric Specialty Advisor-Air Force
eric.m.flake2.mil@mail.mil

Maj Megan B. McDonald, MD, FAAP
Executive Committee Member – Air Force
megan.b.mcdonald2.mil

CDR Bridget Cunningham MD, FAAP
Executive Committee Member – Navy
bridget.k.cunningham.mil@mail.mil

CDR Christopher Foster, MD, FAAP
Executive Committee Member – Navy
christopher.foster2@usuhs.edu

LCDR Andrew J Delle Donne, DO, FAAP
Executive Committee Member – Navy
andrewdelledonne@gmail.com

Jennifer Wiltz, MD, MPH, FAA
Pediatric Specialty Advisor – Public Health Service
jgc2@cdc.gov

COL Ashley M. Maranic MD, FAAP
Executive Committee Member – Army
ashley.m.maranic.mil@mail.mil

LTC Ryan Flanagan, MD, FAAP
Executive Committee Member – Army
ryan.p.flanagan2.mil@mail.mil

LTC Jeffrey R Limjuco MD, FAAP
Executive Committee Member – Army
jeffrey.r.limjuco.mil@mail.mil

COL Patrick W. Hickey, MD, FAAP
Liaison, USU
patrick.hickey@usuhs.edu

CPT Saira Ahmed, MD, FAAP
Liaison, Section on Pediatric Trainees
saira.ahmed.mil@mail.mil

CAPT Sean D. Sullivan, MD, FAAP
Pediatric Specialty Advisor - Navy
sean.d.sullivan4.mil@mail.mil

Lt Col Candace S. Percival, MD, FAAP
Newsletter Editor
candace.s.percival.mil@mail.mil

Staff

Jackie Burke
Section Manager
jburke@aap.org

Mark A. Krajecki
Newsletter Production Specialist
mkrajecki@aap.org

Membership in the Section and Chapters is encouraged for all uniformed services members of the AAP.

Notification of desire for membership, subscription requests and address changes should be sent to:
AAP Division of Pediatric Practice
345 Park Blvd.
Itasca, IL 60143
Phone: 800/433-9016
Fax: 847/434-8000
E-mail: membership@aap.org

For an application visit https://fs25.formsite.com/aapmembership/affiliate/secure_index.html

Copyright© 2022
American Academy of Pediatrics
Section on Uniformed Services
Greetings from the Incoming Chair

Courtney Judd, MD, FAAP
Col, MC, USAF
Incoming Chairperson, Section on Uniformed Services

Hello, Section on Uniformed Services (SOUS) members!

I am Col Courtney Judd, and I have now officially taken on the role of SOUS Chair, as of 01 November 2021. Before I introduce myself, I want to express my gratitude to COL Catherine Kimball-Eayrs for her many years of service to the SOUS, and especially for her wisdom, dedication, and passionate leadership over the past 3 years as Chair. Thank you, CKE!

For those of you who do not know me yet, I am an Active Duty general pediatrician who is passionate about military pediatrics and medical education. I am currently assigned to Naval Medical Center Portsmouth. After more than 18 years of service in the Air Force, I understand how important this SOUS community is for the health of our individual members and our overall mission. Over the next 3 years, I will be working closely with the SOUS Executive Committee as we engage in strategic planning to articulate our priorities and to continue to provide advocacy and innovative solutions to optimize the health, well-being, and care of our military patients and their families. There is no better network of people with whom to share this journey than you, the members of the SOUS.

I hope that many of you were able to join in for the virtual delivery of our annual Uniformed Services Pediatric Seminar (USPS). Thank you to everyone who made the event a success, especially the USPS Program Chairs (Lt Col Candace Percival and MAJ Liz Perkins), the Chairs of the Scientific Awards Competition (LTC Jeff Livezey and Maj Michelle Kiger), and, as always, the incomparable Jackie Burke! Congratulations once again to all of our award winners! The quality and depth of submissions to our conference each year is always inspirational.

I am sure that I speak for all of us when I say that I am very hopeful that 2022 will allow us the opportunity to meet in person once again for the AAP National Conference and Exhibition (NCE). Please mark your calendars and plan to attend the NCE from October 7-11, 2022, in Anaheim, CA. We will move forward optimistically with our planning for a live USPS event within the NCE.

If you have any questions, concerns, or ideas, please feel free to contact me via my email or cell phone number. I am always eager to hear more of the stories of our members, and I want to know how the Section can work to serve you better in the future. I look forward to working alongside all of you over the next few years!

Sincerely,
Courtney

Courtney Judd, MD, MPH, MHPE, FAAP
Col, USAF, MC
Chairperson, AAP Section on Uniformed Services (SOUS)
Email: courtney.a.judd.mil@mail.mil
Cell: (210) 632-9404

For more information or to join the section…

visit our website at: http://www.aap.org/pedsuniform
and our Collaboration Site at: collaborate.aap.org/sous
AAP and 23 Other Medical Organizations
Oppose Reduction of Military Medical End Strength

(re-printed with permission)

October 6, 2021

The Honorable Jack Reed, Chairman
The Honorable James Inhofe, Ranking Member
Senate Armed Services Committee Senate Armed Services Committee
228 Russell Senate Office Building 228 Russell Senate Office Building
Washington, DC 20510 Washington, DC 20510

The Honorable Adam Smith, Chairman
The Honorable Mike Rogers, Ranking Member
House Armed Services Committee House Armed Services Committee
2216 Rayburn House Office Building 2216 Rayburn House Office Building
Washington, DC 20515 Washington, DC 20515

The Honorable Kristen Gillibrand, Chairwoman
The Honorable Thom Tillis, Ranking Member
Senate Armed Services Committee Senate Armed Services Committee
Subcommittee on Personnel Subcommittee on Personnel
228 Russell Senate Office Building 228 Russell Senate Office Building
Washington, DC 20510 Washington, DC 20510

The Honorable Jackie Speier, Chairwoman
The Honorable Mike Gallagher, Ranking Member
House Armed Services Committee House Armed Services Committee
Subcommittee on Military Personnel Subcommittee on Military Personnel
2216 Rayburn House Office Building 2216 Rayburn House Office Building
Washington, DC 20515 Washington, DC 20515

Dear Chairman Reed, Ranking Member Inhofe, Chairman Smith, Ranking Member Rogers, Chairwoman Gillibrand, Ranking Member Tillis, Chairwoman Speier, and Ranking Member Gallagher:

As you finalize the Fiscal Year (FY) 2022 National Defense Authorization Act (NDAA), the undersigned organizations representing healthcare clinicians and educational institutions that comprise the backbone of the Military Health System (MHS) would like to express our concern with the continued push to significantly reduce military medical end strength. A report sent to the House and Senate Armed Services Committees in late August by the Department of Defense (DoD) and the Defense Health Agency (DHA) proposes to reduce military medical billets by 12,801 positions. While lower than other recent proposals to reduce military medical billets, reductions of this size are alarming and fail to recognize the value of the uniformed medical clinician. As such, we strongly urge you to include language in the final NDAA conference report from House Section 721 that would halt any reductions in medical billets until further analyses can be conducted.

Section 721 in the House bill addresses continued concerns among military families, medical clinicians and educators alike regarding DoD/DHA moving forward with proposed reductions and realignment of military medical billets, despite not yet fulfilling Congressionally mandated requirements. According to the recent report submitted to the Congressional Armed Services Committees, DoD and DHA are proposing to reduce military medical billets by 12,801.i Among many medical clinicians, this includes 150 family physicians, 73 general pediatricians and 29 pediatric subspecialists, 70 behavioral health/mental health providers, 54 obstetrician-gynecologists, and 33 internal medicine physicians as well as 97 related internal medicine subspecialists. In addition, the services also propose to eliminate 136 licensed practical nurses and 81 advanced practice nurses. While less than the Department’s initial FY 2020 request of 17,005, our organizations remain greatly concerned about the potential wide-ranging impacts of these reductions on access and quality

Continued on page 6
of health care services for members of the military and their dependents. We are also concerned that DoD and DHA have not provided sufficient analyses that local areas surrounding military medical treatment facilities (MTFs) will be able to appropriately serve affected beneficiaries if care is transferred to the civilian sector.

In recognition of these concerns, Section 721 of the House bill modifies previous limitations imposed in the FY 2020 and FY 2021 NDAsas on the realignment or reduction of military medical manning end strength. Specifically, it extends the halt on reduction or realignment to a year after the date of the enactment of the FY 2022 NDAA. It adds billet validation requirements determined pursuant to estimates provided in the joint medical estimate under section 732 of the FY 2019 NDAA and also requires a Comptroller General report within one year of enactment on the analyses used to support any reduction or realignment of military medical manning, including any reduction or realignment of medical billets of the military departments.

The inclusion of Section 721 in the final FY 2022 NDAA conference report is essential to preserving access to care for our servicemembers and their families, particularly as America is still grappling with the COVID-19 pandemic. The COVID-19 public health crisis has impacted nearly all aspects of life for individuals across the country, including service members and their families. Members of the Armed Forces and their families are already experiencing disruptions to health care services, childcare, education, permanent change of station orders, finances, and employment, among others. While there was a sense earlier this spring that we might have been getting control of the pandemic with the introduction of COVID-19 vaccines, the latest surge of the virus being spurred by the Delta variant shows that we are still in the grips of the virus and that it continues to stress health care systems and health care clinicians across the country, including facilities and physicians staffing the MHS. Many uniformed clinicians have been utilized to provide surge capacity to help run civilian hospitals and COVID-19 vaccination clinics around the country, proving once again the value of the uniformed clinicians to respond to public health emergencies. In addition, even once spread of COVID-19 is more thoroughly contained in communities, there will likely be long-term effects that remain, including physical and mental health symptoms.

Many of the undersigned organizations have raised concerns about DoD and DHA's proposed cuts in previous years, noting that they would be detrimental to the more than 9.6 million TRICARE beneficiaries, including 2 million children, who receive care through the MHS. Moving forward with proposed reductions, while health care services are already being disrupted for beneficiaries and uniformed and civilian physicians are already overburdened, would simply exacerbate the devastating impacts on service members and their families. Further, we are also concerned about what these proposals mean for Graduate Medical Education (GME) and training programs, in which some 30 GME positions would be eliminated, especially at the Uniformed Services University of the Health Sciences (USUHS), that help train and supply the MHS with expertly trained uniformed medical clinicians that provide needed care for our military servicemembers and their families.

In light of these concerns, we believe it is wholly appropriate to delay any reductions or realignments in military medical billets until the Comptroller General’s office has conducted a thorough study of the analyses conducted by DoD and DHA for their proposed reductions. We owe it to the members of the Armed Forces and their families to ensure that we have conducted proper oversight and analysis on the optimal alignment of the Military Health System.

We appreciate your attention to this letter and urge you to consider the medical needs of members of the Armed Forces and their families and work to pass a bill that preserves and ensures the continued progress of the military medical workforce. This can be done by including language from House Section 721 in the final conference report.

Sincerely,

Academic Pediatric Association
American Academy of Allergy, Asthma and Immunology
American Academy of Family Physicians
American Academy of Neurology
American Academy of Ophthalmology
American Academy of Pediatrics
American Association of Clinical Endocrinology
American College of Allergy, Asthma and Immunology
American College of Obstetricians and Gynecologists
American College of Osteopathic Pediatricians

Continued on page 7
American College of Physicians  
American Geriatrics Society  
American Group Psychotherapy Association  
American Medical Association  
American Pediatric Society  
American Psychiatric Association  
American Society for Gastrointestinal Endoscopy  
Association of American Medical Colleges  
Association of Medical School Pediatric Department Chairs  
The Gerontological Society of America  
National Association of Pediatric Nurse Practitioners  
National League for Nursing  
Society of General Internal Medicine  
Society of Hospital Medicine  

Air Force Consultant Update  
Eric Flake, Col, USAF, MC  
eric.m.flake2.mil@mail.mil

I am proud to be a pediatrician! We concluded the Uniformed Services Pediatric Seminar and the National Conference and Exhibition recently and I was honored to be part of such a strong cadre of leaders/advocates and service-minded individuals who dedicate their lives to caring for those in need. As you may know, the AAP has advocated strongly for military pediatrics and the worldwide contribution of specialized expertise in caring for military families.

