Welcome drumsnwhistles | Account | Help | Log Out

Search for Posts

More Options

Forums Search

9 subscribers related feeds unsubscribe edit subscription

drfleablog

100 Items | Sort Oldest First | Updated: Fri, May 25 2007 2:21 AM

A Blog By Any Other Name Would Taste As Crunchy

By Flea on PGR

Ami Chopine, author of the eponymous blog, used to write a tasty little morsel called The Granola Rules. Ami has now finished her granola and is prepared to host Pediatric Grand Rounds 2:3 next Sunday, May 20.

Please send submissions to ami(at)geekatplayDOTcom by May 19th.

Ami humbly asks for posts written on a particular theme: the role of the doctor in the child's life and/or the role of the child in the doctor's life.

Now, Flea doesn't much care for "Theme Rounds". His problem boils down to a difficulty writing about stuff that other people want him to write about. It's tough enough coming up with our own material! Another problem is the scant input PGR has been receiving of late. We certainly want to avoid any constraints that might further depress interest in our already tiny enterprise.

Posted on: Mon, May 14 2007 12:14 AM | Email This | Clip/Blog This Keep New:

The Case for Openness to the Unbidden

By Flea on reviews

The Case Against Perfection: Ethics in the Age of Genetic Engineering, by Michael J. Sandel. Cambridge, MA: Belknap Press, 2007 (176 pp.)

Michael Sandel was as surprised as anyone, when, in 2001, he was invited to join the president's Council on Bioethics. A life-long democrat, Sandel was sure he was brought along as the "token liberal".

In fact, the committee chairman, Leon Kass, and others, must have located something in Sandel's earlier writings that separated him from the herd of the left-wing zealots who accompany Sandel on the faculty at Harvard.

Indeed, Kass was right. Sandel is not your standard-issue Harvard liberal. It turns out there is more thoughtful traditionalist in Sandel than you might find in the average Cantabrigian. In 2004, as part of his work on the Committee on Bioethics, Sandel produced an article for the Atlantic Monthly on the ethics of genetic enhancement. That article became the groundwork for Sandel's latest volume.

[*Full-Disclosure Statement*: Sandel is a member of Flea's shul. Flea was present at Sandel's daughter's Bat Mitzvah. Sandel recently gave a drash based on this book, after which Flea had a long, pleasant and enlightening conversation with the author.]

The triumph of medical genetics presents us with a promise and a problem. In a relatively short period of time, medical science has graduated from the "School of Leeches" to the school of genetic enhancement. We are able to screen embryos for genetic defects that give rise to miserable medical conditions. The current science, then, permits us to reduce a fair amount of human suffering. That same technology permits us to do other things as well: select the sex of a child, for example. Sandel's essential question comes down to this: Should we permit genetic engineering to be used for genetic enhancement? Should we use what we know to make our children better, smarter, stronger, faster, and better-looking?

Sandel's answer is 'no'.

There are two reasons for this: First, Sandel argues, genetic enhancement of our children erodes our sense of 'openness to the unbidden'. The latter is defined as an appreciation that we want children, but we cannot choose

what we get. Nevertheless we are enjoined to love our children unconditionally. Would we love them as much if the genetic enhancements we planned for them failed to 'take'? Furthermore, genetic enhancement erodes our sense of the gifted nature of life and of our children.

Second, according to Sandel, genetic enhancement mucks with our ethical sensibilities as well. Part of the reason we agree to share risk with others in an insurance pool is that we all start out products of a sort of genetic crap shoot. We didn't choose our history of coronary heart disease and they didn't choose their history of breast cancer. As we are all in more or less the same boat, our ethical sensibility demands that we sympathize with our fellows. Sandel asks, what happens when you become a product of genetic enhancement? Do you feel the same kinship to your less well-endowed neighbor? Sandel argues in the negative.

Sandel closes the book with a nuanced argument in favor of stem-cell research. Here is where he parts company with the committee as a whole. Flea supposes he needed to reach for some measure of liberal *bona fides*. Sandel succeeds in remaining on message while explaining that stem-cell research can proceed in an ethical manner.

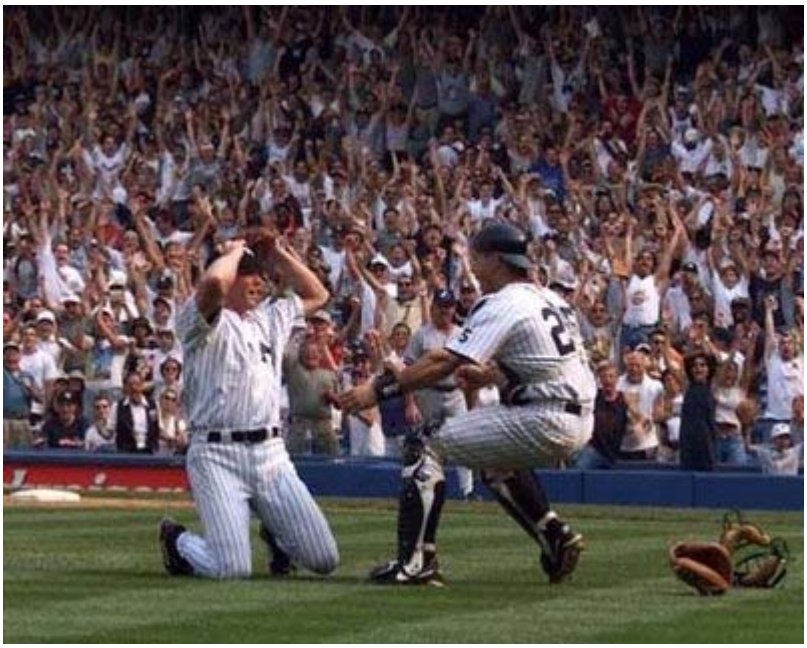
For Flea's readers who are unfamiliar with the bioethics literature, The Case Against Perfection may be a tough read. The argumentation is very tight and spare, but that does not render it any easier to understand. The entire volume, at 176 pages including notes and bibliography, is nevertheless accessible to the novice. It can be polished off during one afternoon under the umbrella at the beach.

This Mother's Day, why not pop over to Amazon and get this book as a gift for your mom? After all, she gave you a gift, too.

Posted on: Sat, May 12 2007 5:04 PM | Updated: Sun, May 13 2007 1:31 PM | Email This | Clip/Blog This Keep New:

SSSSSHHHHH!!!!!

By Flea on malpractice



For a scientist and a physician, Flea is one superstitious mo-fo.

Of course, some superstitions carry with them a higher metaphysical valence than others. For example, if a manager steps on the baseline on his way to the pitcher's mound, for Flea, this is no big deal. For others such a mis-step constitutes a blunder so heinous that the team might as well declare a forfeit right then and there, so small become the chances of his team winning.

In contrast, the "no-hitter" superstition is one that virtually everybody who knows and cares for the game of baseball regards with the greatest degree of reverence.

Say the pitcher for your team (we'll call him Davy) reaches the 6th or 7th inning and he has failed to surrender a base-hit to his opponents. That's pretty good. There's a measurable though small likelihood that he might finish the game without surrendering any hits. That circumstance, a no-hitter, is *very good* indeed.

Here's the catch: Though everybody in the stadium, not least the pitcher's teammates, knows that a no-hitter might happen, they are absolutely forbidden by the gods of baseball to suggest **out loud** that such a thing might happen. Late in the game, speaking to the pitcher becomes illegal. By the eighth inning, baseball custom demands that between innings the pitcher's teammates will sit as far away from him as possible so as to reduce the chances that they might accidentally speak to him.

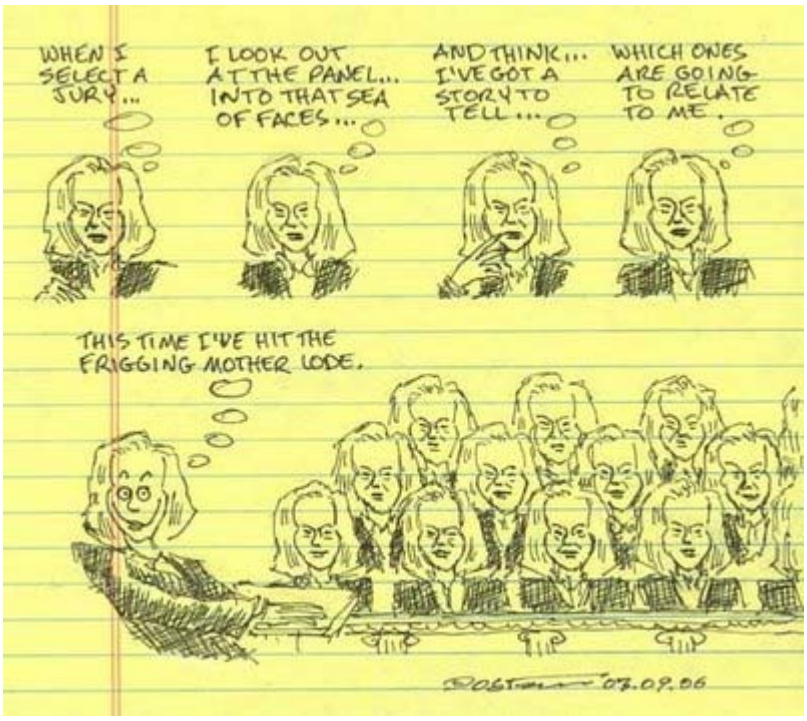
Say, for example, your 10-year old nephew, in a weak moment, blurts out "Hey Flea, d'ya think Davy's gonna pitch a no-hitter? Do ya', huh?". There is now a metaphysical certainty that the ball now leaving Davy's hand will next encounter a bat, swung in its direction *very hard*. When that ball then rolls to a stop under a car parked outside the stadium, the nephew is ritualistically drowned in beer.

What's happening in Flea's life right now is not unlike a pitcher at mid-game, doing pretty well. But it's not like he's gonna... you know... whatever. Not even gonna mention it. Right?

Posted on: Fri, May 11 2007 1:59 PM | Updated: Fri, May 11 2007 4:14 PM | Email This | Clip/Blog This Keep New:

Flea on Trial - Day One: Jury Selection

By Flea on malpractice



Flea hadn't seen his patient's mother in almost five years. She looked awful. She was there with her ex-husband and their daughter, neither of whom Flea had ever met. For the entire four hours that it took to select a jury, it appeared that she did not move a muscle. In fact, none of the family moved hardly at all, with the exception of the father, who occasionally turned his head from side to side. Flea felt terrible for them. It seemed as though they really didn't want to be there. The daughter certainly didn't want to be there. Was it the same for the mother?

