Chairperson’s Report

Steven E. Rubin, MD, FAAP

Spring has sprung, or at least it will have done so by the time you read this. Public health measures are melting like winter’s snow, and life is starting to return to pre-pandemic normalcy. I’m dipping my toe in the water, and this month’s AAPOS Annual Meeting in Scottsdale will be my foray into airports and crowds. Our AAP Section, unfortunately, will not have an official presence at the meeting in Arizona due to continued AAP restrictions on staff travel and in-person meetings through the end of March. Given that, you are all deputized as official ambassadors and recruitment officers. I hope to see you there!

I encourage you to talk up the AAP and Section on Ophthalmology membership with your colleagues at home and at the meeting, as we need to keep the voice of Ophthalmology strong within the AAP. Membership is an important way to show commitment to the larger pediatric community and to advocacy for children’s health. Leaders of the Section continue to represent the voice of pediatric ophthalmology with a seat at the table at many important AAP meetings where significant decisions are made, including at a recent AAP Subspecialty Advocacy Meeting, a March 2022 AAP Surgical Advisory Committee meeting, an April 2022 Female Leadership & Excellence Summit for women in pediatric subspecialties, and of course at the upcoming AAP Annual Leadership Conference, which will take place at AAP Headquarters in suburban Chicago this summer. Advocacy has always been important, but never more so than now, as the health care pie keeps shrinking. We must speak not only for children, but also for ourselves, to participate in the annual Mid-Year Forum and the participation of a worthy trainee in the future, hopefully before summer is upon us. Other polices in progress include: Screening for Retinopathy in the Pediatric Patient with Type 1 Diabetes Mellitus; Screening for Early Detection of Ocular Disorders in Two Populations: Children with Juvenile Idiopathic Arthritis and Children Being Treated with Hydroxychloroquine; Abusive Head Trauma in Infants and Children; Telemedicine for Evaluation of Retinopathy of Prematurity; and Cortical Visual Impairment.

This next item should not be news: the Section election is ongoing, and I strongly encourage your participation before it closes on March 31st. Information on the open positions and our candidates appears on page 2. Please exercise your right to vote at the AAP website (Note: You will need your AAP ID and password to log in).

As in the past, the Section is supporting the participation of a worthy trainee in the AAO’s 2022 Advocacy Ambassador Program, which provides residents and those in fellowship training an opportunity to participate in the annual Mid-Year Forum with seasoned advocates and leaders in the field. Advocacy Ambassadors participate in Congressional Advocacy Day, including scheduled visits to Capitol Hill and programs in leadership, engagement, advocacy, and practice management.

(Continued on page 2)
Chairperson’s Report
(Continued from page 1)

Dr. Lulwa El-Zein from the Bascom Palmer Eye Institute will have the opportunity to attend the Mid-Year Forum as the AAP SOOp’s 2022 Advocacy Ambassador.

This fall, we will be looking forward to Dr. Gregg Lueder giving the 2022 Leonard Apt Lectureship at the Pediatric Subspecialty Day meeting in Chicago, generously supported by the AAP’s Leonard Apt Endowment. Also in Chicago this fall we will be sponsoring our 5th biennial symposium jointly with the American Association of Certified Orthoptists at their national meeting. The meeting will address many aspects of Immigrant and Refugee Healthcare. Please stay tuned for more information on both of these events as we grow closer to late September/early October. We will also have a number of section-sponsored sessions at the 2022 AAP National Conference and Exhibition, which will take place October 7-11 in Anaheim, CA.

We encourage you to reach out if you have ideas for getting more involved in the work of the Section or the AAP. The ears of our Executive Committee are open, and we are poised to hear your ideas. On page 9 of this newsletter, we have re-printed an article from the December 2021 issue of AAP News, “Vision loss another potential consequence of delayed care due to COVID”. The publication of this article is the direct result of one Section member, in this case Dr. Daniel Greninger, reaching out with an interest in working with the section to do more to raise awareness about the importance of vision screening during the pandemic. We look forward to hearing from more of you going forward.

Safe travels to Scottsdale. I hope that, like me, you are beginning to enjoy life as you remember it prior to two years ago. May these baby-steps toward normalcy turn into bold, confident strides.

2022 Section Election

WHAT: Elect the future leaders of your AAP Sections & Councils and vote on any applicable bylaw referendums.

Our Section on Ophthalmology has three positions currently open for voting. There are (2) member positions open on our Section Executive Committee for which there are three candidates running (Dr. Mitchell Strominger, Dr. Alina Dumitrescu, and Dr. Rahul Bhola; bios available below). In addition, the position of Chairperson-Elect is currently open, a role for which Dr. Sylvia Yoo is running unopposed.

WHY: Exercise your right to vote as a member and to influence the future direction of the Section.

WHEN: March 1-31, 2022. The elected Council leaders will take office on July 1, 2022. The elected Section leaders will take office on November 1, 2022.


Note: If you are a member of more than one Council or Section, you will see ballots only for the council(s) and section(s) conducting elections this year.

Any questions about this service may be directed to the Section and Council Elections Team, sectionelections@aap.org. Thank you in advance for your participation!

About Our SOOp Candidates

For Chairperson-Elect (Unopposed):

Sylvia Yoo, MD, FAAP

Sylvia Yoo, MD, FAAP, is an Assistant Professor of Ophthalmology at Tufts University School of Medicine and has been dedicated to teaching medical students and both pediatrics and ophthalmology residents at Tufts Medical Center in addition to practicing in a suburban satellite office, working closely with referring pediatricians to provide the best care possible for mutual patients. She serves on the Tufts Ophthalmology Residency Program Evaluation Committee and has been invited for lectures locally and regionally, including at the New England Ophthalmological Society and the Eastern Regional Orthoptic Meeting. In addition to serving on the Executive Committee of the Section on Ophthalmology of the American Academy of Pediatrics, she has served on committees for the American Association of Pediatric Ophthalmology and Strabismus and is currently President of the Massachusetts Society of Eye Physicians and Surgeons, an advocacy group for Massachusetts ophthalmologists.

Dr. Yoo completed residency in Pediatrics at Stanford University, followed by Ophthalmology residency at UCLA. She then went on to a fellowship in Pediatric Ophthalmology and Strabismus at Johns Hopkins Hospital.

For Section Executive Committee Member – 2 Positions (Contested):

Rahul Bhola, MD, MBA, FAAP

An international recognized expert in pediatric ophthalmology, Dr. Bhola has over 20 years of experience specializing in the complete array of pediatric vision conditions and eye diseases. Dr. Bhola is board certified in ophthalmology with expertise in pediatric ophthalmology and adult strabismus.

Dr. Bhola completed his medical degree and ophthalmology residency at University of Delhi, India, and a second residency in ophthalmology at University of Louisville, Kentucky, where he served as chief resident. Dr. Bhola was a visiting assistant professor and fellow in ophthalmology at Jules Stein Eye Institute, UCLA, and completed an advanced clinical fellowship in pediatric ophthalmology at University of Iowa.

Dr. Bhola is currently the Chair of Ophthalmology at Children’s Hospital of Orange County and serves as the division chief of Pediatric Ophthalmology at CHOC Children’s Specialists; he is also an Associate Clinical Professor at University of California, Irvine School of Medicine.

Dr. Bhola has held leadership roles in major national and international pediatric ophthalmology organizations to disseminate education and awareness to healthcare professionals worldwide. He is the immediate past editor-in-chief of the pediatric section of the ONE network (Ophthalmic News and Education), American Academy of Ophthalmology’s
global platform for ophthalmic education. He currently serves as a member of the Program Committee for the American Association for Pediatric Ophthalmology and Strabismus (AAPOS). He also serves as a member of Scientific Board of WSPOS (World Society of Pediatric Ophthalmology and Strabismus). In addition, Dr. Bhola pursued an MBA with a focus on healthcare policies from University of California, Irvine.

Dr. Bhola’s research interests are focused on diseases resulting in irreversible vision loss in the pediatric population such as amblyopia, strabismus, retinopathy of prematurity and pediatric glaucoma. He is currently involved in research projects to better understand the pathogenesis and innovative treatment of Inherited Retinal Disorders and metabolic disorders with ocular involvement like Batten’s Disease.

