LETTERS

MOC Is Tedious, Not Worthwhile

I agree with the criticisms by Dr. Victor Strasburger and Dr. Darren Franczyk regarding the Maintenance of Certification (MOC) exam ("MOC Program Gets Off to Controversial Start," November 2010, p. 1; "New MOC System Is a Waste of Time," January 2011, p. 21).

Like Dr. Franczyk, I passed the boards in 1998 and recertified in 2004 with no problems. When MOC was first launched a few years back, I went along with the new rules and finished my Part 2 (Lifelong Learning and Self-Assessment) online with no complaints.

Part 4 (Performance in Practice), however, was a major struggle. At the start of 2009, there were hardly any options for fulfilling Part 4 and, by midyear, there were only two choices for EQIPP (Education in Quality Improvement in Pediatric Practice) – asthma and gastroesophageal reflux disease (GERD). I decided to do the asthma study, but I found the whole thing tedious and did not learn anything from the experience.

I understand we need some sort of standard to prove that we are "competent" pediatricians, but doing EQIPP or anything similar is not the way to go. I would prefer that the American Board of Pediatrics (ABP) mandate that each pediatrician should do PREP activities such as Pediatrics in Review (PIR), and do all the PIR quizzes after reading the articles. They could continue the open-book exams as they do with Part 2 now. In my everyday practice, that is how I learn. I look up what I don't know and use it in my diagnosis and treatment decisions. I am not a fan of the closed-book exam requirement every 10 years. And I don't think I am a slacker. Life after residency just is not conducive to taking closed-book exams. The reality is my life as a primary care pediatrician means I am overworked, underpaid, and I also moonlight as mom, wife, driver, and maid.

I wonder if the ABP even listens to pediatricians like me, part of the rank and file. I hope they do because our work in the front lines is equally as important as work in academe and in research.

Abigail Kamishlian, M.D.
Carrollton, Georgia

A New Kind of Recertification

Recent letters to the editor of PEDIATRIC NEWS have been critical of the American Board of Pediatrics' maintenance of certification process and echo widespread dissatisfaction among many pediatricians.

One letter suggested the ABP and American Academy of Pediatrics leadership may be out of touch with the everyday problems of medical practice ("New MOC System Is a Waste of Time," January 2011, p. 21). This critique rings true to many of us out in the clinical trenches.

Going through the hoops of maintenance of certification (MOC) requirements every 5 or 10 years only verifies that a physician is still sufficiently mentally intact to search out answers to academically oriented questions and still able to comply with other ivory tower learning activities.

The current MOC "things to do" are expensive and very limited in scope, and they waste time. Worst of all, the MOC fails to reinforce the more important habit of lifelong learning. Did not early medical educators like Sir William Osler believe in promoting medical education as a way of life essential for better physicians?

A year-round, flexible continuing medical education (CME) based system of recertification would be easier, more enjoyable, and cost effective by simply requiring a reasonable amount of study in pediatrics. We already have abundant, high-quality, certifiable CME in the form of hospital-sponsored lectures, medical journals, CDs, DVDs, and online courses.

I encourage all ABP diplomates and AAP members to lobby for a CME-based recertification process. Let's support the existing CME system, as it can best provide clinical updates and refresh our knowledge base in a more practical, self-directed, less burdensome manner.

Juan Pablo Cueva, M.D.
Evergreen Park, Ill.

Details Needed on GBS Prophylaxis

In the December issue, there was an article on new recommendations for GBS-positive mothers and babies ("CDC Updates Infant GBS Prevention Guide," December 2010, p. 1). In question is the sentence, "Observation for at least 48 hours – but no routine diagnostic testing – in well-appearing infants of any gestational age whose mother received adequate intrapartum GBS prophylaxis (clarified in the newly revised guidelines to be at least 4 hours of intravenous penicillin, ampicillin, or cefazolin before delivery)." This is not what we are doing in our pediatric group. The impression that my partners and I get is that this may be incorrect. If indeed it is correct, then perhaps a little more detail to clear up the confusion would be in order.

In our practice, babies whose mothers were adequately treated for GBS prophylaxis with two doses of antibiotic at least 4 hours apart prior to birth are treated as normal babies, and may be discharged prior to 48 hours. The article indicates that observation should be at least 48 hours.

John Ritrosky Jr., M.D.
Fort Myers, Fla.

Editor's reply:
Indeed, Dr. Ritrosky is correct that more detail is needed. The sentence above should have been qualified by the following information from the CDC guidelines: "Such infants can be discharged home as early as 24 hours after delivery, assuming that other discharge criteria have been met, ready access to medical care exists, and that a person able to comply fully with instructions for home observation will be present."

Correction

In "Experts Differ on Treatment for Group A Strep" (January 2011, p. 18), the article should have read, "The standard recommendation for amoxicillin is 750 mg, *divided into four doses*, but administering a drug three to four times a day is hard for families."

LETTERS FROM MAINE

The Bells Are Ringing

WILLIAM G. WILKOFF, M.D.