The jurors really *really* didn't want to be there. The poor young woman sitting in seat number one looked as though she wanted to jump out the window when she realized she was actually going to be impanelled. Some of the jurors appeared to be sleeping by the end of the selection process. Flea trusts they will remain awake during the actual proceedings.

Flea was able to form an opinion of the plaintiff's attorney (we'll call her Carissa Lunt). Attorney Lunt has not an ounce of fat on her body. Her features are sharp and angular and not particularly pleasant. You don't get a warm and fuzzy from her. She has no sense of humor. You know when you overhear someone chit-chatting and she tries to say something funny and it really isn't and nobody laughs? That's her. Attorney Lunt bites her fingers. In court. She's a finger-biter. Wonder if she's a pillow biter too?

The judge (we'll call him Judge Acres) is a tall guy with lots of grey wavy hair. In robes and horn rim glasses he looks like a judge. In T-shirt and shorts he looks like the guy shooting hoops by himself at the playground on Saturday. Flea likes him a lot.

Attorney Lunt eliminated six jurors with preemptory challenges. All were men and all were college-educated. We challenged two. Both were women. One sounded like she might accept the "Flea is a blithering idiot" argument. The other suffered from the disease that killed Flea's patient. That left nine women and five men (Flea realizes this sum makes fourteen. Two are alternates) Most of them are young. Flea supposes that attorney Lunt believes that poorly-educated young women are more likely to be sympathetic to her clients. Maybe she's right, but Flea would much rather speak to fourteen poorly-educated young women than fourteen college-educated men. Flea spends all of his working hours speaking to young moms. Young women are his natural constituency.

The enduring memory of jury-selection day was *the quiet*. It was kinda like a monastery. For most of the day all, even when the room was full of hot, impatient, discomfited jurors, all that could be heard was the sound of conditioned air rumbling through the ducts in the ceiling.

Flea made lots of eye contact with the jury. These look like people we can speak to. We very much look forward to speaking to them.

Posted on: Wed, May 9 2007 2:54 PM | Email This | Clip/Blog This Keep New:

Dress Rehearsal

By Flea on malpractice

"Yes, I miss him too. Mind you, he's not dead yet. This is just the rehearsal."

Today Flea spent two hours on the phone with his lawyer, going over questions that he plans to ask Flea when the defense gets the case (probably early next week).

Flea had in front of him a large black loose-leaf notebook called a "jury book" that all of us will be looking at during the trial. For the thousandth time, we read together the notes Flea wrote about the patient and went over answers to questions about it.

The jury book is prepared by the plaintiffs, so its organization is such that Flea is designed to look negligent. That is to say, the sections are not organized chronologically. Surely the jurors will notice this and will not care.

In our conversation we focused on the areas that we think Flea's adversary will try to impugn our management of the patient. Flea's lawyer even suggested that she may pull articles from Flea's "legitimate" web site to use against him.

Finally, Flea's lawyer suggested that the first few days of the trial are probably not going to go well for us. That is because the plaintiff's are in the driver's seat and they get to drive the agenda. That agenda, for those who haven't been following this saga, is to demonstrate that Flea is a blithering idiot. As the plaintiff's case will bridge the coming weekend, we may have to sit with the feeling of a trial going badly through Shabbes. Then we get the case.

Jury selection begins tomorrow.

Are you ready? Let's roll.

Posted on: Tue, May 8 2007 5:50 AM | Updated: Tue, May 8 2007 1:47 PM | Email This | Clip/Blog This

Keep New:

A Witness for the Prosecution

By Flea on malpractice

A word of explanation and apology: Flea has kept silent on the details of the case for which he is being sued. This is a deliberate attempt to preserve the patient's anonymity until the trial is over. It appears to Flea unseemly and disrespectful to his memory to do otherwise.

For this reason, many readers are likely to become confused as to what's going on as the trial gets underway. We promise we'll try to summarize the case as best we can when it's over, making sure to alter details as appropriate.

Flea's lawyer called him today. It seems the managers have exchanged line-up cards. To extend the baseball analogy for those who are still reading, we now know what the batting order will be at our trial this week.

On the second day of the trial, a former colleague of Flea's will testify against him.

During the very brief period that Flea knew the patient, he called this colleague (let us call him "Dr. Arnold") and asked for advice. It had been taking an unreasonably long period of time to acquire a consult for Flea's patient. Flea called Dr. Arnold to ask him what we could do for the patient's benefit until a consult could be obtained. Dr. Arnold gave Flea the name of a drug and a dose. Flea documented the conversation in the patient's chart.

When Flea's lawyer deposed Dr. Arnold three years ago, Dr. A denied ever having made such a suggestion. In fact, Dr. A claimed that he would *never* make such a suggestion.

Today, Flea learned that Dr. Arnold has become a witness for the prosecution. He started out as our witness. Now he's theirs.

It is important for readers of Flea to understand that the problem for which we called Dr. Arnold had nothing whatsoever to do with the circumstances that led to the patient's death.

Dr. Arnold is being called to the stand for only one reason: to damage Flea's credibility. The argument goes like this: if Dr. Flea can muff the details of a simple phone call with a colleague, surely he's enough of an idiot to miss a diagnosis that any first-year medical student could make!

All Flea wants to know is, what on earth possessed Dr. Arnold to testify against his former colleague? Surely he isn't concerned with covering his ass! When Flea reveals the details of the case, the reasons why Dr. Arnold's ass is not in jeopardy will become apparent. It can't be the money, Dr. Arnold has a full-time practice that keeps him very busy. Flea and Dr. Arnold got along very well when we were both at TBFCHITW.

Why'd he turn on Flea now?

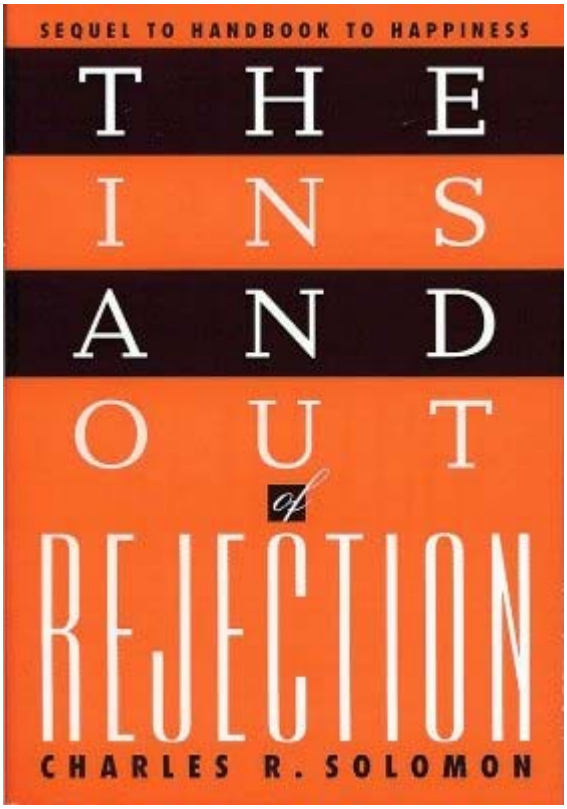
Update! Here's why: As suggested by one of the commenters, Dr. Arnold was subpeonaed to appear. According to Dr. A's lawyer, Arnold feels badly about having to do this. According to Flea's lawyer, the reason Dr. A is being called by the plaintiff's is to argue that Flea fraudulently documented a phone conversation with Dr. A.

Flea almost wishes the plaintiffs were still accusing him of being a friggin' moron - accusations of fraud smell nastier.

Posted on: Mon, May 7 2007 7:41 AM | Updated: Tue, May 8 2007 10:55 AM | Email This | Clip/Blog This Keep New:

Suppose They Gave PGR and Nobody Came?

By Flea on PGR



The first edition of Pediatric Grand Rounds' second year is up over at Moreena's blog, The Wait and the Wonder.

Moreena sent Flea an email last night. With apologies for neglecting to ask permission first, here's what it said (with a minor emendation):

"Thank you! The number of submissions was piteous. Do you have any ideas how to increase participation? Do the med bloggers feel it is being hijacked by parents? Or is that my paranoia speaking again?"

Sadly, Moreena's right. Flea-bloggers haven't exactly jumpted aboard the PGR bandwagon with both feet. And as Moreena correctly points out, Parent-bloggers occupy increasingly large portions of PGR space. Flea has nothing

against parent bloggers, certainly nothing against Moreena, who writes a lovely blog. He believes only that the letters "PGR" ought to stand for "Pediatric Grand Rounds", in the commonly understood sense, if there is such a thing as a "commonly understood sense" in the blogosphere. That means presentations by the "professional half" of the doctor-patient relationship. Again, there is nothing wrong in principle with parent-blogs. Flea only wishes they had their own forum. If PGR were to fail then for lack of participation, so be it.

Flea does indeed have ideas as to how to increase participation: Send emails to flea-bloggers on your blogroll and remind/ask them. Flea has done this in the past. Or you could just wait for Shinga to send you her long list of excellent suggestions.

Posted on: Mon, May 7 2007 5:27 AM | Email This | Clip/Blog This Keep New:

QED

By Flea on fleadom

In the course of our discussion regarding hospitalists, two of Flea's interlocutors, including Clark Bartram, pointed out that the skills of the pediatric hospitalist and your garden-variety office-based primary-care flea are "different".

Their comments lend proof to an uncomfortable truth about office-based Pediatrics about which Flea has been ranting for a long time.

Let us examine the differences, shall we?

Clark, a pedie-hospitalist, encounters many "vocally unhappy parents who are relieved to have their child managed by a hospitalist". He also notes, anectdotally, "an ever growing number of patients who come in with a history of wrong diagnoses and subsequent wrong medical management or, more often, right diagnoses with wrong medical management."

An anonymous commenter apolgizes in observing that "outpatient and inpatient skills in medicine can be two very different skill sets. In the perfect world one doc can do it all." (DIGRESSION: Folks! Please don't apologize for expressing points of view. We're all grown-ups here.)

Anon reiterates and expands: "The other fact is that outpatient and inpatient skills can be very different. My expertise now is in inpatient medicine and when I am handing off discharged patient's to PCP's it shows."

Clark and Anon appear to be observing two slightly different takes on the same disturbing trend. Their arguments

can be rephrased as follows: Fleas in primary care are so out-of-practice in taking care of hospitalized children that they do a bad job of it.

That would be scann'd: What the hell are fleas doing in primary care? Flea and Clark and Anon (if he's a flea) were all trained in hospital settings to care for sick kids! When Flea was unleashed on the world, he was very good indeed in the diagnosis and management of pediatric disease, particularly in hospitalized patients. By contrast, he sucked at taking care of well kids. The latter "skill" had to be learned on the job.