We are part of a very large system that often seems chaotic and having multiple priorities. Many of you may feel like me that the changes to our medical system, limitations of funding, challenges with staffing, and ongoing statements about our profession’s usefulness in the military often make it difficult for us to care for our primary objective – military kids.

For our wellness and to continue to provide the best care for military children, we must push forward through change and maintain our position as some of the most trusted experts on military family readiness. We can hone our leadership skills, partner with other service support agencies that also are concerned about family readiness, and speak out about how family readiness is one of the most critical components of a medically ready force. In addition to caring for today’s families, we are also preparing the next generation of service members to protect our country. Never underestimate the impact you have on military families. I encourage you to continue advocating and be opportunistic during dynamic change!

Changes are a part of life. Using the airplane example, it is incredible how many changes airlines have gone through in the past hundred years. I see these changes as opportunities for us to influence a better way to care for our families and while also maintaining our wellness. For example, I am a strong advocate for requiring an entire team to perform your duties. In my opinion, there should be no expectation for you to complete a full clinic load without a full staffing model. A staff reduced by 75% or 50% should not be expected to have 100% productivity. I equate this to the airplane again. A flight crew would never take off without only being partially staffed.

Additionally, our responsibility is to speak out for the quality of care military kids receive both on and off base. For example, if our partners in family health (PA, NP, Family Physician) do not have the ongoing exposure to kids to maintain their credentials for children 0-18 then we have the responsibility to help them assess their capabilities. I am concerned that many non-pediatric trained providers are expected to see kids from 0-18 that need additional training to maintain their credentials. We have a role in serving as a base pediatric specialty consultant by providing additional training and oversight. This critical function also needs to be part of our job and accounted for in our workload. Medical education, whether in a formal residency training program or informal with a colleague that needs additional help to refresh their skills, must be a recognized decrement in overall productivity expectations.

Continued on page 8
Every year, many of us have to make the hard or easy decision to separate and decide where we will be next year. The moving process is not easy. It is challenging to know who are separating and what vacancies are open for those staying in and moving next year. We do our best to accommodate requests during this dynamic process, including some bases having reduced pediatrics or increased depending on the number of military children that we continue to provide care. As some families receive more care in the network, some bases are pushed to balance on-base and off-base care. Due to this movement and force reduction, 20,000 fewer AF children are empaneled now than three years ago as you can imagine, these numbers impact staffing.

I am incredibly proud to serve with so many outstanding individuals that do the incredible work day in and day out. It is a humbling honor to serve as your consultant. My thanks to all, particularly those called up to serve in many other capacities (FEMA taskers, COVID specialists, and Humanitarian Refugee Care).

In summary, I ask that we;
• continue to maintain realistic expectations
• doing the best with what we are given but not do more with less
• inform leadership the impact of staffing shortages on patient safety and productivity
• be a lifelong learner looking for ongoing training/leadership opportunities
• seek assistance from the AAP (Uniform Services Chapter and Section)
• #1 - Be well.

Army Consultant Update
Catherine Kimball-Eayrs, COL, USA, MC
catherine.kimball-eayrs@usuhs.edu

Colleagues – I recognize that each time I have written one of these, I talk about how this year is one full of amazing things, but it just continues to be true. From COVID surge responses to stepping up support during the Afghan crisis, this community has done its part to complete any task required.

Your ability to fulfill countless roles, from treatment facility general pediatricians to battalion/brigade surgeons to senior hospital leadership, and everything in between, makes my job easy as I explain how uniformed pediatricians are key to the Army mission. Because of your dedication, Army Pediatrics is alive and well and has full support from all of our senior leaders.

If nothing else, this year has shown many things for which I am grateful, and that includes this amazing community of Army pediatricians! Thank you for all you do and please know that it does not go unnoticed. Please reach out to me at catherine.kimball-eayrs@usuhs.edu if there is any way I can provide support.

COL Catherine A. Kimball-Eayrs, MD, FAAP, IBCLC
Navy Specialty Advisor Update
CAPT Sean D. Sullivan, MD, FAAP
sean.d.sullivan4.mil@mail.mil

Navy Pediatrics Island Style
Hafa adai from Guam where Navy’s Pediatric day begins.
LCDR Heather Soloria, Naval Hospital Guam

Here in Guam we’re settling in with our new team. While it seems like endless summer, 13 degrees above the equator in the South Pacific, we have gratefully seen some return to the seasonality of pediatrics with school physicals and respiratory illness (fortunately not heavily COVID-19) amid the shuffle of a busy PCS season for our pediatricians and our patients. We have been doing the daily work of pediatricians - probably not unlike our colleagues stateside with requests for COVID testing and catch up immunizations. Fortunately, mask mandates and social distancing prevail due to civil ordinances and we have not seen an inpatient surge of pediatric COVID-19 patients. We shall see what the fall brings as things sometimes take time to show up here in Guam.

The pandemic’s impacts and the geographic distance of being on a remote Pacific island continue to make specialty evaluations difficult and strain threadbare pediatric mental health resources. Still, there are reasons to be optimistic. We welcomed a Neonatal Stabilization Team of a neonatologist, NICU RNs, and a respiratory therapist led by the Neonatology Specialty Leader, Dr. Lisa Peterson, and followed shortly by Dr. Jamie Overbey. The team’s presence alongside our team helps to ensure neonatal stabilization until MEDEVAC and train our staff in the care of vulnerable neonates. This has been a joint effort across MTFs and military branches and we welcome the support.

We said farewell and following seas to Drs. Allie Wessner, Brandon Costello, and Sarah Anderson who took the utmost care of the families here during the toughest time of the pandemic including being called to service during the USS Theodore Roosevelt extended visit. Their efforts help the Naval Hospital Guam team earn a Meritorious Unit Commendation while keeping the Pediatrics department at the top for hospital-wide patient satisfaction. Theirs is a tough act to follow.

We welcomed three new staff pediatricians (Drs. Chris Burnett, Kaitlyn Mosteller, and Kelly Richmond) this PCS season and with them new energy and process improvements. In their short time onboard, we continue to leverage our lifelines of telehealth portals like the Global Teleconsultation Portal, video telehealth consults with pediatric sub specialists at Tripler Army Medical Center and Navy Medicine and Readiness Training Command San Diego, and the text/call to our friendly mentors stateside.

I am ever so impressed by my colleagues and those sent here to help us. Hoping that one day soon the SOUS can meet in person to share the lessons learned and challenges overcome in an ever changing landscape for military pediatrics.

Public Health Service Update
CAPT Jennifer Wiltz
igc2@cdc.gov

Hello fellow USPHS officers and colleagues,

I’d like to give a special nod of appreciation to all USPHS officers who continue to answer the call to public health service, wherever they are needed. USPHS officers serve in their critical daily duties, fulfill the ongoing COVID-19 Response activities, and deploy for the Unaccompanied Children Response at the southwest border as well as aided the Afghan Repatriation mission.

Officers on the COVID-19 response rapidly accelerated and prioritized work to understand the burden and severity of COVID-19 on children, including any changes over time and with the Delta variant. Several PHS pediatricians are working with the Health Systems Workers Safety Task Force of the CDC COVID-19 response to investigate severity of pediatric COVID-19 now that Delta is the predominant strain and also evaluate care capacity in pediatric hospitals. As part of this assessment, pediatrician LCDR David Siegel led an MMWR report which described the increasing rates of pediatric COVID-19 cases, ED visits, and admissions during July and August 2021. Of importance, the rate COVID-19 hospital admissions among children and adolescents was 4 times higher in the US states with the Continued on page 10...
lowest vaccination coverage compared to those with the highest vaccination coverage. These findings have been incorporated into CDC and White House key messages to encourage vaccinations for all eligible individuals. CDC continues to evaluate the changing burden of COVID-19 in the pediatric population.

Following the recent approval of the COVID-19 vaccine for 5- to 11-year-olds, Pediatric PHS officer, CDR Kevin Chatham-Stephens, and others on the Vaccine Task Force ensure readiness for the vaccine distribution and administration. They provided initial guidance with jurisdictions and professional societies to deliver key information and aid in planning. Vaccine.gov can be used to find a vaccine administration location near you.

Under the leadership of CAPT Michael Bartholomew (Pediatrics), the Director for the Division of Health for Unaccompanied Children (DHUC) in the Office of Refugee Resettlement (ORR) in ACF, LCDR Shaanan Meyerstein (Pediatrics) and CDR Sarah Hartnett (Pediatrics) have played key roles in the medical oversight and coordination of care for Operation Artemis, which has cared for tens of thousands of Unaccompanied Children who have crossed the border this year and who have been placed in several Emergency Intake Sites around the country. ORR has been supported by numerous deployed USPHS Pediatric officers both supporting DHUC at Headquarters and serving as Federal CMO’s in the field at the EIS sites including CAPT Lara Akinbami, CAPT Kip Baggett, CDR Matt Gianferente, CDR Aly Goodman, CDR Julia Hutter, LCDR Jennifer Nelson, CAPT Laura Polakowski, RADM Paul Reed, CDR Melissa Reyes, CAPT Paul Sato, and CDR Witza Seide. In addition to the increased arrivals at the Southwest Border, ORR has also been supporting Operation Allies Welcome and the care of Unaccompanied Afghan Minors who have migrated in recent weeks from overseas. Overall, the UC program is responsible for the provision of wrap around care services, including the delivery of healthcare services for Unaccompanied Children after they are referred by Department of Homeland Security Customs and Border Protection until they can be safely unified with family in the US or placed in long term foster settings in the absence of a viable sponsors. Also, for Operation Allies Welcome, pediatricians CDR Kevin Clarke and CAPT Maggie Brewinski-Isaacs worked for Department of State on the response.

USPHS officers are being called on like never before. They stand ready for immediate activation at a moment’s notice for multiple response priorities. LCDR Jennifer Nelson, who is boarded in pediatrics and in lifestyle medicine, is a leader in mental health advocacy for our own officers. At the time of this report, the COVID-19 Response activation has been ongoing for over 650 days. As we take care of the nation, do take time for yourself and check in on others as the marathon continues.

There are multiple resources available to support officers as they continue to increase their resiliency during this trying time. Additionally, with increasing rates of mental health disorders, including attempted or completed suicide, among both children/adolescents and active-duty service members, it is important for healthcare professionals caring for military families to screen and intervene, if appropriate, for both children and their caregivers. Providers should be familiar with resources available to their patients and within their communities and help facilitate connection to those services.

I am very proud of the work we are doing and I hope you know your contributions are appreciated. These are just a few examples of pediatric officers that I’ve seen recently who are making a difference. Thank you all for your continued support of these responses and each other as we work together to end the pandemic and support child health in our nation.

In Officio Salutis,
CAPT Jennifer Wiltz, MD, MPH, FAAP, FAHA, USPHS Liaison to AAP SOUS
This article reflects opinions of the author and is not an official statement of HHS
Section on Pediatric Trainees
Liaison to the Section on Uniformed Services Update

CPT Saira Ahmed
Adolescent Medicine Fellow (PGY-6)
ahmed.saira@gmail.com, saira.ahmed.mil@mail.mil

The AAP Section on Pediatric Trainees (SOPT) has been hard at work this year! Here are some highlights from the past year.

The AAP SOPT, the largest section in the academy, has 2,047 medical student, 12,021 resident, and 3,442 fellowship trainee members as of October 2021.

