Chair Letter
Courtney Judd, MD, MPH, MHPE, FAAP
Col, USAF, MC
Chairperson, AAP Section on Uniformed Services (SOUS)

Hello, Section on Uniformed Services (SOUS) members!

What a wonderful opportunity we had to meet in person in Anaheim for the Uniformed Services Pediatric Seminar (USPS) at the AAP National Conference and Exhibition (NCE)! I think I speak for all of us who were present that we are indeed - as the theme of this year’s NCE proclaimed - “Better Together.” We missed those of you who were not able to attend and hope you will join us this year.

I want to personally thank Col Candace Percival (USPS Program Chair) and Lt Col Michelle Kiger (Chair of the Scientific Awards Competition) for their incredible dedication and for making USPS a huge success. Ms. Jackie Burke (SOUS Section Manager) also deserves a wellspring of gratitude for ensuring a seamless return to our in-person gathering – thank you is never enough for what you do! There were so many submissions for the scholarly competition within USPS, and I was very impressed with the depth and quality of the presentations. Congratulations to all of the award winners for their amazing accomplishments!

Over the past year, the SOUS Executive Committee created our strategic plan for the next 5 years. Your input is crucial, so let us know if you have any insights into how we can accomplish these important goals. One of the priorities we selected specifically highlights the importance of each of you, and your individual health and well-being – you matter. The top priorities on which we plan to focus are:

1) Consulting with the AAP Department of Federal Affairs on issues important to our military-connected children and providers, such as the Autism Care Demonstration program, Tricare changes, and military medical billet and staffing issues (see the medical society letter to the DoD on military medical billets on page 5).
2) Addressing the mental health of SOUS members.
3) Expanding the presence and impact of junior members within the SOUS.

Please mark your calendars and try to join us for the next AAP NCE, which is scheduled from October 20-24, 2023, in Washington, D.C. The USPS programming will be held on Sunday, October 22, 2023.

If you have any questions, concerns, or ideas, I would love to hear from you – my email address and cell phone number are listed below.

Every story matters, and I am happy to hear yours.

Sincerely, Courtney
Email: courtney.a.judd.mil@health.mil
Cell: (210) 632-9404
Looking Up
Artist: Capt Kevin Brinkman, MD, USAF, MC
# Section on Uniformed Services

## Executive Committee Roster

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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
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Medical Society Letter to the Department of Defense on Military Medical Billets

July 1, 2022

The Honorable Lloyd J. Austin III Secretary
United States Department of Defense 1000 Defense Pentagon
Washington, DC 20301-1000

Dear Secretary Austin:

On behalf of the undersigned organizations representing healthcare clinicians and educational institutions that comprise the backbone of the Military Health System (MHS), we write to thank you and President Biden for delaying all future medical military end strength divestitures by one year. This announcement in the FY23 Defense Budget Request Overview aligns with the FY 2022 National Defense Authorization Act (NDAA) that paused any medical billet reductions for a year from the bill’s enactment and required a study from the Comptroller General’s office on the data used to justify the individual services’ proposed reductions to uniformed physicians, nurses, and allied health professionals. While this “pause” in reductions is welcome, the undersigned organizations are concerned that the service branches, particularly the Navy and Air Force, are still planning to move forward with a substantial reduction in military medical end strength over the next several years which we feel does not align with the current state of our country’s health care system and does not fully consider the second- and third-order consequences for the military health system and service members and their families who rely on it for care. In fact, military medicine is already feeling the effects of reduced training numbers and years of slow billet cuts. In addition, previous proposals to eliminate 12,000 to 18,000 uniformed medical billets also do not consider the ways in which the MHS and the country’s overall health care system are intertwined and benefit from each other.

Existing Stress on Military Medicine

While there is a current pause on military medical billet reductions, there have already been reductions to overall medical end strength through open billets not being filled and smaller billet divestitures over the years. Many MTFs are currently understaffed and more remote locations are having staffing challenges. In addition, the news of previous proposed reductions is already having a dampening effect in recruiting medical students for military residencies, especially in pediatrics. The number of medical students interested in these residencies has been declining across the services because the proposed cuts to military training billets gives the perception that there is no longer a viable long term career path in military medicine. This same phenomenon is even beginning to negatively affect retention of current uniformed clinicians. In short, constant proposals to reduce medical billets and training programs is hampering the future supply of uniformed clinicians. While we welcome a pause in future medical divestitures, we are already dealing with the deleterious effects of reducing medical billets. Continuing to propose large-scale reductions in medical billets will only worsen the situation.

COVID-19

When proposals to transform the military health system began in 2017, the nation and the world were in a much different place. As we have seen over the past two and a half years, the COVID-19 pandemic has impacted all aspects of life for individuals across the country, including service members and their families. Members of the Armed Forces and their families have experienced numerous disruptions to health care services, childcare, education, permanent change of station orders, finances, and employment, among others. The country has weathered several large COVID-19 surges, with the Delta and Omicron variants causing huge spikes in cases, hospitalizations, and deaths. While these waves have disrupted the lives of military families, they have also dramatically affected 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 civilian hospitals and COVID-19 vaccination clinics around the country, proving once again the value of the uniformed clinician to respond to public health emergencies. But the toll of the COVID-19 pandemic—long work hours, sporadic lack of protective gear, caring for people dying from the virus, dealing with misinformation and disinformation about COVID-19 and vaccines, and even having to deal with threats of bodily harm from fellow Americans upset with public health recommendations to mitigate the spread of the virus—has weighed heavily on the nation’s medical community.

Because of the stress caused by the pandemic, many health care professionals have retired early or have left the medical field for another profession. A recent article in JAMA highlighted an ongoing survey of COVID-19’s effects on primary care practices that demonstrated that many clinicians are increasingly burned out, traumatized, anxious and depressed.1 In a February 2022 survey, the Larry A. Green
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Center in Virginia also found that 62 percent of 847 clinicians surveyed had personal knowledge of other primary care clinicians who retired early or quit during the pandemic and 29 percent knew of practices that had closed.2 According to the National Institute for Occupational Safety and Health (NIOSH), worsening staffing issues are now the biggest stressor for clinicians. Health care worker shortages, especially in rural and otherwise underserved areas of the country, have reached critical and unsustainable levels. Data like this underscores our organizations’ concern about the ability of the private sector to absorb a large influx of Tricare beneficiaries in the contracted sector, as previous divestiture proposals have urged. This is particularly true for pediatric subspecialties and mental health services for all ages.

From a pediatric perspective, the United States’ supply of pediatric subspecialists is inadequate to meet children’s health needs. Many children must wait more than 3 months for an appointment with a pediatric subspecialist. Approximately 1 in 3 children must travel 40 miles or more to receive care from a pediatrician certified in adolescent medicine, developmental behavioral pediatrics, neurodevelopmental disabilities, pulmonology, emergency medicine, nephrology, rheumatology, and sports medicine. This problem is compounded by the fact that in some subspecialties, fewer medical residents are choosing careers in pediatric subspecialties, and the existing subspecialist workforce continues to age. There is also a significant disparity in the geographic distribution of pediatric subspecialists across the country, resulting in many underserved rural and urban areas.

Along with excessive distances and lack of capacity to accept new patients, many practices have been severely affected by workforce shortages because of the pandemic and are not accepting new patients. On top of the stressors caused by the pandemic, there are many private sector clinics and hospitals in the United States that cannot participate in Tricare because of the low payment rates. In addition, a report by the GAO in May of 2020 found that DoD methodology to determine MTF’s restructuring relied on civilian health care assessments that did not consistently account for provider quality or account for access to an accurate and adequate number of providers near MTFs.

Mental Health Crisis

In addition to stress on the medical community caused by COVID-19, the pandemic has accelerated the mental health crisis in our country. The COVID-19 pandemic has created profound challenges for communities, families, and individuals, leading to a range of emotional and behavioral responses due to uncertainty, duration, need for quarantine, and loss of family members or loved ones during the pandemic. For the pediatric population, we have witnessed soaring rates of mental health challenges among children, adolescents, and their families, exacerbating the situation that existed prior to the pandemic. For example, rates of childhood mental health concerns and suicide rose steadily between 2010 and 2020 and by 2018 suicide was the second leading cause of death for youth ages 10-24. The pandemic has intensified this crisis, as across the country we have witnessed dramatic increases in the past two years in Emergency Department visits for all mental health emergencies including suspected suicide attempts. According to the CDC, between April and October 2020, hospital emergency departments saw a rise in the share of total visits that were from children for mental health needs. This situation is why the American Academy of Pediatrics, the Children’s Hospital Association and the American Academy of Child and Adolescent Psychiatry declared a national emergency in children’s mental health last fall and recently released the Blueprint for Youth Suicide Prevention.

On top of this, we know that children in military and veteran families face all the typical stressors impacting their civilian counterparts, as well as unique factors such as parent regularly in harm’s way, deployments and prolonged separations, frequent moves, and possibly having to care for a parent with a service-related injury. Yet military families continue to face barriers to receive needed services for mental, emotional, and behavioral health needs, for both active-duty members and their beneficiaries. From prevention to early intervention, community supports, crisis care, and better understanding and navigation of higher acuity care, we must improve coverage and incentivize easy access for service members as well as children and youth in military and veteran families.

Unfortunately, proposals to reduce the number of uniformed mental health professionals in the MHS will only worsen the situation for military families. The civilian sector does not have enough mental health providers to keep up with demand as it stands now. With a lack of mental health professionals, it often falls upon primary care family physicians and pediatricians to screen for and provide integrated mental health services to their patients. But military families will also lose access to many of these clinicians as well if past divestiture proposals were to move forward with no changes. Removing options for military families to access mental, emotional, and behavioral health services at MTFs and military hospitals belies the current reality and will only make it harder to military families to access needed care. These services not only need to be maintained in the military health system, but they also need to be expanded, as fewer options within the Tricare network and the civilian sector squeeze out military families.

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Restraints on Deployment and Surge Capacity

As world events have demonstrated over the past several years, the role of the uniformed health professional is more important than ever and a key component of the Armed Forces. During the withdrawal of the United States military operations in Afghanistan, medical manpower was critical to the success of Operation Allies Welcome (OAW). From screening refugees in theater, to providing evacuee medical care on planes—including delivering babies while in flight—uniformed medical personnel, who had received proper training and were deployable at a moment’s notice, were able to screen for infectious disease, provide primary and specialty care, and ensure that the withdrawal was able to lift more than 100,000 out of the country in a manner of weeks.

Medical personnel have played critical roles throughout the whole of our nation’s response to COVID-19, with many deploying in support of Defense Support of Civil Authorities (DSCA) missions, staffing FEMA vaccination sites and integrating with civilian hospitals across the country, proving once again the value of the uniformed clinician to respond to public health emergencies. If we have learned anything from the pandemic it is that we must ensure our military medical system can work in support of national surge capacity to fulfill the crisis response mission without compromising beneficiary access to essential medical care. Reducing medical billets, especially considering the pandemic and the recent withdrawal from Afghanistan, undermines this military surge capacity.