What we are left with is a cohort of physicians who have forgotten almost everything they learned in training! And yet we retain an apprehension that the well children we see in the office are identical in essence to the sick children we cared for as residents and fellows. As a result, we tend to over-test, over-diagnose, and over-treat many children who do not even require the ministrations of a physician! And too often we hand the children over to pediatric hospitalists who shake their heads in disbelief at how dumb we've gotten since going out into the world.

The primary-care flea is neither fish nor fowl. He's not even an insect. He is over-trained to care for well children and yet forgets how to care for sick kids.

It's time for pediatricians to retreat to the hospitals from whence we came and focus our efforts on the things we do best: caring for sick children. Let the Family Practitioners and Nurse Practitioners care for the healthy kids.

3 References

Posted on: Fri, May 4 2007 4:52 AM | Email This | Clip/Blog This Keep New:

Hellooooo Monkey Girl!

By Flea on pedie ED

Faithful readers of Flea, say hello to Monkey Girl, host of Musings of a Highly Trained Monkey. She appears to be an ED nurse out there somewhere. Her latest post is a gem. Check it out.

Flea wishes to use this opportunity to point out that his so-called "problem with the ED" begins and ends with the

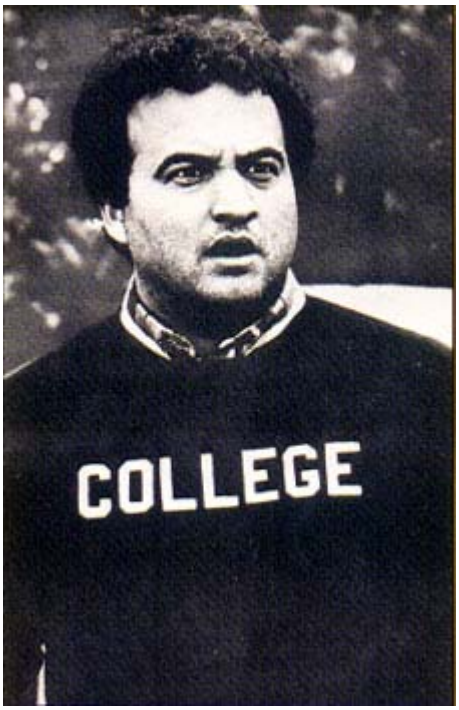
fleas who send their non-emergently ill patients there, and who fail to instruct the parents to call them first. Once in the ED, Flea expects ED docs to do what ED docs do. If the lines of communication between Flea and the ED were more open, that would be good. But the "lesion" lies further upstream.

Flea's got nothing against ED docs. Some of them are real-life personal friends of his. And some of them are *killer* bloggers.

Posted on: Wed, May 2 2007 7:19 AM | Email This | Clip/Blog This Keep New:

The Surgeon is a Flea

By Flea on fleadom



Aggravated DocSurg gave us a shout yesterday.

It seems my "brotha from anotha motha" has been forced to manage his surgical patients' medical problems. This is because the hospitalists where he works aren't doing a very good job. It goes without saying that the primary care docs aren't in the hospital to do the same. So management of congestive heart failure, brittle diabetes, and COPD falls to DocSurg.

It's not that medical management is tough for a surgeon. If nothing else, it's good practice for him. The point is h*e shouldn't freakin' need to be doing it*!

So he calls himself a flea.

At the risk of diverting attention from the subject at hand, Flea wishes to point out that the designation "flea" has myriad meanings in the context of this blog. At times, the name is a sort of reverse-chic badge of courage. At other times it is used as a cudgel to club our pediatric colleagues for allowing larger, more powerful forces to walk all over us. Such is the case with the hospitalist movement.

Flea has little sympathy for docs who complain about hospitalists. It's our own friggin' fault that the hospitalist movement exists in the first place! Too many of us were happy enough to hand off patients to other docs. For those of us unhappy with the concept, Flea believes we could have bitched louder and longer. Flea won't admit patients to hospitals with hospitalist programs. This is one approach, but Flea acknowledges that such selectivity is easy for him because he has *choices*. If a pediatrician has no choice, we guess he's gotta bend over and take it.

There is no more stinging indictment of the hospitalist phenomenon than this: *The patients hate it*. They want to be cared for by their own doctors. When will the peeps speak up and tell the hospitals they hate the hospitalists? If the powers that be won't listen to the fleas, perhaps they'll listen to the customers.

2 References

Posted on: Mon, Apr 30 2007 11:56 AM | Email This | Clip/Blog This Keep New:

In Her Own Words

By Flea on malpractice

If the plaintiff's lawyer in Flea's upcoming trial is any good at all, she's already Googled Flea.

Goodness knows Flea's Googled her.

Flea knows where and when she went to high school, college and law school. We have her engagement and wedding announcements from the New York Times. We even found her mother online.

Our favorite find is a set of PowerPoint slides she made for a lecture at a local law school. For reasons presently unclear, Flea's adversary chose a rusty lock and key as the graphical theme of her presentation.

The subject of the lecture was malpractice, naturally.

According to Flea's adversary, there are three reasons why patients become clients:

1. They want explanations for what happened to them.
2. They want money to be able to care for a child or family in the future.
3. They want to prevent the bad outcome that befell them from happening to others.

The first reason makes no sense. Surely a lawsuit is not necessary to extract an explanation from a physician, is it? The second reason, on the other hand, makes *a lot of sense*. Flea's favorite, though, is the last reason. You have to

admire some people's altruism.

The so-called "benefits" of malpractice litigation are listed as the following:

1. Particular physicians will take better care of their patients in the future.
2. Practice guidelines and protocols will be developed.
3. "Society" will be relieved of the obligation of paying for the care of the injured.

If "more defensive medicine" equals "better care", then Flea's adversary is right... except that defensive medicine is *worse* care, so she's wrong. As for practice guidelines and protocols, Flea acknowledges one paramount advantage: they relieve a physician of the obligation of having to think. Finally, "society" does *indeed* pay for the cost of paying for the injured. We're all paying dearly.

What patients hope for and expect from malpractice litigation is "compensation, explanation, and a safer healthcare system". Flea's adversary could have stopped with compensation. As we said before, if a patient wants an explanation, he can acquire it much less expensively than a lawsuit: He can ask the doctor.

There is also a slide that summarizes what doctors need. The list certainly does not exhaust the desiderata of the average physician, even with respect to malpractice. Nevertheless, Flea was impressed to see that his Adversary was right on all four points:

1. We want to be paid reasonably.
2. We want to be able to afford our malpractice premiums.
3. We want to be able to admit we are human without fear of being sued for saying so.
4. We want incentives to improve outcomes.

Number four opens the whole "P4P" can of worms, but the concept is sound.

The concluding slide was puzzling. It includes a plea for honesty on the part of doctors (attorneys, presumably, do require such a plea). There is also a cryptic statement identifying the malpractice insurance industry as a "business" (What? Flea thought ProMutual was in the game to make friends!)

Last was a prayer for safer and better care.

Amen, sister (or something...)

Posted on: Sat, Apr 28 2007 6:16 PM | Updated: Sun, Apr 29 2007 5:34 AM | Email This | Clip/Blog This Keep New:

Flea's Ties

By Flea on fleadom

Flea has never purchased a tie for himself. He doesn't need to. Folks buy him Save the Children ties.

These are great ties. Most neckwear for men is too flashy or fruity for Flea. It's increasingly difficult to find a tie that does not embarrass the wearer.

Now we learn that Save the Children has hooked up with American Idol to raise money for the kids. Flea heard Mark Shriver (yes, that Shriver family) on the radio yesterday talking about the work that STC is doing in the states and Africa. Shriver mentioned that the organization helps raise awareness of poverty and hunger in the U.S. and overseas.

Mike Barnicle, who was interviewing Shriver, asked him if hunger was defined differently in the U.S. than in Africa [Great question!, Flea thought]

Shriver answered that STC's efforts in the U.S. were directed not at hunger but at *literacy*. Flea's heart jumped. This is exactly the kind of effort that is needed to stamp out hunger and poverty here and throughout the world.

There's a hackneyed saying that goes: "Give a man a fish and you feed him for a day. Teach a man to fish and you feed him for the rest of his life."

Save the Children, it turns out, is in the business of teaching men to fish, or teaching children to read as the case may be. It's not about income redistribution, and it's not about entitlements. Teaching reading provides humans with one of the most valuable tools we need to improve our circumstances in life.

Flea would buy a tie for that cause. Hell, he'd buy ten!

Posted on: Fri, Apr 27 2007 4:22 AM | Email This | Clip/Blog This Keep New:

What Do Malpractice Juries Care About?

By Flea on malpractice

More notes from Flea's day with his trial-prep advisor:

Question: Besides the defendant, what other party is present in the courtroom completely against their will?

Answer: The jury.

Juries, Flea is told, sympathize more with the flea in the box than you might guess. Jurors, like physician-defendants, tend to feel anxious and unsure of themselves, at least initially.

All that was nice and reassuring. What Flea heard next, however, fairly blew him away.

A jury's decision-making process depends more on the doctor's character, or what they perceive the doctor's character to be, than on the medical facts of the case. The break-down was astonishing: Doctor's character accounts for 97% of a jury's decision, the medical facts of the case, 3%.

Did y'all get that? The facts of the case amount to roughly squat. What really matters is the impression Flea will make on the jury.

Regarding the doctor's character, a juror asks himself the following questions:

1. **Can I trust this doctor?** The advisor told Flea that a lot of his trustworthiness has less to do with the words that come out of his mouth and more to do with the shape of his face. She told Flea he has a "compassionate face", according to some arcane biometrics. All good so far. The effectiveness of Flea's presentation at trial is 80% visual and 15% non-verbal communication (body-language, etc.) Very little of the trust factor comes from from the content of the medical decision-making the jury will learn about.

2. **If I was in a medical crisis, would I be in safe hands with him?** This question breaks down further into two more bits: What are the doctor's credentials, and does he appear to have good judgment? The former counts for about 25%, the latter for about 75%. Flea hasn't mentioned his embarrassingly flashy CV, but he has worried that it might come back to bite him in the context of a malpractice trial ("Doctor, you have all this Ivy League parchment hanging on your wall and yet you acted like a dumb-ass pre-med, did you not?") Fortunately, the CV doesn't matter as much as we had worried.

And most important:

3.**Under the circumstances, did Flea do the best he could**? This will not be difficult to demonstrate at trial.