At the 2021 AAP Annual Leadership Conference, two of the top eleven (there was a tie for number 10) resolutions were written by SOPT members. Resolutions are written and submitted by AAP members every year and are statements that help to advocate for change to improve child health and wellbeing, to support pediatricians, and to improve the AAP as a whole. Of note, the number 4 resolution was written by one of our own pediatric residents, Capt Brittany Flemming, MD (Class of 2022) and recent graduate, CPT Christin Folker, MD (Class of 2020) from NCC Pediatrics. The resolution entitled “Combatting Racism in Graduate Medical Education Through Accreditation Council for Graduate Medical Education (ACGME) Curriculum Changes” asks that the AAP “petition the American Board of Pediatrics and the Accreditation Council for Graduate Medical Education (ACCGME) to require graduate medical education (GME) programs to include a curriculum addressing racism and bias (including implicit bias), and their effects on the work environment and care delivered to patients.” Their resolution was selected from about 60 resolutions submitted by various AAP groups and members, and it is a huge honor to be selected!

The 2020-2021 SOPT Advocacy Campaign was called Unite for Kids Mental Health and is wrapped up their last quarter on Racism, Adverse Childhood Experiences, Toxic Stress and Resiliency in October 2021. Other topics covered in this campaign included community and school based mental-health for children and adolescents, substance use in the pediatric population, and mental health advocacy for populations with unique healthcare needs. The new 2021-2022 campaign was announced at the NCE in October 2021 and is entitled “Rx Against Racism – Racism as a Public Health Crisis.” The yearlong campaign will be broken up into trimesters, focusing on equipping with the knowledge and skill sets to implement programs to fight systemic racism in their communities and institutions and to share what they have learned with others. You can check out https://collaborate.aap.org/SOPT/Pages/SOPT-Advocacy-Campaign.aspx for more information.

The SOPT has also started to record webinars on various topics which are available to all AAP members. One highlight of these webinars is a series entitled “Subspeciality 101” which helps showcase the various subspeciality fields for pediatric trainees. Check out https://collaborate.aap.org/SOPT/Pages/MediaCenter.aspx to view these webinars.

In addition, the AAP Mentorship Program is looking for more subspecialty mentors. Your participation can vary from formal to “flash” mentoring depending on your availability. Residents and fellows, if you are looking for a mentor, this is a great opportunity to find someone as well. For both mentors and mentees, you can specify your military branch in your profile, and you can also filter your search for mentors or mentees based on military branch. Check out https://aapmentorship.chronus.com/about to sign up.

Lastly, please check out what the SOPT is up to on social media. The SOPT News and Views Blog can be found at https://collaborate.aap.org/SOPT/Pages/News-and-Views-Blog.aspx. You can also follow SOPT on Twitter @AAPSOPT or on Facebook at facebook.com/AAPSOPT.
Uniformed Services & the AAP Mentorship Program

Overview
Mentorship is an important tool for professional development and has been linked to greater productivity, career advancement, and professional satisfaction. There is an opportunity among uniformed services pediatricians to mentor each other on training choices, focused career development, professional development, and promotion. The AAP recognizes that mentorship is critical in helping to nurture and grow future leaders and that a mentorship program is key to career development.

The AAP Mentorship Program seeks to establish mentoring relationships between trainees/early career physicians and practicing AAP member physicians.

Connect with others and strengthen the field of pediatric uniformed services.

What are the goals?
The AAP Section on Uniformed Services (SOUS), Uniformed Services Chapter East, and Uniformed Services Chapter West aim to promote career and leadership development. Physician mentors will have opportunities to further develop leadership skills and learn about emerging trends from the next generation of their peers. Physician mentees will gain a trusted advisor and learn methods to enhance career training and advancement.

How does it work?
Participants will complete an online mentor/mentee profile form. The profile form collects information on education, training, subspecialty interests, practice/professional/clinical interests, and the amount of time the participant is willing to commit; these factors all facilitate the matching process. Mentor/mentee pairs will have the ability to meet traditionally in person (if they choose a local match) or use one of several online tools to meet virtually.

What is the time commitment?
The program offers opportunities for long-term (one full academic year) or short-term “flash” mentoring. Mentors/mentees will be asked to set regular phone meetings to discuss mentee goals, objectives, and progress. Mentors/mentees should also answer all communications in a timely manner.
Uniformed Services & the AAP Mentorship Program

Who can participate?
All national AAP members in good standing are invited to participate. Visit http://bit.ly/2wluh3N for information about how to become an SOUS member or renew your membership.

How can I find another uniformed pediatrician?
You can search for other users in the Mentorship program as a mentor or mentee easily. Simply filter by the ‘designation’ field and look for those with the ‘Uniformed Services’ credential.

How do I get involved?
Visit http://bit.ly/22rvQVx to access the AAP Mentorship Program. You’ll be asked to sign in with your AAP login and password. You can sign up to be a mentor, mentee or both, as well as long-term or flash mentoring.

How do I get more information?
• Send an email to mentorship@aap.org.
• Visit http://bit.ly/2eH0CRI.
• Contact Tina Morton at tmorton@aap.org with any questions about the AAP Mentorship Program.

Visit us:
• aap.org/pedsuniform
• uschapterwest.com
• facebook.com/UniformedServicesChapterEast
Greetings from Uniformed Services University! The Department of Pediatrics was pleased to welcome the pediatric clerkship directors to campus for a School of Medicine-wide meeting of site directors. Eleven pediatric faculty members from across the Military Health System were able to join (8 in-person, 3 remotely). During this week, directors shared best practices in student education, discussed challenges and solutions, and both reviewed and suggested changes to the clerkship curriculum. Pediatric components of the pre-clerkship and clerkship curriculum are incredibly important tools for establishing the foundational knowledge, skills, and abilities that USU graduates will come to rely on in caring for children in the future. One out of three USU graduates will directly provide medical care to children as a core part of their primary duties in the specialties of Pediatrics, Family Medicine, and Emergency Medicine. The incredible teaching that so many of you provide to these students has a lasting impact across the Military Health System.

I would also like to offer a few reminders about the faculty appointment and promotion process. My overarching goal and philosophy is to ensure that all pediatricians working in the Military Health System, as well as colleagues from Health and Human Services who can find a way to support our mission, see USU as their academic home. Whether assigned as a pediatrician at a remote duty site overseas, serving an operational tour as a general medical officer, or assigned to one of the GME hubs, all of you make valuable contributions to improving the health and well-being of children by sharing your knowledge and skills with peers, trainees, nurses, physician assistants, independent duty corpsmen, corpsmen and medics. USU wants to recognize that.

Initial faculty appointments at the Instructor or Assistant Professor Rank can be applied for through an on-line system. Step 1: To Access the online site, first request a Single Sign On (SSO) account at https://apps.usuhs.edu/account-registration/. Ms Diana Lanahan, the Department of Pediatrics Administrative Officer should be selected as the approval point of contact: diana.lanahan@usuhs.edu. If you receive an error message, or are otherwise having problems, you can also e-mail sakaihelp@usuhs.edu. Once your account is created go to the Faculty Appointment Workflow: https://workflow.usuhs.edu. The workflow has a “how-to” video and labelled locations to submit up to 5 documents, available on the site. The first 4 documents are required. Command (or designee) endorsement is also required, and can either be submitted as a signature line on the Letter of Support, or as a separate Command Letter.

1. CV – Make sure your CV indicates your involvement in teaching members of the MHS community. No CV format is required, but the AAMC offers a great CV template if you are in the early stages of building an academic CV.
2. USU Form 107 – Only fill-out the fillable sections.
3. USUHS Faculty Form – Please be sure to include your personal email and cell phone numbers so that we can still reach you if military emails change or you separate / retire from service.
4. Letter of Support – This letter is typically written by the Program Director or Department Chair. The required command endorsement can be included as a signature line on this letter.
5. Command Letter – Optional document to submit, if the command endorsement is not on the Letter of Support.

For those faculty, particularly assistant professors who have been in that rank for four or more years (not including time in a GME program such as a fellowship), the Department of Pediatrics Faculty Development Committee should be reviewing your CV to discuss opportunities and criteria for promotion in rank. Each of the medical centers associated with a residency program has a faculty member representative to that committee. While your local representative can play an important role advising you, all members of the faculty-including those not assigned to the medical centers should feel free to reach out to the committee via email: ped-faculty-promotions-ggg@usuhs.edu.

I would like to offer my congratulations and gratitude to the following faculty for their academic promotions this past year-

Continued on page 15
It is my honor to serve and support each of you as the Chair of Pediatrics at USU, and I am so incredibly impressed with the caliber of teaching that you provide to students, residents, fellows and other colleagues within the MHS. Thank you for your support to our collective mission to build the most robust academic environment possible.

Patrick Hickey, MD, FAAP, FIDSA
COL, US Army
This October, USU medical and graduate nursing students completed their culminating field practicum, Bushmaster, in Ft Indiantown Gap, Pennsylvania. Initially championed by Col Courtney Judd (USU Faculty, NMRTC Portsmouth), pediatric case scenarios were new to the Bushmaster exercise only two years ago. This year, the simulation training was spearheaded by MAJ Sara Bibbens (USU Faculty, Pediatric Intensive Care) and involved multiple Pediatric faculty members who traveled to the field with Broselow bags and infant-sized mannikins in tow. Students had to carry out a trauma evaluation, establish IO access, manage the airway, resuscitate with fluids, and discuss the ethical aspects and rules of engagement involved in pediatric patients in a deployed setting. With the recent experiences from Operation Allies Refuge, these Peds skills have never been more important!
USU AAP Highlight!

On Wednesday, 21 July 2021 Dr. Lee Savio Beers, President of the American Academy of Pediatrics visited the Uniformed Services University of the Health Sciences in Bethesda Maryland. She was the invited Grand Rounds speaker to speak about “Supporting the Military Pediatrician”. She spoke to the residents in the National Capital Consortium pediatric residency program, pediatric staff, and medical students. Her talk highlighted her career in the United States Navy medical department as a pediatrician and the opportunities for leadership and growth that set her on her course to becoming an advocate for children in the American Academy of Pediatrics. The meeting was at the invitation of the USU department chairman, Dr. Patrick Hickey and organized by Dr. John Barry. Enclosed is a picture of Dr. Beers with some pediatric residents from our program and with some faculty from the uniformed services University who knew her well.
Uniformed Services Chapter East (USCE) Update
Lt Col Nitasha Garcia, USAF, FAAP
Chapter East President

- USCE is continuing the series called Snap Chats. 15-20 minute educational sessions followed by a short question and answer period. The next topic is Pediatrician’s Role in Real-World Operations. No registration required. Monday, 25 Oct @ Noon Eastern Time. Link: https://us02web.zoom.us/j/86210619270 Dial-in number: 301 715 8592 with meeting ID: 862 1061 9270. We are also looking for motivated clinicians to join our leadership team. Please email us at uniformedserviceschapteast@gmail.com regarding your interest, or if you have suggestions for initiatives we can partner with you on.

- The recent NCE was a great opportunity to connect virtually and celebrate some well-deserving individuals. USCE is thankful to have Col (r) Michael Rajnik as part of the executive board in his role as our Senior Career Liaison. He was highlighted as the 2020 Section on Uniformed Services “Outstanding Service Award” recipient. We also had the chance to announce the recent recipients of the Outstanding Young Pediatrician Award for Chapter East: Army-CPT Kirsten Miller-Jaster, Navy-LCDR Colleen Lail, and Air Force-Maj Daniel Hammond. Further, we had the opportunity to announce the Joint Chapter East and Chapter West Public Health Service recipient, LCDR Matthew Gianferante. There were many exceptionally qualified applicants who are all doing wonderful things for the Military Health System.