Medical Education and Training

For decades, the DoD Graduate Medical Education (GME) program has provided the millions of Armed Forces families with a highly trained, well-staffed, and accessible health care provider workforce. Most uniformed clinicians train at a medical military center (MEDCEN), staffed with a combination of uniformed and civilian (often retired military) physicians who have experience with remote duty stations and deployments. In addition, the Uniformed Services University of the Health Sciences (USU) plays a critical role in training and supplying military clinicians that civilian training programs do not. For example, USU is the single largest accession source of military medicine and provides development training, resources, and research support to faculty at military training facilities worldwide. USU specialized programs provide unique education and training opportunities to develop medical force readiness through military field exposure and military-specific treatment competencies that are not available through training in the civilian sector. A November 2019 analysis by the non-profit Institute for Defense Analysis (IDA) found that USU is a far better value for DoD than other means of training military healthcare professionals and called for expanding USU to better meet national military and civilian priorities. Consequently, the USU serves as a force multiplier for military and non-military physicians and other health care providers throughout the military and non-military health systems.

Being able to perform both simple and complex medical procedures in combat environments and post deployment settings is vital for military readiness and overall troop health. Accounting for more than 25 percent of physicians on active duty, medical practitioners trained at USU are more than 70 percent likely to commit to military career service after training. University graduates participate in more operationally relevant training courses and are deployed more than 250 percent longer than other accession sources—an average of 731 days compared to 266 for other military physicians.

In light of physicians, nurses and allied health professionals leaving the medical workforce in large numbers due to the pandemic, medical education and training programs take on a greater importance to help replenish the workforce. Graduate medical education training positions within the military health system play a vital role in producing culturally competent, combat ready, military medical officers. Reducing such positions would undermine a well-functioning military health system. If GME billets were dramatically reduced, these training opportunities would not automatically be picked up in the civilian sector. Even if one were to propose a partnership with civilian GME programs to ensure the military specific training that is required, the capacity may not exist. The current number of residency positions are unable to address growing nationwide physician shortages. The excess need created by the elimination of military GME may not be able to be replaced in the private sector. This problem is compounded by the fact that fewer medical residents are choosing careers in certain subspecialties and the existing subspecialist workforce continues to age. The training programs provided through military GME billets and USU in these much-needed subspecialties are crucial to providing needed medical care for children in military families, as well as the civilian population that benefits from this training. It would be unwise to leverage short-term cost savings by cutting GME programs, which puts at risk access to highly qualified and military trained medical personnel.

Quality of Care at MTFs and Military Hospitals

As we have emphasized previously, major structural changes such as billet cuts can have far-reaching, unintended, second- and third-order consequences. While the MHS transformation has resulted in closing and consolidations of MTFs at certain bases, we strongly encourage DoD to re-evaluate what continued large scale reductions in medical billets that are crucial for staffing MTFs and hospitals may have on the readiness
level of uniformed surgeons and clinicians. One recent study has already demonstrated a loss of surgical skills for military surgeons due to moving care out of MTFs and shifting care to civilian facilities. The result from this study is the exact opposite outcome of what the MHS transformation was intended to achieve. Another recent study showed that limiting access to MTFs could worsen quality and safety of care for military families. Both studies are important to consider in any proposals to reduce military medical billets and close MTFs moving forward.

Considering these concerns, we believe it is appropriate to pause any reductions or realignments in military medical billets and re-evaluate further closings of military treatment facilities. 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 overstressed and overburdened, would simply exacerbate the devastating impacts on service members and their families.

Further, any proposals to eliminate GME and training programs, especially at the Uniformed Services University of the Health Services, which help train and supply the MHS with expertly trained uniformed medical clinicians that provide needed care for our military servicemembers and their families, should be reconsidered. 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.

If the health of our families is indeed considered a national security priority, then the reduction or elimination of military medical end strength would do little to improve military wartime readiness. Depriving Armed Forces families and their children of accessible, effective, and affordable medical treatment within the MHS will also reduce family readiness. Servicemen and servicewomen who are deployed need the peace of mind to know that their family back home can get access to needed health care clinicians.

We appreciate your commitment to the men and women of our Armed Forces and their families that support them during their service. As the Department pauses any reductions in medical billets, we would encourage you, along with leadership at the Defense Health Agency, to meet with officials of the undersigned organizations for a dialogue on the current state of medicine in our country. We live in a different world than we did just two and a half years ago, let alone since 2017 when the MHS transformation began. We look forward to working with you to ensure that the MHS is in the best position possible to achieve its mission and provide optimal care for our service members and their family members.

Sincerely,

American Academy of Allergy, Asthma & Immunology
American Academy of Family Physicians
American Academy of Ophthalmology
American Academy of Pediatrics
American Association of Clinical Endocrinology
American College of Allergy, Asthma & Immunology
American College of Obstetricians and Gynecologists
American College of Osteopathic Physicians
American College of Physicians
American Group Psychotherapy Association
American Pediatric Association
American Pediatric Society
American Psychiatric Association
American Society for Gastrointestinal Endoscopy
Association of American Medical Colleges
Association of Medical School Pediatric Department Chairs
Council of Pediatric Subspecialties
The Gerontological Society of America
National Association of Pediatric Nurse Practitioners
North American Society for Pediatric Gastroenterology, Hepatology and Nutrition
Society of Critical Care Medicine
Society of General Internal Medicine

In addition to Afghanistan, the current pandemic has highlighted the risks of cutting surge capacity within the military health system. Uniformed

References:
1 Abbasi, J. “Pushed to Their Limits, 1 in 5 Physicians Intends to Leave Practice,” *JAMA*, April 19, 2022, Vol. 327. No. 15. doi:10.1001/jama.2022.5074
2 Ibid.
Medical Society Letter to Department of Defense on Military Medical Billets  Continued from page 8


Army Consultant Update

COL Mark Craig
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Army pediatricians continue to serve their dual roles of physician and Officer with excellence. Our GME programs produce outcomes that exceed those of our civilian counterparts. Our junior pediatricians either practice the full scope of pediatrics following residency, or practice soldier medicine at the Battalion and Brigade levels. Many young pediatricians balance their time between full spectrum pediatrics and soldier medicine. Another common route for young pediatricians is fellowship. Nearly 30% of this year’s graduating pediatricians were selected for fellowship immediately following residency.

Senior pediatricians typically choose leadership positions in GME, at the hospital, or in operational units. Pediatricians commonly spend time in a combination of these roles. Senior pediatricians volunteer for operational leadership positions in higher percentages than almost all other specialties and excel in these roles. Pediatricians are represented across the Army in Command positions, and at the Division, Corps, and even Combatant Command level of physician leadership. Similarly, pediatricians serve as physician leaders in positions at Major Commands such as TRADOC, USARPAC, AMC, and the Army Futures Command.

In the past few years Army pediatricians have deployed across the globe serving as experts in the care of children and supporting soldiers far away from home. Pediatricians cared for refugees from Afghanistan, and for adult patients with COVID-19. Army pediatricians continue to answer whenever the Army calls.

Pediatricians enjoy diverse assignments and experiences throughout their careers. Opportunities abound across the Army in clinical, educational, and leadership routes. The Army continues to need the expertise of pediatricians in the care of dependents, but also in the care of soldiers and children both at home and abroad.

Air Force Consultant Update

Lt Col Crystal Palmatier
crystal.m.palmatier.mil@health.mil

I would like to first introduce myself; I took over as Air Force Pediatrics Consultant in mid-July 2022 from Col (ret) Eric Flake. I am a general pediatrician, currently stationed at Lackland Air Force Base in TX and working within the San Antonio Pediatrics market. I have three kids ages 9, 7 and 3 so I am in a busy but fulfilling stage of life! It was great to meet some of you at the American Academy of Pediatrics National Conference and Exhibition in October, all of the in-person and poster presentations were very informative and inspiring! If you were unable to attend this year then please mark your calendars for October 20-24, 2023, to attend in Washington D.C., I would love to meet you there!

Recently two Air Force pediatricians (Col Renee Matos, Pediatric Intensivist and Capt Kevin Brinkman, 2nd year pediatrics resident at San Antonio Uniformed Services Health Education Consortium) served a vital role for a Critical Care Air Transport Team, transporting a critically ill child from Guam to San Diego CA and ultimately saving the child’s life. More details regarding the story can be found here dvidshub.net. We also have an Air Force Pediatric Gastroenterologist, Lt Col Patrick Short, deployed in support of Afghan evacuees in Qatar. I appreciate his willingness to support the Air Force and the DoD in this mission.

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Air Force Pediatricians are doing great things across the world, whether its transporting newborns in the Pacific, serving as core faculty at one of our residency or medical student training sites or taking care of families at each military treatment facility, all with unique missions.  You are all greatly needed and appreciated!

Navy Specialty Advisor Update

CDR Jennifer Eng-Kulawy
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I recently attended the AAP National Conference and Exhibition in October and was reminded of the incredible work being done in pediatrics for the health and wellbeing of our nation’s children. During the Uniformed Services Pediatric Seminar, we discussed adverse childhood experiences and trauma informed care for our military children. I learned about the incredible research that was done during COVID and met some up and coming pediatricians currently in residency. The day I left the conference was the day I was informed of my selection as the Navy Pediatric Specialty Leader, one of the most important and humbling moments in my career thus far. I have the honor of both representing the pediatric community to the Navy Surgeon General and working to shape the community of Navy pediatrics for the future.

Since I first joined the Navy, there have been shifts in how the pediatric community has been viewed. The swing of the pendulum has reached all the way from getting rid of all pediatrics in the Navy to needing more pediatricians to care for our military families and train our non-pediatric colleagues. The one constant that I have noticed throughout the years is that pediatrics has always been viewed as an “extra.” We are “nice to have” but have not been seen as an operationally relevant specialty and that makes it challenging to show our value. The DOD is finally realizing the error of their ways. We forget that we care for our nation’s future warfighters and that is something the Navy, and all of DOD is now realizing. With the recent study that came out earlier this year, 77% of young Americans would not qualify for military service without a waiver due to being overweight, using drugs, or having mental and physical health problems. Children of service members understand the military lifestyle, appreciate dedication and service to one’s country, and are more willing to join the military than the average American.  Military pediatricians, physicians who have trained in military programs to understand the challenges and special needs of military children, help create a bond between that child and the military that can help promote trust for the future.