Finally,

4. **Did Flea make the proper medical decision?** This is the bit that amounts to only 3% of a jury's decision-

making process.

The plaintiff's attorney's job, then, is to destroy Flea's character. Flea's job is to preserve it.

We've said it before and we'll say it again: if the basis of this case is that Flea is an arrogant, uncaring jerk who maliciously neglected a patient, resulting in his death, the plaintiff will not win, *period*. As much of a cocky bastard that Flea may appear in the blogosphere, the readers who have a personal acquaintance with the real 3-D doctor understand how such an approach cannot succeed.

The only tack that has a prayer of prevailing is to prove to the jury that the doctor is a drooling, blithering idiot.

Flea's only remaining fear is that the (female) plaintiff's attorney will be mean to him.

Posted on: Thu, Apr 26 2007 4:45 AM | Email This | Clip/Blog This Keep New:

Don't Just Do Something, Stand There!

By Flea on fleadom

Great post from Sandy over at Junkfood Science:

It turns out there is a stunning lack of evidence that obesity screening and prevention programs are working. To be precise, there is no evidence that obesity screening and prevention programs *aren't* working, either: There's simply no evidence, period.

A group from York, England published a systematic review of published and un-published works from the electronic databases (subscription is required for the full link). They included "any study that evaluated measures of overweight and obesity as part of a population-level assessment and excluded studies whose primary outcome measure was prevalence".

The findings? "There were no trials assessing the effectiveness of monitoring or screening for overweight and obesity. Studies focussed on the diagnostic accuracy of measurements. Information on the attitudes of children, parents and health professionals to monitoring was extremely sparse."

And yet, Flea's community and communities throughout the English-speaking world are going full-bore at interventions aimed at obesity. Many of Flea's contracts with third-party providers include requirements that he make "some kind of intervention" for any child with a body-mass index of 85 m2/Kg or greater. To spell this out in plain English: if Flea doesn't do "disease management" for obesity he doesn't get paid.

Folks, let's be clear about this: obesity is a problem. We don't know how to fix it. Let's stop pretending we do.

Posted on: Wed, Apr 25 2007 11:58 AM | Email This | Clip/Blog This Keep New:

Don't Just Do Something, Stand There!

By Flea

Great post from Sandy over at Junkfood Science:

It turns out there is a stunning lack of evidence that obesity screening and prevention programs are working. To be precise, there is no evidence that obesity screening and prevention programs *aren't* working, either: There's simply no evidence, period.

A group from York, England published a systematic review of published and un-published works from the electronic databases (subscription is required for the full link). They included "any study that evaluated measures of overweight and obesity as part of a population-level assessment and excluded studies whose primary outcome measure was prevalence".

The findings? "There were no trials assessing the effectiveness of monitoring or screening for overweight and obesity. Studies focussed on the diagnostic accuracy of measurements. Information on the attitudes of children, parents and health professionals to monitoring was extremely sparse."

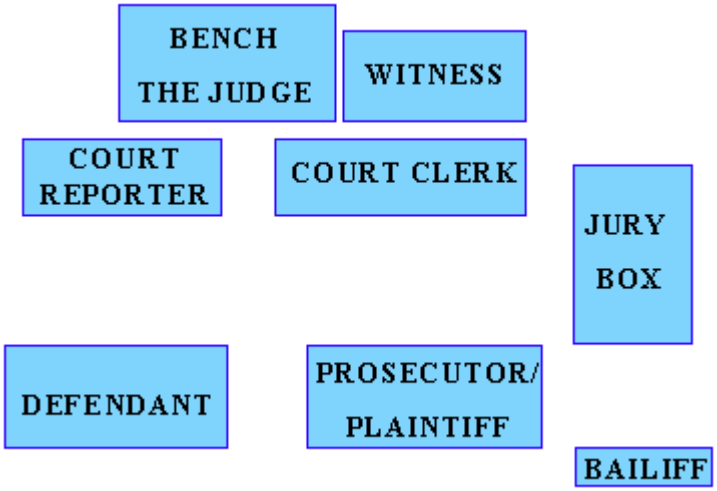
And yet, Flea's community and communities throughout the English-speaking world are going full-bore at interventions aimed at obesity. Many of Flea's contracts with third-party providers include requirements that he make "some kind of intervention" for any child with a body-mass index of 85 m2/Kg or greater. To spell this out in plain English: if Flea doesn't do "disease management" for obesity he doesn't get paid.

Folks, let's be clear about this: obesity is a problem. We don't know how to fix it. Let's stop pretending we do.

Posted on: Wed, Apr 25 2007 7:58 AM | Updated: Wed, Apr 25 2007 8:14 AM | Email This | Clip/Blog This Keep New:

Flea Takes a Screen Test

By Flea on malpractice



Flea spent most of the day in his attorney's office. A well-known jury preparation expert had been brought into town to teach Flea how to be examined by a hostile plaintiff's attorney.

Flea was shown a diagram of the courtroom similar to this one. There is a subtle yet important difference to what is shown here: In Massachusetts, the defendant himself does not sit at the "defendant table". Flea was instructed to find a seat in the front row of the gallery on the right as close to the jury as possible.

Flea will probably be the plaintiff's first witness. He was instructed to angle his chair slightly toward the jury, and to keep his claws folded in his lap. He was instructed to turn his head toward the plaintiff's attorney while answering questions, then to turn to face the jury and answer slowly, separating words, and loudly enough for the farthest juror to hear. Answers should be kept to no more than three sentences.

With that introduction, Flea's instructor set up a camera and we tried it out. With the camera rolling, Flea turned his head toward the "plaintiff's attorney" and heard generic questions about Pediatrics. Then he turned his head back toward the "jury" that he was facing and answered in slow, measured sentences. Most of the time, he exceeded the three-sentence limit. We'll have to work on that.

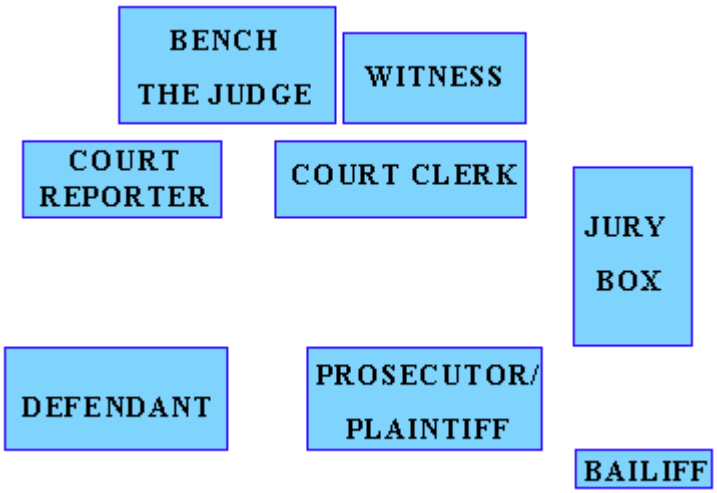
Finally, Flea was given a DVD of his screen test and a script to practice the head turning and slow-question-answering-thing daily until trial date.

Along the way, Flea was given some fascinating insights as to what makes juries tick. More on this later.

Posted on: Tue, Apr 24 2007 1:29 PM | Email This | Clip/Blog This Keep New:

Flea Takes a Screen Test

By Flea



Flea spent most of the day in his attorney's office. A well-known jury preparation expert had been brought into town to teach Flea how to be examined by a hostile plaintiff's attorney.

Flea was shown a diagram of the courtroom similar to this one. There is a subtle yet important difference to what is shown here: In Massachusetts, the defendant himself does not sit at the "defendant table". Flea was instructed to find a seat in the front row of the gallery on the right as close to the jury as possible.

Flea will probably be the plaintiff's first witness. He was instructed to angle his chair slightly toward the jury, and to keep his claws folded in his lap. He was instructed to turn his head toward the plaintiff's attorney while answering questions, then to turn to face the jury and answer slowly, separating words, and loudly enough for the farthest juror to hear. Answers should be kept to no more than three sentences.

With that introduction, Flea's instructor set up a camera and we tried it out. With the camera rolling, Flea turned his head toward the "plaintiff's attorney" and heard generic questions about Pediatrics. Then he turned his head back toward the "jury" that he was facing and answered in slow, measured sentences. Most of the time, he exceeded the three-sentence limit. We'll have to work on that.

Finally, Flea was given a DVD of his screen test and a script to practice the head turning and slow-question-answering-thing daily until trial date.

Along the way, Flea was given some fascinating insights as to what makes juries tick. More on this later.

Posted on: Tue, Apr 24 2007 9:29 AM | Updated: Tue, Apr 24 2007 10:17 AM | Email This | Clip/Blog This Keep New:

Happy B-Day, PGR!

By Flea on PGR

The father of Pediatric Grand Rounds, Clark Bartram, provides a retrospective on the occasion of PGR's first birthday. It's sort of a *meta* Best Of the pediatric blogosphere.

Flea's impression one year later is that ours remains a teeny-weeny corner of the medical blogosphere, that itself represents a teeny-weeny corner of the universal blogosphere. Is anybody out there listening? Clark's contribution helps focus attention to us and what we have to say, and for this we all owe him a debt of appreciation.

Posted on: Tue, Apr 24 2007 2:30 AM | Email This | Clip/Blog This Keep New:

Happy B-Day, PGR!

By Flea

The father of Pediatric Grand Rounds, Clark Bartram, provides a retrospective on the occasion of PGR's first birthday. It's sort of a *meta* Best Of the pediatric blogosphere.

Flea's impression one year later is that ours remains a teeny-weeny corner of the medical blogosphere, that itself represents a teeny-weeny corner of the universal blogosphere. Is anybody out there listening? Clark's contribution helps focus attention to us and what we have to say, and for this we all owe him a debt of appreciation.

1 Reference

Posted on: Mon, Apr 23 2007 10:30 PM | Updated: Mon, Apr 23 2007 10:46 PM | Email This | Clip/Blog This Keep New:

Why Flea Blogs

By Flea on on blogging

Dinah from Shrink Rap tagged Flea with the "Why Do You Blog?" meme.

1. **Catharsis:** There are things that Flea has been dying to say for years but can't precisely because he is a physician (see #4 below). It's positively therapeutic to be able to unburden ourselves in this forum.

2. **Neosporin:** It's a wonder drug, a floor wax *and* a dessert topping! Thank God for Neosporin!

3. **Writing Practice**: Flea's gonna write a book some day, maybe, if he can stop blogging long enough to commit more than 100 words to paper.

4. **Malpractice:** See #1. There is such shame and stigma attached to being sued that we doctor-types find we can't even talk about our own malpractice cases amongst ourselves! Flea believes the folks ought to hear our stories.