Uniformed Services Chapter West Update
LTC John Campagna, USA, FAAP
Chapter West President

Chapter West is looking ahead to 2022 and continuing to support our members. This year we were pleased to announce our 3 Outstanding Young Pediatrician of the Year award winners, MAJ Kayla Jaeger (BAMC), LCDR Eric Pasman (NMCSD), and MAJ Katherine Ottolini (USNH Okinawa). This past year has continued to be difficult with emergence of the Delta variant that has impacted children at a higher rate and strained our capabilities. We have continued to improve our responses to the virus and made impacts throughout the country. Our chapter has made significant impact on the health and wellness of our Afghani guests as they arrived through Qatar, Europe and the continental United States. Many of our members were mobilized to meet this response and many more volunteered. Our members have continued with groundbreaking research and developing technology to assist our medical teams and patients.

In all, Chapter West remains dedicated to improving the health and wellness of all children and in all situations. We look forward to working with our members in 2022.

We welcome contributions to the newsletter on any topic of interest to the pediatric community.

Please submit your idea or article to: Lt Col Candace S. Percival, MD, FAAP
candace.s.percival.mil@mail.mil
Tools

Kevin Brinkman, PL-1, SAUSHEC
Capt, USAF, MC
Myocarditis and COVID-19

Zachary Turner, MD
LTC, USA, MC

Our pediatric cardiology practice at Brooke Army Medical Center has received hundreds of questions, emails, and consults from patients, parents, and providers regarding the risk of myocarditis related to COVID-19. Should my child receive the vaccination? When can my patient return to sports? This adolescent had COVID and now can’t keep up with their peers-do they have myocarditis? With a new “disease” comes many unknowns and worries. Fortunately, there has been a significant uptick in evidence-based literature evaluating these and other questions.

“I'm not sure I want to vaccinate my child because they may develop heart disease.” Unfortunately this is possible, but fortunately an extremely rare, occurrence. In a recent Israeli study, 54 cases of myocarditis were diagnosed among 2.5 million recipients of the vaccine, or 2.13 cases per 100,000. 98% of these cases were mild or moderate, with only 5 not completely resolving within several weeks1. While the highest risk age group was 16 to 29 year old males, this risk remains exceedingly rare for pediatric patients. In contrast, risk for developing myocarditis in children under 16 when infected by COVID-19 is 37 times higher than the background/baseline rate. Overall risk (all ages) was about 16 times higher (0.146% with COVID vs 0.009% without)2. We recommend all eligible patients receive the vaccine, and we especially encourage our patients with congenital heart disease to protect themselves through immunization.

Myocarditis after infection with COVID, although more likely than at baseline, remains unusual. Who is most at risk? A French study showed a 70% risk of myocarditis in pediatric patients who developed pediatric multisystem inflammatory syndrome (PIMS) or multisystem inflammatory syndrome-covid (MIS-C)3. Anecdotally, we have not seen myocarditis in any outpatient/non-hospitalized patients. Many pediatric patients are taking longer to return to their pre-COVID exercise tolerance, but these typically have normal cardiac function without signs of myocarditis. Our group has not found any myocarditis after dozens of evaluations for exertional symptoms or exercise intolerance following infection with COVID.

Myocarditis can be asymptomatic when mild, but most cases have some signs or symptoms including chest pain, shortness of breath, exercise intolerance, fatigue with exercise, syncope or near-syncope, palpitations, and almost always a resting tachycardia. A screening ECG (see below) shows low voltages and inversion of the T waves in leads V5 and V6. A chest X-ray would show pulmonary edema and cardiomegaly. A gallop rhythm and hepatomegaly may be appreciated. Suspicion for myocarditis should warrant exercise restriction and referral to pediatric cardiology.
“My patient had COVID, and they want to return to sports. Do they need to see cardiology first?” The AAP has an excellent return to play guideline regarding COVID infection and cardiac screening4 (see below). Myocarditis is a concern with COVID, but fortunately is rare with immunization or outpatient cases.

Myocarditis and COVID-19  Continued from page 20

References:
The Utility of Deploying a Pediatrician

Luis Rohena, MD, FAAP
LTC, USA, MC

The most important aspect of any deployment is to remain ready, vigilant, and flexible! I deployed as a Brigade Surgeon for the 31st Air Defense Artillery Brigade in Qatar. I met my commander on the first day and he informed me that the most important focus I should have while on this deployment was soldier medical readiness. He wanted to make sure that every soldier was green across the board on the Medical Protection System (MEDPROS). This meant ensuring Periodic Health Assessments (PHAs) were updated, profiles were efficiently written, and all health screens were completed. I quickly became accustomed to treating adults, delivering frequent command briefs, and tracking everything related to COVID-19 in theater. Most importantly, my background as a pediatrician did not impede any function of serving as a brigade surgeon, and likely was beneficial in completing my assigned tasks.

Having gained some comfort with my new role, I heard about the fall of Kabul to the Taliban. I saw on the news that a flight had departed from Kabul with over 600 Afghans, the images of many children staring at me from the TV news screen. Shortly, I realized those same refugees landed in Qatar, where I was serving as a Brigade Surgeon with a focus on my soldiers’ medical readiness. The refugee-laden flights into Qatar seemed unending. Over 55,000 refugees transited through Qatar. The medical clinic at Al Udeid Air Base (AUAB) was being run by the Air Force, while the medical clinic at Camp As Sayliyah (CAS) was being run by the Army. The need for a pediatrician at the Army clinic was pressing and though I was the only pediatrician in Qatar, I could not forget my primary function in theater, a Brigade Surgeon. Through candid communication with my commander, he quickly cleared my afternoon schedule so that I could see pediatric patients on a daily basis.

My team quickly gathered the supplies we needed and started seeing pediatric patients, establishing a new pediatric clinic on the Army base. It was clear we were needed, as we provided regular sick-child care for common illnesses and more specialized care for less common ailments. We cared for children with upper respiratory tract infections, strep throat, viral pharyngitis, sinusitis, otitis media, otitis external, pneumonia, seasonal allergies, enteritis, gastroenteritis, candidal rashes, irritant diaper rashes, and every type of skin condition imaginable, from impetigo to epidermolysis bullosa. Upon reflection, I realized what helped me most in running the pediatric clinic at CAS was that I have regularly covered the general pediatrics clinic at the Brooke Army Medical Center (BAMC), despite being a pediatric subspecialist. I have also continued to cover the inpatient pediatrics ward each year as an attending physician for our resident trainees. This continual practice of general pediatrics has allowed me to maintain my skills and I felt well-prepared to handle the cases we encountered in-theater.

As soon as we started the clinic, we initiated careful monitoring and documentation of the illnesses children were experiencing. From the first week to the second week, we noticed a dramatic increase in diarrheal illnesses. We initially attributed this to changes in nutrition, as many of the children were using different infant formulas than the ones they were accustomed to, but one of the refugees was tested and found to have parasites. We did not have the ability to test each patient for parasites, but we followed CDC guidelines for empirically treating the population appropriately with antiparasitics. The monitoring of illnesses and treatment guidelines, especially for malnutrition, came from the Military Medical Humanitarian Assistance Course (MMHAC). This is a course that I had taken over a decade ago and thankfully, Dr. (COL) Steven Spencer, Chief of Pediatrics at BAMC and a Pediatric Infectious Diseases Specialist, sent
me the MMHAC curriculum on the day that the first refugees arrived, giving me ample time to implement many of the things covered in this course. It goes without saying, every pediatrician should complete this course, as we may be relied upon resident should try to complete this course before graduating from their residency.

As thousands of refugees made their way to Qatar, we began tracking dozens of pregnant women between the Air Force and Army bases. Multiple babies were delivered successfully on the Air Force base while others were allowed to be delivered at the host nation hospital. This goes to show the importance of being NRP certified and covering the nursery when you are back at home station.

One of the major bonuses of this deployment for me was the fact that not only was I able to practice pediatrics, but I was also able to render care to genetic and metabolic patients. Many of the providers were surprised by the number of complex genetic cases, but it should not be surprising because the rate of consanguineous marriages in Afghanistan is nearly 50%. This is important to know because as these children resettle in the United States and other countries, if their conditions are not easily explained, they will need genetic evaluations.

The key takeaways of this deployment are to always be ready, vigilant, and flexible. Volunteer to cover the general pediatrics clinic, the nursery, and the inpatient pediatrics ward as much as possible. Take the Military Medical Humanitarian Assistance Course. Make sure that your certifications are up to date. Also remember that deploying as a pediatrician is an asset to any unit, because children will unfortunately continue to be caught in the middle of these conflicts.

Be Informed!!! Get Involved!!!

Join the Section on Uniformed Services LISTSERV® Today!

If you are interested in joining the Listserv, e-mail jburke@aap.org.
10 Gender Affirming Healthcare Facts for Active Duty Pediatricians

Noelle Larson, MD, FAAP                  Courtney Bleach, MD, FAAP
LTC, USA, MC                               Lt Col, USAF, MC

1. Inclusive healthcare for transgender and gender diverse youth requires commitment and effort.
   One way Pediatricians can demonstrate respect for patients and communicate a commitment to inclusive healthcare is by ensuring all team members understand basic concepts of gender and sexual identity, and use inclusive language in clinical settings. The AAP Policy Statement provides an excellent overview of core concepts, terms, and some unique healthcare needs of TGD youth.¹

2. Sex and gender are not the same thing.
   Sex is a label, routinely assigned at birth, and based primarily on the appearance of external genitalia. Sex is determined by the interplay among genetics, gonadal tissue, hormones, and other reproductive structures. Most infants are assigned a binary sex (male or female) and some children are born with external genitalia that do not clearly match a typical male or female phenotype. Assigned sex is presumed to align with “gender identity”, but for some individuals it does not.

3. Gender identity is not outwardly visible.
   Gender Identity is an individual’s internal sense of who they are, which can be influenced by phenotypic traits, social context, personal beliefs, and other environmental factors. Individuals may feel that their gender identity is male, female, somewhere in between, a combination of both, neither, or another gender. Recognizing and respecting patients’ Gender Identities has an important impact on the working environment for TGD healthcare team members.

4. Gender Expression and Sexual Orientation are distinct concepts.
   Gender Expression refers to the ways people may communicate their gender to others, and includes clothing, hairstyle, mannerisms, and voice. Sexual Orientation is distinct from both Gender Identity and Gender Expression. The “Gender Warrior” above illustrates these four key, distinct concepts. When Sex Assigned corresponds with Gender Identity, a person is considered cisgender. Transgender is an umbrella term that may apply when sex assigned does not align with Gender Identity or Expression. Clinicians who want a deeper understanding can visit www.thegenderbook.com.

5. Gender exploration is developmentally normal and all children benefit from loving support.
   It is common for children to demonstrate a variety of gender expressive behaviors in play. Children who identify as transgender follow similar patterns of gender identity development as their cisgender peers.² All children benefit from unconditional love and

Continued on page 25
acceptance as they explore and discover their most authentic selves. Transgender children are no exception.

6. **Transgender identities are not pathologic; repetitive discriminatory experiences are harmful.**
   There are well documented health disparities experience by TGD adolescents and adults. Affirming environments can buffer against these negative health impact of discrimination, abuse, transphobia, bullying, stigma, and rejection in a variety of social contexts. Transgender children who assert, and are supported in, their gender identities from an early age do not have an elevated risk for depression or anxiety, relative to their cisgender peers or siblings.

7. **Using a person’s pronouns is a sign of respect and commitment to providing inclusive care.**
   Pronouns are an important expression of gender and knowing a person’s pronouns allows you to easily refer to them in a respectful manner. Being misgendered or repetitively having to provide unsolicited correction to others can be draining. It is important to use a person’s pronouns consistently and alert healthcare team members when electronic health records do not accurately reflect patient identity. The word “preferred” should not be used before pronouns. It implies that pronouns are a choice, rather than an integral part of a person’s identity. For more information, visit [https://www.mypronouns.org/](https://www.mypronouns.org/).