Navy Pediatrics is currently looking at a manning crisis, one that we have not faced in recent memory. Historically, we have been an overmanned community and have not had problems filling our billets. Due to a number of factors, including the threat of divestitures, the decreased training opportunities for residency and fellowship, and the increased attrition rates in all of Navy Medicine, our numbers will soon be the lowest that they have ever been. While this will be challenging for the coming few years with multiple gapped billets around the world, this also puts us in a unique position to show the Navy the importance of our contribution to the organization and the warfighter. Our continued research in obesity, mental health, and neonatal care highlights the areas where we are essential to the Navy and all of the DOD. Our stabilization and care of sick and premature neonates has been discussed at some of the highest levels of the DOD due to the loss of the Guamanian neonatologist and the lack of community NICU resources on Guam. Our obesity research is now being highlighted due to the recruiting crisis and lack of qualified young Americans. Our mental health screening that we provide to all adolescent patients is being emphasized due to the mental health emergencies we are seeing in our active-duty population. Developmental pediatrics was the only medical specialty specifically named by the Commandant of the Marine Corps as a tool needed for retention and recruitment of their force. The work we are doing every day is important and beneficial on a larger scale which the Navy and DOD are finally seeing. My goal for the next three years as Specialty Leader is to ensure that the Navy sees how our care of military children translates not only to our current active-duty population but also to the future force that they are looking to recruit. I will be honest with you that it will be a struggle for the next few years while we work to build our community back up, but I ask you to have patience and reach out to me with your concerns, questions, and comments. I work for you and want to hear your thoughts, ideas, and plans for the future. Our community is just that, it’s ours. It will be what we make it and when we work together, we can accomplish anything.
Public Health Service Update

CAPT Jennifer Wiltz
igc2@cdc.gov

Hello fellow USPHS officers and colleagues,
I hope everyone enjoyed AAP NCE this year. USPHS officers attended, led, provided expertise, learned, collaborated, enjoyed, and presented. One such officer, CAPT Andrew Terranella, MD MPH FAAP, presented a talk in collaboration with Dr. Scott Hadland of Harvard School of Medicine on the state of the opioid epidemic in youth and the path forward. They shared data on the epidemiology of overdose and opioid use in youth, public health approaches to reducing overdose, and clinical approaches to screening, treatment, harm reduction, and stigma reduction.

Unfortunately, there were more than 108,000 overdose deaths in 2021, most associated with illicitly manufactured fentanyl (IMF). The epidemic has not spared adolescents - in whom overdose fatality associated with IMF nearly tripled from 2019-2021. Public health approaches such as strengthening recovery services in communities are important to linking adolescents with opioid use disorder to care and treatment. Additionally, as pediatric providers, we can play a vital role by increasing screening for substance use disorders, expanding treatment availability, and reducing stigma surrounding addiction. Remember that Facing Addiction in America: The Surgeon General’s Spotlight on
Continued on page 12
Introduction to the Diversity, Equity, and Inclusion Taskforce Chairperson

Maj Sharen Wilson, MD, FAAP
sharen.wilson@nccpeds.com

Like many people, I joined the military because I saw the potential for adventure, community, and opportunity like none other. Further, the call to a greater mission made me gravitate towards the call to serve. The medical community, however, is facing assaults on multiple fronts, leading to poor job satisfaction and retention. While this is incredibly multi factorial, I dare say that a good part of this is due to inequity built within our own professional ranks. For that, DEI has become a nationwide priority amongst the military and within our medical community. As pediatricians, we have been at the forefront of this even before this movement with our patients and within our community. However, our work is just beginning as we start to reflect on our own medical force and what we are doing to improve.

As the new DEI chairperson in the AAP SOUS, my goal is to help recruit and maintain a workforce that is talented, diverse, and committed to fostering strong culture and camaraderie. This vision is built on recognizing that we currently do not really know where we stand as a workforce. To execute on this vision, I am taking a comprehensive look into demographics data across the uniformed services, advocating for decision making that respects the diversity of our services, and building and improving programs that cultivates relationships for better comradely and fulfilling career.

My strategic plans starts with a few different goals for this year. Amongst these include, collecting data across the services and SOUS for analysis, starting a new DEI spotlight within the SOUS newsletter, building a SOUS DEI team, and promoting and finding ways to incentives membership and mentorship within our ranks.

I hope that many of you will recognize that with any new goals, it will take time, hard work, a changing in our cultural framework, and an open mind. Further, I want others to see the potential that we have to make long lasting changes that will truly strengthen our force. Please feel free to reach out to me personally if there are members who have ideas on how to make this dream come true or want to take an active part of that change.

Thank you.
Section on Pediatric Trainees Liaison
to the Section on Uniformed Services Update

CPT Noelle Molter Pediatric Resident (PGY-2)
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Follow us on social media!
Twitter: @AAPSOP
Facebook: facebook.com/AAPSOPT

The AAP Section on Pediatric Trainees (SOPT) has been hard at work! Here are some highlights from the past year:
The AAP SOPT membership continues to grow and currently has 1,739 medical student, 11,959 resident, and 3,310 fellowship trainee members as of October 2022.

At the 2022 AAP Annual Leadership Conference, four resolutions sponsored by SOPT were adopted, including one in the top ten! 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. The SOPT-sponsored resolutions included, “Reducing Evictions in Pediatric Patients,” “Opposition to the Practice of Virginity Testing,” “Alleviating Childhood Poverty Through Tax Credit Policies” (TOP TEN), “Improving Healthcare Visit Equity for Patients with Limited English Proficiency,” and “Expanding Hematopoietic Stem Cell Transplant Opportunities for Patients of Ethnic Black, Asian, Pacific Islander, Hispanic, and Native American Populations”

The 2021-2022 SOPT Advocacy Campaign, Rx Against Racism – Racism as a Public Health Crisis, completed its final trimester with:

TEACH: Sharing our understanding and interventions with others. Learning how to support underserved families and communities.

The new 2022-2023 campaign, announced at the NCE in October 2022, is entitled “Racing Against ACES.” The yearlong campaign will be broken up as: Trimester 1: UNDERSTAND
Trimester 2: EVALUATE
Trimester 3: RESPOND

Check out https://collaborate.aap.org/SOPT/Pages/SOPT-Advocacy-Campaign.aspx for more information.

The section has many resources and venues to support trainees, including the following:

• The AAP Mentorship Program is thriving with over 2,300 active participants! The section is always in need of more subspecialty mentors. 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.

• Digital learning through recorded webinars, which are available to all AAP members. These webinars cover a broad range of topics from Subspecialty 101s to Advocacy topics to Learning and Growth as leaders. Check out https://collaborate.aap.org/SOPT/Pages/MediaCenter.aspx to view these webinars.

• Opportunities to get your voice out there! The SOPT News and Views Blog provides a space to read, write, learn, and grow from others in the field of pediatrics. More information and submission details can be found at https://collaborate.aap.org/SOPT/Pages/News-and-Views-Blog.aspx. SOPT Storytellers is a way for trainees to share their personal stories in medicine, for more information and submission, visit https://collaborate.aap.org/SOPT/Pages/Storytellers.aspx. Consider submitting a piece for the SOPT Monthly Feature in Pediatrics, more details and submission information can be found at https://publications.aap.org/pediatrics/pages/author-instructions#SOPT.

Finally, I am YOUR liaison between SOPT and SOUS. Please let me know what will be most helpful and how I can facilitate communication and opportunities between the sections. I am readily available by either of my emails above. I look forward to serving as your liaison!
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/22ryQVx 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.
- Contact Tina Morton at tmorton@aap.org with any questions about the AAP Mentorship Program.

Visit us:
- aap.org/podsuniform
- uschapterwest.com
- facebook.com/UniformedServicesChapterEast
Greetings from Uniformed Service University! The Department of Pediatrics was pleased to welcome the pediatric clerkship directors to campus for a School of Medicine wide meeting of clerkship site directors in September. Nine pediatric faculty members from across the Military Health System were able to join in-person and others joined remotely. During this week they 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 rely on caring for children in the future. One out of three USU graduates will directly provide medical care to children as 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.

Our student pediatric interest group is expanding its reach to include outreach to HPSP students. The USU PEDs Education Division is working to create opportunities for HPSP students, particularly those in the pre-clerkship phase of their education to connect with active-duty pediatricians either as mentors, or just to briefly discuss career opportunities and get “ground truth” about what it’s really like to serve as a uniformed pediatrician. If you have interest in supporting this initiative, please contact the lead faculty mentor for the interest group, Alison Helfrich at Alison.helfrich@usuhs.edu.

For faculty, please remember that if you will be migrating to new email addresses (e.g., health.mil) in the near future, have PCS’ed, retired or ETS’ed please be sure to send your new email address to facultyupdate@usuhs.edu and cc: Ms Angela Johansen (angela.johansen@usuhs.edu), our Faculty Coordinator in Pediatrics. Doing so will ensure that you continue to receive departmental communications and will also prevent any issues in contacting you during our next faculty reappointment period. Also, there are a tremendous amount of professional development resources available to you through the USU Faculty Development portal. I would encourage each of you to register at: https://fac-dev.usuhs.edu and take advantage of the opportunities there, including an opportunity to participate in virtual New Faculty orientations (see online schedule for details).
Congratulations to CAPT (sel) Melissa Buryk from Naval Medical Center Portsmouth for winning the Dean’s Teaching Award for Senior National Faculty. This award is the result of a competitive nomination process drawn from across all departments and faculty at USU.

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

To the rank of Professor:
Wanda Salzer
Virginia Randall
Matthew Borgman
Michael Rajnik

To the rank of Clinical Professor:
Amy Michalski

To the Rank of Associate Professor:
Lauren Vasta
Allison Malloy
Danielle Monteil
Nanda Ramchandar
Shelton Viola
Karla Davis
Sean Hipp

To the rank of Clinical Associate Professor:
Sebastian Lara
Angela Bryan
Silena Chapman
Marcia Frye
Sean O’Meara
Charles Nguyen

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.

Best Wishes,
Patrick Hickey, MD, FAAP, FIDSA
Colonel, US Army
Professor and Chair of Pediatrics
Uniformed Services University

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
USU Bushmaster Update
Sebastian Lara, MD, MA
LCDR, Medical Corps, US Navy

Over several chilly October days in Ft Indiantown Gap, Pennsylvania, medical students and graduate nursing students from USU and partner nation students (Israel, Germany, UK) participated in the annual Bushmaster field exercise. USU faculty, led by MAJ Sara Bibbens (Pediatric Critical Care), delivered two pediatric simulation scenarios to each platoon. Students had to demonstrate their use of the Broselow tape, how to insert an IO for access, intubation, and fluid/blood resuscitation. This year, one of the scenarios included a pediatric trauma patient who sustained deadly injuries. One of the objectives was to focus on the unique psychological effects, cultural aspects, and emotional difficulties in caring for pediatric trauma, including death. Through discussions during the exercise and in focus groups afterwards, reflection and support are offered for this aspect of military pediatric care in the deployed setting that has been insufficiently studied. The students leave Bushmaster knowing that—no matter their ultimate specialty choice—they are very likely to encounter children in conflict environments, and they now have some of the basic skills to begin caring for them.
Uniformed Services Chapter East Update
Maj Caitlin Hammond, MC, USAF, FAAP
Chapter East President

Chapter East continues to focus on finding ways to adapt to help our members. Over the last year we have worked hard on some initiatives:

— Scholarship for military medical students interested in pediatrics. We offered financial assistance to offset the costs of visiting pediatric programs outside of their active duty tours.
— Working with Chapter West and the Section on the Oral History Project of Dr. Alden.
— CME on Combating Burnout for Physicians and Child Advocacy

We have some upcoming/current openings in Chapter Leadership Team and are looking for interested pediatricians to join us: Vice President, member-at-large, social media chair, Treasurer. Accepting applications with letter of intent and copy of CV to UniformedServicesChapterEast@gmail.com.