"Jared, have I told you that when I played football in high school we wore leather helmets?" Of course I had. For decades I have been telling boys just starting their football careers that I had been a "leatherhead." Jared is a junior, so I'm sure he'd heard my story at least a couple of times. But he's a nice kid and simply shrugged his strapping shoulders, and looked down at his six-pack abs.

Mostly, I tell the anecdote to watch expression on their parents' faces. The kids already assume I am older than dirt. But I enjoy watching their folks struggle to do a bit of quick math to figure out my age.

In the 1960s plastic football helmets were in regular use, but my high school coach was wise beyond his years and realized that their canvas strap suspension systems similar to those for a construction hard hat were inferior to the 1-inch- to 1½-inch–thick all-leather helmets, which were more absorbent. So Coach passed the plastic headgear down to the scrubs and ordered what must have been one of the last production runs of leather helmets for the varsity.

The equipment wasn't the only thing antique about my football career. By the time I was in college, I had on more than a couple of occasions stood in a huddle next to a teammate who was too fog headed from a hit on the previous play to know his assignment on our simplest running play. If he wobbled to the bench, the odds were high that he would be back in the huddle later in the game.

When I became the new doc on the block, I inherited the job of team physician to a pitifully underperforming high school football team. In that role I know that I sent more than a dozen young men with concussions back into action. Despite clearly having had their bell rung, if they knew who they were, who the opponent was, and had a general sense of the score, they could play. If they failed to meet those skimpy criteria, I sat them out and made sure I talked to their parents to be sure they would be watched closely at home that evening. There was never any discussion of limiting their activity for the next week.

Nowadays, concussion is a hot topic at all levels of sport. And while I tend to be an old school kind of guy, this new emphasis is clearly a change for the good. Maybe the biggest step has been the acceptance by physicians, coaches, players, and parents that loss of consciousness is no longer a requirement for the diagnosis. Maybe it never was for some, but the prevailing notion was "no loss of consciousness, no worry." The second revelation has been that it's the subsequent concussions that are usually the most damaging.

Media coverage of the cautious and patient management of concussion in high-profile athletes has made it much easier for me to recommend the same approach for my patients . . . and for them to accept it. When high-paid professionals – tough guys by reputation – are willing to sit out big games until

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POINT/COUNTERPOINT

Is it appropriate for pediatricians to stop treating children if their parents refuse their vaccination?

Vaccine Refusal Endangers Everyone

Prevention of childhood illness is the heart of a pediatrician's mission. Immunization refusal violates that mission, putting everyone at risk: child, pediatrician, other children, and society as a whole. If we allow families to remain in our practices unvaccinated, we are giving tacit approval to parents that refusing vaccines is just fine. It is anything but fine.

First, the child is at risk to acquire deadly diseases with which few pediatricians have any familiarity.

HERSCHEL R. LESSIN, M.D.

Second, others in your office are at risk. If an unvaccinated child contracts vaccine-preventable disease and comes to your office for care, every patient you see that day is potentially exposed. This is not a hypothetical situation for my practice and many others around the country.

Third, pediatricians are put at risk. In the above situation, I must call every patient exposed, upset them, and provide services to their kids that would never have been needed had the parents of the index case been responsible. Furthermore, if I allow unvaccinated patients in my practice, I must remember to ask every ill child whose parents call me whether they have been vaccinated. I must consider invasive septic work-ups that I have not done in decades for simple febrile illness.

Refusal to vaccinate is a marker for noncompliance with medical advice.

If the parents don't believe me when I tell them vaccinations are safe and important, are they any more likely to accept my advice about diet, illness, or medications? What if the unvaccinated child contracts a preventable disease? The parents might file suit, claiming that they were inadequately informed about the benefits of the vaccine or the risks of refusing it.

Last, vaccine refusal is a danger to society and a public health hazard. When a large enough population is unvaccinated, herd immunity is lost. One only has to witness the many infants who died in the recent pertussis outbreak in California – a hotbed of anti-immunization fervor – to realize the impact.

The American Academy of Pediatrics has a somewhat different outlook on this issue. They discourage discharging patients solely because of vaccine refusal. However, they do acknowledge that the relationship might not be able to continue if there is a high level of distrust or major differences in the philosophy of care. For me, it comes down to whether you can have a relationship with a family when their choice not to vaccinate goes against pediatric core values and puts so many innocents at risk. I don't believe that I can have a functioning doctor-patient relationship with parents who aren't willing to accept my advice about such a core issue as keeping their children safe from potentially deadly diseases. I have practiced in an era when these diseases were common. I do not wish to return. Being codependent with the baseless and disproven antivaccine movement is not a choice we should be willing to make. ■

DR. LESSIN is a pediatrician in Poughkeepsie, N.Y., and is a member of the AAP Committee on Practice and Ambulatory Medicine. Dr. Lessin serves on the advisory boards of several vaccine manufacturers including Merck & Co., Novartis, Pfizer, and MedImmune. He is also a member of the speakers bureau for GlaxoSmithKline.

Staying With Patients Builds Trust

Pediatricians rightly feel proud of progress made in primary prevention of infectious disease through immunization. Vaccines make up a huge portion of the backbone of primary care pediatric practice. Thus, families who refuse to have their children immunized challenge a basic tenet of modern practice. We can understand a pediatrician's frustration and even anger when parents invoke nonrational or irrational reasons to decline recommended vaccination. Does the refusal justify asking the family to seek pediatric care elsewhere? No, it does not.