8. **Inclusive clinical care environments improve health outcomes for TGD youth.**
   Patient experience starts before the exam room. It impacts the quality of therapeutic relationships and healthcare outcomes. Displaying positive images and including educational materials of interest to TGD patients in waiting areas sends the message that they are expected, welcome, and can trust their healthcare needs will be met. All staff should be encouraged to honestly assess internal biases and genuinely work to eliminate processes and language that presume patients are cisgender, heterosexual, or have only one partner. Military healthcare teams may need to exert extra effort to earn beneficiaries’ trust due to a history of exclusionary policies impacting LGBTQIA+ communities.

9. **Military Pediatricians have a duty to lead and promote a culture of meaningful improvement.**
   Lifelong learning requires awareness of knowledge gaps and a growth mindset. Leaders must model humility and take responsibility for self-education without placing added burden on LGBTQIA+ patients or colleagues. Constructive feedback should be welcomed. Mistakes warrant acknowledgement of harm done, genuine apology to the person harmed, commitment to do better in the future, and substantive follow-through.

10. **Subspecialty care is available to TGD youth in the MHS.**
    Even with social support and affirmation, some TGD individuals may experience Gender Dysphoria and seek medical interventions. Gender Dysphoria describes clinically significant distress due to incongruence between gender identity and sex assigned. If dysphoria is present, consider referral to behavioral health, adolescent medicine, and/or pediatric endocrinology. Medical treatment options for pubertal children include GnRH agonists (also known as reversible “puberty blockers”), menstrual suppression, and gender-affirming hormone treatment for older adolescents.

References:
Awards and Highlights from the Virtual AAP NCE SOUS Meeting 2021

Despite high hopes that we could be together in person this year, our annual Uniformed Services Pediatric Seminar (USPS) day was again held in affiliation with the all-virtual AAP National Conference and Exhibition. The AAP and the SOUS worked hard to still offer rewarding, and entertaining, content, as you can see! The opening the AAP NCE meeting not only included Justin Williams demonstrating his virtual magic, but also a personal interview with former military-pediatrician turned AAP President, Dr. Lee Beers, and the G.O.A.T in women’s gymnastics, Simone Biles.

Then, the AAP celebrated in style with a virtual, live-stream concert by none other than Keith Urban!

Continued on page 27
Our SOUS Chair, COL Catherine Kimball-Eayrs, USA, FAAP, again facilitated the SOUS virtual session, which included an outstanding line-up of experts to share their knowledge and experience with our community.

CAPT Gregory Gorman kicked off the event with the Ogden Bruton Lectureship, *Are Military Pediatricians Really Needed? How the DoD Knowledge-Skills-Abilities Effort Can Answer that Question.* He concluded his presentation, stating, unsurprisingly, that military pediatricians have knowledge, skills, and abilities that are “irreplaceable on the scale needed in our forward-deployed volunteer force,” reemphasizing our shared purpose and usefulness to the military operational mission.

Next, we had an incredibly timely presentation from Col (ret) Deena Sutter, MD, FAAP, on *Vaccine Hesitancy, Resistance, and Organization Programs in the MHS.* In her presentation, we learned about the past and present of resistance to vaccines and how to better educate providers, patients, and families about the benefits of robust vaccination programs.

Finally, COL Sean Hipp provided a comprehensive review in his presentation, “*Virtual Health: Past, Present, and Future.*” He described the history of virtual health and several of the recent advances that have occurred, many just over the past few years, accelerated by the response to the global COVID-19 pandemic.

Continued on page 28
Awards and Highlights from the Virtual AAP NCE SOUS Meeting 2021  Continued from page 27

Though our section hoped to present the annual SOUS awards in person, it was felt that our awardees deserved recognition for the amazing achievements and selected recipients from 2020 and 2021 were recognized virtually. The Outstanding Service Award, which recognizes a uniformed pediatrician who demonstrates a long-term commitment to military medicine, was presented, for 2020, to Dr. Mike Rajnik, and for 2021, to Dr. Gregory Blaschke.

The Dave Berry award, which honors the qualities and characteristics embodied by MAJ Dave Berry, MC, USA to encourage the development and career of promising junior staff pediatricians in military education, was presented to Dr. LCDR Terrence Bayly for 2020 and Dr. MAJ Milissa Jones for 2021. Also recognized were Chapter East and Chapter West Young Pediatrician awardees (see Chapter updates above).

Finally, Dr. Michelle Kiger and Dr. Jeffrey Livesey, our scientific abstract program chairs, and their team, reviewed many excellent submissions and selected our very impressive AAP SOUS Scientific Award Winners (see pages 29-30).

Though not presented at the AAP NCE meeting, additional award winners included our newest members of the military pediatric community, the USU graduating class of 2021. These students were selected for the Outstanding Achievement in Pediatrics Award, based on the MTF region where they completed their Pediatrics Clerkship rotation. These were presented by the Uniformed Services University in May 2021 to the following graduates:

**Outstanding Student in Pediatrics Award:**

- **Dr. Kaitlyn Mullin** (matched Pediatrics—SAUSHEC)

**AAP Uniformed Services Chapter East Outstanding Achievement in Pediatrics Award:**

- **Dr. Kaitlin Beyrau**

**AAP Uniformed Services Chapter West Outstanding Achievement in Pediatrics Award**

- **ENS Johanna Barron** (matched Pediatrics—NMC San Diego)
AAP SOUS Scientific Award Winners

(only first authors listed)

2021 Ogden Bruton Award (Basic Science/Technology)


2nd—Patrick Reeves: Development and Implementation of DIGEST: The Digital Interactive Gastroenterology Education Suite for Trainees

2021 Andrew Margileth Award (Clinical Research)

1st Place: Superior Labial Frenulum Attachment Site and Correlation with Breast Feeding Outcomes Gayle Haischer-Rollo

2nd Place: Impact of Respite Care on Perceived Stress, Anxiety, and Depression Symptoms in Military Parents with a Child on the Autism Spectrum Rebecca Christi

3rd Place: Length of Maternity Leave Impact on Child Health Outcomes Alyse Carlson

2021 Howard Johnson Award (Resident Research)

1st—Elyse Geibel: Feast or Famine: A National Stay-At-Home Order is Associated with an Increase in Pediatric Foreign Body Ingestions Presenting to Emergency Departments in 2020 Compared to 2011-2019

2nd—Samantha Rowe: Baby Wearing Injuries Presenting to Emergency Departments, 2011-2020: A Dangerous Fashion Trend

3rd—Emma Prichard: Does Prior ECMO Experience Lead to Better Performance on Simulation Scenarios?
AAP SOUS Scientific Award Winners

(only first authors listed)

2019 Leo Geppert Innovation Award

1st—Patrick Reeves: The Uniformed Services Constipation Action Plan is Superior to Standard of Care for the Management of Functional Constipation in a Pediatric Subspecialty Clinic for Military Beneficiaries

2nd—Jonathan Chooey: Military HealthSteps Pilot Program Outcome Study

3rd—Elizabeth Polston: Utilizing MHS Genesis to Identify and Treat Military Children Exposed to Adverse Childhood Experiences (ACEs)

2019 Leo Geppert Case Report Award

1st—James Stewart: Refractory Macrophage Activation Syndrome Secondary to Anti-MDA5 Antibody Positive Juvenile Dermatomyositis

2nd—Jennifer Bencze: Bilious Emesis and Failure to Pass Meconium in the Nursery

3rd—Taylor Blackburn: Restrictive Dermopathy: Case Presentation of a Rare and Lethal Laminopathy with a Novel Genetic Variant

2019 Val G. Hemming Award (Medical Students)

1st—Rona Yu: The Association Between Obesity and Severe Influenza Outcomes in Pediatric Population
Conference on Military Perinatal Research
COMPRA Update—2021

Maj Caitlin Drumm, MD, FAAP

The Conference on Military Perinatal Research (COMPRA) has been taking place since the 1970’s, thanks to the dedication of many individuals over the years. This conference has traditionally offered a forum for the presentation of neonatal-perinatal research by both early career and established physician scientists currently serving in, or affiliated with, the military. This year, thanks again to the continued generous support from Mead Johnson Nutrition (MJN) and the AAP Section on Uniformed Services, the 40th annual COMPRA occurred at the Westin, Riverwalk in San Antonio on November 5th-7th.

This year’s theme, Health Equity in Neonatology, featured Dr. Wanda Barfield, MD, MPH, USPHS RADM (Ret.), as the 2021 Robert A. deLemos Guest Lecturer. Dr. Barfield currently serves as the Director of the Division of Reproductive Health at the CDC. Her talk, entitled “Understanding Disparities and Critical Issues in Perinatal Health: Considerations for Military Medicine” was timely and extremely well received.

Additionally, we were lucky to welcome Dr. Jochen Profit, neonatologist and Chief Quality Officer at the California Perinatal Quality Care Collaborative, as a guest speaker. His excellent talk, entitled “Health Equity in the Neonatal Intensive Care Unit” inspired discussion and reflection.

Nine military affiliated fellows, three pediatric residents, and three staff were selected to present their research in platform format to their current and future colleagues. This represents our largest turnout yet! Three active duty fellowship programs were represented with basic, translational, clinical, epidemiological, and quality improvement/patient safety abstracts presented.

For information regarding attendance or abstract submissions for the 41st annual COMPRA held in fall 2022, please contact Caitlin Drumm (caitlin.drumm@gmail.com).

The AAP Section on Uniformed Services would like to thank Mead Johnson Nutrition for their support of COMPRA.
SAVE THE DATE: CALL FOR ABSTRACTS

AAP SECTION ON UNIFORMED SERVICES

AAP National Conference and Exhibition

October 7-11, 2022            Anaheim, California

Tentative Submission deadline:

Opening: February 25, 2022

Deadline: April 22, 2022

Submissions will soon be accepted for the Scientific Awards Competition (SAC) for 2022. You can only submit an abstract to one category. If you are unsure which category to submit, contact Michelle Kiger, MD or Jeff Livesey, MD at michelle.e.kiger.mil@mail.mil or jeffrey.r.livezey.mil@mail.mil, respectively.

As part of the call for abstracts, six scientific awards will be given to honor research efforts by Uniformed Pediatricians. The awards are:

**The Ogden Bruton Award** (certificate of merit): for the best paper by a Uniformed Pediatrician on either basic science research or research on the development, evaluation, or application of an emerging technology in pediatrics.

**The Andrew Margileth Award** (certificate of merit): for the best pediatric paper by a Uniformed Pediatrician documenting clinical findings or assessing clinical diagnostic studies, therapeutic regimens, and outcomes leading to improved quality of health care for children.

**The Howard Johnson Award** (certificate of merit): for the best paper by a Uniformed Resident (of any specialty) on a pediatric topic.

**The Leo Geppert Innovation Award** (certificate of merit): for the Uniformed Pediatrician with the best paper outlining a Quality Improvement or Patient Safety innovation affecting the care of pediatric patients.

**The Leo Geppert Case Award** (certificate of merit): for the best case report by a Uniformed Pediatrician. It is the only category that accepts case reports.

**The Val G. Hemming Award** (certificate of merit and a travel award per individual command’s approval): for the USUHS, HPSP, or ROTC medical student submitting the best paper on a pediatric-related topic in clinical or basic science research.
Taking the Role of Primary Care Manager to New Heights

CPT Brandon Fong, MD
Pediatric Resident, TAMC

Recently, I had the honor of accompanying one of my empaneled patients on a medical transport from Tripler Army Medical Center to Lucile Packard Children’s Hospital at Stanford. Although his transport was rather uneventful, there are several takeaways from this experience that I will cherish throughout my career.