Across the globe, our members are working hard to provide quality care though facing many challenges with post-pandemic medicine, operational utilization for OAW, shortages of antibiotics/ADHD medications, as well as adapting to the changing face of military medicine. We loved seeing our members active at NCE and appreciate those who were able to tune in from afar. We were fortunate to recognize the following members for the 2022 Outstanding Young Pediatrician award: LCDR Susana Agudelo-Uribe (Navy), Capt David Mari (Air Force) and MAJ Rian Calo (Army). Congratulations to all selected! The accomplishments highlighted in all the nomination packages were impressive and I am blown away at the endeavors of so many in our membership.

We are looking forward to the upcoming celebrations for Month of the Military Child in April and are busy working on planning CME events for the year. Our goal is to “meet you where you are” to provide supports and education. We are open to suggestions through our email above. Chapter East is excited to see what 2023 will bring!

Uniformed Services Chapter West Update
LCDR Manju Hurvitz, MC, USN, FAAP
Chapter West Vice President

Chapter West is looking ahead to 2023 and continuing to support our members. We had a great turnout for 2022 AAP NCE where we recognized three exceptional recipients of the 2022 Pediatrician of the Year award: LCDR Heather Solaria (Navy), Maj Caitlin Drumm (Air Force) and MAJ Sebastian Welsh (Army). Additionally, we celebrated the 2022 Chapter Special Achievement recipients MAJ Sebastian Welsh (Army), LTC Luis Rohena (Army) and CAPT Luke Zabrocki (Army). Congratulations to all our awardees on their chapter achievements and outstanding performance in Pediatrics.

This past year has brought challenges to military medicine with the emergence of COVID-19 variants and nation-wide hospital staffing shortages with direct impact on pediatric health and access to care. Our chapter members have continued a standard of excellence by directly supporting nationwide COVID-19 emergency response, USN Mercy medical mission and Operation Allies Welcome. Members directly contributed to over 100,000 hours of medical care for over a dozen missions resulting in vaccination programs, pediatric advocacy, and infectious screening programs. Our members have continued scholarly achievements with groundbreaking research, quality improvement initiatives and developing technology.

In all, Chapter West remains dedicated to improving the health and wellness of all children in a myriad of challenges. We look forward to working with our members in 2023.
Let Go, Can't
Artist: Capt Kevin Brinkman, MD, USAF, MC
Gratitude and Resilience: Lessons from the Afghan Guests at Fort McCoy

Renuka Rees, MD, FAAP
CPT, USA, MC

At the end of August 2021, I was sent to Fort McCoy, Wisconsin in support of Operation Allies Refuge/Welcome, the humanitarian mission to assist Afghan allies who had assisted our country in Afghanistan. Approximately 12,600 Afghans, known as Guests, were evacuated to Fort McCoy after the Taliban overran their government. Many arrived with only the clothes on their backs. Others packed luggage, only to lose it along the way. Many forgot their identification cards and passports in a rush to leave, or simply never had them. They left behind their homes, jobs, friends, and families as they rapidly fled their country. In many cases it was the only way to save their lives and the lives of their families.

Their stories are forever engrained in my mind. A child brought on a plane in desperation, only to discover his parents were left behind. A woman, pregnant with triplets, alone because her husband and other children were left in Afghanistan. Siblings taken in by strangers because their parents had died in the Afghan airport suicide bombing. When I arrived, my hope was to listen to their stories and begin to understand what this transition had been like for them. And while that intention came to fruition, I left this experience with something I hadn’t expected: a new found appreciation and understanding of gratitude and resilience.

Despite the trauma of their lives being completely uprooted, every Guest who came through the medical examination site or one of the two mass vaccination drives we conducted, received our services with graciousness and respect. Though they faced frustrations of language barriers, foreign customs and courtesies, and uncertainties about their futures, they greeted us with their hands over their hearts and a warm Salam. After having their blood drawn and receiving multiple vaccines, many of the guests repeated Thasakur or Thank you over and over to us as they left. Their ability to be appreciative despite experiencing unfathomable despair taught me that even in the most desperate situations, gratitude is a choice I can make. When frustrations crept into my mind on this mission, I used their example as motivation to choose gratitude, which has since allowed me to view my own life with clearer and softer eyes.

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Gratitude and Resilience: Lessons from the Afgan Guests . . . Continued from page 21

I learned about resilience not through my interactions with the Guests, but by observing them. The Guests were housed in Army barracks and had fairly open access to the grounds of Fort McCoy. They ate food from the DFAC, bought supplies at the Exchange, and did laundry at the base laundromats. There were times when this on-base lifestyle seemed ordinary and routine; our mission to support the Guests was rolling out relatively smoothly. However, in moments of contemplation, I realized the gravity of what I was seeing. This was anything but ordinary and yet the Guests continued to live their lives and even find joy. This was most apparent when watching children create makeshift swings made out of sheets, scrimmage the Military Police in a game of soccer, or just play amongst themselves. However, it was not only the children who created a sense normalcy amidst such sudden and jarring change. Families went for walks and picnics on the grounds. Women took selfies with each other in front of the fall foliage. People went out for morning jogs. The Guests’ ability to adapt to their new lives on Fort McCoy attests to their incredible resilience and strength. In moments when I felt most weary on this mission, the strength of the Guests helped renew my own fire and motivation. The lessons I learned are my own interpretations of a very short series of interactions with the Guests at Fort McCoy. I understand that my observations are only tiny fractions of their experiences. These, though, are my takeaways from my brief interactions with the Guests and how I felt seeing them continue their lives on Fort McCoy. I am honored to have been a very small part of their lives in the United States and am grateful for the lessons they taught me. I hope to move forward from this experience with a more gracious, resilient and compassionate heart.

To all the Guests at Fort McCoy, Thasakur.

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10 Allergy Myths to Dispel for Active Duty Pediatricians
Aubri Waters, MD, FAAAAI
MAJ, USA, MC

1. Myth: The treatment of anaphylaxis consists of Benadryl and steroids.
Epinephrine is the only effective treatment to halt or prevent progression of an anaphylactic reaction, but it is often underutilized. Parents are hesitant to use the medication on their child, and even physicians can be hesitant to order it to be administered in favor of a wait and see approach. Although rare, truly emergent situations can arise, and I have never had a parent who made the confident call to use the epi-pen tell me they regretted it.

Understanding how to correctly utilize the right autoinjector and taking time to teach caregivers and children is extremely important.

2. Myth: The antihistamine isn’t working, so I should switch from Zyrtec to Claritin every couple months.
There is no evidence that second generation anti-H1 antihistamines such as cetirizine (Zyrtec), fexofenadine (Allegra), or loratadine (Claritin) cause tachyphylaxis, or diminishing response to successive doses of a drug, thus rendering it less effective. H2 receptor blockers such as famotidine (Pepcid) CAN cause tachyphylaxis. The first line medications for allergic rhinitis are still an intranasal spray such as fluticasone (Flonase) or azelastine (Astelin), so if you are switching to anything, switch to these!

3. Myth: The patient had hives with penicillin, so I must avoid all cephalosporins out of precaution.
Although this cross reactivity has always been felt to be low, new 2022 Drug Allergy Practice Parameters suggest even lower rates of reaction than previously thought, perhaps even negligible. For patients with a non-anaphylactic reaction to penicillin such as rash/hives, they may receive any cephalosporin with no additional testing from allergy/immunology.

4. Myth: The patient has allergic rhinitis, but his parents want to get him a “hypoallergenic dog”.
Certain dog breeds (like Labradoodle, Poodle, Spanish Waterdog, and Airedale terrier) are described and marketed as being “hypoallergenic” on the basis of anecdotal reports that these dogs are better tolerated by patients allergic to dogs. Hair, dander, and saliva are all important sources of allergen when it comes to pets, so the term “hypoallergenic” here is a misnomer unfortunately, because even...
10 Allergy Myths to Dispel for Active Duty Pediatricians  Continued from page 22

allergists love our cats, dogs, and other furry friends and want everyone to have pets they can love! For some kids, visiting animals in controlled environments or getting allergies a bit more well managed is a better step so they can be healthier.

5.  Myth: *The child has an allergy to egg, so she can’t get the influenza vaccine.*
Influenza vaccines should be administered to individuals with egg allergy of any severity, just as they would be to individuals without egg allergy. No special precautions beyond those recommended for the administration of any vaccine to any patient are necessary for administration of influenza vaccine to egg allergic individuals! Use of non-egg-based influenza vaccines in egg allergic individuals in the age groups for which they are approved is acceptable but not medically necessary or preferred.

6.  Myth: *The patient has a shellfish AND iodine allergy.*
Years ago doctors believed that shellfish allergy stemmed from increased amounts of iodine present in the shellfish, so patients with a shellfish allergy were told to avoid iodine. Iodine is an element in your body, and we can observe contact hypersensitivity to iodine antiseptics but this is not in relation to shellfish allergy. Shellfish allergy is NOT a contraindication to the use of iodinated contrast during imaging studies or other procedures and patients should not be given an “iodine allergy” label.

7.  Myth: *The family found mold in their house, and that is the cause of muscle aches, headaches, and ADHD.*
Mold is an ubiquitous indoor and outdoor allergen, and while there are some well-defined albeit uncommon illnesses to treat such as allergic fungal sinusitis (AFS) or allergic bronchopulmonary aspergillosis (ABPA), these entities are very distinct from nonspecific complaints we often hear, and there is no evidence to link specific exposures to fungi in home, school, or office settings to the establishment of fungal colonization that leads to ABPA or AFS. Evidence also does not link molds convincingly to nonspecific vague complaints like muscle aches or memory issues. It should be noted that molds are not dominant allergens and outdoor molds rather than indoor molds are the most important, and for almost all allergic individuals, reactions will be limited to rhinitis or asthma.

8.  Myth: *The child was stung by fire ants on her foot and her leg swelled up to her knee. She is allergic and needs a Fire Ant IgE, an Epi Pen, and an Allergy Referral.*
This is a large local reaction (LLR); these are usually IgE-mediated, and are almost always self-limited and rarely create serious health problems. There is a very low risk of systemic reaction in patients who experience LLR but they may re-experience LLR with future stings. Further IgE testing and venom immunotherapy is not indicated. Future LLR may be treated symptomatically if needed with cold compresses or analgesics. Epi-pen is not required.

