## COMMENTARY

# Florida Infringes on Patient-Physician Relationship

Despite valiant efforts to defeat Privacy of Firearm Owners (HB 155/SB 432), the bill passed in both Florida House and Senate sessions and is awaiting Gov. Rick Scott (R-Fla.) to sign it into Florida law. The Florida Pediatric Society (the Florida chapter of the American Academy of Pediatrics) maintains its opposition to this irrational and irresponsible bill, which will restrict physicians' ability to discuss gun safety.

LISA A. COSGROVE, M.D.

Ultimately, the bill will infringe on the patient-physician relationship, increase government intrusion in the practice of medicine, and decrease the safety and health care of Florida's children. The bill is an unnecessary intrusion into the physician-patient relationship as privacy regarding patient visits is currently covered under national law under the Health Insurance Portability and Accountability Act. Because of the existence of HIPAA, no law is needed.

A substantial amount of research has shown firearms in the home pose significant risks. Most notably, the 2008 annual summary of vital statistics found that firearms contribute to otherwise avoidable suicide, homicide, and accidental death, which are among the leading causes of death in children and teens. In the American Academy of Pediatrics Bright Future Guidelines, pediatricians are given explicit recommendations to ask about firearms and safe storage as standard routine for child health counseling.

It is important to understand that, during an exam, several aspects of the home are discussed, including swimming pools, hazardous chemicals, smoke detectors, medications, and firearms. Answers to these questions help parents protect their child from multiple forms of harm.

The Florida Pediatric Society remained strong in its opposition of the bill amidst a compromise between the National Rifle Association and the Florida Medical Association. The agreement between these two major organizations removed civil and criminal penalties from the original bill, yet introduced referral to the Florida Board of Medicine for possible sanctions if a physician harasses a patient or enters unnecessary information in a medical record regarding firearms in the home. However, the compromise language does allow physicians to ask patients about gun ownership and enter it into the medical record, if it is found medically necessary. The physician can also choose which patients to see for reasons other than firearm ownership.

The AAP joined with the Florida Pediatric Society in opposition. Their involvement was extremely beneficial to the Florida chapter, as they provided governmental and communications staff support, press releases, leadership advocacy, and major media coverage. The AAP received further support from the American College of Surgeons and the American Academy of Child and Adolescent Psychiatry, who also vigorously objected to this bill.

Surprisingly, these bills are not new to the profession. Similar legislation has already been proposed in Alabama and North Carolina this year. In 2006, similar bills were introduced, yet subsequently defeated, in Virginia and West Virginia. Since Florida's version of the bill has been pacified, these states and more receive bills that are expected to be worse.

Aside from the obvious infringement of the First Amendment, this potential Florida law raises medical malpractice concerns by limiting the appropriate standards of care a physician is obligated to perform. Referencing the Virginia and West Virginia bills, an article in the 2006 issue of Pediatrics noted that a pediatrician who failed to inquire about firearms and counsel appropriately might have been subject to a malpractice claim if a child were injured or killed as a result (Pediatrics 2006;118:2168-72).

What is next? Will physicians not be allowed to ask about sexuality issues in teens or whether the patient takes care of their teeth? We cannot help prevent health risks if we do not ask about them. ■

DR. COSGROVE *is president of the Florida Pediatric Society and she practices pediatrics in Merritt Island, Fla. Dr. Cosgrove said she had no relevant financial conflicts to disclose.*

## LETTERS FROM MAINE

# A Bedtime Story

Regular readers of this column know that I think a lot about (my wife might say obsess over) the role of sleep in the whole wellness package. I suspect that many parents here in Brunswick believe that regardless of their child's diagnosis, I always will manage to include "more sleep" in my list of therapeutic recommendations. Whether the problem is a sprained ankle or nocturnal leg pains, better sleep habits couldn't hurt.

WILLIAM G. WILKOFF, M.D.

I have recently stumbled across two new studies that have added more fuel to my fire. The first was a survey of more than 15,000 adolescents by James E. Gangwisch, Ph.D., and his associates in the journal Sleep (2010;33:97-106). These researchers found that adolescents who were depressed had shorter sleep durations and later bedtimes than those who were not depressed. Surprisingly, there seemed to be no difference between the groups when they were asked to report whether they were compliant with their bedtimes. In other words, it appears that simply the parental act of setting a bedtime had some protective effect.

I discovered the second study here in the pages of PEDIATRIC NEWS ("Regular Bedtimes May Improve Development" [August 2010, p. 25]). Erika Gaylor, Ph.D., a researcher from SRI International in Menlo Park, Calif., reported at the annual meeting of the Associated Professional Sleep Societies held in San Antonio that earlier bedtimes were associated with higher scores in several developmental areas including receptive language and early math, in a survey of 8,000 preschoolers. I was unfortunately not surprised to learn that three-quarters of the children had bedtimes between 8 and 10 p.m. and that a little more than 20% got to bed at 10 p.m. or later. Children living in a higher socioeconomic status household were more likely to have an earlier bedtime and to have been given a rule about bedtime.

I suspect that you aren't surprised by the findings in either of these studies. My mother knew all this stuff already. In fact, anyone who has been observing children for more than a handful of years could have predicted the results. Ben Franklin was right, at least about the early to bed bit. But why isn't the message filtering down to parents?

Are we pediatricians not being vocal enough about the importance of sleep? How much anticipatory guidance do you give parents about sleep? Do you wait for them to raise the issue when they perceive a problem? Do you recommend a bedtime? These studies suggest to me that the benefits of having a parentally mandated bedtime are so substantial that every pediatrician should be including this recommendation at every visit.

We all have participated in the Back to Sleep initiative. Why not a To-Bed-by-Seven campaign aimed at new parents. Although adolescent depression and sub-optimal school performance don't tug at our emotions the way that SIDS does, they are nonetheless problems that affect a larger segment of the pediatric population. And there are scores of other conditions – including obesity, attention-deficit/hyperactivity disorder, and migraine headaches – that have some link to sleep deprivation.

I don't have to tell you that it won't be an easy sell. Societal forces that have nudged children's bedtimes well out of the healthy range are deep and complex. A parent who returns from work after 7 o'clock would like to have some "quality time" with his or her child and share in the bedtime ritual is not going to accept this recommendation happily. It should be our job to point out that there isn't much quality going on when a child is kept up past a healthy hour. However, I may just have to be content when I can get the family to at least set a bedtime – even if I know it is too late. It looks like half a loaf may be better than none at all. ■

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## LETTERS

### More on the MOC

I applaud the responses of Dr. Victor Strasburger and Dr. Darren Franczyk, criticizing current maintenance of certification (MOC) procedures ("MOC Program, Real Criticisms," January 2011, p. 21; "New MOC System Is a Waste of Time," January 2011, p. 21).

Specifically, I appreciated their comments about the inordinate time and expense burden, which removes any possibility of a learning experience from the testing process, unlike the prior system – a home personal computer–based test. That version, like most things the American Board of Pediatrics does to/for its constituency, was cumbersome and time-consuming, but it at least was somewhat functional.

Dr. Strasburger's observation that most of the doctors involved were academicians rather than practicing pediatricians is striking. Much like the observation I made when first informed of the new system: The letter was signed by the program coordinator/director – a PhD, not an MD or DO.

Moreover, the letter estimated the cost to be "about the same" as the old PC-based system. This did not include the cost of taking off work for 2 days, traveling to a testing site, and staying overnight in a motel.

Clearly, it's yet another case of bureaucrats living outside the real world, making unreasonable and expensive rules for those of us who do.

*James Horspool, D.O.*
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