Dr. Bhola recently obtained a certification in “Artificial Intelligence in Healthcare” from the Massachusetts Institute of Technology. His current passion is incorporation of AI systems to improve healthcare access and to meaningfully augment clinical decision making.

Alina Dumitrescu, MD, FAAP

I am a clinical associate professor of pediatric ophthalmology in inherited eye disorders and am passionate about education. I enjoy teaching and mentoring medical students, ophthalmology residents, fellows, faculty, and trainees in other disciplines (pediatrics, neurology), and medical providers at a local, national, and international level. Educating patients and families about complex conditions, such as inherited eye disorders and new diagnostics and treatments, is equally important to me.

During my career so far, it has been my pleasure to serve my department, the University of Iowa Carver College of Medicine, and national organizations through involvement and leadership positions in the American Association of Pediatric Ophthalmology and Strabismus (AAPOS) and the American Academy of Ophthalmology (AAO). My long-term career goals are to continue to expand my knowledge and the knowledge of my peers in the amazing field of ocular genetics and to improve the outcome of treatment of strabismus and retinopathy of prematurity (ROP). I plan to continue this work through collaborative multispecialty research, critical analysis of current and novel treatment modalities, and the development of objective endpoint measures to evaluate treatment outcomes.

I am committed to continuing to provide the best possible care to our patients, to providing outstanding training to the next generation of physicians, to advance the state of the art of ophthalmology and visual science through well-conducted research and ultimately to seek diagnosis and treatment for all pediatric eye disorders so no child will ever lose eyesight from a preventable or treatable disease.

Mitchell Strominger, MD, FAAP

Professor of Ophthalmology and Pediatrics, University of Nevada Reno School of Medicine
Medical School: Washington University School of Medicine, St. Louis
Internal Medicine Residency: University of Rochester
Ophthalmology Residency: Albert Einstein Neuro-ophthalmology Fellowship: Bascom Palmer Eye Institute
Pediatric Ophthalmology Fellowship: Manhattan Eye Ear and Throat Hospital
Senior Honor Award - AAO (Self Assessment Committee Chair)
Editorial Board - JPOS
NEJM - Knowledge Base section editor
> 50 peer reviewed articles published
6 Book Chapters

While in Boston and now here in Reno, Nevada, I have been heavily involved in organized medicine, pediatric education in regards to pediatric eye care, and have been a member of the AAP Section on Ophthalmology since its inception. In Boston I was a member of the Massachusetts Children’s Vision Coalition, working to set up legislation and networks in regards to pediatric eye care and vision screening. I also served as the vice president of the Massachusetts Society of Eye Physicians and Surgeons and was a Professor and Director of the Pediatric Ophthalmology Service at Tufts Medical Center. Since moving to Reno, I am in the process of forming the Nevada Children’s Vision Coalition working with legislators, school nurses and the statewide vision services committees to improve and advance vision care and screening for Nevada’s Children. In addition, I am heavily involved in teaching pediatricians, pediatric residents and medical students about eye care issues and have given numerous lectures at both local and national meetings. I am also involved in helping to establish a pediatric residency here at the University of Nevada Reno.

Finally, and probably most importantly, I am the Vice President of the Nevada Chapter of the American Academy of Pediatrics. In this role I am involved in supporting all childcare issues in the state, and I represent all pediatrician interests locally and nationally. As such, I have participated in leadership conferences at the national AAP level. Just recently it was announced that a policy statement and clinical report that I have worked on as an author under the direction of Drs. Tina Master and Darron Bacal was accepted for publication in Pediatrics, “Vision and Concussions: Symptoms, Signs, Evaluation & Treatment” and its companion Clinical Report, “Evaluation of the Visual System by the Primary Care Provider Following Concussion.”

I am proud to be a member of AAP and SOOp and would be honored to play a larger role nationally by becoming a member of the Executive Committee.

Calling for Newsletter Articles!

For our next SOOp newsletter, the Fall 2022 edition

Please send proposals to Geoff Bradford, Newsletter Editor, at bradfordg@hsc.wvu.edu by September 1, 2022.
In November 2021, the American Academy of Ophthalmology honored Dorothy M. Moore, MD, long time AAP Section on Ophthalmology member, with the 2021 Outstanding Advocate Award. This award recognizes Dr. Moore for her extensive and exceptional advocacy efforts to champion the health and well-being of children, their vision and their ocular health.

The American Association for Pediatric Ophthalmology and Strabismus and the American Academy of Pediatrics Section on Ophthalmology nominated Dr. Moore for her more than 30 years of advocacy on behalf of patients and the profession. Dr. Moore has positively influenced the lives of thousands of children in her care.

Dr. Moore has served multiple leadership roles at the local, regional and national level. On the local level in Delaware, Dr. Moore has been President of the Delaware Academy of Ophthalmology (DAO) and has held the position of Legislative Chair since 2000. She is considered the “go to person” when there is a governmental or legislative policy threatening the quality of care of patients in Delaware and beyond. Dr. Moore has also been active in the Medical Society of Delaware as Chair of the Public Laws Committee where she would review any laws proposed that could affect the quality of care for patients in Delaware. Her dedication to advocacy was never more clear than during her term as Medical Society of Delaware President in 2016, bringing issues involving ophthalmology to the forefront.

On a national level, Dr. Moore has served on the American Academy of Ophthalmology’s OPTHPAC Committee and as Councilor from 2017 to present. Her tireless dedication to advocacy also involves working in concert with the American Medical Association’s AMPAC conferences to develop coalitions of like-minded health providers to make ophthalmology advocacy more impactful.

One of Dr. Moore’s most significant contributions to ophthalmology arose during her involvement in 2015-2016 when optometrist regulations were going before the Sunset Committee of the Delaware legislature. The optometrists wanted it all—injectons, lasers and minor surgical procedures. Dr. Moore, along with two other ophthalmologists who helped spearhead the efforts to fight scope issues, worked over one and a half years to weaken the bill. A diluted bill was signed into law with optometrists prohibited from performing injections, surgery and laser surgery, and only permitted to perform minor procedures on the surface of the skin, conjunctiva and cornea under topical anesthesia. This win for ophthalmology can be greatly attributed to Dr. Moore’s undaunted commitment to protecting patients, her skillful negotiations with all stakeholders, and her personal relationships with so many Delaware legislators.

Dr. Moore’s long history of advocacy and exemplary service is an example for ophthalmologists on the importance of physician advocacy.

**Children’s Vision Equity Alliance**

Our Section on Ophthalmology is committed to promoting diversity and inclusion in both professional and clinical aspects. One of the collaborations we have worked with to promote better care for our patients in under-represented minorities is the Children’s Vision Equity Alliance.

Socioeconomic and racial inequities impact all aspects of health care in the U.S., causing certain racial and ethnic groups to face increasing challenges to health and well-being. One of the issues in the United States affecting healthy vision development is access to care. Healthy vision supports early childhood development, school readiness, overall health, and well being.

The mission of the Children’s Vision Equity Coalition is to advance equity in children’s vision and eye health through education, access to care, policies, and partnerships. Initiatives are targeted to helping underserved Black, Indigenous and Latinx communities. We are working to accomplish this through a two-pronged approach of Patient Education and Data & Research. Recent initiatives of the Alliance have focused on education for parents on myopia progression and signs of possible vision problems in children.

The Alliance was formed in August 2020 with leadership from Prevent Blindness and several eye care and early childhood education organizations; participants are members of the American Association for Pediatric Ophthalmology and Strabismus, the American Academy of Ophthalmology, the American Academy of Pediatrics, the American Academy of Optometry, the National Association of Neuro-Ophthalmologists, the National Medical Association and the National Association of School Nurses. It is led by Dr. Stephanie Mariouneux, Dr. Fasika Woreta, Dr. Janet Alexander, and Ms. Donna Fishman.

“As part of this coalition, we can be a voice for for all children’s eye health no matter their background and socioeconomic circumstances. I’ve been able to work with physicians of all backgrounds, especially our pediatricians, to advocate for improving health equity and patient education for children’s eye diseases. It truly has been wonderful to work with this organization and make a difference in both education and advocacy,” Honey Herce, MD Pediatric Ophthalmologist, member of the Children’s Vision Equity Alliance, and member of our AAP Section of Ophthalmology.