9.  Myth: “I just want you to put the referral to allergy test him to see what food he’s allergic to, or just order the test yourself please”.
While parents like this are not exactly a myth, without a clinical history, this is not indicated or great clinical medicine, especially when it comes to foods. Ordering allergy panels when there is no suggestion of a type I IgE-mediated reaction may show one or many *sensitizations* because food specific tests are ~90% sensitive, but they are not highly specific (~50%) and this is not proof of clinical *allergy*. In a large room of non-allergic people, if food panels were run, many people who have always tolerated a food just fine (peanuts, eggs, etc) would come up “positive” or “sensitized” to that food even though they aren’t allergic because of the high sensitivity of the test. Children with eczema also often come up sensitized to multiple foods simply due to their high IgE or atopic burden and have this label that must be carefully sorted out by an allergist. Testing kids who have NOT had IgE-mediated reactions leads to parents restricting foods in kids unnecessarily, sometimes for years.

10. Myth: *Allergies are a harmless problem we all just have to deal with sometimes.*
Allergies are associated with poor oral health, sleep disorders, and poor grades. There is even a relationship between allergic rhinitis and mood disorders, anxiety disorders, and suicidal tendencies. The good news is that the condition can be very well controlled by PCMs, or with additional help from your local allergist!

References:

Religion in Medicine: A NCC Panel educating on spiritual assessment to improve patient care

Emily Ferraro, MD
Capt, USAF, MC
PGY-2, National Capital Consortium Residency

During the 2021-2022 academic year, the Walter Reed Pediatrics Diversity, Equity, and Inclusion committee (DEI) organized a Religion in Medicine panel as part of our regularly scheduled DEI lecture series. These lectures cover a range of DEI topics and are held during dedicated morning academic times, typically six to eight sessions per year.

Last year proved to be particularly challenging as our department cared for numerous critically ill and injured children who sought care at Walter Reed in the months following the withdrawal of American troops from Afghanistan. Most of the families we cared for were Muslim, which allowed us to face the intersection between religion and medicine head on.

Using the challenges from these experiences and others, we developed a panel of religious leaders from the clergy team at Walter Reed to help us explore this difficult topic. The panel included a Protestant Chaplain, Muslim Imam, Buddhist Monk, and a Franciscan Brother. A Jewish Rabbi was invited, but was unable to attend due to a family emergency.

During the session each of the religious leaders shared their personal backgrounds, anecdotal patient experiences, and unique tenants of their religions. The panel members also shared emotionally difficult patient encounters and how they use their spiritual beliefs to guide patients and families through death, dying, end-of-life care, and even mild illnesses.

A question many of us had for the panel members was how to bring up the discussion of spirituality and religion with families, especially when we might not have a shared religious experience. The clergy members taught us how to use a spiritual assessment as a routine part of every patient encounter. By adding a few simple questions to our history taking such as, “where do you find your sources of hope or personal strength” or,

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Religion in Medicine: A NCC Panel educating . . . Continued from page 24

“tell me about your personal spirituality or religious practices,” we learned how to convey to our patients that we are fully present in all aspects of their care, regardless of our own spiritual background.

Feedback after the panel was overwhelmingly positive. The religious leaders reinforced the importance of discussing and incorporating spiritual and religious care as a routine part of a patient’s treatment. Members of our program also became more informed about how to connect patients and families with the spiritual resources available at Walter Reed.

This session helped to identify and close an important gap in our standard medical training. Discussion with our panel of experts allowed us to engage with a challenging, personal topic through a lens that encouraged personal and professional growth and ultimately improve care of our patients and families.

ADHD: Debunking Common Myths
George Benson, MD
Capt, USAF, MC
Developmental Behavioral Pediatrics Fellow

ADHD, the abbreviation for Attention Deficit Hyperactivity Disorder, is the most common childhood neurodevelopmental disorder. The specific pattern of behavior characterizing ADHD has been defined and studied for over 100 years. Today 7-9% of children and adults may have ADHD. Despite being common and well-studied, many misconceptions about this condition contribute to people with ADHD not getting the help they need to succeed and minimize the disorder’s lifelong impact. A survey of hundreds of adults, including individuals with ADHD, parents of children with ADHD, and medical and other professionals working with people with ADHD, revealed these ten most common myths. We hope that debunking these myths will help dispel the misunderstanding that contributes to people with ADHD.

1. MYTH: People with ADHD are stupid, lazy, misbehaving, undisciplined, or “bad.”
TRUTH: ADHD is not a reflection of a person’s intelligence, work ethic, or character. ADHD is a difference in neurocognitive development that impairs a specific category of mental tasks known as “executive functioning.” Executive functions include mental activities such as planning, organization, impulse control, and sustained attention. A person with ADHD may be brilliant and capable
ADHD: Debunking Common Myths

Continued from page 25

despite weakness in this specific category of tasks. In fact, people with ADHD are commonly strong in creativity and problem-solving. Appropriate treatment is essential in helping a person with ADHD maximize their strengths and be successful.

2. MYTH: ADHD medications are dangerous and addictive and should only be used as a “last resort.”

TRUTH: Medications approved for treating ADHD, when used as prescribed by a qualified physician, are essential to ADHD management and shouldn’t be considered a “last resort.” Kids with untreated ADHD get stuck in an unhealthy thought pattern known as the “bad kid” cycle. Struggling to sit still, stay organized, pay attention, and perform other executive functions in school or different settings where these behaviors are expected results in a child with ADHD getting in trouble repeatedly. The child then feels singled out and eventually starts to see himself as the “bad kid,” killing their motivation and self-esteem and leading to continued behavior challenges. The continued behavioral difficulties then reinforce their self-image as the “bad kid,” continuing this self-destructive cycle. The “bad kid” cycle can lead to school failure, risky or delinquent behavior, poor personal relationships, depression, and other problems. Appropriate medication use can prevent or break this cycle by making it easier for a child with ADHD to perform executive functions, avoid getting in trouble, and becoming labeled (both by others and themselves) as the “bad kid.” ADHD medications are safe and not addictive, although they do have the potential for abuse if used inappropriately. While people with ADHD are more prone to developing addictions, the use of ADHD medications improves impulse control and can actually help prevent addictions.

3. MYTH: All people with ADHD have the same symptoms or behave the same way.

TRUTH: ADHD is characterized by a standard set of challenges defined in the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5). While all people with ADHD struggle with executive functioning, an individual with ADHD may be stronger in some executive functions and weaker in others. For example, one person with ADHD might struggle with impulse control but have more substantial planning and organizational skills. Another person with ADHD might need to work with organization and planning while having better impulse control. The DSM-5 classifies ADHD into three distinct types - predominantly hyperactive-impulsive presentation, predominantly inattentive presentation, and a combined presentation. However, just like everybody else, people with ADHD are unique individuals with different strengths and weaknesses; and even the same type of ADHD may look different between people.

4. MYTH: ADHD is due to poor parenting or discipline practices.

TRUTH: ADHD is a brain condition that a person is born with and tends to run in families. In other words, a person is more likely to have ADHD if they have one or more parents, siblings, or relatives with ADHD. Because of their neurological condition, even with good parenting and discipline practices, a person with ADHD will struggle with executive functioning and may need medication or other treatment. There are, however, behavioral management strategies that aid parents in helping their child with ADHD improve executive functioning skills and be successful.*

5. MYTH: Academics are the only area of a person’s life impacted by ADHD.

TRUTH: Executive functions are required to navigate many areas of life. While a child with a short attention span is more likely to struggle in school, they are also more likely to have difficulty completing chores or other activities of daily living at home. Problems with impulse control can result in a child talking out of turn or not being able to sit still in class. It will also make it harder for them to play well with other kids and make friends due to challenges with taking turns and other socially appropriate behaviors. Poor organization affects a child’s ability to keep track of homework and school materials and makes it harder to manage their duties and perform necessary daily activities at home. As a child moves into adolescence and adulthood, demands increase, further taxing their executive functioning skills. As a result, people with ADHD are more likely to struggle in school and with personal relationships, employment and finances. In fact, a person must show challenges in at least two different settings (for example, at school and home) to meet the criteria for a diagnosis of ADHD.

6. MYTH: If someone can focus on some things or pay attention and sit still in some settings, they can’t have ADHD.

TRUTH: People with ADHD have abnormal regulation of primarily two essential brain chemicals (or “neurotransmitters”) known as dopamine and norepinephrine, critical to the brain’s pleasure and reward system. High levels of dopamine and norepinephrine drive focus and attention. Enjoyable, exciting, or otherwise mentally stimulating activities cause the brain to produce higher levels of dopamine and norepinephrine, making it easier for anyone to focus on activities that stimulate dopamine and norepinephrine production. For this reason, a child who struggles to stay seated in school may have no problem sitting for extended periods during screen time or

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other highly stimulating activities. This effect is more pronounced in someone with ADHD due to impaired regulation of dopamine and norepinephrine. In fact, it is common for someone with ADHD to become “hyper-focused” on an activity that induces high levels of dopamine and norepinephrine production and have difficulty switching their focus to another task.

7. MYTH: ADHD is “not real.”
TRUTH: ADHD is an actual neurodevelopmental condition characterized by patterns of behavior that have been well defined and studied for over a century. Over the past few decades, research has confirmed that ADHD is associated with chemical and physical differences in multiple brain regions, including the prefrontal cortex, the limbic system, the basal ganglia, and the reticular activating system. The executive function impairment characterized by ADHD results from impaired communication between these brain regions.

8. MYTH: ADHD can’t coexist with other mental health disorders.
TRUTH: The brain regions involved in executive functions such as sustained attention, planning, organization, and impulse control contribute to various complex intellectual, behavioral, and emotional processes. The structural and chemical differences in the brain that contribute to ADHD can manifest in many ways. As a result, ADHD is commonly associated with other mental health conditions. In fact, it is estimated that nearly half of people with ADHD also have at least one other coexisting mental or developmental disorder. Coexisting conditions, or “comorbidities,” commonly associated with ADHD include disorders of high-level brain functioning, such as learning disabilities, language impairments, and motor (movement) disorders; emotional regulation problems such as depression, anxiety, obsessive-compulsive disorder (OCD), oppositional defiant disorder, tic disorders, and bipolar disorder. Therefore, it is essential that doctors look for and appropriately treat these comorbidities in a person with ADHD.

9. MYTH: Medication will “fix” or “cure” ADHD.
TRUTH: While medication is a key component of treating ADHD, and is considered the first-line treatment in school-aged children, medication is neither a “cure” for ADHD nor the sole treatment modality. ADHD medications work by improving the regulation of neurotransmitters in brain regions involved in performing executive functions. Treatment modalities other than medication, such as behavioral management strategies, school accommodations, and behavioral health counseling, are essential components of comprehensive ADHD management, helping a person with ADHD develop skills to compensate for and improve weak executive functioning.

10. MYTH: Kids with ADHD will “outgrow” it.
TRUTH: The differences in brain development that cause ADHD to create structural brain differences with lifelong effects. While many people with ADHD develop skills to compensate for or enhance weak executive functioning and improve as they progress through adolescence and adulthood, most people with ADHD will have some degree of symptoms throughout their life. Therefore, approximately two-thirds of people needing ADHD medication during childhood will continue to need a prescription into adulthood.