5. **The Message**: Our culture is suffused with messages telling parents that their children are sick, or potentially sick: one sniffle away from certain doom. Flea's message is that American children are the healthiest children that ever lived on planet Earth. We should *celebrate* our good fortune.

The culture tells us the children are defined by series of capital letters: ADD, ADHD, ASD, PDD-NOS, OCD. Flea wants children to be called by the *names their parents gave them*.

Pediatrics today consists of daily exercises in over-testing, over-diagnosing, over-treating, and over-admiting to hospital. Flea wants the folks to know that often the best thing to do for a child is to keep him or her the hell out of

the pediatrician's office!

Pediatricians who write for newspapers and magazines produce icky, squishy pap that bears only the faintest resemblance to expository writing, and that is astonishingly void of original points of view.

Flea is trying to keep it real.

Now, would the following Flea-bloggers care to take a crack at it?

Clark, Sam, Gwenn, Bryan, and Mary

Posted on: Sat, Apr 21 2007 5:08 PM | Email This | Clip/Blog This Keep New:

Why Flea Blogs

By Flea

Dinah from Shrink Rap tagged Flea with the "Why Do You Blog?" meme.

1. **Catharsis:** There are things that Flea has been dying to say for years but can't precisely because he is a physician (see #4 below). It's positively therapeutic to be able to unburden ourselves in this forum.

2. **Neosporin:** It's a wonder drug, a floor wax *and* a dessert topping! Thank God for Neosporin!

3. **Writing Practice**: Flea's gonna write a book some day, maybe, if he can stop blogging long enough to commit more than 100 words to paper.

4. **Malpractice:** See #1. There is such shame and stigma attached to being sued that we doctor-types find we can't even talk about our own malpractice cases amongst ourselves! Flea believes the folks ought to hear our

stories.

5. **The Message**: Our culture is suffused with messages telling parents that their children are sick, or potentially sick: one sniffle away from certain doom. Flea's message is that American children are the healthiest children that ever lived on planet Earth. We should *celebrate* our good fortune.

The culture tells us the children are defined by series of capital letters: ADD, ADHD, ASD, PDD-NOS, OCD. Flea wants children to be called by the *names their parents gave them*.

Pediatrics today consists of daily exercises in over-testing, over-diagnosing, over-treating, and over-admiting to hospital. Flea wants the folks to know that often the best thing to do for a child is to keep him or her the hell out of the pediatrician's office!

Pediatricians who write for newspapers and magazines produce icky, squishy pap that bears only the faintest resemblance to expository writing, and that is astonishingly void of original points of view.

Flea is trying to keep it real.

Now, would the following Flea-bloggers care to take a crack at it?

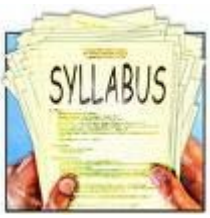
Clark, Sam, Gwenn, Bryan, and Mary

1 Reference

Posted on: Sat, Apr 21 2007 1:08 PM | Updated: Sat, Apr 21 2007 1:47 PM | Email This | Clip/Blog This Keep New:

Flea Gets His Syllabus

By Flea on malpractice



Received in the mail this morning:

Protector and Defender, LLC
A Professional Corporation
Not so fancy address
Boston, MA 02114

April 18, 2007

PERSONAL AND CONFIDENTIAL

Flea
Flea's Office
The Blogosphere

Re: Flea's Upcoming Malpractice Trial

Dear Flea:

Enclosed please find three sections from two text books (Pediatric Diagnosis and Treatment, and Nelson's Textbook of Pediatrics) that plaintiffs intend to introduce into evidence at trial. Please review these pages carefully, since plaintiffs' counsel may use them to cross examine you at trial.

If you have any questions, please call me.

Very truly yours,

Flea's lawyer.

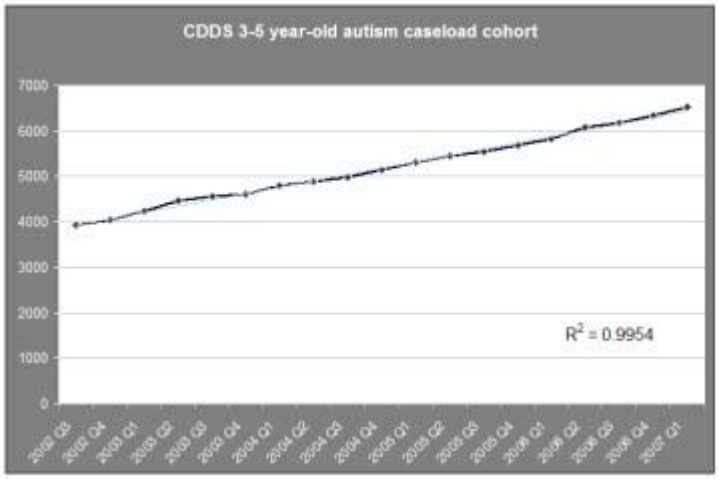
cc:
Flea's malpractice insurance carrier

So Flea has to study for his (cross) exam.

Posted on: Fri, Apr 20 2007 6:38 AM | Email This | Clip/Blog This Keep New:

What's Wrong With This Picture?

By Flea on autism



It fails to support the hypothesis that mercury in vaccines causes autism.

Dad of Cameron, the author of Autism Street, deserves a ton of credit for his statistical analyses of data from the California Department of Developmental Services. It seems that the 3-5 year-old autism caseload continues to rise steadily despite the removal of Thimerosal from vaccines in 2001.

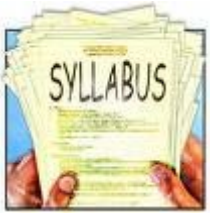
Please be sure to read the comments section. Folks from the "mercury causes autism" crowd are tying themselves in knots attempting to explain away the data.

Folks, the data is what it is. How much more data will it take to convince you?

Posted on: Fri, Apr 20 2007 3:55 AM | Email This | Clip/Blog This Keep New:

Flea Gets His Syllabus

By Flea



Received in the mail this morning:

Protector and Defender, LLC
A Professional Corporation
Not so fancy address
Boston, MA 02114

April 18, 2007

PERSONAL AND CONFIDENTIAL

Flea
Flea's Office
The Blogosphere

Re: Flea's Upcoming Malpractice Trial

Dear Flea:

Enclosed please find three sections from two text books (Pediatric Diagnosis and Treatment, and Nelson's Textbook of Pediatrics) that plaintiffs intend to introduce into evidence at trial. Please review these pages carefully, since plaintiffs' counsel may use them to cross examine you at trial.

If you have any questions, please call me.

Very truly yours,

Flea's lawyer.

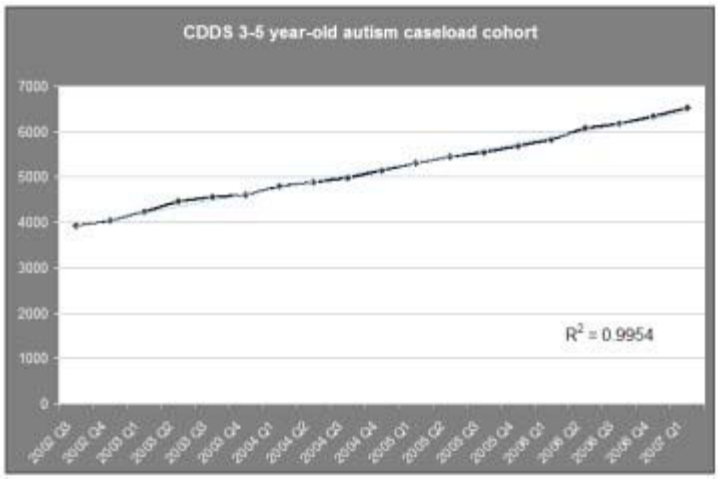
cc:
Flea's malpractice insurance carrier

So Flea has to study for his (cross) exam.

Posted on: Fri, Apr 20 2007 2:38 AM | Updated: Fri, Apr 20 2007 3:12 AM | Email This | Clip/Blog This Keep New:

What's Wrong With This Picture?

By Flea



It fails to support the hypothesis that mercury in vaccines causes autism.

Dad of Cameron, the author of Autism Street, deserves a ton of credit for his statistical analyses of data from the California Department of Developmental Services. It seems that the 3-5 year-old autism caseload continues to rise steadily despite the removal of Thimerosal from vaccines in 2001.

Please be sure to read the comments section. Folks from the "mercury causes autism" crowd are tying themselves in knots attempting to explain away the data.

Folks, the data is what it is. How much more data will it take to convince you?

Posted on: Thu, Apr 19 2007 11:55 PM | Updated: Fri, Apr 20 2007 12:04 AM | Email This | Clip/Blog This Keep New:

Arrivals - Departures

By Flea

Flea's day begins with gratitude. The rabbis were smart guys: they knew the best way to train a person to become a mensch was to start his or her day acknowledging that every day is a gift. Some mornings, when we say "Modeh ani", we *really* mean it. This morning is one of those.

At this time, Flea has nothing to add to all that has been written in the blogosphere and elsewhere regarding the events of April 16 in Blacksburg Virginia. Therefore he will remain on silent on the matter.

Several years ago, an older colleague gave Flea a piece of advice: "Patients are going to leave you. If you let it get to you, you won't last five minutes in this business".

Flea thought at the time that this advice would never come in handy because patients would never leave! The depths of his own naivete never cease to amaze Flea.

Every departure stings. Some sting more than others. If a family moves away, it's sad, but life is tough in our part of the world. Massachusetts remains one of only two states whose population is declining. Most families leave because they just don't like Flea.

Some families depart for the classic reason patients leave doctors: Flea didn't listen to me or take my problems seriously, either because he was rushed or just didn't seem to care. Some depart over disagreements as to whether a child's illness was serious enough to warrant an office visit. Others depart because they didn't get antibiotics here. At least two families departed after Flea diagnosed their child with a chronic illness. Some just plain don't like Flea.

Two items for the record: ONE: Flea cares about *all* his patients. He cares so much about them that he labors mightily to teach their parents about their essential wellness, to the end that they do not become victims of our culture of medicalization. Some parents are more receptive to the message than others. TWO: Flea does *not* refuse to see patients on principle: sometimes, in response to a phone call or email, we ask a parent to bring a child to the office. Knowing the doctor as well as they do, parents view an invitation from Flea to come to the office is an invitation to panic: if it worries Flea enough to see the child, they reason, it may be something serious!

There have been a number of departures lately. This drives Flea to ponder whether he's over-doing it, or under-doing it as the case may be. Perhaps so-and-so should have been seen? Perhaps so-and-so should have gotten Amoxicillin. Perhaps Flea just sucks as a pediatrician?