To find out more, please visit: Children’s Vision Equity Alliance (preventblindness.org).
New AAP Surgical Advisory Panel Workgroup to Address Access to Pediatric Surgical Care in Rural Communities

Nearly 1 in 5 Americans live in a Census-designated rural community, according to the 2010 U.S. Census. Children who live in rural areas face tremendous barriers to access to important pediatric health services. These challenges include geographic remoteness from a tertiary pediatric care center, small local hospitals with limited surgical options, as well as socioeconomic and financial barriers that make it difficult to travel for families who may have other children. As many as 20% of children and youth have complex, special healthcare needs that require subspecialty services, and these children in underserved areas are especially vulnerable to suboptimal care, increased complication rates and poor clinical outcomes. These children end up relying more heavily on the emergency department and hospital admissions for care instead of outpatient visits with pediatric subspecialists, further worsening the financial burden of health care.

The AAP Surgical Advisory Panel (SAP) has, therefore, created a workgroup to address the unique challenges that children living in rural areas face in order to gain access to surgical subspecialty care. Members from relevant surgical subspecialties (including pediatric urologic surgery, general surgery, gynecology, cardiac surgery, orthopedic surgery, neurosurgery, otolaryngology, ophthalmology, plastic surgery, oral health, anesthesiology, critical care, and radiology) are represented on the task force to help define accessible standards of surgical care and reasonable solutions such that patients can safely receive surgical care locally while limiting suboptimal clinical and surgical outcomes. The main goal of the workgroup is to provide strategies to the AAP which would optimize delivery of pediatric surgical care for rural children in the United States. Traditional delivery models have included (i.) travel to an urban center for specialty or subspecialty care, (ii.) provision of outreach to urban areas and (iii.) telehealth. The workgroup seeks to critically evaluate these traditional models and propose innovative strategies and partnerships to promote quality surgical care for rural patients.

The workgroup aspires to provide estimates for the future workforce of subspecialty providers to forecast future access to care in these regions and provide recommendations for care delivery. We hope to explore avenues to increase presence of subspecialty care in rural settings through novel approaches using existing resources such as increased use of telehealth or providing support for rural hospitals, providing education to families about options for care, and increasing the availability of providers through development of alternate medical school/residency tracks for rural surgical care.

We look forward to updating the AAP SOOp with recommendations from the Surgical Advisory Panel that will help promote optimal surgical care for all of our patients regardless of their place of residence. We would welcome input from SOOp members with any novel delivery models or ideas that might benefit this target population. Dr. Eniolami Dosunmu from Cincinnati Children’s Hospital Medical Center is our SOOp representative to the new SAP rural health workgroup.

Adapted for SOOp and Re-printed with permission from the Fall 2021 Issue of the AAP Section on Urology Newsletter
Call for Abstracts for 2022 AAP National Conference and Exhibition – Due April 22

The Call for Abstracts for the 2022 AAP National Conference and Exhibition is now open through April 22nd.

The AAP National Conference & Exhibition will accept abstracts of case reports, original research, program evaluations and quality improvement projects for presentation within various section and council programs. Section/council programs are developed by AAP member specialty and subspecialty communities to provide a forum for the advanced discussion of clinical matters, research developments, or special interest areas.

The 2022 AAP National Conference Abstract program is comprised of 41 section/ council programs accepting submissions (Note that the Section on Ophthalmology does not have a dedicated educational program at the NCE so there is no call specific to the field of pediatric ophthalmology, however, many AAP Sections cover topics that may involve children’s eyecare). Each participating section and council has program specific guidelines, which must be reviewed in detail before submission. Submission of an abstract indicates acceptance of all guidelines, policies, and procedures.

Abstracts will be accepted through April 22nd at 11:59 pm CDT on the National Conference Abstract Submission site. The Sections/Programs accepting abstract submissions for the 2022 NCE are below. Their program specific guidelines can be found here:

- Council on Child Abuse and Neglect (COCAN)
- Council on Children and Disasters (COCD)
- Council on Clinical Information Technology (COCIT)
- Council on Community Pediatrics (COCP)
- Council on Early Childhood (COEC)
- Council on Foster Care, Adoption and Kinship Care (COFCAKC)
- Council on Immigrant Child and Family Health (COICFH)
- Council on Injury, Violence and Poison Prevention (COIVPP)
- Council on Quality Improvement and Patient Safety (COQIPS)
- Council on School Health (COSH)
- Council on Sports Medicine and Fitness (COSMF)
- Innovations in Obesity Prevention, Assessment, and Treatment Forum (IOPAT)
- Provisional Section on Urgent Care Medicine (PSOUC)
- Section on Administration & Practice Management (SOAPM)
- Section on Adolescent Health (SOAH)
- Section on Advances in Therapeutics and Technology (SOATT)
- Section on Breastfeeding (SOBr)
- Section on Cardiology and Cardiac Surgery (SOCCS)
- Section on Child Death Review and Prevention (SOCDrP)
- Section on Critical Care (SOCC)
- Section on Emergency Medicine (SOEM)
- Section on Global Health (SOGH)/ Section on Infectious Diseases (SOID)
- Section on Hospice and Palliative Medicine (SOHPM)
- Section on Hospital Medicine (SOHM)
- Section on Integrative Medicine (SOIM)
- Section on LGBT Health and Wellness (SOLGBTHW)
- Section on Medicine-Pediatrics (SOMP)
- Section on Minority Health Equity and Inclusion (SOMHEI)
- Section on Neonatal Perinatal Medicine (SONPM)
- Section on Nicotine and Tobacco Prevention and Treatment (SONTPT)
- Section on Obesity (SOOb)
- Section on Oral Health (SOOH)
- Section on Orthopaedics (SOOr)
- Section on Pediatric Trainees (SOPT)
- Section on Senior Members (SOSM)
- Section on Simulation and Innovative Learning Methods (SOSILM)
- Section on Surgery (SOSu)
- Section on Telehealth Care (SOTC)
- Section on Transport Medicine (SOTM)
- Section on Uniformed Services (SOUS)
- Section on Urology (SOU)

AAP Section on Ophthalmology Executive Committee Roster 2021-22

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<td>Immediate Past Chairperson</td>
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<td>Committee on Young Ophthalmologists (YO)</td>
<td>Christie L. Morse, MD, FAAP</td>
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<td>Jennifer Riefe, MEd</td>
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Race and Ethnicity of Children Enrolled in Clinical Trials Not Representative of the United States as a Whole: Study Abstract

Authors found that pediatric clinical trials lacked participant diversity that was representative of the U.S. population in research presented at the 2021 American Academy of Pediatrics National Conference & Exhibition.

When conducting pediatric clinical trials, the scientific process is best served when participants come from diverse racial and ethnic backgrounds, so that conclusions are more likely to be generalizable to a broad population. Yet, according to an analysis of articles on U.S. pediatric clinical trials, Black children were enrolled at a proportionally higher rate than their representation in the U.S. population, while other populations were under-represented.

Researchers presented the study abstract, “Race and Ethnicity in Published Pediatric Clinical Trial Enrollment in the United States, 2011-2020,” during the virtual American Academy of Pediatrics 2021 National Conference & Exhibition.

“Our study identifies key areas in which we, as a pediatric research community, can improve enrollment in clinical trials to be more equitable for all groups,” said study author Chris A. Rees, MD, MPH, pediatric emergency medicine physician at Children’s Healthcare of Atlanta and assistant professor of pediatrics and emergency medicine at Emory University, who performed this study along with researchers from Boston Children’s Hospital.

“Results from clinical trials that lack American Indian, Alaska Native, Asian, and Native American-Pacific Islander participants may not be generalizable to all populations that may benefit from trial results,” he said.

The cross-sectional study reviewed 612 articles published in five leading general pediatric and five leading general medical journals from January 1, 2011 – December 31, 2020. Researchers determined the reporting of participant race and ethnicity in published clinical trial results, comparing the number of children enrolled with U.S. Census populations of pediatric racial and ethnic groups.