*ADHD resources:
Books for parents of children with ADHD:
- Taking Charge of ADHD: The Complete, Authoritative Guide for Parents by Russell A. Barkley, PhD
- Smart But Scattered: The Revolutionary Executive Skills Approach to Helping Kids Reach Their Potential by Peg Dawson, EdD, and Richard Guare, PhD
- Thriving with ADHD Workbook for Kids: 60 Fun Activities to Help Children Self-Regulate, Focus, and Succeed (Health and Wellness Workbooks for Kids) by Kelli Miller, LSCW MSW

Books for adults with ADHD:
- The Smart but Scattered Guide to Success: How to Use Your Brain’s Executive Skills to Keep Up, Stay Calm, and Get Organized at Work and Home by Peg Dawson, EdD, and Richard Guare, PhD
- The Couple’s Guide to Thriving with ADHD by Melissa Orlov and Nancie Kohlenberger, LMFT
- Taking Charge of Adult ADHD by Russell A. Barkley, PhD

Websites:
- www.additudemag.com
- learningworksforkids.com
- www.understood.org
Awards and Highlights from the AAP NCE SOUS Meeting 2022

It was great to be back in person for the AAP NCE and SOUS meeting in October, 2022, in Anaheim. Aside from Disneyland and other fun activities, we were able to enjoy great company and important education from our top colleagues in pediatrics. Our SOUS meeting was facilitated by our new chair, Col Courtney Judd, with the tireless assistance from Ms. Jackie Burke.

We had an impressive lineup of faculty and guests, including our invited speakers, Col (ret) Eric Flake, MD and COL (ret) Stephen Cozza, MD. Dr. Cozza kicked off our educational section with the Ogden Bruton Lectureship. His timely and informative presentation entitled, Risk and Resilience: Military Connected Children and Families, resonated with our military connected physicians in the audience, particularly following the past year of COVID-19 related patient care as well as the increased exposure and need for humanitarian support with our Afghan guests. He discussed how military connected children and families experience unique stressors and trauma and how we can provide care in a trauma-informed manner to improve relationships and resilience in our patient population. Dr. Flake continued the theme in his lecture, Resilience Support and Tools Specific for COVID-19 for Military Pediatrics, helping our audience understand, and even apply tools such as the Hand Brain Model, that physicians can introduce to patients, families, and even themselves, to enhance resilience and support specifically in a world following the COVID-19 pandemic.

Together, our two guest lecturers then provided an in depth introduction to the concept of Communities of Care, entertaining questions from our audience and empowering physicians to consider their own approach to supporting the whole military connected child in their own communities of care.

It was a pleasure to have the opportunity to present the annual SOUS awards in person, to better provide the recognition and attention that our awardees deserved, given their amazing achievements. The Outstanding Service Award, which recognizes a uniformed pediatrician who demonstrates a long-term commitment to military medicine, was presented to our immediate past chairperson, Col (ret) Catherine Kimball-Eayrs.

The David Berry award, which honors the qualities and characteristics embodied by MAJ David Berry, MC, USA to encourage the development and career of promising junior staff pediatricians in military education, was presented to Dr. Lauren Vasta for 2022.

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Awards and Highlights from the AAP NCE SOUS Meeting 2002  
Continued from page 28

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Also recognized were Chapter East and Chapter West Young Pediatrician awardees for 2022 (for more details, see Chapter updates above).

Chapter West Vice President, LCDR Manju Hurvitz, presents Outstanding Young Pediatrician Awards to LCDR Healther Solaria, Maj Caitlin Drumm, and MAJ Sebastian Welsh.

Chapter East Past President, Lt Col Nitasha Garcia, presents Outstanding Young Pediatrician Awards to MAJ Rian Calo, LCDR Susana Agudelo-Urle, and Capt David Mari

Chapter East also bestowed a 2022 Outstanding Young Pediatrician award to: Rebecca Chancey, LCDR, USPHS

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 following pages). These scholarly projects were presented at the AAP NCE SOUS meeting where awards were received.
AAP SOUS Scientific Award Winners
(only first authors listed)

2022 Ogden Bruton Award (Basic Science/Technology)
1st—Kristen Smith: Boosting the Maternal Antibody Response Against SARS-COV-2 Results in Increased Transfer to Infants During Pregnancy
2nd—Eric Pasman: Concordance Between Pathologists Grading Peak Eosinophil Count and Fibrosis in Eosinophilic Esophagitis
3rd—Sarah Anisowicz: Parity Does Not Alter Corticosterone Response to Restraint-induced Stress After Mild Blast Traumatic Brain Injury in Mice

2022 Andrew Margileth Award (Clinical Research)
1st—Agnes Montgomery: Comparing the Clinical Outcomes of Human Rhinovirus/Enterovirus to Influenza and Respiratory Syncytial Virus Among Children in an Outpatient Setting
2nd—Jon Speer: Long-term Efficacy, Safety, and Tolerability of a Subcutaneous Immunoglobulin 16.5% (cutaquig®) in the Treatment of Adult and Pediatric Patients with Primary Immunodeficiencies
3rd—Blake Cirks: Body Piercings Resulting in Emergency Department Visits: Addressing a Hole in the Literature

2022 Howard Johnson Award (Resident Research)
1st—Taylor Duplessis: Pitfalls of Applying Neonatal Sepsis Guidelines to Recently Vaccinated Neonates
2nd—Dakota Tomasini: Utility of the Neonatal Early-onset Sepsis Calculator in a Low Risk Population
3rd—Kevin Claunch: Microbiology and Epidemiology of Orbital Cellulitis in the US Military Health System
AAP SOUS Scientific Award Winners

(only first authors listed)

2022 Leo Geppert Innovation Award

1st—Patrick Reeves: The Cystic Fibrosis Action Plan: A Low Health Literacy, Pictographic Self-management Tool with Clinical Automation
2nd—Bailey Howard: Worth a Shot: Quality Improvement Efforts to Monitor and Increase Routine Childhood Immunization Catch-up Rates Across the Military Health System During the COVID-19 Pandemic
3rd—Dakota Tomasini: A Standardized Protocol to Reduce Readmission for Hyperbilirubinemia in Infants ≥ 35 Weeks Estimated Gestational Age

2022 Leo Geppert Case Report Award

1st—William Bennett: False-positive Troponins in a Pediatric Patient with Post-vaccine Myocarditis
2nd—Michael Clarion: Infant with COVID-19: Progressive Bilious Emesis Due to Intussusception
3rd—Michael Clarion: Bilateral Dacryocystoceles Atypically Presenting as Respiratory Distress and Stertor

2021 Scientific Awards Competition Manuscript Winner

awarded to best manuscript from the previous year

LCDR Eric Allen Pasman, MD, FAAP

Quantitative analysis of Tug Sign:
An endoscopic finding of Eosinophilic Esophagitis
Awards and Highlights from the AAP NCE SOUS Meeting 2002  Continued from page 31

2022 AAP NCE SOUS Meeting
Top: All attendees

Top-Bottom:
Air Force, Army and Navy, affiliated
SOUS members
Conference on Military Perinatal Research

COMPRA Update—2022

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. Thanks again this year to the continued generous support of Reckitt-Mead Johnson Nutrition and the AAP Uniformed Services Section, the 41st annual COMPRA occurred at the Westin, Riverwalk in San Antonio on November 4th-6th.

This year’s theme was Periviability: Ethics and Outcomes. Dr. Jonathan Klein served as the 2022 Robert A. deLemos Guest Lecturer. Dr. Klein is a Professor of Pediatrics and currently serves as the Neonatal Intensive Care Unit Medical Director at the University of Iowa Stead Family Children’s Hospital. His talk, “Beyond Extreme Prematurity: Management and Outcomes of Perivable Infants Born at 22-23 Weeks Gestation with a Positive Philosophical Approach,” was extremely well received.

Additionally, we were lucky to welcome Dr. Brian Carter, Professor of Pediatrics and medical ethicist, for his outstanding talk “Viability, Variability, and Disability – Ethical Considerations for the Neonatologist.”

Ten military affiliated fellows, seven residents and two staff were selected with travel expenses provided to present their research in platform format for 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 abstracts presented.

For information regarding attendance or abstract submissions for the 42nd annual COMPRA held in fall 2023, please contact Andrew Groberg at andrew.j.groberg.mil@health.mil.

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 20-24, 2023
Washington, D.C.
Opening: February 2023
Deadline: April 14, 2023

Submissions will soon be accepted for the Scientific Awards Competition (SAC) for 2023. You can only submit an abstract to one category. If you are unsure which category to submit, contact Michelle Kiger, MD at michelle.e.kiger.mil@health.mil.

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.

Resources for Military Families and Deployment
AAP Military Patient Care Resources
Join Us, Won’t You?
Lt Col Elizabeth V. Schulz, USAF, MC
Maj Caitlin M. Drumm, USAF, MC

If you are unfamiliar with the following acclaimed (and shortest to date!) TED Talk, please take the next three minutes to watch Derek Sivers’ “How to start a movement.” Next, know that as you read this perspective piece, we are the (self-professed) lone nuts…are you the first follower? Join us, won’t you?

An Opportunity
Each year the Accreditation Council of Graduate Medical Education (ACGME) asks our graduate medical education (GME) programs to reflect on their recruitment and retention strategies. Every year, we, in the military, struggle with this ACGME request. And why wouldn’t we? Our respective applicant pool was often recruited, on average, five, if not 10 or more, years prior to their interview season with our GME programs. As such, we throw in the towel and say/think, “This is out of our control, so we will just accept a lower score on this portion of the ACGME survey”. No more, I say! And for those not convinced, allow me the opportunity to change your mind or, at minimum, expand your point of view. Join us, won’t you?

The American Academy of Medical Colleges (AAMC) has highlighted the benefits and aspirational goals of a holistic review process for the spectrum of undergraduate-to-graduate medical education. Holistic Review refers to “mission-aligned admissions or selection processes that take into consideration applicants’ experiences, attributes, and academic metrics as well as the value an applicant would contribute to learning, practice, and teaching. Holistic Review allows admissions (and selection) committees to consider the “whole” applicant, rather than disproportionately focusing on any one factor.” Again, this model focuses on experiences, attributes, characteristics, and metrics (EACMs) of the applicant and highlights how organizations/programs should use these for selecting the right individual for the right program. While the Electronic Residency Application System (ERAS) can filter application factors to narrow the applicant pool for programs to offer interviews, we do not have that luxury with the current Medical Operational Data System (MODS—the military equivalent of ERAS). We are certain that we are not the lone nuts in our vision to bring a holistic review process to our military GME programs. Join us, won’t you?

Be the Change You Want to See in the World
Visualize John Lennon’s “Imagine” playing in the background as we share the personal experience of our program’s buy-in of the holistic review process (“You may say I’m a dreamer…”). In the summer of 2022, our GME program embarked on a three-part pre-interview season workshop designed to:

1. Demonstrate current research on undergraduate medical education recruitment efforts at the Uniformed Services University of the Health Sciences (a primary GME pipeline for the military)
2. Introduce program faculty and current trainees on the definition of holistic review, review the program’s mission statement, collaboratively identify program-specific mission-focused EACMs, and selected a priority of focus within each EACM.
3. Solidify and reflect on the program’s plan for holistic review efforts for interview season 2022.