For sake of privacy, the patient’s name will be John. He was born just two days before I started my first NICU rotation. He was known to have double outlet right ventricle (DORV) prenatally. His problem list also included William’s Syndrome, imperforate anus with fistula, pelvic kidney, and more. As an intern with hardly any NICU experience prior to this moment, this was very overwhelming. I was struggling enough just trying to get my numbers for morning rounds! Of course, parents had many questions when I visited their room, and unfortunately, I didn’t have many answers for them early on during his admission. However, I made sure I took the time to hear all of their concerns and relay their questions to my attendings. Several days into his NICU course, his saturations began to decrease. There was concern that the closing of his PDA may have been compromising his hemodynamic stability. Echocardiograms were obtained. Alprostadil was ordered for the bedside if needed. It was a whirlwind for the family, especially because their older child required heart surgery at a young age as well. The mother spent most of the time at bedside while the father had been in and out of the hospital taking care of other matters. Most of his understanding of the situation was relayed from the mother. One afternoon, he asked me to clarify some things, so I started by walking him through the physiology of a ductus arteriosus on a piece of scratch paper. I feel that this was the moment I gained the respect and trust of the family, so much so that they asked me to be the PCM of all three children. After much observation, John was able to go home at around 1 month of life. The plan was for him to keep growing in order to meet a weight goal for cardiac repair.

A few weeks after his discharge, John began to have cyanotic spells and needed urgent transfer to a cardiac center of excellence. Luckily, I was about to switch to a flexible outpatient rotation and quickly volunteered myself to be a medical attendant. Our program is very familiar with medevacs, but mostly on the receiving end from places like Guam and Okinawa. There’s a saying here at Tripler – “We’re it for this side of the Earth.” But occasionally, some patients’ needs exceed the capabilities of our network, and a mainland tertiary care center is more appropriate. Our program has sent residents on medevac flights before, and we have even had some lectures about flight physiology from one of our neonatologists. However, this had become a rare occurrence as of late due to COVID-19 precautions. The hospital and program staff worked quickly to secure my spot on the flight, and I was told we would be leaving in less than 24 hours. Due to staffing limitations, the transport was delayed a day, and a NICU team from Okinawa was sent last-minute. The transport physician began combing through John’s records as soon as he arrived,

Continued on page 34
Taking the Role of Primary Care Manager to New Heights  Continued from page 33

and I quickly realized that I would be the most knowledgeable person on that flight regarding John’s medical history. Over the past year, I have had a hard time feeling true ownership of my patients since I only have one half-day of continuity clinic per week. But in this moment, I could be the authoritative figure advocating for John’s health.

When we arrived to Hickam AFB, I stepped foot onto the tarmac and was in awe of the sheer size of the C-17 in front of me. My military experiences thus far have essentially been limited to officer training and C4. Since my family does not have a rich history of military service, moments like this remind me of the incredible things I get to do as a soldier. We secured John’s transport isolette and were on our way to Travis AFB. His parents were disappointed they had to sit on the other side of the aircraft, but I think they were comforted by me looking back at them and giving an occasional thumbs up. Once we landed, it took another two hours via ambulance to get to the hospital, and I used that time to get to know John’s parents even better. Upon arrival to the hospital, we gave report to the accepting NICU, and I flew back to Hawaii the next day.

Overall, it was a quick, uncomplicated trip, but the experiences were invaluable. I learned that sometimes, a parent feeling truly heard can be almost as healing as our medical interventions. Sometimes, a familiar face can be the one thing pushing someone forward. And always, going the extra mile (or ~2434 miles) will make you a better PCM.
The Power of Parents in Pediatric Obesity

(What we’ve been missing in our current approach)

CAPT (ret) Wendy Schofer, MD, FAAP, DipABLM

According to the CDC, over 35% of American children are diagnosed with overweight and/or obesity (report from 2017-2018). And as the media and medical journals continue to report, the “epidemic” of obesity has been growing with the social changes of the pandemic. What I’ve seen in practice and in the community is that these reports and statistics, while well-intended to shed light upon the public health implications, are having significant effects upon our families. And specifically, our parents.

Parents are worried about their kids’ weight.

Parents are being blasted by information daily about the hazards of obesity, about the increasing prevalence of obesity, and the concerns about increasing rates of eating disorders as well. Parents have kids who have been diagnosed with overweight or obesity, other kids who are “skinny and need more calories” and others who have developmental body changes (like the early adolescent belly) that make them worry if their kids have inherited the family genes leading to obesity. Parents have their own concerns about weight: a history of dieting, body image challenges, and doubt that so often is reported to me as “I can’t be the role model for my kids” to reach a healthy weight.

Emily was 6 years old when we met for a well visit. I looked at her vitals and growth charts as I did for every visit, and she had always been tracking >85%ile for BMI. Her growth was nothing if not consistent. I learned about her varied diet, daily activity, sleep routines, love of animals, and great connection with her family and peers. There were zero red flags. Her mom asked me, “When are you going to talk about her BMI?” I asked her what was her concern. “Every time we come, I hear about how she’s still overweight, no matter what we do. I’m failing her.” Emily was thriving. And her mom thought that she was failing her based on a number.

This is what I call reframing obesity:

Weight is a number. It is a measurement. But there is so much meaning packed into it. We go from celebrating “chunky” infants to then raising the red flags when the BMI gets calculated at 2 years old. As physicians, we have such good intentions to help our patients. We identify growth patterns, and make diagnoses. Because after all, if we don’t identify the diagnosis, how can we ever address it? The real problem isn’t the weight, or necessarily the diagnosis - it’s what happens with that information: The worry, the fear of complications, the sense of failure, the doubt that changes can be made. And this is all experienced by the parents. Parents who are experiencing worry, fear, failure, and doubt are unable to make meaningful changes for their family. They look at the tip sheets, recommendations for change, referrals to specialists and think, “This isn’t going to work for us.” Or “this never worked for me.” They keep looking for the “right diet,” the “right plan,” a “second, third, fourth opinion,” and the new genetic test or medication for obesity. Or, they focus on the calories to be consumed with each meal and lose sight of the child who’s wondering why they’re being punished with food. They receive pushback from the kids on mandated fitness.

This is where the power of parents emerges. Parents are the key ingredient for the family. Everything that happens to the child (including education, nutrition, activities, housing) is filtered first through the parent. There is a ripple effect that expands outward from the parent in every family. You know, “The parent sets the tone.” Parents are role models for their children. They always have been, and always will be. They are the first role models. Their beliefs, values, and habits are passed along to their children who grow up in the environment created by the parent. A parent who believes that they cannot change their habits, routines and beliefs will first not create change for themselves, and will model a lack of self-efficacy for their children.

This is where we need to focus our attention as physicians. Not on the weight, not on the BMI, and against the spirit of our individualized medical system, not on the child. The focus needs to be on empowering the parent to own their role as the role model for their children, and to create lifelong healthy habits for the whole family.

What does that look like?

Emphasizing healthy relationships (with food, with one’s body, and with each other).

• Understanding motivation: What emotions are driving us to take action - and why do kids push back when they are told to do something? Helping parents become more connected to their own emotional experience goes a long way in modeling healthy habits for children.

Continued on page 36
The Power of Parents in Pediatric Obesity  Continued from page 35

- Creating structure: Planning for adequate restful sleep, nourishing meals, regular movement, and developmentally-informed - within which kids will thrive

- Understanding and questioning beliefs around food: What is healthy vs unhealthy, does there really need to be a dichotomy between good and bad? What happens when dinner is served and a child is not hungry?

- Longing at the long-game: Sustainability. Short-term fixes (diets, fitness blitzes, pantry clean-outs) mean nothing if they aren’t sustainable.

- Understanding growth: We as parents are continuing to learn. We have not failed - as we continue to show up for our kids. But we can learn, evolve, and acknowledge that we are still learning every single day. Growth is not just for children!

The real challenge isn’t weight. It’s looking upstream of weight: what are the habits that created overweight in the first place - and empowering the parent to create lifelong habits that the whole family can share. Supporting the parent, helping them become the change they want to see in their own family, is the first step.

Wendy Schofer, MD, FAAP, DipABLM (CAPT, USN, Retired) is a Certified Health and Life Coach for parents who are worried about their kids’ weight. She helps them shift focus from the scale and the individual child to create lifelong healthy habits for the whole family to share, at every weight. She is a practicing pediatrician in Virginia, celebrating her recent retirement from the Navy. Her podcast is Family in Focus with Wendy Schofer, MD, and she can be found at www.wendyschofermd.com.

References:

Updated Message from the AAP Department of Membership

If your AAP membership expires soon, please watch your mail for your renewal invoice. You will receive an e-mail notifying you when your renewal invoice has been mailed. When you receive your invoice, please review it for accuracy. If you currently hold other AAP memberships, they will be on your renewal invoice in the following order:

- National membership
- Chapter Membership (Uniformed Services and State)
- Section membership(s)
- Council membership(s)

A couple of things to note:
1) The state chapter is added to all national renewal invoices regardless of current state chapter membership status.
2) Uniformed Services chapter membership is added to your invoice if you are currently a member or if you are associated with the military in the AAP database.
3) Chapter membership is not mandatory, though is strongly encouraged.
4) The Section on Uniformed Services does not charge dues. You can easily join the section online. Log on to the Member Center, in the Member Community section click the “Join a Section or Council” link.

Please Note:
Members can pay and/or edit their membership renewal invoice online at http://eweb.aap.org/myaccount. Log in with your AAP ID and password. Chapter, section, or council memberships can be removed from your invoice prior to entering credit card information. If you wish to change your member type or add additional chapter, section or council memberships please contact Member and Customer Care at mcc@aap.org or 866-843-2271.

Thank you for your continued membership and support of our mission.
Mission Essential: Refugee Mission Reflections


1Department of Pediatrics, National Capital Consortium, Bethesda, MD
2Department of Obstetrics and Gynecology, National Capital Consortium, Bethesda, MD
3Department of Obstetrics and Gynecology, Royal Air Force Lakenheath, United Kingdom

Disclaimer: The views expressed in this article are those of the author(s) and do not necessarily reflect the official policy of the Department of Defense or the U.S. Government.

“Military operations other than war, more recently referred to as stability operations, are now among the most frequent operational deployments.”

Stateside veterans hurriedly assisted Afghan patriots, who they worked closely with during former deployments, with special immigration visa paperwork. Evacuation support included multinational commercial aircraft recruitment and the U.S. “heavy” community of transport lifters. A scared population of men, women, and children overflowed the Kabul airport while every global news outlet covered the days following the nation’s infrastructure change in August 2021. This was our call…

Medical operations are essential when evacuation efforts exist. Among these endeavors, Pediatricians and Obstetricians will be at the forefront. This latter point was never more evident than the mass exodus from Afghanistan in late summer. The influx of Afghan families poured into Germany, Qatar, and multiple CONUS bases – to name a few. Within hours and days, a showcase of humanitarian aid was in full effect. To support relocation efforts involving vulnerable Afghan travelers with medical needs, Walter Reed National Military Medical Center accepted numerous obstetric, neonatal, and pediatric critically ill patients. Below are the stories, memories, and recollections from joint service individuals who answered the call to serve this population.

“Getting the news that we would be working to help the Afghan refugees, stirred up a whole pot of emotions that evolved rapidly during the short time we have had them here. At first, excitement equal to that of a soldier getting ready to go out into battle. I remember even sending my Program Director a meme that perfectly reflected this emotion. It said, “Put me in coach!” I was ready to serve this mission and to serve my country proudly. Then, I got the opportunity to go on a transport to assist with some of the pregnant women arriving by military aircraft. As you can imagine, that energy was spinning within me as I prepared my team and myself for any possible scenario my imagination could conjure up. Once we escorted and walked these women from plane to bus and finally to the hospital, the feeling drained from me quite quickly and was replaced with embarrassment.