Black children were enrolled in higher proportions than their representation in the United States. Hispanic and Latino children were enrolled commensurate with their population, and American Indian, Alaska Native, Asian, and Native American-Pacific Islander children were enrolled significantly less relative to their population, the authors found. White children were enrolled less than expected based on their representation in the U.S. population, but made up 46% of participants in trials reporting race or ethnicity. More research is needed to determine the cause of these differences, but authors hypothesize they may be due to the locations where pediatric clinical trials are performed, the types of diseases and conditions that are studied, or may represent disparities in the trial enrollment process.

Researchers also observed that a substantial number of trials did not report participant race or ethnicity at all.

Pediatric clinical trials conducted exclusively in Arizona, Tennessee, Georgia, West Virginia, and New Hampshire had the lowest mean diversity indices and those conducted in California, Maine, Illinois, and North Carolina had the highest diversity indices, indicating that the representativeness of clinical trials may differ by state.

The research was supported in part by the National Institutes of Health.

To view the abstract in full, click here.

Study Looks at Pandemic Changes, Health Care Worker Burnout

Research presented at the 2021 American Academy of Pediatrics National Conference & Exhibition finds that technology changes during pandemic may have contributed to burnout.

A survey of health care providers at a regional pediatric health care network found that the practice changes made in response to the pandemic may contribute to burnout among health care professionals.

The study abstract, “The Impact of COVID-19 and the Rapid Adoption of Telehealth on Provider Burnout in a Pediatric Healthcare Organization,” presented during the virtual American Academy of Pediatrics 2021 National Conference & Exhibition, found that those experiencing burnout are more likely to have negative perceptions about telehealth visits.

This may be because the switch to telehealth was done on an emergency basis during the pandemic, and there may not have been enough policies in place to support health care providers, especially for those already experiencing burnout, the authors write. The study also found that institution-level policies to reduce burnout are more likely to be perceived as insufficient by those experiencing burnout.

“Change is hard. The pandemic created the necessity for a massive shift to the adoption of telehealth in health care organizations. There was no time to follow all the rules of change management. Survival and leadership strength fueled change. Recovery must include awareness of the burden of rapid change, plus a crisis, placed on the health care team,” said study author Kenneth Grant, MD, a pediatric gastroenterologist at Children’s Health Orange County.

Previous research on burnout among health care providers has shown that it can have serious negative consequences for health care providers and patients, with clinicians experiencing burnout being more likely to make medical errors, the authors note.

For this study, a brief questionnaire was designed by a multidisciplinary team and sent to all 378 providers at Children’s Health Orange County in June 2020. Eighty-four responded.

The survey found that 56% of respondents reported that they were experiencing burnout. The survey also found that 84.5% of respondents believed that their patients seem satisfied with service provided through telehealth. However, more negative perceptions of telehealth increased the odds of reporting burnout by 47%.

The data show that, when controlling for the other variables in the model, the self-reported experience of burnout is predicted by three perceptions: COVID-19 has exacerbated provider burnout, the benefits of telehealth do not outweigh the challenges, and there is insufficient institutional support to reduce burnout.

Adequate institutional resources for promoting provider well-being, and combating provider burnout, during these difficult times are important, the authors note.

To view the abstract in full, click here.
As I begin my term as AAP president, I want to say what an honor it is to serve this extraordinary organization. I am proud of the influence our Academy has had on the health and well-being of our country and the impact it has had on children everywhere. I am filled with gratitude and a deep sense of responsibility by the trust you have placed in me.

The past 22 months have been grueling. But through our innate resilience, fueled by our commitment to children and families, we have provided the hope and healing that have been needed so badly.

In the coming year, we will continue to work to end the pandemic by promoting vaccination, science and education, while using the power of our voice to push harder for what we know children need. We will apply lessons learned from this crisis to address challenges such as mental health, achieving health equity and improving access to quality care.

Rising rates of depression, anxiety and suicidality have been made worse by the pandemic as have inequities in access to mental health screening, diagnostics and evidence-based therapeutic services. The AAP has embarked on a comprehensive strategy and set of initiatives to support healthy brain development. I look forward to furthering our leadership in this area by incorporating a trauma-informed care approach to prevent and respond to mental health concerns.

Equity must be infused in all we do. This work began in earnest seven years ago and is being embedded throughout our organization. As we embark on year two of our Equity Agenda Workplan we will continue to address root causes of health disparities by alleviating the challenges and stressors many families and communities face. We will advocate to:

- reduce poverty,
- promote quality education, child care, affordable housing, adequate nutrition and safe environments, and
- reverse centuries of health inequities — largely rooted in structural racism and social injustices — that have led to devastating consequences for our Black, Latino, Indigenous and Asian communities, as well as LGBTQ+ youths and some immigrant populations.

I’ve spoken often about my own childhood and what a relief it was when my father got a job at Ford Motor Co. with medical benefits. It meant not having to make impossible choices between health care and life’s basic needs. I ran for AAP president to give every family that same sense of security. Indeed, universal health coverage — where families can access the care they need when they need it without suffering financial hardship — is central to ensuring every child has a healthy future. And, of course, it has to be designed to pay pediatricians for the care we provide.

As chief of a division at the University of California, Los Angeles that includes primary care pediatricians and subspecialists, I deal daily with the challenges of maintaining high-quality, compassionate care in a climate of slim financial margins where access is mediated not by what a child needs but by insurance coverage. Inequities in coverage promote inequities in health care and access to it.

As an academic, I also know the importance of data and will step up efforts to use data in deciding the care children need and advocating for equitable access and fair payment.

Many pediatricians were suffering from burnout prior to the pandemic. We now face new challenges and financial stressors. We will continue to use advocacy and education to improve physician wellness, including:

- addressing the culture of medicine and aspects of the practice environment that lead to stress and inefficiencies, including administrative burdens and regulatory requirements, and
- fighting for increased payment for the care we provide with all payers, including Medicaid.

To our members who are hurting, I will ensure we do all we can to support you.

Our voice — individually, collectively, locally and nationally — is important, and its impact must not be underestimated. The new year is filled with promise and the power of 67,000 pediatricians who can tell the story of this country’s children and advocate for the needs of the pediatricians who care for them. I look forward to advancing this conversation with you and moving toward a better future for our nation and its children.
Vision loss another potential consequence of delayed care due to COVID
by Daniel A. Greninger, MD, FAAP

During the COVID-19 pandemic, a decrease in pediatric preventive care visits combined with a lack of in-person schooling have led to a significant drop in childhood vision screening. The result may be an increase in permanent visual impairment due to amblyopia.

Amblyopia is a disease of vision development affecting about 3% of children. Amblyopia is caused by uncorrected refractive error (need for glasses), strabismus (eye misalignment) or other conditions depriving the eye of normal images during the critical visual development period from birth to age 7. After age 7, amblyopia is more difficult to treat, and a patient diagnosed thereafter has a greater risk of permanent vision loss.

Amblyopia often goes undetected because young children can be asymptomatic. As such, vision screening and subsequent follow-up with eye care are essential to detect and treat the disease.

The AAP and other national organizations recommend all children be screened for amblyopia in primary care during early childhood when the disease is most treatable (https://bit.ly/3q2QgsB). The U.S. Preventive Services Task Force recommends vision screening for all children at least once between 3 and 5 years to detect amblyopia or its risk factors (JAMA. 2017;318:836-844).

Traditionally, screening has occurred as part of in-person well-child care visits. In-person vision screenings also take place in preschool and primary school settings, creating a safety net to help ensure that amblyopia does not go undetected.

Data from Kaiser Permanente Northern California, which tracks vision screening within primary care for tens of thousands of children, suggest the rate of vision screening during well-care visits held steady from 2019-'21. However, the opportunity to perform screenings in children ages 3-6 decreased by about 30% due to a reduction in in-person well-care visits. Rates of follow-up visits with optometry after failed screening decreased as well.

Data collected by the American Association of Certified Orthoptists also suggest that in Iowa and Oregon, two states with robust school and community screening programs, in-person vision screening of children in school and community settings decreased by 70% in 2020. Many families also may be concerned about the effects of extended screen time on their children’s eyes due to the shift to online education during the pandemic.


Vision screening is important to help to identify myopia at an early age when behavioral modifications and treatments to slow progression, such as low-dose atropine eyedrops and specially contact lenses, may be most effective.