There have also been a number of arrivals. Happily, these outnumber the departures. Grateful parents, particularly in the Brazilian community, continue to refer their friends here. A long-time pediatrician in the community recently retired, and Flea is one of the beneficiaries. The word of mouth machine is in full swing.

So, at the end of the day, there are more reasons for gratitude than at the beginning.

Posted on: Tue, Apr 17 2007 11:39 PM | Updated: Wed, Apr 18 2007 12:33 AM | Email This | Clip/Blog This Keep New:

Sweet Vindication?

By Flea

From this month's number of Pediatrics (that inexplicably arrives in my box when the month is already half over):

Do All Infants With Apparent Life-Threatening Events Need to Be Admitted?
Ilene Claudius, MD and Thomas Keens, MD (Pediatrics Vol. 119 No. 4 April 2007, pp. 679-683)

Answer: *No*.

Apparent Life-Threatening Events (ALTE's) are scary as hell. An ALTE is defined as "an episode that is frightening to

the observer and that is characterized by some combination of apnea (central or occasionally obstructive), color change (usually cyanotic or pallid, but occasionally erythematous or plethoric), marked change in muscle tone (usually marked limpness), choking, or gagging." In short, it looks like the baby is going to die...

...except that the baby *isn't* going to die. As scary as ALTE's appear, they seldom signal any truly life-threatening event. Claudius and Keens show as much in this three-year prospective study. Among "well-appearing" patients presenting to the E.D., the only children that truly needed admission were less than 30 days old, and/or had numerous ALTE's. In other words, according to the authors, if a baby were older than one month and had a single ALTE, he may be safely discharged from the hospital.

A few months ago, the parents of 10 month-old twins transferred out of Flea's practice because of an ALTE. It seems one of the twins (whom we already suspected had symptomatic reflux), had an ALTE while sitting in his swing. The P.A. in the E.D. paged Flea. The child looked great and the work-up including a chest x-ray and EKG, was entirely normal.

Then the P.A. said she wanted to admit the child for a 24-hour Holter monitoring. After Flea picked himself off the floor, he said he'd be okay with admitting overnight, but please could we do it without the Holter?

Somehow the message got transmitted to mom that Flea didn't want the child to be admitted at all (this was true, but we agreed to the admission nonetheless). The next morning at 5:30 mom told us she didn't want Flea to be the flea for her twins any more.

Never mind that sending the child home was the right thing to do.

Here's the "take-home message": In the real world, evidence-based medicine often doesn't make a dime's worth of difference. It doesn't matter to parents and it doesn't even matter to some of Flea's colleagues. This is especially true in the current climate of over-test, over-diagnose, over-treat, and over-admit.

A few months back, Clark had a nice post on ALTE's and the confusion surrounding them. Clark nails the biggest reason why healthy babies with ALTE's should be sent home:

> "All too often once a child has a problem, or even when they don't but it requires admission to a hospital, something funamentally changes in the family dynamic. Little Johnny is now a "sick" baby or at least one that needs to be watched like a hawk night and day."

Flea is right but he has two fewer patients than he had before. So who is blue-faced now?

Posted on: Mon, Apr 16 2007 4:01 AM | Updated: Mon, Apr 16 2007 5:02 AM | Email This | Clip/Blog This Keep New:

Superstition Ain't the Way

By Flea

MMR and Autism: What Parents Need to Know, by Michael Fitzpatrick.

London and New York: Routledge, 2004, 176 pp.

Don't let the title fool you: This devastating volume by London-based GP Michael Fitzpatrick is *not* yet another product of the scaremongering industry that has grown up around the "MMR/Autism" industry since Andrew Wakefield's infamous Lancet article in 1998.

To the contrary, Dr. Fitzpatrick has produced a meticulous, blow-by-blow account of the Wakefield story and the resulting harm done to the universal immunization program in the U.K.

For those readers of Flea unfamiliar with the Wakefield debacle, journalist Brian Deer provides the best on-line summary. For those like Flea who are familiar with the story but who do not happen to be British, Fitzpatrick provides an invaluable description of the social and cultural context in the U.K. that provided the background for the MMR scare.

One important piece of social context turns out to be the "Mad Cow" scandal of the 1990's. Few outside the U.K. realize the magnitude of the impact that Mad Cow had on the British public. Fitzpatrick credits public anger over Mad Cow and its handling by the Conservative government as a key factor in Tony Blair's Labour Party landslide victory in 1997.

In the wake of Mad Cow (which, Fitzpatrick argues contrary to popular opinion, the Tory ministers handled quite well), public distrust at government especially on matters of health was at low ebb in 1998. "Maverick" doctors such as Andrew Wakefield received a respectful hearing from a disgusted public. The lay press, with few exeptions, provided a willing and enthusiastic sounding board for Dr. Wakefield.

At the same time, the British public health apparatus found itself in the grip of what we would call in the U.S. the "patient empowerment" movement. The expert opinion of patients (or in the case of autism, of *parents*) became priveleged over that of the erstwhile experts, doctors and scientists. Coincident with the rise of the internet, the firestorm over MMR, and its presumed causal link to autism, could not be extinguished. MMR coverage rates fell sharply, especially in inner-city London.

Fitzpatrick then meticulously tears apart the "evidence" linking MMR to autism; but he doesn't stop there. He then throws the broken shards of the argument to the floor and jumps up and down on them a few times. Finally, Fitzpatrick offers a careful, nuanced account of the motivations that might have driven Andrew Wakefield, an ostensibly sane pediatric gastroenterologist, off the deep end.

Dr. Fitzpatrick's title delivers what it promises: everything parents need to know about the relationship between MMR and autism. In short, there is none.

There are a few shortcomings worth mentioning: Though aimed at parents, the argumentation is too dense and difficult to follow for the lay reader. The college-educated mom who recommended the book to Flea admitted to having a fair amount of difficulty understanding it. Flea fears that Fitzpatrick and his editors got carried away and forgot their audience!

There are also a few minor editorial gaffes that produced some amusing effects. For example, Fitzpatrick writes that the DTaP vaccine is given at 2, 4, and 6 weeks of age. That should read *months*, not weeks. No wonder the anti-vax folks are up in arms! There is also a section where Fitzpatrick becomes suddenly and inexplicably enamored of the word "scope". Happily, the affliction is brief in scope.

On the plus side, Fitzpatrick provides the best discussion Flea has yet seen of the relative risks and benefits of MMR. This is precisely the kind of argument that Flea's parents are asking for. Fitzpatrick quotes a length the work of Paul Offit, who demolishes the argument that early multiple vaccination somehow "overwhelms" the infant immune system. Offit is quoted as observing that infants could probably handle the introduction of antigens from 10,000 vaccines at a time without suffering any ill effect.

Finally, you have to love a man who closes his book with a quote from Stevie Wonder:

When you believe in things that you don't understand,
Then you suffer.
Superstition ain't the way.

Stevie *knows*! Flea's only worry is that the folks won't understand *or* believe Fitzpatrick's book. But he'll take "MMR and Autism" over superstition any day.

Posted on: Sun, Apr 15 2007 11:09 AM | Updated: Sun, Apr 15 2007 12:35 PM | Email This | Clip/Blog This Keep New:

Is Obesity a Threat to Longevity?

By Flea

Kirstie thinks not.

Life expectancy in the U.S. has been rising steadily for a long time. There are many reasons for this. The phenomenal drop in infant mortality during the first half of the last century contributed to a major jump in life expectancy. Improved living conditions, advances in public health, and medical interventions account for a fair bit of life elongation as well.

Now that we're not dying as early, we have the opportunity to eat and gain weight! It's true that morbidly obese people (BMI > 45 Kg/m2) live significantly less long than thinner people. It's also true that there are more morbidly obese people than there used to be.

Two questions arise from these facts: Will the rise in the prevalence of obesity negatively impact rising life expectancy? And if so, could the upward trend stop or even reverse?

The received wisdom seems to suggest that our children will become fat actors (and actresses, see above) and then will keel over at younger ages than we did, all because of weight. Where did this idea come from?

Flea doesn't know for sure who came up with this idea first, but a strong candidate is this 2005 article in the New England Journal of Medicine a few years ago by a group led by Flea's former colleague David Ludwig. Ludwig and

his colleagues suggest, but do not state definitively, that obesity could have an effect on life expectancy. Here's the money quote:

> "We anticipate that as a result of the substantial rise in the prevalence of obesity and its life-shortening complications such as diabetes, life expectancy at birth and at older ages *could* level off or even decline within the first half of this century. (emphasis added)"

So this isn't exactly a bold confident statement of fact. An accompanying editorial by Samuel Preston throws some cold water on Ludwig's prediction:

> "Decreases in the rate of death at older ages have been the principal force driving American longevity for at least half a century, and they show no signs of abating... The effect of an increase in the prevalence and severity of obesity on the longevity of U.S. citizens is already embedded in extrapolated forecasts made in recent periods. In fact, these forecasts implicitly assume that the severity of obesity will continue to worsen, and the prevalence will rise, since it is the rate of change in the determinants of mortality, rather than the level, that drives projected changes in life expectancy. Hundreds of factors affect a population's rate of death in any particular period, and it is their combined effect that establishes the trend."

Preston concludes:

> "The rising prevalence and severity of obesity are capable of offsetting the array of positive influences on longevity. How likely is that to happen? One promising observation is that the recent increase in the levels of obesity was produced by relatively few excess calories in the typical daily diet. The consumption of a median of 30 excess calories a day produced the observed increase in weight during an eight-year period for Americans 20 to 40 years of age. At the 90th percentile of weight gain, the excess consumed was about 100 calories a day. Reversing the increase in body mass might be accomplished through small behavioral changes that fit relatively easily into most people's lifestyles. The food and restaurant industries would be valuable allies in this effort, and there are recent indications of their willingness to cooperate."

The bottom line is, there's no need to go freaky on the "obesity epidemic". Who knows? Take off a few extra bites of cheese per day and we may be looking at average life expectancies close to the century mark.

Posted on: Fri, Apr 13 2007 3:42 AM | Updated: Fri, Apr 13 2007 5:27 AM | Email This | Clip/Blog This Keep New:

My Carmona

By Flea

In an earlier post, Flea wished desperately that someone made up the story of the Surgeon General saying that the "obesity epidemic" was worse than terrorism. We're disappointed to report that the story is true.