Many of the women were separated from their families due to medical necessity and to help speed up the process. I imagine most, if not all, of them were arriving to America for the first time. More importantly, they were forced to leave their country all of a sudden, with little-to-no warning, and with many of their families left behind (dead or alive—who knew?--or injured). The look on these women’s face said it all. Fear. Fear of us, fear of what would become of them, and shock from a trauma that I could never even start to imagine. This hit me hard in a way that it humbled me quite a bit and made me feel very angry. Angry at the situation that I could never fully understand and at myself for emotions that primarily were selfishly driven towards novelty and heroism. What these women needed was their family, community, time to mourn and process their traumas, and much more that I was ill prepared for.

While maybe not as large scale as this scenario, I feel this is something that I likely fail at more often than I like to admit. We get excited about the cool or rare cases because they are our “war stories” as physicians. At the end of the day, I have to ask myself, “did I get lost in novelty and valor?” or was I the best doc I could be? …and could I recognize when it is not me they may need? Lastly, what can I prepare better for?”

— Sharen Dukes, DO (PGY2, NCC Pediatrics)

“‘Doctor, I’m so hungry.’ Of all the chief complaints I heard during my time at Ramstein Air Base caring for displaced Afghan traveler patients, hunger was among the most common. Such a seemingly simple complaint, which I’ve come to realize, perfectly encapsulates my experiences caring for this population. One could easily imagine that for the tens of thousands of people displaced from their homes due to political unrest, separated from their families, and with an uncertain future ahead, hunger would be the least of their concerns. On top of that, children in particular, were dealing with infectious diseases that have been all but eradicated in the United States, chronic

Continued on page 38
Mission Essential: Refugee Mission Reflection  
Continued from page 37

malnutrition, and extensive dental caries. As a healthcare provider trained to view all of these things as issues requiring prompt medical attention, learning to shift my focus to hunger as the primary complaint was relatively novel for me. In interviewing patients, however, I quickly realized that hunger meant something different for everyone. Physical hunger was the case for nearly all travelers, as there were a limited number of meals per person, and identifying Halal options was a difficult task due to the emergent nature of our mission. But in addition to physical hunger, there was a hunger to be understood that was palpable as patients were waiting for translators to be able to express their ailments. There was the hunger of separation, which plagued thousands of those forced to leave family members behind in their hasty relocation. A spiritual hunger lingered in the air as people used sleeping bags for prayer rugs. A hunger for normalcy. A hunger for certainty. A hunger for intimacy. A hunger for cleanliness. A hunger for home.

Even as a young physician, I tend to be solution-focused in most of my patient encounters. Does this patient need antibiotics or does that person need laboratory testing? But I quickly realized that no amount of medical education could equip me to address the ‘hunger’ these souls were experiencing. There were only so many meals to go around. Our skilled translators were often stretched thin and unable to fulfill all requests at once. I was unable to reunite separated families and I lacked a complete understanding of the spiritual needs of this population. In fact, in many ways, I couldn’t even address my own hunger. My hunger to find answers, to heal, to treat, to understand, and to be culturally competent all panging inside me daily as I sought desperately to find some way to be of use to my patients. As a trainee, I never anticipated being the senior-most pediatric provider in a camp of 2,000+ Afghan traveller families. But what is even more striking to me is that while it’s very likely that I successfully treated infectious diseases, rashes, oral complaints, respiratory illnesses, chronic disease exacerbations, and severe dehydration -- what came home with me at the conclusion of my time on this mission was not the clinical diagnoses, but rather the hunger I left behind.”

“My experiences aiding in the medical transport of Afghan refugees allowed me the opportunity to fulfill a dream of mine when joining the military pediatric community - to help others through humanitarian aid. These medical transports taught me to quickly plan, think on the fly, adapt, and be resilient in non-ideal circumstances. This mission also provided the opportunity to work with people from a variety of backgrounds and experience levels to plan and execute an ever-changing mission. I will forever carry forward a deep-found appreciation for our country and the opportunity to serve; to make a difference globally and help those in need.”

—Brittany Flemming, MD (PGY3, NCC Pediatrics)

“My experiences aiding in the medical transport of Afghan refugees allowed me the opportunity to fulfill a dream of mine when joining the military pediatric community - to help others through humanitarian aid. These medical transports taught me to quickly plan, think on the fly, adapt, and be resilient in non-ideal circumstances. This mission also provided the opportunity to work with people from a variety of backgrounds and experience levels to plan and execute an ever-changing mission. I will forever carry forward a deep-found appreciation for our country and the opportunity to serve; to make a difference globally and help those in need.”

—Sidney Zven, MD (PGY2, NCC Pediatrics)

“Ladies of Steel, A World Apart -- There have been many revelations for me as a gynecological surgeon and obstetrician over the last 50 days. Polio still exists, women are made of steel, and cultural barriers are surmountable. Confronted with providing care for women in an extremely low resource circumstance, I am amazed at the resiliency that I witnessed. Operation Allied Refuge, the mission to support the evacuation of Afghan citizens, presented a complex medical crisis that centered around large numbers of women and children. Women’s health care has been extremely deficient in Afghanistan resulting in circumstances of absent or limited prenatal care, nutritional deficits, and restricted access to family planning. Grand-multiparity is a common finding with patients having 10 to 14 deliveries on a routine basis. Precipitous deliveries as a result were always concerning. No prenatal care resulted in limitations to accurate dating and a large proportion of the community with anemia and identifiable as underweight. I encountered a young woman at 28 weeks gestation with bilateral lower extremity limitations to mobility secondary to a history of polio. I had to ask twice where her limitations originated, as I was not prepared for the answer of polio. This patient further had the complex history of spousal abuse and was clear in her desire for a change. I cared for her and provided her a flight separate from her husband. I encountered a woman who had a precipitous delivery on a flight that was turned around two hours after taking off to fly to the United States. Upon arrival, the patient was patiently waiting on the floor in a secluded first class bay where she had been for the last two hours. Her placenta had not delivered and required a manual extraction. The patient never said a word and subsequently stood up and walked off the plane. The only thought in my head was “this woman is made of steel”. I have cared for countless women who experienced an incomplete abortion in our tent during our care and have used translators to bridge a divide of culture and complicated medicine. The cultural challenges were enormous. Women with limited voices to interact with others. Male providers were absolutely prohibited secondary to culture. Communications were mainly completed through the husband and rarely directly with the patient. It was especially difficult at times to process as a woman who has stood on the shoulders of those who came before me and paved the way for me to be the doctor I am today. It is with a heavy heart that I watched women not have a voice or an education. While I did see those who could speak English and were able to choose their own path, this was not always the case. I am in admiration of these women and am hopeful America will provide them the freedom to choose a path that reflects their heart’s every wish.”

—Suzanne Stammler, MD (Staff, OB/Gyn, RAF Lakenheath)

Continued on page 39
“Doctor, doctor, please, my baby, she won’t eat.’ ‘Doctor, you see, he has fever.’ ‘Doctor…’ ‘Doctor…’ My memories of working in the medical tents in the Afghan refugee tent cities of Ramstein Air Force base consist largely of innumerable echoing voices relaying hundreds of chief concerns about the thousands of children who milled about the 500sq yard cordoned off area. Some played soccer and laughed merrily, while others were carried in bundles or were led sluggishly by hand to my medical tent. To be given the opportunity and honor to travel across the world to aid children in need was like a wave on the horizon I was eager to jump into as soon as it arrived; but as the water began to crest over my head, it loomed much larger than I could have imagined. It threatened to drown me for days. As I would scan quickly over the faces of these children before they were handed off into my care, seemingly thousands of questions would enter my mind. Who are they? What have they been through, both medically and psychosocially? When their parents say diarrhea, fever, or sore throat, are we meaning the same thing? Are they vaccinated? Without records, even if they say yes, what does that mean? The concept of a differential as I knew it was burst wide open. With only a year and a handful of months of pediatrics residency under my belt, how could I – of all people – help? I can’t count the number of fathers and mothers who sat their children on their laps, helped them cooperate with my exam, and patiently waited with the expectation and trust in me to excise sickness from their loved ones. They brought in mouth sores, rashes, fevers, abscesses, coughs, diseases eradicated in the US. They listened intently as I told them, time and time again, what was most likely and what could be done about it. Behind these words, I was hardly ever confident of my diagnoses. How could I have been? Without ready access to hospital-grade lab testing, serial vitals, a medical record, even simply the quiet examination spaces and bright otoscopes I had become used to during my residency, I couldn’t find a way to convince myself of my conclusions. With seasoned adult providers also manning the tent, I fell into the role of resident pediatric expert. This was in stark contrast from only days beforehand, where every patient interaction was staffed with an attending pediatrician. I sent tens of children per day back off into the crowd, their parents holding antibiotics, creams, sometimes only cough drops or syringes of honey. Each intervention I chose seemed like pressing a button on an endlessly large switchboard of pathologic possibility: a switchboard in a dark room I could only look at with a flickering flashlight. Each button I pressed, I would hope against all hope that if inexperience led me to miss something, they would at least know to come back if things got worse. I wish the fact that many didn’t return was more of a comfort than it is.”

—Billy Bennett, MD (PGY2, NCC Pediatrics)

“My first interaction with the Afghan travelers was on Labor Day. Only two days prior, the OB/GYN department heard that a plane full of pregnant Afghan women was landing. In those two days, we converted our clinic space into a full-service OB/GYN triage unit. We had rooms set aside for ultrasounds, physical exams, labs and blood draws, and fetal monitoring. A group of 20 corpsmen, nurses, and physicians worked together (on a federal holiday in a military hospital!) to greet these women and provide them with the excellent medical care that is the standard at Walter Reed. Within three hours, we had evaluated, triaged, and dispositioned seven pregnant women, many of whom had not seen an OB/GYN their entire pregnancy. We have continued to care for pregnant travelers as they arrive from various sites in Europe, and it has been an honor to care for them – in the clinic, on Labor and Delivery, and even on the ambulances to meet them as they land in America for the first time. I am still in awe of what our department has been able to accomplish together, and I will always remember Labor Day of my chief year as my favorite holiday.

Most days, I don’t feel like a military doctor. My day-to-day life is not that different from any other civilian OB/GYN resident. I wear scrubs instead of a uniform, I recite medical facts instead of the Sailor’s Creed, and I schedule call shifts instead of a watch bill. Helping with this mission is the first time I felt like my service has contributed to a higher mission within the military. It has reconnected me with the calling that I felt when I joined the Navy, and it renews my sense of purpose and commitment to my career as a Naval medical officer.”

—Ashleigh Hemphill, MD (PGY4, NCC Obstetrics-Gynecology)

“Operation allied refugee/welcome was one of the most rewarding experiences I have had in my military career. When I was first told I was going to be deployed, I was nervous of the unknowns of the mission. Those feelings quickly melted away, knowing I would be serving a population that vulnerable population that had just lost everything because they previously helped my brothers and sisters at arms. The camp at Fort Bliss was unique in the sense there were no structures to be used for medical screening, instead our team set up a field hospital to create a chart, obtain labs and chest x-rays, medically screen, and finally immunize about 10,000 Afghan refugees. This was likely the first use of a field hospital in this capacity. Communication between the whole team was vital especially as the mission changed from screening to mass vaccination to prevent an outbreak of preventable diseases, back to completing medical screening of the camp. As we completed screening each family, the look of gratitude and relief on their faces as they were one step closer to a new life was priceless. I can say I am proud to have worked with the soldiers of the 528 to not only help the refugees, but pioneer new roles for field hospitals for future applications.”

—Zachary Weber, DO (Staff, NCC Neonatal-Perinatal Medicine)
Mission Essential: Refugee Mission Reflection  Continued from page 39

“This mission made me appreciate the unique training that military pediatricians receive; we are taught to care for complex pediatric patients, wherever they might need our help. We know how to prepare non-pediatric medical teams for unique pediatric care considerations (like when a Snickers bar might work better than a sedating medication!) and when immediate action is indicated. I am so proud to be a part of a military medicine team with the resources to execute this global mission; it has been one of the great privileges of my career to help these most vulnerable children in their time of greatest need.”