As families and providers become more comfortable with telehealth for preventive care, there may be an opportunity for traditional vision screening to be supplemented by home-based screening. Systematic reviews of home-based visual acuity apps have been performed in adults (Samanta A, et al. J Telemed Telecare, https://bit.ly/3bell9Jo). While no app has been validated for home-based amblyopia screening, a systematic review is forthcoming (Sii S, et al. BMJ Open. 2021;11:e051830, https://bit.ly/3GTDPoI).

Vision screening is not just for detecting a need for glasses; it is essential for early detection of problems that can cause permanent visual impairment. Therefore, pediatricians should include vision screening on the list of catch-up items to address for patients who have delayed in-person care.

Dr. Greninger is a member of the AAP Section on Ophthalmology.

Resources
- AAP policy statement Visual System Assessment in Infants, Children, and Young Adults by Pediatricians
- AAP clinical report Procedures for the Evaluation of the Visual System by Pediatricians
Equity, Diversity, and Inclusion has Risen to the Forefront of our Agenda

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Amid a global pandemic, the death of a black man at the hands of a white police officer incited protests of millions around the globe, illuminating another pandemic that had previously taken an insidious back seat - racism. Soon, the entire world, rather than only those who experience it daily, would come to recognize that racism is still present and deeply incuated in our normal way of life. For some, conversations of reflection and need for change emerged. For others, there was denial of any reality of racism’s continued hold on our culture with an inability to perceive its existence.

Through these events, conversations of equity, diversity and inclusion have come to the forefront. While many know their relevance, we often fail to understand the true meaning of these concepts and their individual importance. Equity is ensuring that each individual, despite varied access or abilities, has the same opportunities available to others. We cannot only be concerned with what personally affects us, but we need to elevate those around us as well. Diversity is the presence of people from different race, ethnicity, gender, gender identity, sexual orientation, religious affiliation, socioeconomic status, or other varied groups. Having diverse voices at the table is critical to understand the needs of everyone and keep those naive to the experience of others accountable. Inclusion is ensuring that all are welcomed so that they are comfortable to speak, act, be involved, and strive to their highest potential.

Diversity without equity and inclusion is not progress. Not only do individuals have to be present, they must know that they are invited, have equal opportunities, feel welcomed, and have the ability to thrive. Although we understand that diversity and inclusion is the way forward, some of these concepts and their ultimate goals are somewhat misplaced. Some may believe that diversity of thought can achieve the same goals as racial and ethnic diversity, but there is a special understanding of practices among those who are culturally similar and of those that have been excluded from the unique experience of segregation. Therefore, it is imperative that there is diversity of varied groups who have a seat at the table, and more importantly that these individuals are given the freedom and security to speak while there. Pediatrician Dr. Rhea Boyd puts it best: “diversity and inclusion is the active desegregation of those that have been excluded.”

In medicine racism not only shows up at these professional levels, but is manifested through racial health disparities. For example: in nephrology, “race was originally included in eGFR calculations because clinical trials demonstrated that people who self-identify as Black/African American can have, on average, higher levels of creatinine in their blood. It was [ascribed] to differences in muscle mass, diet, and the way the kidneys eliminate creatinine”. Race has since been a part of the eGFR estimating equations attributing a higher kidney function for any particular creatinine level if someone was Black/African American. This contributes to delayed referral for transplant evaluation and worsens the racial health disparity in kidney disease care and outcomes for Black patients. With race being a social construct, as opposed to a biological one, race in itself does not predispose someone to worse outcomes. Instead, race and the experience of racism in America is linked to social determinants of health, including zip code, education achievement, health insurance, and food and housing insecurity - all of which are linked to worse health outcomes.

In her grand rounds presentation on Racism and Kidney Health, Making Equity a Reality, Dr. Dinushika Mohottige discussed racial essentialism, which is the false “belief that races capture biological distinctions with defining core essences”. She described how this is associated with racial bias as it allows for “categorization of large groups of biologically heterogeneous people as the same”. In nephrology the well-known APOL1 gene has been linked to kidney disease in African Americans. Dr. Mohottige reported that “APOL1 associated kidney disease is not solely a concern for Black individuals or persons of African descent and that this may lead to mis-assessed risk for APOL1 high risk alleles among other non-Black subgroups”. In addition, it leads to stigmatization of Black Americans assuming that all may have this disease. “Race and ethnicity are poorly defined and flawed surrogates for environmental and genetic causes of disease, so genetic conclusions cannot be made about continental or racial populations” as this further contributes to provider bias and perpetuates racial health disparities.

(Continued on page 11)
To achieve the goals of equity, diversity and inclusion, some believe that the complete removal of racial categorization may allow us to focus less on our differences. Rather, Dr. Mohottige discusses that we must “carefully define race and specify reasons for its use. Without data on race, we cannot understand how racism shapes experiences and we are unable to identify the disparities.”15 Without knowledge on how racism impacts us all, “children are forced to ignore racial differences, [and instead gather unchecked] implicit biases from social cues. [We therefore need to] identify, name and systematically examine the role of racism in producing health inequities; [in order to] move beyond systems that perpetuate the erroneous association between race and genetics; push for an evidence based ideal.”

Racism is a social determinant of health and so as clinicians, we must be invested in combating it. For us to achieve health equity we must have difficult and uncomfortable conversations among a diverse group of individuals who all feel welcomed and empowered to be a part of the change. We can get there through continued advocacy. Anyone can be an advocate. This is clearly exemplified to be a part of the change. We can get there through continued advocacy. Anyone can be an advocate. This is clearly exemplified by the work of Dr. Lilia Cervantes, who challenged policy to push for an evidence based ideal.

Advocacy can take many forms: from understanding and dismantling policies that contribute to bias, amplifying voices at the table that have not been heard, advocating for research in racism and inequity, or reinvesting in communities of color, among others. We all have a part to play to move forward to a more equitable future, but it will take humility, empathy, and consistent advocacy efforts to achieve it.

**References:**
5. Mohottige D. Racism and Kidney Health: Making Equity a Reality. The Division of Nephrology & Hypertension at Nationwide Children’s Hospital, Nephrology Grand Rounds 2021.

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**AAP PODCAST: “PEDIATRICS ON CALL”**

“Pediatrics on Call” is the AAP’s podcast, exploring the latest news and innovations in children’s health, discussing the science behind child health recommendations, and providing a forum to hear first-hand from leading experts in child and adolescent medicine. Each 30-minute, weekly episode features interviews about new research and hot topics in the field of pediatrics.

Some recent episodes of interest include:

**Parental Leave for Pediatric Trainees, Pandemic’s Effect on Children with Special Needs**

*Episode 105*

In this episode Jennifer Cohen Takagishi, MD, FAAP, co-author of the AAP policy statement on parental leave for pediatric trainees, talks about recommended changes to support young families. Hosts David Hill, MD, FAAP, and Joanna Parga-Belinkie, MD, FAAP, also talk to Dennis Z. Kuo, MD, MHS, FAAP, immediate past chair of the AAP Council on Children With Disabilities, about efforts to get our most vulnerable children back on track.

**Advocacy in Pediatrics, How Opioids Affect Suicidality**

*Episode 102*

In this episode Annie Andrews, MD, MS, FAAP, who is running for Congress in South Carolina, talks about the importance of advocacy in pediatrics. Hosts David Hill, MD, FAAP, and Joanna Parga-Belinkie, MD, FAAP, also talk to Patrick Quinn, PhD, about his research on how opioids affect suicidality.

**Sports and Exercise for People with Disabilities, Increased Rates of Underinsured Children**

*Episode 97*

In this episode Paul Carbone, MD, FAAP, former chairperson of the AAP’s Council on Children with Disabilities Autism Subcommittee, shares the latest guidance on promoting sports and activity for children with disabilities. His son Ben, a 19-year-old with autism, joins the interview to describe his personal success in sports. Hosts David Hill, MD, FAAP, and Joanna Parga-Belinkie, MD, FAAP, also talk to Justin Yu, MD, MS, about his research on the increasing rates of underinsured children.

**A Mental Health Emergency, Reading’s Effects on Social-Emotional Development**

*Episode 95*

In this episode AAP President Lee Savio Beers, MD, FAAP, describes the national crisis in mental health children and teens are facing today. Hosts David Hill, MD, FAAP, and Joanna Parga-Belinkie, MD, FAAP, also talk to Keith J. Martin, DO, MS, FAAP, about research in the journal *Pediatrics* on how reading affects children’s social-emotional development.