In early March, 2006, then Surgeon General Richard Carmona spoke at the University of South Carolina and said, among other things, the following:

> "Obesity is the terror within... Unless we do something about it, the magnitude of the dilemma will dwarf 9-11 or any other terrorist attempt... Where will our soldiers and sailors and airmen come from? Where will our policemen and firemen come from if the youngsters today are on a trajectory that says they will be obese, laden with cardiovascular disease, increased cancers and a host of other diseases when they reach adulthood?"

Aparently this was not the first time that Carmona used the terrorism analogy. In January 2003, he sat down with a reporter from U.S. Medicine, a government web site. It appears his interviewer presses Carmona on the relative seriousness of obesity and terrorism:

> "Dr. Carmona ranked obesity as the biggest problem facing the U.S. in the future, saying that it was as big a threat, if not a bigger threat, than terrorism.
>
> 'Not that [terrorism] isn't important, but this rises to the level of the terrorism threat today, if not exceeds it, because it involves the whole country and it's clear where we're going,' he said."

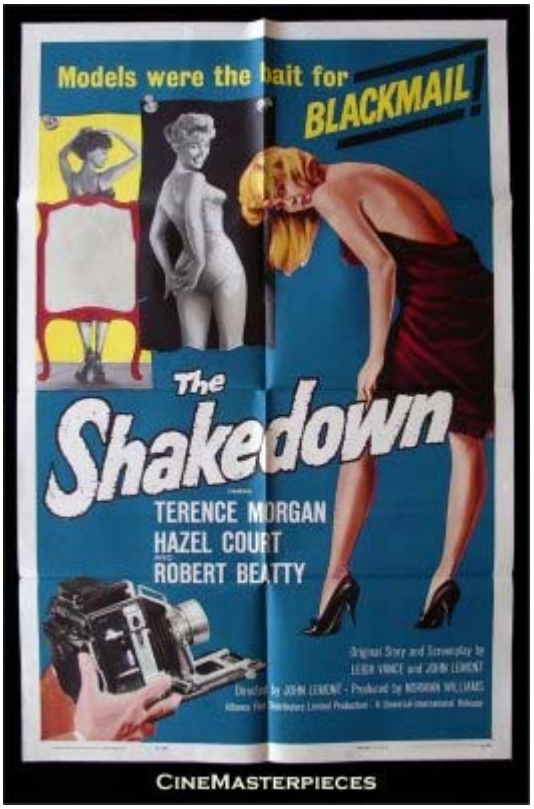
So it appears this was no momentary lapse of reason. The best thing that can be said for this sorry excuse for a doc is that he is no longer the Surgeon General.

The best commentary from the blogosphere we can find on the Carmona/obesity/terrorism kerfuffle comes from Gene Healy of AFF Brainwash. Enjoy.

Posted on: Thu, Apr 12 2007 12:26 AM | Updated: Thu, Apr 12 2007 2:11 AM | Email This | Clip/Blog This Keep New:

Imus Shakedown?

By Flea



What follows is rash, rushed, from-the-hip speculation on a subject Flea knows next to nothing about. But this is the blogosphere, so what the heck? Here goes:

Flea suspects that radio and television talk-show personality Don Imus is, or will soon be, the victim of a shakedown.

These are the facts as Flea understands them.

Don Imus' career has brought him wealth beyond his wildest imaginings, with homes on the Upper West Side of Manhattan, Westport, CT, and Ribera, NM.

Imus runs a summer camp for children with cancer that Flea and the rest of the world admires enormously. The foundational principle of the Imus Ranch for Kids with Cancer is that the children will not be pampered and coddled. Instead they are expected to do chores on a working cattle ranch in order to teach them how to maintain self-confidence and self-worth in the face of devastating illness.

On April 4, 2007, Imus made a stupid, tasteless, puerile comment about the Rutgers Women's Basketball team. The comment came in context of 30+ years of stupid, tasteless, puerile comments. Flea, who has a rather low embarrassment threshold, would rather listen to traffic reports every 10 minutes than subject himself to the dribblings of a 67-year old man with bad lungs behaving badly on the air.

By the end of the week, Imus was attacked viciously from all fronts, most notably the Reverend Al Sharpton, who invited Imus into the studio of his own radio program and berated him mercilessly. Among other things, Sharpton is calling for presidential candidates to refrain from appearing on the Imus radio program. [*N.B.*, for many Americans, the only opportunity to hear presidential candidates converse in their own words occurs during Imus in the Morning.]

Now, let's play "Follow-the-Money": Who stands to gain from the Imus controversy? Don Imus has lots of money. Lots and *lots of money*. Imus has been known to be less than diplomatic in his efforts to raise money for the Imus ranch (He fairly twists peoples' arms on the air). Could it be that it's payback time? Perhaps Sharpton, and perhaps

others, have a few favorite organizations that really need some cash? Perhaps these guys are out for more than an apologies from Imus?

If faithful readers of Flea don't get the point, you're forgiven. This is not our usual subject matter. Let's spell it out:

A shakedown occurs when someone pushes you into an alley, beats you up, and threatens to beat you up some more unless you fork over money.

Don Imus already has a couple of black eyes. Is his checkbook lighter as well?

Posted on: Wed, Apr 11 2007 12:17 AM | Updated: Wed, Apr 11 2007 1:03 AM | Email This | Clip/Blog This Keep New:

Where's Sandy?

By Flea

Due to technical difficulties (*viz*. the fact that Yahoo!Mail sucks rubber donkey lungs) we never received a PGR contribution from Sandy Szwarc of Junkfood Science.

That's too bad, because recently Sandy has produced several excellent posts documenting the sensationalization of the "obesity epidemic in children". These are summarized in this post at Sandy's blog.

Fortuitously, Flea saw a special on Food Network yesterday called "Childhood Obesity: Danger Zone".

The blurb from FN's web site gives a flavor of the angle the program takes:

> "Obesity—it's the fastest growing cause of disease and death in our country, and it's attacking more than 12 million of our children. The Food Network goes to the front lines of the childhood obesity epidemic to find out what's fueling the explosion in overweight children and teenagers and what parents, teachers, doctors and public officials are doing to fight a problem the U.S. Surgeon General calls 'more serious' than terrorism."

More serious than terrorism.

Flea cannot verify that Surgeon General Kenneth P. Moritsugu, or any previous S.G., actually said this. We sincerely hope it's apocryphal. Flea has been known to use hyperbole on occasion, but this one is more than a little over the top.

Please go and read Sandy's contributions on this subject. Flea finds much of it convincing and all of it compelling.

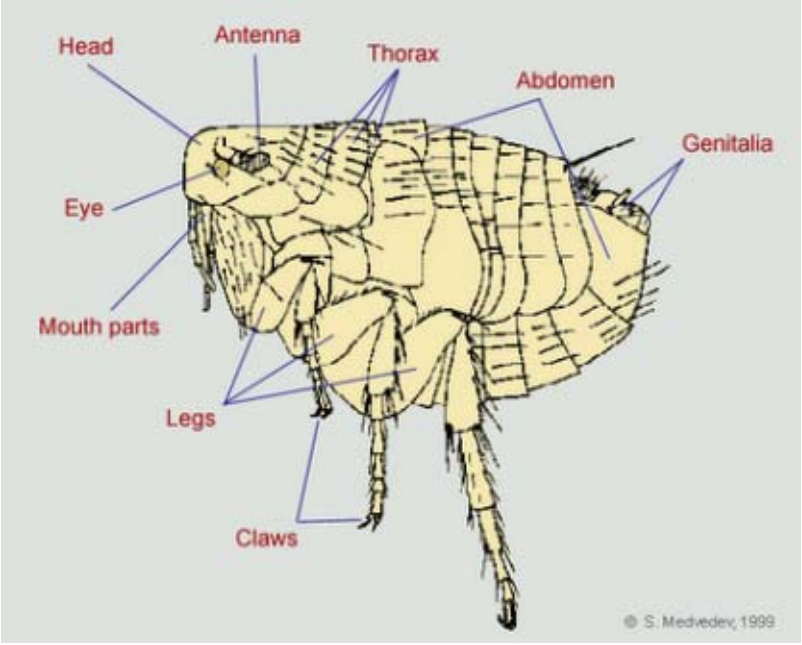
Our take on the whole subject is as follows:

- Childhood obesity is a problem, but it is not a crisis, certainly not one as threatening as terrorism.
- Body Mass Index is a pretty good screening tool (high sensitivity, low specificity), but it stinks as a diagnostic tool.
- We fleas have very little idea how to manage obesity as a disease entity, so we are making this *dreck* up as we go along.
- Making stuff up as one goes along is a perfectly crappy way to practice medicine.

Posted on: Mon, Apr 9 2007 12:54 AM | Updated: Mon, Apr 9 2007 1:23 AM | Email This | Clip/Blog This Keep New:

Pediatric Grand Rounds 1:26 - Flea's Anatomy

By Flea



"You can check your anatomy all you want, but when it comes right down to it, this far inside the head it all looks the same. No, no, no, don't tug on that. You never know what it might be attached to." - Buckaroo Banzai, The Adventures of Buckaroo Banzai Across the 8th Dimension (1984)

Head

The head capsule of fleas is very modified. It is high, narrow and cuneate. The propleurosternum covers the head from below to the peristomal aperture, as result of which it is immobile.

The head spot this week goes to the incomparable Shinga, host of Breath Spa for Kids. Recovering from an unfortunate series of physical ailments, Shinga watches a medical soap opera and nearly has a fit (the angry kind, not this kind) about the (over)dramatization of tonsillitis in a 4 year-old. Flea is certain he would have hurled heavy objects at his television set had he been unfortunate enough to catch this program on the telly.

Antennae

The antennae of fleas are in antennal fossae. The antennal fossa divide the head into anterior and posterior parts.

Let us point our port-side antenna toward Walter at Highlight Health. Walter contributes "An Inconvenient Financial

Truth - Healthcare Costs Endanger U.S. Financial Stability". This story isn't exactly a news-flash. We've known for some time that as the boomers age we're gonna run out of cash to pay for the entitlements we've promised them. The bit that really sticks in Flea's craw is this quote from U.S. Comptroller General David Walker:

> "On [health care] cost we're number one in the world. We spend 50 percent more of our economy on health care than any nation on earth. We have the largest uninsured population of any major industrialized nation. We have above average infant mortality, below average life expectancy and much higher than average medical error rates for an industrialized nation."

These are serious charges that require serious examination. We've already discussed the meaning of our infant mortality numbers. As for our average life-expectancy, does the fact we rank 29th between Bosnia-Herzegovina and Cyprus mean that our health-care dollars are ill-spent? Finally, as to medical error rates, what does Comptroller Walker suggest we do about the problem, spend *fewer* health care dollars to solve it? (Note to self: check anatomy text - does a flea have a craw?)