JOEL FRADER, M.D.

While most support universal immunization, we must admit that vaccines are neither 100% effective nor 100% safe. We cannot guarantee each child will benefit, and some children *will* have adverse reactions. As long as enough children are fully vaccinated for a given threat, typically around 85%-90% of the target population, the community will maintain herd immunity, limiting disease spread. While the 10%-15% not vaccinated have a "free ride," that is, they get the public health benefit but do not incur the risks of immunization, the still-high vaccination rates permit some latitude in personal, if idiosyncratic, parental choice.

Keeping families that refuse vaccinations in one's practice permits the pediatrician to continue to develop a professional relationship and build trust with the family. Our experience suggests that many parents modify their antivaccine stance with continued discussion and education. More important, the children of antivaccine parents deserve expert pediatric care. Their pediatricians need to be especially mindful of and vigilant about an increased risk of serious infection when these children have febrile illnesses. Physicians who *fully embrace* or even encourage antivaccine attitudes and "collect" families of unimmunized children might harbor other less-than-fully scientific views, compromising the vigilance and care that ill, nonvaccinated children deserve. Pediatricians who turn away at-risk children and families may unwittingly deprive especially vulnerable patients of the best available care.

It surely does not feel good to do less for a patient than our rigorous and demanding scientific standards demand. However, we constantly make choices involving how much to do. We fret over how extensive an evaluation to do for what usually turns out to be a common, self-limited problem and not the potentially disastrous "zebra" we – and the parents – fear. We administer a 10-day course of antibiotics for an infection that some may treat for 3 weeks. Providing care for unvaccinated children does not differ fundamentally from other actions where we intervene less than some might claim is "optimal."

Many factors influence our decisions to limit treatment: family resources, our own resources (time/effort), and family beliefs and preferences (say, to avoid ionizing radiation or use watchful waiting in a child with fever and middle-ear effusion). The troubling question is whether withholding care violates an ethical imperative. In the case of vaccine refusal, it's more gray than certain. ■

DR. FRADER is the A Todd Davis Professor of General Academic Pediatrics and professor of medical humanities and bioethics at Children's Memorial Hospital and Northwestern University, Chicago. He said he had no relevant financial disclosures.

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their symptoms clear, the wimp factor evaporates.

Many emergency room physicians still seem to be relying less on good histories and exams and instead ordering needless and potentially dangerous head CTs.

While protocols vary, the ones that I have seen seldom call for imaging studies in a patient with a normal exam and a reliable family.

Preseason baseline testing has become standard in our school department, but postconcussion management continues to remain an area with fuzzy edges. Athletes can have reasons for a headache other than a lingering concussion. Even uninjured teenagers can be drifty by nature. But that's never going to change. This old leatherhead has learned some new tricks and is going to err on the side of sitting out the concussed athlete until the fog is a distant memory. ■

DR. WILKOFF practices general pediatrics in a multispecialty group practice in Brunswick, Maine. E-mail him at pdnews@elsevier.com

LETTERS

Letters in response to articles in PEDIATRIC NEWS and its supplements should include your name and address, affiliation, and conflicts of interest in regard to the topic discussed. Letters may be edited for space and clarity.

Mail: Letters, PEDIATRIC NEWS, 5635 Fishers Lane, Suite 6000, Rockville, MD 20852

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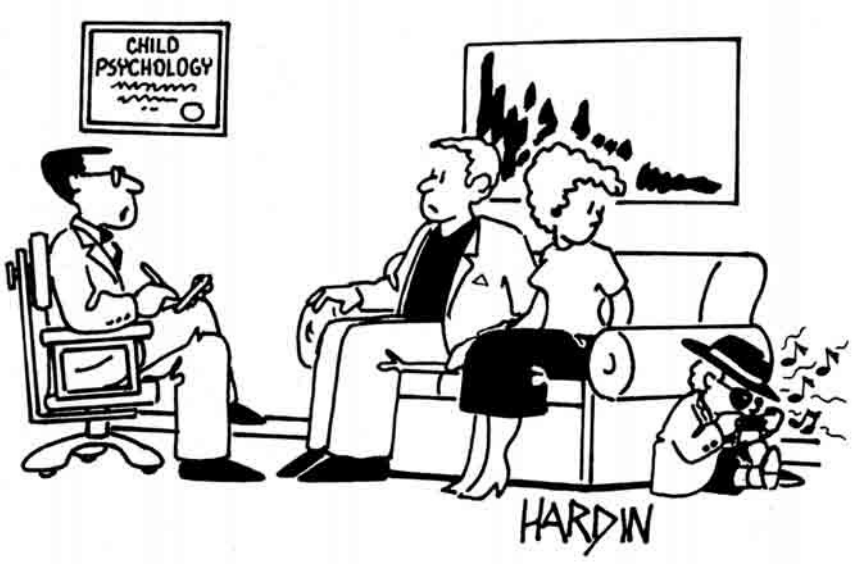

"When did you first notice he had the Blues?"