New episodes are released on Tuesdays. See all episodes at www.aap.org/podcast.
**In Memoriam: Marilyn T. Miller, MD, MS**

Dr. Marilyn Miller, a renowned pediatric ophthalmologist, teacher, and leader in global ophthalmology, passed away this past fall. She obtained her medical degree and training in ophthalmology at the University of Illinois at Chicago (UIC), where she was on the faculty since 1965.

During her career, she served as president for both the American Ophthalmological Society and the American Association for Pediatric Ophthalmology and Strabismus, and held board and advisory positions for the AAO Board of Trustees, the AAO Foundation, and the World Health Organization. She was also the winner of the 2017 Leonard Apt Lectureship Award, presenting on Zika Virus. For more than 25 years, she worked with a small NGO to visit rural Nigeria, providing clinical care and lecturing.

In recognition of her exceptional contributions to improving eye care worldwide, Dr. Miller received the Humanitarian Award from the AAO, the Howe Medal from AOS, and the 2019 Academy Laureate Award. “Dr. Miller was a dear friend, an incredible mentor, and a trailblazer in ophthalmology who made an impact on all of us,” says Dr. Paul Chan, Department Head of Ophthalmology and Visual Science at UIC. “The contributions she made to our profession are beyond measure.”

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**Telehealth for Support of Care Coordination for Children and Youth with Special Health Care Needs**

**New Telehealth Use Cases in the Pediatric Care Coordination Curriculum 2nd Edition**

Announcing two new resources for pediatric subspecialty providers, pediatric hospital-based providers, and primary care providers, as well as anyone who does care coordination to support the care of patients with complex needs; those with a specific interest in learning about opportunities for leveraging telehealth will be interested.

These two new use cases have been integrated into the **HRSA/MCHB funded Pediatric Care Coordination Curriculum, 2nd Edition**. Each use case presents an overview of needs and goals to consider for the given patient/family, describes alignment with AAP policy recommendations, and provides considerations for equitable access to care coordination via telehealth. These use cases were developed through a collaboration between Boston Children’s Hospital and the American Academy of Pediatrics, with support from the Maternal and Child Health Bureau Health Resources and Services Administration. Brief summaries of each use case follow:

- **Care Planning and Coordinating Transitions from Inpatient to Outpatient Settings**: 11-year-old with Multisystem Inflammatory Syndrome in Children (MIS-C) as a result of COVID-19 infection.
- **Using Telehealth to Coordinate Care for Youth with Complex Needs Transitioning from Pediatric to Adult Care**: 19-year-old young adult with autism spectrum disorder, intellectual disability, and attention-deficit/hyperactivity disorder.

The development of these resources is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $6,000,000 with no percentage financed with nongovernmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS or the U.S. Government.

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**National Research Agenda Highlights Priority Research Topics for Children and Youth with Special Health Care Needs**

A new supplement to *Academic Pediatrics* features seven papers and an executive summary that outline a national research agenda to improve how health systems work for children and youth with special health care needs (CYSHCN). The research agenda was developed through the CYSHCNet, a national research network supported by the Maternal and Child Health Bureau of the Health Resources and Services Administration. Research topics were identified through a rigorous process with a diverse group of stakeholders, including youth and family caregivers. The following priorities are outlined in the national research agenda:

- Child health and social determinants of health, to examine how the places people live, learn, work, and play impacts health
- Family health and how to support the adaptability of families with CYSHCN
- Caregiving and at-home support
- Telemedicine and supporting families living in rural areas
- Principles of care, to better understanding the keys to successful care management
- Health care financing, including payment models and value outcomes
- Youth-to-adult transitions and how gaps in support impact outcomes

The *Academic Pediatrics* supplement is available here. For more information about CYSHCNet, visit their Web site here.
Cultivating a Social Media Presence to Combat Medical Misinformation

David R. Stukus, MD, FAAP (@AllergyKidsDoc)
Professor of Clinical Pediatrics, Director, Food Allergy Treatment Center
Associate Director, Pediatric Allergy & Immunology Fellowship Program
Nationwide Children’s Hospital and The Ohio State University College of Medicine

“I am urging all Americans to help slow the spread of health misinformation during the COVID-19 pandemic and beyond. Health misinformation is a serious threat to public health. It can cause confusion, sow mistrust, harm people’s health, and undermine public health efforts. Limiting the spread of health misinformation is a moral and civic imperative that will require a whole-of-society effort.”

~Vivek H. Murthy, MD, Surgeon General of the United States

Even before the COVID-19 pandemic, social media had fundamentally changed the manner in which people search for and receive information. In March 2020, during the very early stages of the pandemic, the World Health Organization declared an ‘infodemic’ due to the sheer volume of continuously flowing information. Social media and popular cable news outlets create a sense of urgency with every headline or article labeled BREAKING NEWS. We are no longer afforded time to vet information for accuracy or place into proper context. Throughout the pandemic, misinformation and disinformation have negatively impacted individual medical decision making and public health efforts. The online assault on our collective well-being is so pervasive that the Surgeon General of the United States issued a call to arms in his report “Combating Health Misinformation”.

Medical professionals have long held powerful roles in the lives of our patients. People come to us in pain, scared, and in need of help. They trust us to listen to them and offer advice on how to improve their health and their lives. Unfortunately, our current times dictate the need for all of us to recognize the powerful influences our patients have in their lives that erodes that trust. Even if professionals are not actively involved in social media, they still must educate themselves about the impact it has on medical decision making. By actively addressing this during individual encounters, we can learn valuable information about rationale why patients may decline evidence-based measures and allow for follow up questions and discussion. However, our need to intervene goes beyond the exam room.

As outlined in the Surgeon General’s report, two of the key steps that all medical professionals can do to combat misinformation include proactively engaging with patients and the public on misinformation and using social media platforms to share accurate information. Medical professionals have knowledge, expertise and perspective surrounding complex areas such as pathophysiology, diagnostic testing, and treatment options. The more medical professionals are involved online, the greater chance we have to combat and dilute the bad information with evidence-based resources.

There are some strategies for medical professionals to consider when cultivating their online presence. It is important to identify a target audience to determine what type of content to share, as well as which social media platforms to utilize. Facebook is used more by older generations, whereas Instagram is popular with younger generations and new parents. Some may have multiple target audiences, or they may change over time. It is also useful to create a professional profile and choose an account name, picture and bio that indicates what each account represents.

Growing a social media presence requires persistence, frequent engagement, and use of colorful imagery, videos, infographics, or gifs. Sharing content such as open access journal articles, media reports and websites from vetted professional or advocacy organizations is helpful, particularly while also offering perspective. Professionals can directly combat misinformation by using relatable analogies or anecdotes and providing clear explanations. Protection of patient privacy is always paramount, but professionals can use social media to discuss common concerns or conditions they treat, along with treatment options or prognosis.

Hopefully it is evident why more medical professionals are needed on social media. We all have a unique voice and perspective to offer. Even those who decide they lack the time or desire to actively engage online need to learn more in order to best help their patients. For those who do get involved, the real key to cultivating a social media presence lies in three simple words: Provide valuable content.

Reference:

Reprinted with permission from the Fall 2021 issue of the AAP Section on Hematology-Oncology newsletter
Perspectives in Safety and Quality: 
Striving for the Delicate Balance of Resident Autonomy

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The apprenticeship model of medical training is familiar to most physicians, with a long history brought into our current practice by Osler and Flexner around the turn of the last century. The adage of ‘see one, do one, teach one’ captures this philosophy where medical learners acquire the necessary skills from their mentors and then pass it along to their followers. Competence-based medical education (CBME) provides opportunities for resident to go beyond basic medical knowledge and clinical skills to emphasize competencies in the core activities of the discipline. CBME attempts to better define these competencies in terms of their milestones and endpoints to ensure that residents are equipped with the necessary skills for their ultimate specialty practice. In the end, however, the final decision on achievement of competence still rests in the judgement of the supervising preceptor.