In our experience, faculty and trainees were eager for the opportunity to have a voice and to begin our program’s journey to change an outdated system. They were passionate about the opportunity to play an instrumental role in modernizing an outdated process. What can we say? We work with an amazing group of first followers! We are certain you have many of these colleagues in your own departments, too. Join us, won’t you?

Recognizing we could not change everything about our process in one year and understanding the constraints of our organizational system, we chose one area of focus for our leap into holistic review. We selected “standardization of the interview day” as our phase-focused intervention for the 2022 applicant cycle. As part of this initiative, we (as a program) identified the EACMs that meant most to us, identified interview questions that represented those EACMs, and developed a rubric for each. This rubric highlighted our values as a program while also improving score subjectivity. We also made directed efforts to improve our inter-rater reliability (more to come on this as we work to publish our efforts). Lastly, we notified our applicants about our efforts and, without fail, received positive verbal feedback on these efforts.

There are numerous ways to adopt holistic review processes in our programs, but you must be willing to take those first steps, harness the knowledge of your teams/teammates, and take a stand to make each year better than the next. Let’s start a movement to be the change we want to see in THIS part of the GME world. You can and do have a voice! Join us, won’t you? If you have interest in implementation in your own GME program (i.e., being the change you want to see in your world!), email us!

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Food insecurity is an increasingly important concern in the military, with multiple recent studies showing that 1 in 4 military families suffer from food insecurity. The Center for Strategic and International Studies (CSIS) published a brief that highlights the multifaceted negative impacts of food insecurity on the military to include: healthcare costs for families, recruitment, retention, and overall military readiness.

One strategy to address food insecurity in the military is to utilize existing state and federal programs. The Supplemental Nutrition Program for Women, Infants, and Children (WIC) can be an invaluable resource for pregnant women and families with children under 5 years of age; which is the age group that includes 41% of active duty dependent children. Since launching in 1975, WIC enrollment has demonstrated health benefits for women and children who participate – including lower rates of food insecurity and improved nutrition.

Despite its value, there is not a protocolized method to ensure families are screened at Walter Reed National Military Medical Center (WRNMMC) or to our knowledge, at any Military Treatment Facility (MTF). A previous quality improvement project led by members of this research team at WRNMMC in 2021 demonstrated that 31% of pediatric and obstetric providers were not aware of the WIC program, and for providers who were aware of WIC, 74% were not comfortable discussing the benefits of WIC with families or guiding them through the enrollment process. This data raised concern that military families may not be screened for and enrolled in WIC in the clinical setting, a missed opportunity to utilize an available resource to mitigate food insecurity and improve health for military families.

In the next step of the project, from June-August 2022, our team sought to further evaluate frequency of food insecurity within military families at WRNMMC. We surveyed 437 families with children under 5 years of age at the WRNMMC Pediatric and Obstetric clinics for a 1-month period and discovered rates of food insecurity of approximately 12% and that 70% of WIC eligible families at WRNMMC were not enrolled in WIC. Though the rate of food insecurity was below the DOD-rate of 24%, this could be attributable to the patient demographics at WRNMMC and raises concern for bases where junior enlisted members are the predominant population. This data furthered our conviction that implementation of standardized WIC screening and removal of barriers to enrollment in the clinical setting could provide effective relief for military families at risk of experiencing food insecurity.

Funded through a USU VPR Intramural Grant, we plan to survey military families to further gain their perspective on their experiences with the WIC program, and their insight on interventions that may be effective at combating food insecurity for military families and increasing their enrollment in WIC. We will begin with a quantitative survey of military families and will then do follow-up focus groups with interested individuals to obtain in depth information. We hope that this information will position our research team well to further apply for federal funding to develop high yield intervention for DOD-wide implementation in early 2023.

Through the continuation of our project and increased utilization of the WIC program, we propose an option to directly impact military food insecurity. This option will limit overall cost to the DOD, utilizing an existing state-based program, while likely also improving military recruitment, readiness, retention, and MHS cost. We have discussed our findings and project with multiple military advocacy organizations and WIC offices, all of whom support these research endeavors and unanimously agree to its necessity. Food insecurity is
an issue that impacts us all - as military servicemembers, doctors, and pediatricians. It is imperative that we, as military medical officers, take every step possible to address food insecurity and fight to improve the lives of our servicemembers and their families.

Note - WIC eligibility also extends to many within the USU community. Single income households of medical students without prior service (O1 with 0 years TIG) are below the income threshold for WIC eligibility upon their family’s first pregnancy (3 household residents) and should be screened for WIC eligibility and enrollment at their local WIC office. We strongly believe in the utility of these benefits and hope that future generations of military doctors are able to advocate for themselves, their patients, and fellow military members, beginning with their time at USU.

References:

Unique Experiences at Camp Upshur: Pediatric Residents Supporting Humanitarian Efforts
Capt Jenna Hoobler, USAF, MC
Capt Jenny Jung, USAF, MC
LCDR Shawn Miller, USN, MC

The authors are third-year pediatric residents at Naval Medical Center Portsmouth in Portsmouth, Virginia. They were among the few residents who were selected to participate in Operation Allies Welcome. They provided care to the pediatric patients who were seen in the acute care clinic at Camp Upshur on Marine Corps Base, Quantico.

Operation Allies Welcome was the Department of Homeland’s security (DHS) coordinated effort to safely resettle over 65,000 Afghan evacuees in the United States. The United States military medical team played a significant role in this process, providing initial processing, vaccination, and acute medical services to name a few, as documented in “Early Management of Afghan Evacuees” by Goetzman et al published in Pediatrics in October 2022. As we read Goetzman et al’s account of their time at Camp Upshur, it brought back memories of our experience in the Fall of 2021. We were some of the few residents who had the opportunity to work as pediatricians at Camp Upshur, one of the military facilities in Virginia that housed over 5,000 Afghan evacuees. We provided medical services for children, many with acute and chronic medical conditions not routinely seen in our daily practice.
Below we talk about the unique experiences we encountered during our time at Camp Upshur.

**(Hoobler)**

One of the patient encounters which will forever be ingrained in my mind is that of a 4-month-old infant. She had been seen and treated multiple times for a diaper rash. Mom’s complaint at this visit was for the worsening diaper rash as well as a new rash with fever. When I examined her, alarm bells went off in my head; she had a fever and a maculopapular, coalescing rash that had spread in a cephalocaudal pattern accompanied by cough, coryza, and conjunctivitis (also known as the 3C’s). Although I had never seen measles previously, I was aware Afghan travelers were a high-risk population. I alerted my attending to my suspicion. This led to isolating the infant and her family, contacting our public health liaison to obtain titers to confirm the diagnosis, and evacuating the clinic for two hours. She was empirically started on Vitamin A to reduce morbidity and mortality while her measles labs were pending. Her lab results were positive, making her the first confirmed case of measles at Camp Upshur. During my time at Camp Upshur, I utilized skills learned previously in the Military Medical Humanitarian Assistance Course (MMHAC), which focuses on training military medical providers to recognize and manage acute and chronic conditions associated with high mortality amongst vulnerable populations including children in austere environments such as a refugee camp. These conditions most commonly include malnutrition, diarrhea and dehydration, and a variety of infections to include malaria, respiratory illness, and measles as seen in this patient. Our rapid recognition and management of the disease successfully treated our patient who recovered without any further sequelae. Her diaper rash also improved over time.

While this is one of the cases which shines the brightest in my memory, I recall many of my interactions fondly. Working in a resource limited environment with an abundance of cultural and communication barriers was challenging and at times frustrating, though it was also one of the most rewarding experiences of my medical career.

**(Jung)**

It was a brisk cold morning on my third day at Camp Upshur and I was getting acclimated to the mission, working with interpreters to provide pediatric patient care. While walking to the supply tent to find a bassinet for a newborn, I received an urgent call from one
of the attendings about a mom in labor. As the team ran to the tent to triage the patient, I was tasked with getting the needed supplies for Neonatal Resuscitation Program (NRP). More information filtered in as I was gathering supplies, including that the mom was 32 weeks gestation and was pregnant with twins! Replaying the steps of NRP in my head, I ran into the clinic and realized we only had one Kangaroo bag. As I started looking through the inventory to ensure we had additional supplies, the obstetrics (OB) team was gathering emergent medications to slow down labor if needed. Although I was not present in the tent, it was relayed the situation was so chaotic, the OB provider had the mom placed in the ambulance to triage her. As she was in active labor, the decision was made to transfer her to the closest Labor and Delivery facility. Thankfully, one of the pediatricians on the team was a neonatologist. The OB and peds team gathered their needed equipment and the patient, a translator, the OB, and neonatologist were transported via ambulance to the nearest facility. The mom was able to receive antenatal steroids and the infants were delivered, premature, but healthy 48 hours later. Despite the myriad of constraints from lack of medical history, language barriers, limited resources, and staffing, it was humbling to witness the whole medical team fully engaged in one mission, jumping in to provide the upmost care for this family. The opportunity to serve the Afghans has been a great learning experience and truly a blessing. As a junior officer, in the training stages of my career, I am yet again thankful for our service members and humbled to be part of the U.S. Military Forces.

(Miller)

My experience at Camp Upshur came near the end of the humanitarian mission. I was in awe of the camp when I first arrived and how this small, fully functional city had been erected in the middle of the woods. It truly felt like I was in a different country. Many of the challenges documented in Goetzman et al had been rectified by the time of my arrival though others persisted in this resource limited clinic. One of my clinical encounters which highlights the challenges the medical infrastructure faced is that of a school-aged child brought in by her father with new onset jaundice, hepatomegaly, decreased oral intake, loss of appetite, and nausea/vomiting. We confirmed our suspicion of Hepatitis A with serology testing as they reported her sibling had recently been diagnosed. Temporary lodging, lack of telephones, and language barriers made it challenging to locate the family to explain the diagnosis and discuss supportive as well as preventative measures. It felt as if the extraordinary efforts made by our medical team were helpful in providing a diagnosis for which the family was grateful, but with the limitations of the family situation and the camp itself, I left unsure if our medical guidance would be followed or successfully prevent further spread.

In pediatrics, supportive care and reassurance with watchful waiting is the optimal plan of care for many clinical scenarios. At Camp Upshur, there was the added element of triaging the needs of our patients not only based on acuity of medical needs, but also on which resources were available at any given time. This exemplified to me the themes of this operation which were adaptability and resiliency.

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Unique Experiences at Camp Upshur: Pediatric Residents Supporting . . .  Continued from page 39

There was rarely a quick fix or solution for many of the challenges that arose. This allowed us to develop our skills to thoughtfully use limited resources, brainstorm creative alternatives to overcome barriers, and improve cultural competency to serve the mission and provide high quality patient care.