—Charles Groomes, MD (PGY5, NCC Neonatal-Perinatal Medicine)

“I was drawn to join the military after September 2001. I wanted to serve my country. I knew my calling was to help. When I signed my HPSP scholarship, I fanaticized about future humanitarian missions. Obstetrics and Maternal-Fetal Medicine -- 7 years of my life I have dedicated to training, ready to serve. When I did start my service the messaging that I received from the bigger Air Force is that my specialty is not mission essential. In the past 10 years I have seen decreasing training positions, I have seen Labor and Delivery nursing staffing deprioritized, I have seen amazing OB/Gyns leave the military because of the changes. Personally, I have been proud of my role in supporting the military mission by keeping Airmen, Soldiers and Sailors healthy, assuring safe delivery of their babies and even grieving with them when tragedy falls upon their pregnancy. I have always felt a sense of belonging within the mission of the DoD. In the days following the bombing at the Kabul airport, our hospital stepped into action. We prepared for the patients we knew would be coming. The hospital stopped elective surgeries and inpatient units prepared by decreasing census. All units, except Labor and Delivery. I spoke to a colleague of mine who was one of two obstetricians deployed at Ramstein AB. She described to me the 100,000 travelers who were living in the facility there. She told me the tales of the babies whom she had delivered in the EMEDS tent and on the tarmac. She told me of the exhaustion she was feeling taking call for 24hrs at a time every other night. I could not help feeling a sense of pride and awe in her contribution to the mission. More and more of my colleagues would be called to deploy for this mission. Some overseas, some stateside.

I stepped outside and answered the call at 8 am on Saturday morning while enjoying brunch with my family. My department chief, informed me WRNMMC would be receiving an AE Flight with several pregnant Afghan travelers. After discussions for about 30 minutes, we came up with a next step and agreed to talk again in a few hours when we had more information. He had been awake fielding phone calls since 3 am. In the next 24 hours, our department created a one-stop shop OB clinic. Over 50% of our department volunteered their time to come in on a holiday weekend so that they could help with this mission. Everyone was mission essential. We had little medical information about these women, none spoke our language, few even had a comprehension of what we were asking when we asked what their due date is. We had corpsmen, nurses, residents and several members of our attending staff. Over the next 24 hours, I would connect with the OB GYN who would be traveling with women. He told me he had an entire OB emergency kit in hand, pitocin, magnesium, blood, FFP…everything an OB would want in an emergency. He got them to us safely and another OB/Gyn and Pediatrician received them at the flight line. We welcomed seven women who were exhausted and in shock. In the coming hours we would receive a crash course in understanding these women, what information was critical, what information was unnecessary, and we did our best to provide them with compassionate care. Most women were anemic, hyponatremic, most were multiparous…and all of them were kind and understanding and incredibly patient with our inabilities to communicate. All of them were exhausted but gracious.”

—Krista Mehlhaff, DO (Staff, NCC Maternal-Fetal Medicine)

Mission essential. Gynecologists, Obstetricians, and Pediatricians are mission essential. The team of doctors and nurses in Ramstein, Sigonella, the AE Mission flight teams, the obstetrics and pediatrics departments at WRNMMC and those down the line at Quantico, Ft Lee and all the other locations where OB Gyn’s and Pediatricians have been deployed since August-- we are all mission essential. Those of us who have stayed at our duty stations and covered down for those who are deployed. Short staffed, still maintaining our usual patient volume. We are all mission essential. Those of us who have been called to care for women and children are uniquely qualified to assist and serve during stability operations. Above are the reflections of doctors who answered the call to serve and contributed in different ways. All are honored, humbled, courageous and forever changed by their involvement in this mission.

References:
Bald Eagle in Flight
David Estroff MD FAAP COL(R) MC USA

Yellow-rumped (Audubon) Warbler
David Estroff MD FAAP COL(R) MC USA
Resources and Support for Military Pediatricians via DoD’s Military OneSource

By Military Community and Family Policy
Office of the Deputy Assistant Secretary of Defense

For questions, please contact Andrea Cox at 571-230-4724 or via email @ andrea.k.cox2.civ@mail.mil

All families go through stressful times. But the emotional strain of an upcoming move or a baby who won’t sleep through the night can be more challenging for military families. As a pediatrician, you are in a unique position to learn about the issues that can affect the health and well-being of the children you care for. Connecting families with Military OneSource is an efficient and effective way to get them the help they need.

Military OneSource is a Department of Defense-funded program that supports service members and their families with non-medical counseling, consulting services and a range of tools and resources to help them manage life’s challenges.

All services are free and available 24/7 to active duty, National Guard and reserve service members and their immediate families. Military OneSource is also available to survivors and DoD expeditionary civilians, as well as veterans and their families up to one year after separation or retirement.

Non-medical counseling through Military OneSource can help parents and youth with a range of issues, such as stress or anger management, adjustment difficulties, relationship troubles and coping with grief and loss. Military OneSource cannot address emergency or crisis situations, including suspected child abuse and neglect or domestic abuse. Non-medical counseling is available in person, by phone, secure online chat or secure video sessions. Military OneSource also provides targeted support in the following areas:

Parenting and Child Care
Expectant and new parents of children up to age 5 can get individualized, confidential support through Military OneSource’s New MilParent specialty consultations. Sessions are available through video or phone on a wide variety of parenting topics, such as managing sleep issues, single parenting and addressing difficult behaviors.

The New Parent Support Program through the Family Advocacy Program provides home visits for new and expectant parents. While it is a voluntary program available to all new and expecting military parents, priority is given to parents who are at risk for domestic abuse and child abuse and neglect, and referrals from pediatricians are key to ensuring families who could benefit most from home visits are notified about the program. Parenting classes and supervised playgroups are offered at some installations.

Finding child care can be difficult for military families with unconventional schedules, which is why the Department of Defense now offers expanded hourly child care options. Free access to a national database of caregivers makes it simpler for military families to find quality hourly, flexible and on-demand child care.

Teenagers struggling with healthy eating, physical fitness or stress may benefit from Health and Wellness coaching for teens. With the support of a coach, the teen will set and work toward goals, celebrate successes and learn lifelong healthy habits. Health and Wellness coaching is available for adults as well.

Continued on page 43
Resources and Support for Military Pediatricians . . . Continued from page 42

Education and entertainment options

The Morale, Welfare and Recreation Digital Library offers free, online education and entertainment resources. Families will find e-books and audiobooks on virtually any topic. Service members and their families can learn new skills and get homework help using databases and reference books.

Financial concerns

Military OneSource financial consultants are trained professionals who understand military pay, benefits and financial issues common to service members and their families. They can help with budgeting, debt reduction, taxes and more.

Spouse employment

Frequent moves can delay military spouses’ education and interrupt their career progress. The Spouse Education and Career Opportunities program offers personalized support to help spouses overcome these obstacles. This includes free career coaching, resume review, access to scholarships for spouses and much more.

Elder care

Living in an intergenerational home or caring for an older family member can be overwhelming, particularly while balancing military life. A Military OneSource elder care specialty consultation can ease the strain by providing valuable information on resources and services.

Military families can learn more about these and other free services, resources and tools by calling Military OneSource at 800-342-9647 or visiting www.MilitaryOneSource.com.

About Military Community and Family Policy

Military Community and Family Policy is directly responsible for establishing quality-of-life policies and programs that help our guardians of country, their families and survivors be well and mission-ready. Military OneSource is the gateway to programs and services that support the everyday needs of the 5.2 million service members and immediate family members of the military community. These Department of Defense services can be accessed 24/7/365 around the world.
Military Residencies: 
Hard Work and Hard Play making residents happy every day!

Portsmouth residents learn about the USNS COMFORT, exploring assets, capabilities, and roles within the larger GHE mission. They even used the wardroom to conduct their business meeting …how’s that for offsite?

Portsmouth residents worked with the Foodbank of Southeastern VA to prepare 600 backpack lunches for children during their inaugural Day of Service.

San Diego Welcomes their Residents with a wave (and many more waves)

LT Annie Griffioen with CDR Erin Blevins on the USNS Mercy

Celebrating Together—San Diego residents share in baby shower festivities during morning report

Continued on page 45
Dr. Jones and TAMC resident and nurse help console an ill patient

SAUSHEC Residents celebrate the winter holidays in style with a wildly successful toy drive organized by CPT Victoria Coccoza

SAUSHEC Graduating Pediatric Women in Medicine Celebrate with other Women Faculty

Tripler AMC Pediatric Residents from all three classes along with MS3 and MS4 Pediatric rotating medical students ascending towards the Lanikai Pillboxes

CPT (Dr.) Joseph Nguyen (Tripler Pediatric PGY-2 Resident) exemplifying “near proper” application and implementation of BiPap while assisted by Pediatric Intensivist LTC (Dr.) Mitch Hamele during monthly simulation training sessions

Military Residencies: Hard Word and Hard Play . . . Continued from page 44

Continued on page 46
WP Pediatric Residents complete officership course at the School of Aerospace Medicine, focusing on aeromedical evacuation and transport.

SAUSHEC residents explore San Antonio in their 2nd City Scavenger Hunt.

LT Griffioen (PL3) and LT Gabe Lapid (PL2) with clinic staff and a visiting mini-horse in San Diego.

San Diego Inpatient Team—Holiday!
Living Longer: An Enjoyable and Healthy 2022
Andrew Margileth, MD, FAAP, FACP

Tips from a Red Sweater Owner

- Mediterranean Food (include Kefir Daily)\(^1, 2\)
- Vaccines!!! Use the AAP Redbook\(^3\)
- Friends—Loving and Kind—Children!\(^8\)
- Exercise Daily (Swimming, Dancing)
- Sleep—7 hours
  - NO TV, Internet
- Self-care (Relaxing Baths)
- Purpose—creative activity daily
- Nature calms (parks, woods, trails)\(^4\)
- Family Support—compatible, loving\(^5\)
- Positive Thinking—Always!\(^5\)
- Music—Jazz, Country, Blue Grass\(^7, 8\)
- Dogs: 2 Stress Relievers Daily!\(^9, 10\)

Recommended Readings
1. *Eat to Beat Disease* by W. Li MD
2. *10% Human* by A. Collen
3. AAP Red Book Committee Report
5. *A Year of Miracles* by M. Williamson
6. *Power of Positive Thinking* by N. Peale
7. [www.drjazzmusic.com](http://www.drjazzmusic.com)
8. *The Mind Gut Connection* by E. Mayer
9. *All Creatures Great and Small* by J. Herriott
10. *Brain Wash* by D. and A. Perlmutter
Editor’s Note:

Many thanks to all our generous contributors to this edition of the AAP Section on Uniformed Services Newsletter. It is truly an honor to help our members share their experiences and stories. Over the past several months, our pediatric community has clearly contributed to the military mission in countless ways and I couldn’t be more proud to have such impressive and service-oriented colleagues!

I hope that I can continue to help you share both your talents in the workplace and outside of it—thanks to those that shared their more creative sides with our audience!

Please feel free to send me article ideas, pictures, poems, stories, or anything you might be interested in seeing in future newsletter editions. Send all types of submissions to candace.s.percival.mil@mail.mil.

Have a concern about a feature or story that appeared in a past edition of the Uniformed Services Newsletter? Just want to comment on something related to uniformed services? We will do our best to respond to your concerns. Just send my way or to Jackie Burke at jburke@aap.org.

Happy New Year to you all and I look forward to seeing you (fingers crossed) at the AAP NCE this fall.

Respectfully,

Candace S. Percival, MD, FAAP
Lt Col, USAF, MC
candace.s.percival.mil@mail.mil