The role of supervisor oversight is crucial in this consideration of clinical learning. Residents must learn to perform the skills of their chosen specialty, and the entrustment scales used in CBME highlight that residents are often starting at a level where the preceptor judges that ‘I needed to do it myself’. For residents to progress to the stage where a preceptor believes ‘I didn’t need to be there’ requires opportunities to practice with real patients and families, which includes the progressive autonomy to perform the skills independently. Of course, the learning environment must consider the medicolegal responsibility of the preceptor and institution and the safety of the patient and family in providing this graduated autonomy.

A commentary by Cioffi highlighted the challenge of that medicolegal tightrope in the Italian context. While medical learners must practice under appropriate graduated supervision, the court found that they were fully liable for their own conduct and responsible to decline a delegated task if they did not feel able to perform it successfully. This decision makes it nearly impossible for residents to acquire the developmental competencies, and it also puts them at risk of unfavourable evaluations if they consider themselves unable to complete a task. This is aptly described as “being caught between the hammer of possible mistakes and the anvil of potential disciplinary measures”. The Canadian Medical Protective Association (www.cmpa-acpm.ca) expects residents to be able to perform tasks that would be reasonably delegated based on their level of training and ability, and the supervising physician could be held liable for inadequate supervision or inappropriate delegation. While this puts the liability on the supervising physician, the responsibility to decline the task might still rest with the resident between the hammer and the anvil.

Mieczkowski et al. noted that promoting autonomy improves self-directed learning and medical knowledge and skills among residents, which could result in improved patient and family autonomy and fewer medical errors. In their qualitative study of residents in Pediatrics, Internal Medicine, and combined Medicine-Pediatrics, they discovered a general erosion of autonomy in Pediatrics. Surveys with residents in all three programs showed more attending oversight and less autonomy on Pediatrics compared to Internal Medicine, which was even more pronounced for the Med-Peds residents. Similar surveys of faculty in the two programs found that the faculty believe they are providing more autonomy than the residents are experiencing. This suggests a perceptual disconnect between resident and faculty expectations of resident autonomy which could impact the opportunities provided for the residents to acquire the necessary competencies.

Crockett et al. surveyed residents from multiple specialties for their views on autonomy and divided these into three main themes categorized with driving analogies. This driving analogy is apt since learning to drive represents another high-risk technical skill which can only be learned with progressive skill development and independence. Residents’ perceptions of autonomy included decision making (driving care), ownership of patient care (taking the wheel), and autonomy gained through experience (learner’s permit), all with the support of the attending physician as a ‘safety net’. Factors promoting resident autonomy were active encouragement for residents to lead patient care (handing over the wheel), collaborative management (two-way street), and supervision from a distance, where the attending physician is absent but still connected (roadside assistance). Finally, factors which undermined autonomy included minimizing resident involvement (failing to yield) and micromanaging care (backseat driving).

One potential solution for both patient safety and appropriate resident supervision is the possibility of attending coverage for the full 24-hour day. This has been established in some centers, particularly in critical care settings. However, Rehder et al. found that all-hours coverage of a Pediatric ICU was associated with a negative perception by residents, fellows, and attending intensivists, who shared the concern of a lack of resident competence because of this loss of autonomy. The commentary on this paper questioned whether the acute solution to patient safety could result in longer term compromise, as the residents may struggle to function independently as attending physicians in the absence of new efforts to foster autonomy.

The challenge of resident autonomy appears to be a balance between the needs of the resident and those (Continued on page 15)
of the patient. However, this is a false dichotomy, since our future patients will need physicians who achieved competence as residents. Medicolegal obligations of the supervising physician and teaching hospital also have an important impact on both sides, with overlapping responsibilities to the patient and the resident. CBME offers an opportunity to better define the required skills and milestones, but unfortunately does not address how to delegate responsibility and increase independence in the process. Addressing these challenges requires awareness of the expectations of the training program and national certifying body as well as any relevant statutes impacting patient care and resident supervision. In our increasingly complex health care environment, it is imperative to identify and foster solutions for our next generations of physicians to practice safely and independently.

References
4. Canadian Medical Protective Association. The physician as teacher

Tips to Incorporating Technological Innovations into Medical Education

Eleny Romanos-Sirakis, MD, MS, FAAP, Assistant Professor of Pediatrics, Staten Island University Hospital Northwell Health, Zucker School of Medicine at Hofstra Northwell

Our current modern learners have grown up surrounded by technology; they are not only comfortable with technology, but they also expect it to be incorporated into teaching and education. With the COVID-19 pandemic, medical educators were thrust into using technology even more with the sudden shift to remote learning. The TPACK model (Technological, Pedagogical, and Content Knowledge) was described in 2006 by Mishra and Koehler, and highlights the importance of integrating and balancing all 3 of these core components in teaching. Technology should be integrated into the content and pedagogy of the learning environment. The TPACK model can be visualized as a Venn diagram with each of these 3 core components of teaching; the ideal learning environment exists in the center, where all 3 circles overlap and the components are balanced.

As everyone might suspect, technology and remote learning are both likely to remain an integral part of medical education. With some preparation, we can all continue to utilize technology to help maximize teaching and learning.

1. Use technology to enhance the lecture: Technology should be used to supplement and enhance your teaching and should not overtake the entire teaching session. Try out the technology in advance and make sure it works. Always have a back-up plan in case you run into technical difficulties.

2. Maximize your presence when teaching remotely: Being an effective teacher requires some degree of charisma and creating the foundation of a connection with learners. Engaging your audience is a necessary step for teaching and learning to occur. It can be even more difficult to engage an audience remotely. Optimizing how you appear to the audience can improve engagement. Consider the lighting in the room, the camera angle (best

(Continued on page 16)
Tips on Including Technology in Medical Education
(Continued from page 15)

angle is at eye-level), and the background (best is uncluttered and neat). Take advantage of platform setting such as the HD setting and an option to “touch up my appearance.”

3. Active learning methods through remote learning: More information is retained when educators utilize active learning techniques. Even though you are teaching remotely, you can still utilize some of the same active learning techniques you would use in an in-person session. Breakout rooms can be used for small group discussions. Use the chat feature to allow for audience participation. The whiteboard allows you to actively illustrate a topic in real-time with the audience. The learners can participate by annotating the drawing. The annotation tools can also be used to survey the learners who can vote on lists you make and present. The whiteboard can also be used to centralize ideas brought forth by the group’s brainstorming efforts.

4. Videos: Incorporating videos into teaching can be very effective. Videos can efficiently share a concept or demonstrate, simplify topics, and serve as attention-grabbers. Videos should be limited in duration, optimally a few minutes long. You can make your own videos or use pre-created material. You can incorporate videos into the teaching sessions or create a library of short videos or even full-length lectures for learners to review at their own pace. Utilizing a flipped classroom approach, videos can be assigned for review prior to the session, allowing for more in-depth discussion during the session. Some free program options include:

• Edpuzzle (www.edpuzzle.com): allows you to make your own videos or take pre-created videos (for example, from YouTube) and add questions for learners to answer throughout the video to make it a more interactive session and include formative assessments.

• Screencastify: Screencastify is a Chrome browser extension that allows you to record, edit, and assign screencasts. While recording, you can use the tools to write, draw, erase, or spotlight a section on the screen. You can record yourself explaining difficult concepts, recapping the day’s main objectives, demonstrating an idea, or giving students audio or video feedback on their work. Students could use Screencastify to demonstrate what they’ve learned, how they solved a problem, or give presentations. The free version allows for 5-minute videos to be created.

5. Games: Gamification and game-based learning can make learning more fun and engaging, and can appeal to the competitive nature often intrinsic to many of our learners. Games can increase motivation to learn, facilitate formative assessments and lead to a higher retention of knowledge. There is a wide range of games and technological components that can be brought into learning sessions, from creating word searches on-line, to jeopardy sessions for use during the session, to using new platforms for quiz-type games. A few options to consider include:

• Kahoot (www.kahoot.com): Create quizzes with a fun game-show-like feel, with music and all! Learners log into kaoot.it and enter the code- they then enter the game. Learners can play all together at the time of the center, or play at their own pace at home.

• Jeopardy: Everyone knows the gameshow, and it can be incorporated into any teaching session. Use a template and create a Jeopardy board that can be presented easily through PowerPoint.