The opportunity to serve the Afghan community was truly humbling. Our hearts overflow with gratitude for their kindness and patience as we navigated the learning curve of providing culturally competent and compassionate care. As we prepare to become independent practitioners, this unique and impactful experience gave us a glimpse into what it can be like to function in remote, resource limited settings both nationally and globally. It also helped better equip us as military pediatricians to competently respond to urgent medical scenarios while also navigating culture and linguistic challenges.
Demystifying Autism for Military Families: Debunking Some Common Myths Regarding Autism

Autism is a neurodevelopmental disorder characterized by deficits in social communication and interaction as well as restrictive, repetitive behaviors, interests, and activities. Updates to the clinical definition of autism spectrum disorder (ASD) were published in the newest edition of the Diagnostic Statistic Manual-5. The prevalence of autism has dramatically increased to impacting 1 in 59 children, according to the Center for Disease Control in 2018. Increased awareness of ASD has improved in the general population due to large-scale efforts in social media and advocacy by ASD organizations. However, the goal of evaluating children with a suspicion of autism by the age of three and starting intensive therapies by the age of four, especially in underserved populations, has been more elusive. Myths surrounding the diagnosis only add to these delays. The following is intended to dispel 10 common myths of autism.
Myth #1  
**Autism is a disease.**

**TRUTH:** Autism is not a disease. It can therefore not be “caught.” It is classified as a biologically-based neurodevelopmental disorder impairing an individual’s ability to communicate and interact with others. The earliest signs of autism, including eye contact with other human faces, can be present before the age of one year old; but symptoms of autism are more easily seen in young toddlers, including impaired communication, play, requesting, and imitation skills. The exact cause of autism is still not understood, but is thought to be an interplay of multiple factors including: genetic, neurological, environmental, and perinatal factors.

Myth #2  
**Autism is caused by unloving, abusive, or neglectful parents.**

**TRUTH:** The concept of “refrigerator mothers” has been dispelled for many years now. Conjecture that “emotionally cold” parents were more at risk for having a child with autism was disproved by the end of the 1960’s by many well-designed medical studies. Any medical professional privileged to work with the parents of children with autism can attest that they constitute some of the most loving and devoted parents.

Myth #3  
**Vaccines cause autism.**

**TRUTH:** This is likely the most dangerous myth regarding autism. Dispelling this myth is paramount to the maintenance of a healthy population especially given the recent alarming increases in vaccine-preventable diseases seen worldwide. There is no current medical evidence that demonstrates a causal link between any vaccine and autism despite thousands of evidence-based medicine studies. Vaccines remain one of the most important medical contributions in history for the good of population health.

Myth #4  
**There is a test that can diagnose autism.**

**TRUTH:** In recent years, several laboratories have marketed “autism testing” panels. While great advances have been made in our ability to identify underlying genetic causes of autism, the notion that a blood test can somehow identify an individual who has autism is misleading. Just as there is no single cause for autism, there is no single test to diagnose autism. It remains a clinical diagnosis and any tests help to support the diagnosis only. Lab testing, to include genetic testing and the currently heavily marketed “autism testing” panels, may help to identify individuals at risk, but remain non-diagnostic. Likewise, psychological testing helps to clarify strengths, weaknesses, and behaviors helpful for making the diagnosis, but it does not confirm a diagnosis in isolation.
Myth #5  Individuals with autism are either savant or intellectually disabled.

**TRUTH:** No two individuals with a diagnosis of autism are the same. Autism is inherently a spectrum disorder meaning that there is significant variability in how the symptoms of autism combine to form the unique diagnosis. Specific autistic traits or behaviors can be seen in many children, but all the diagnostic criteria in the DSM-5 must be met for diagnosis. The limitations of autism are different for everyone.

Myth #6  Individuals with autism do not want to make friends.

**TRUTH:** At its core, autism is an impairment in the ability to socially interact with other people and to form relationships. Additionally, there can be hindrances in verbal communication that further impair social skills. Individuals with autism may demonstrate their desire to connect with others differently, but this should not imply that individuals with autism lack feelings or emotions.

Myth #7  Individuals with autism dislike physical contact.

**TRUTH:** This myth regarding individuals with autism often leads to a delay in diagnosis. While individuals with autism often delay environmental sensitivities, the majority enjoy some level of physical contact and seek out human connection and affection. Individuals with autism are capable of displaying a unique sense of humor and showing pleasure in tickling, teasing, and joking with others.

Myth #8  Autism can be outgrown.

**TRUTH:** Autism is a chronic, lifelong disorder. While early, intensive appropriate therapies can help an individual diagnosed with autism progress to a point where theoretically symptoms are difficult to perceive, it does not equate to a blanket statement that individuals “outgrow” their autism. It simply highlights the need to increase access to the therapies, specialized medical care, and supporting educational and social (i.e. respite care, emotional support groups, advocacy groups) for families raising an individual with autism.
**Myth #9**

**Medications and special diets can cure autism.**

**TRUTH:** There is no cure for autism. Medications may benefit some of the behavioral symptoms of autism as well as symptoms of common diagnoses coexisting with autism (i.e. anxiety, attention deficit hyperactivity disorder (ADHD), insomnia), but they are non-curative. Likewise, no definitive studies have supported any diet or supplement impacting the core symptoms of autism. Diet and/or supplements may, however, help address individuals with concurrent digestive issues, food allergies, or sensory aversions to foods.

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**Myth #10**

**Autism is being over diagnosed due to increased media publicity.**

**TRUTH:** While misdiagnosis is a problem, autism remains underdiagnosed and the diagnosis is often delayed. While the increase in prevalence may be partially perpetuated due to revisions in the DSM-5 consolidating several diagnoses, these revisions did not change the core behavioral symptoms. Moreover, while increased media attention has aided in bringing the disorder to public attention, significant numbers of individuals remain undiagnosed especially girls, minorities, and those socially disadvantaged. The true reasons for the increased prevalence of this disorder remain unclear.

As we continue to demystify the diagnosis of autistic spectrum disorder and focus on the individual and not the diagnosis, we will continue to understand the unique qualities and strengths that individuals with autism lead to a richer, more diversified global community.

Written by: Col. Eric M. Flake, Lt. Col. Rebecca A. Christi, & Dr. Daniel Roy

The authors are military physicians from Joint Base Lewis McChord (JBLM) CARES who are experts in caring for children with autism. They are also parents of military children with and without special needs.

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**Lt. Col. Rebecca A. Christi & family**

**Col. Eric M. Flake & family**

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[Link to militarychild.org](http://www.militarychild.org)
Do We Really Need To Do This?
Artist: Capt Kevin Brinkman, MD, USAF, MC
MEMORANDUM FOR: SEE DISTRIBUTION

SUBJECT: Department of Defense (DoD) Child Collaboration Project – Needs Assessment for MHS Pediatric Beneficiaries with Developmental and Behavioral Health Needs

This memorandum is issued to inform Market and military medical treatment facility (MTF) pediatric personnel who work with TRICARE pediatric beneficiaries with developmental, emotional, and behavioral health (BH) needs of an opportunity to participate in a voluntary needs assessment. The purpose is to explore provider understanding of BH and tele-BH resources within the Military Health System.

The needs assessment is being executed with Congressional Special Interest funds dedicated to increasing support for military children with developmental, emotional, and behavioral issues. This clinical process improvement effort is led by the Center for Deployment Psychology (part of the Uniformed Services University), and endorsed by the DHA Complex Pediatrics Clinical Community (CPCC), the subspecialty pediatrics advisory board to DHA Deputy Assistant Director for Medical Affairs (DAD-MA).

Market Directors and MTF Commanders are requested to distribute this information to relevant pediatric stakeholders who may wish to participate in the needs assessment. Non-clinical staff such as the Exceptional Family Member Program, the Educational and Developmental Intervention Services, the DoD Education Activity, as well as community-based providers are also welcome to participate. The electronic survey will take participants approximately 15 minutes to complete. The needs assessment is available here: https://jhmi.co1.qualtrics.com/jfe/form/SV_6xSVYmLUiITc5Ei. Participation in the needs assessment is voluntary. Participants who complete the needs assessment will be eligible for further participation in several training and educational offerings; additional information is included within this package.

Questions or concerns regarding this memorandum may be directed to Dr. Krystyna Bienia, Program Manager, DHA CPCC. She can be reached by phone at 703-681-8263, or by email at Krystyna.m.bienia.civ@health.mil. Your support is fundamental to this specific effort, and to the MHS-wide effort to improve healthcare delivery to attain the best outcomes and experiences for our patients. Thank you in advance for supporting this effort.

PAUL R. CORDTS, MD
Deputy Assistant Director - Medical Affairs
Defense Health Agency
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.

I have appreciated the courage and motivation that our authors have had in sharing themselves and I am so proud to be a part of this community, so it is bittersweet that this will be my last Newsletter, but I will continue to serve the SOUS in other ways. If you have any interest in moving into this role and making the Newsletter even better, please contact me or Jackie Burke.

With that, I leave you with an excerpt from a quote reported to be inscribed on the wall of Mother Theresa’s children’s home in Calcutta that will hopefully resonate with many of you:

People are often unreasonable, illogical and self-centered;  
*Forgive them anyway.*

If you are kind, people may accuse you of selfish, ulterior motives;  
*Be kind anyway.*

If you are successful, you will win some false friends and some true enemies;  
*Succeed anyway.*

If you are honest and frank, people may cheat you;  
*Be honest and frank anyway.*

What you spend years building, someone could destroy overnight;  
*Build anyway.*

If you find serenity and happiness, they may be jealous;  
*Be happy anyway.*

The good you do today, people will often forget tomorrow;  
*Do good anyway.*

Give the world the best you have, and it may never be enough;  
*Give the world the best you’ve got anyway.*

Please continue to give your best to each other and to the children we care for.  
Thank you for everything you do.

Very Respectfully,

Candace S. Percival, MD  
Col, USAF, MC  
candace.s.percival.mil@health.mil
Dear SOUS Members –

We are looking for a member of the Section on Uniformed Services (SOUS) to serve as the Newsletter Editor for the AAP SOUS.

This newsletter is produced twice a year and provides a forum for news, human interest stories, ideas, and educational pearls geared toward the Uniformed Services Pediatrician. The main responsibilities of this position include:

1. Helping to find members willing to write for the newsletter (most important role).
2. Reviewing a draft of the newsletter before publication.
3. Communicating with authors and potential authors on a timely basis.
4. Connecting with the Section’s Executive Committee on newsletter updates, request for articles and staying in touch with Section business.

You will be invited each year to attend the Section’s October executive committee meeting, which is in conjunction with the AAP National Conference. The AAP will cover/reimburse for airfare, 2 nights hotel, 2 days of meals and incidentals.

The current newsletter editor is Candace Percival. You can talk with Dr. Percival about the position at candace.s.percival.mil@health.mil.

Any member can apply; in-training, active duty, retired.

If you are interested in this position, please e-mail your bio-sketch to Jackie Burke at jburke@aap.org by March 30, 2023.

Thank you!

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

Please submit your idea or article to: Jackie Burke

jburke@aap.org
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 Services at 800-433-9016, ext 5897 or e-mail us at membership@aap.org.

Thank you for your continued membership and support of our mission.