6. Polls and Quizzes: Use quizzes and polls to objectively assess learners’ understanding or to check in with the audience on their feelings, perceptions, or needs. You can use determine their goals, baseline experiences with a topic, or comfort with aspects of the material. Consider the following free options:

• Socrative (www.socrative.com): Create a set of questions to assess learners’ knowledge with this quiz-based formative assessment tool. The “space race” option can also be used during a session to tap into learners’ competitive nature; learners work to quickly answer questions to help their team win the race.

• Mentimeter (www.mentimeter.com): Create word clouds and questions to engage the learners and check-in with the learners on their understanding or comfort with a topic; the results of the poll or word cloud can be displayed in real-time on your screen and can be used to spark discussion and direct the teaching session. Answers can be multiple choice, open-ended, or rankings. Learners just need to enter the code you post that is created once you activate your set of questions for the presentation. FYI, it works best if you don’t embed the questions into your PowerPoint slides.

References and Resources:
Introduction
Women worldwide spend two- to ten-fold more time on unpaid care work than men in a given week.¹ This may involve care of household members or household work, which could theoretically be delegated to a paid third party, but for which the individual performing it is unpaid.² On superficial analysis, one might attribute the gender gap in unpaid care work to societal and cultural attitudes about gender norms, femininity, and motherhood. However, newer data have revealed that economic and public policies have a substantial impact on the gender care gap. This particular gender gap not only contributes to labor and wage inequality, but is an infringement on women’s rights and agency.³ Furthermore, if mothers of healthy children suffer from this inequality and infringement on their rights, those who care for children with medical complexity (CMC) must suffer to an even greater degree. As physicians who care for them, we must examine the issues facing families of CMC, reasons for the gender gap in their care, ethical frameworks for activism, and high-yield areas to advocate for policy change, including home nursing, paid caregiving for CMC by family members, family leave, and increased job flexibility. If our laws prohibit gender discrimination, our public policies simultaneously should promote gender equity.

Caring for Children with Medical Complexity
Those who provide medical care for CMC recognize that some parents’ proficiency in providing bedside care rivals that of some nurses, and their diagnostic acumen rivals that of some physicians. Through varying degrees of choice, they have devoted their lives to caring for their children, with varying degrees of support from a partner or other caregiver. Even in a high-income country such as the United States, many states lack the rehabilitation facility beds and home nursing support to give CMC the medical support they need when they leave the hospital. The following is an unfortunate but common scenario: a baby born extremely premature who needs a tracheostomy for long-term ventilatory support might have no home nursing available in her area, regardless of insurance status, and might wait months for a rehabilitation bed in the closest facility in a neighboring state. If she is able to be discharged home, her mother will quit her job to provide bedside care and her father will work full-time (or more) for the provision of financial support and medical insurance. In the most recent example this writer recalls, the father’s work schedule did not permit him to come into the hospital to learn tracheostomy care. The weight of this responsibility is considerable for all parties, but the scale tends to tilt heavily toward women. The public policies which tether one caregiver to the home, including lack of home nursing and job inflexibility in this example, result in strained relationships, loss of autonomy, and sacrifice of economic and educational opportunities.

Significant literature exists on how caring for CMC impacts parents. In a cross-cultural study, Krulik et al. found that mothers of young children with chronic illness experienced more problems with attachment, depression,
Three theories maintain oppressive social orde
First, virtue ethics concentrates on living a moral life in order to achieve a state of happiness. For those who are victims of oppression, fulfilling moral virtues such as courage and proper ambition, as well as intellectual virtues, becomes significantly more difficult due to their lack of choice, making happiness less likely to be achievable. For decades, economists have demonstrated how women’s roles in parenting diminishes their ability to finish education, pursue careers, and compete in the workforce, contributing in part to the gender pay gap.7 Thus, primary caregivers of CMC suffer at an individual level from unmet goals and society as a whole suffers when a subset of individuals and their talents are absent from public life.

Second, contractarian ethics states that laws of morality derive their normative force from mutual agreement.10 Situations and relationships in which persons have not entered into a fully willing agreement, due to existing forces of gendered oppression, are not moral. As such, mothers who care for CMC frequently are subject to economic dependency on their partners, making them more likely to be victims of abuse, have less ability to exit a marriage, and have a significantly reduced standard of living after divorce.11 By perpetuating the gender care gap, the US drives some mothers who care for CMC into a lifetime of indenture that is less often imposed upon their children’s biological fathers.

Third, one cannot discuss care for children without mention of the ethics of care, which holds that moral action centers on interpersonal relationships and care for one another. Critics of this theory contend that oppression throughout history has intertwined caregiving with femininity, and thus focusing on their caregiving abilities lessens women’s agency.12 Yet, the value of caregiving by anyone in our society, especially parents, cannot be diminished. One must advocate for fathers to embrace its value and participate actively to become co-primary caregivers, as well as for society to provide the needed social supports.
Closing the Gender Care Cap
Several explanations have been offered for the gender gap in unpaid care work, including attitudes about gender roles in a given country and the nature of the jobs that women hold. However, these microeconomic reasons have failed to explain cross-country variation. In an analysis of thirteen European countries, comparative modeling demonstrated that the single most important factor in predicting a gender care gap was presence or absence of public care services, and that gender attitudes and women’s position in the labor market played a minor role. This key observation should inform our efforts at the national, state, and local levels.

Most importantly, the dearth of home nursing availability in the throughout the US negatively affects families. Studies of work-family policies from 38 developed democracies confirm that where the availability of childcare is very limited, very expensive, or of poor quality, women are more likely to be unemployed, hold low-quality jobs, have job turnover, and lower wages. The same is true for those who care for CMC due to lack of home nursing, with 52% dropping to part-time and 21% quitting their jobs. Due to disproportionately low wages, nurses are disincentivized from working in homecare agencies. Although every state’s Medicaid program allows paid caregiving for adults by their family members, including by adult children and spouses, most states prohibit paid caregiving for CMC by family members. No justification for this differential treatment is apparent. Some private insurances simply do not cover home nursing. Increasing Medicaid reimbursement for pediatric home nursing, allowing family caregivers for CMC to be paid by insurance, mandating private insurance coverage, and instituting national standards for waivers to obtain Medicaid coverage would increase availability of home caregiving services, particularly to low-income patients, and decrease healthcare dollar expenditure on intensive care hospital stays.

In addition, job flexibility for part-time and full-time employees would expand a family’s ability to share the responsibility of caring for CMC. With respect to family leave policies, the US remains one of a handful of countries in the United Nations that does not guarantee paid parental leave. The father in the aforementioned case was unable to even learn how to care for his child due to job inflexibility. For families receiving insurance through an employer, one parent often needs to work full time, thereby perpetuating the traditional dynamic of one bread-winning parent and one caregiving parent. Pediatricians and sub-specialists who saw outpatients during the COVID-19 pandemic may recall a serendipitous phenomenon: an upsurge in fathers taking their children to appointments, likely due to increased job flexibility for higher-income families. An early study corroborates more egalitarian division of household labor during the pandemic. Another study has shown that increased physical involvement by fathers in their child’s cancer care improves marital outcomes and decreases the burden each parent experiences. Iceland is at the forefront of equitable leave policy, with the overwhelming majority of fathers (88%) using their three-month leave demonstrating its necessity. As such, reform in labor policy promotes steps toward gender equity.

Conclusion
Of course, most parents derive fulfillment from caring for their children, and would choose the same path again if given the choice. The same holds true for many mothers who care for CMC. However, almost none of them were actually presented with that choice, and likely not to the same degree as their child’s father or other parent. Although they might choose the role of full-time caregiver, they likely would not choose to serve as full-time, unpaid bedside nurse/nursing assistant/paramedic/care
coordinator/physical therapist/teacher/parent. Options likely are further narrowed for mothers who are single or have low incomes. When women are forced into situations beyond their control, they are victims of oppression, yet it is all members of society who ultimately suffer from the gender gap in unpaid care work. In a high-resource, high-income country such as the US, the problem is not inadequate financial resources, but misplaced priorities which systematically overlook the needs of families.

Thus, we as pediatricians and other healthcare providers have an obligation to advocate for expanded home nursing availability, institution of paid caregiving for CMC by family members, universal and egalitarian paid family leave, and increased job flexibility for our patients’ families.

References


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