Meanwhile, the starboard antenna detects newcomer Manu Varma of Transplant Headquarters. Manu offers us this discussion of several issues that impact upon the care of the young transplant recipient. In particular, Varma focuses on the difficulty young transplant patients encounter in transitioning to adult hospitals. I'm not sure if Varma is aware of this, but as of 10 years ago TBFCHITW was following its transplant patients for life. Perhaps this is a model to study?

Thorax

The thorax consists of three modified segments.

The first modified segment is brought to us by Clark Bartram, father of PGR and host of Unintelligent Design. It's a somber deliberation on death and our relationship as pediatricians to it. Death is a rare occurrence in pediatrics. In general, this flea believes we deal with it rather badly. Trouble is, the parents need us most at the most horrible moments. It's almost too bad we don't get more practice dealing with patient deaths; But on further reflection, Flea likes it better the way it is.

In every thorax beats a heart (not in arthropods, of course. Flea is reaching for a metaphor here). Adventures of an Awesome (Sometimes) Mother offers this heart-warming story of the dawning realization that her child Evan is no longer a heart-patient, but instead is transitioning into a normal child. Flea has witnessed how life with a child born ill can consume a parent with anxiety. His wish for parents is that they should be able to see past the congenital anomalies (in this case, a malformed heart) to appreciate the essential child within. Awesome Mom is now blessed with the opportunity to put the worst behind her and simply enjoy her boy.

The third modified thoracic segment is offered up by Dr. Scott of Just Practicing. The Last Generalist offers up a fairly complete summary of the future of M.D.-level solo pediatrics. In a word, we're *toast*. Flea agrees with this assessment. Dr. Scott figures that mega-practices and government clinics might well become the last remaining habitats of the M.D.-level primary care flea. And he's right. After that comes extinction.

Mouth Parts

When a flea blood feeds, it will crouch low to penetrate the host's tissue with a sawing motion of the mouthparts. A small amount of anti-coagulatant is injected with the saliva, to permit easy siphoning of the blood.

Flea is mindful that today is Easter, a solemn and joyful holy-day throughout Christendom. As celebrated today in the U.S., Easter appears to be more about mouth parts, and the chocolate goodies we place in those parts, than about blood or siphons.

Val Jones, MD of Revolution Health contributes a tasty Easter treat having to do with golf balls and tony vacation

spots. Flea confesses he doesn't really get what this all is doing in pediatric grand rounds but he thanks Val for the contribution nonetheless! (Incidentally, Flea knows a joke involving a golf ball and a garden hose, the latter of which can be used as a siphon).

Legs

Fleas lack wings, but have long legs. The hind legs are the principal jumping organs.

Babies have relatively short legs and arms. They don't break easily. When they do break, fleas are compelled, no obliged, to consider that the limb was purposefully broken by someone else. Rob (Breedlover) Lamberts of Musings of a Distractible Mind offers us a vignette from one of the darker corners of fleadom, the spiral fracture of the infant limb.

Claws

Flea claws are cool! Click above for image.

Fleas don't often jump around breast cancer, but this week Dr. Gwenn sank her claws into the topic with her supercommentary on a Washington Post article originally brought to our attention by Kevin, MD. Flea's super-supercommentary is as follows: the evidence be damned! In the contemporary climate of over-test and over-diagnose, combined with the culture of malpractice litigation for failure-to-diagnose, it's a foregone conclusion that breast MRIs for the detection of cancer will be come the community standard of care in very short order.

Abdomen

The abdomen of the adult flea includes 10 segments.

Would that there were ten segments in this chapter! Sadly, there is but one. It is a contribution from Signout suggested by our friend Shinga, who is always kind enough to suggest several posts to the PGR host. Our girl, now close to the end of her first year of residency, relates a touching story about a developmentally-delayed clinic-patient. "Rosie's" presenting complaint is benign enough, but it turns out the real reason for the visit is altogether different. Flea won't spoil it for you. Signout closes by telling us that Rosie will be seen at the clinic whenever the mom wants her to be seen. The most poignant aspect of the story is that Rosie and her mom really do need to be seen and often too, but not by a rotating clinic doc: This family needs a flea. One flea.

Genitalia

The modified tergites and sternites of the flea's genitalia belong to abdominal segments 7-9. More than 7 terms are used to describe the structures of the genitalia (in ascending size order: petzie, petzele, putz, schmeke, schmekele, schmuck, and schlong). The complexity of the aedeagual structure is caused by the separation of its internal duct (endophallus) into a number of complex sclerites.

This week we welcome a contribution from newcomer Eric Turkewitz of New York Personal Injury Law Blog. The title of the post is "Medical Malpractice is Increasing in Many Hospitals". The report Eric references is called "The Fourth Annual Patient Safety in American Hospitals Study" (April 2007). This HealthGrades report studies "patient safety incidence rates" in hospitals over time. Patient safety is defined as "freedom from accidental injury due to medical care, or medical errors." The word "malpractice" does not appear anywhere in the 26-page report. So Flea is confused: Does Eric identify failures of patient safety with malpractice?

For malpractice to occur, there must be a failure to meet the ***community standard of care****. The community does not demand that we never err, the community demands that we meet the standard of care. Surely Eric Turkewitz understands this distinction. Or does he?*

That's all folks. In two weeks, Clark is cooking up a "Best Of" in honor of PGR's first anniversary. No submissions, please.

Thanks for your attention.

Posted on: Sun, Apr 8 2007 12:00 AM | Updated: Sat, Apr 7 2007 11:57 PM | Email This | Clip/Blog This Keep New:

She's an Actress...

By Flea

Flea emailed "Early Education for All" yesterday to ask if the female voice belonging to the "pediatrician" were authentic. Here's an excerpt from the reply:

> "The ad you heard is a critical component of a comprehensive outreach and advocacy effort targeting the state legislature as it deliberates the FY08 budget. We chose to use a “pediatrician” in one of the two ads currently running because of the credibility pediatricians carry among families and opinion leaders alike. The “pediatrician” in the ad that you heard is an actress- professional talent which is a common practice in ads such as this."

You have to admire their honesty... er... I guess.

So fleas carry credibility among families and opinion leaders? Cool! Does that mean that families and opinion leaders alike will take Flea's advice and stay home with their congested 5 month-olds instead of taking them to the E.D.?

Posted on: Thu, Apr 5 2007 8:56 AM | Updated: Thu, Apr 5 2007 9:12 AM | Email This | Clip/Blog This Keep New:

Political Advocates Masquerading as Fleas

By Flea

Flea heard a bizarre radio commercial the other day. A female voice, claiming to be a pediatrician, implores the audience to support an initiative called "Early Childhood Education for All". The "doctor" references some studies that showed that early childhood education prevents later badness such as dropping out of school and staying back in school. That's all fine as far as it goes.

But the doc never identifies herself. Virtually all M.D.s who lend their voice to some cause or another (typically the hospital for which they work) at least tell us their names, even if we've never heard of them.

Believing he was hallucinating on account of the heavy painkillers and anti-inflammatories he was taking, Flea ignored it. Then the ad came on again today. Again there's this female voice claiming to be a pediatrician, and failing to identify herself.

Flea gathers that the point of her identifying herself as a pediatrician is that we should really **really** believe what she says: After all, she's a *pediatrician*!

Flea went to the Early Education for All web site. It turns out that it is a "front" for a non-profit organization called "Strategies for Children". The latter "specializ[es] in public policy, advocacy and constituency building. [Their] mission is to improve the well-being of children and families by moving their issues to the top of the agendas of communities, states, and the nation."

Let Flea stipulate that there is nothing wrong with political advocacy. There isn't even anything wrong with *fleas* engaging in political advocacy (within the boundaries of professional ethics, of course). But if the voice on the radio ad belongs to an actress and not to a real flea, there's something wrong. Surely they could find a flea in Massachusetts willing to lend her name to the cause of early childhood education!

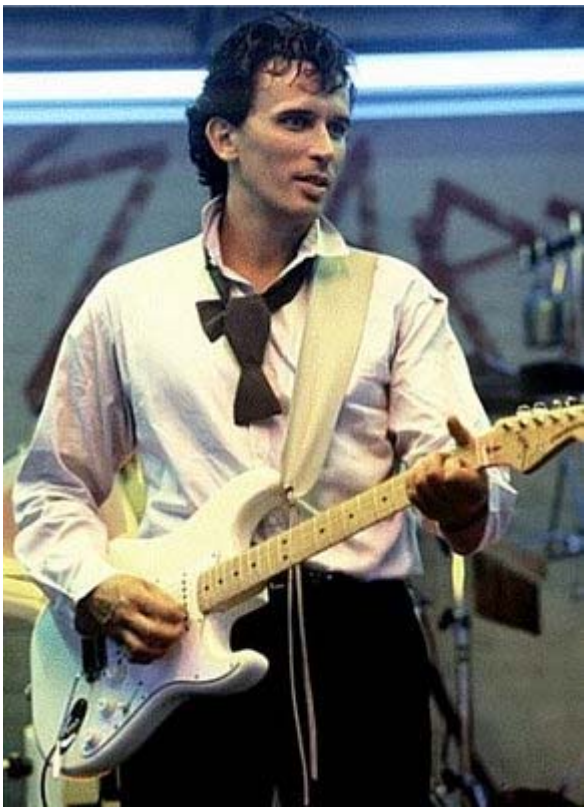
Or could they?

Posted on: Wed, Apr 4 2007 7:50 AM | Updated: Thu, Apr 5 2007 9:01 AM | Email This | Clip/Blog This

Keep New:

Everywhere You Go, There You Are

By Flea



Now, Flea isn't getting antsy or nothin' (you'll pardon the mixed metaphor), but he only wants to remind you all that if you don't submit to PGR by 8 PM Saturday, April 7, Buckaroo Banzai here won't let you hold his overthruster.

flea_fleablog ATSIGN yahoo DOT com

Posted on: Wed, Apr 4 2007 2:14 AM | Updated: Wed, Apr 4 2007 2:17 AM | Email This | Clip/Blog This

Keep New:

All This and Spinal Tap Too?

By Flea

(via Kevin, MD)

An item from the American Medical News:

> "A recent Idaho federal court ruling shows doctors should tread carefully when considering whether to get the state involved to ensure that a child gets critical treatment despite the parent's objections.
>
> The court found, in a Feb. 26 ruling, that the state gave too broad of consent for the treatment of 5-week-old-Taige L. Mueller. Judge B. Lynn Winmill sent part of the case back to trial court to determine, among other questions, whether the doctor involved exaggerated the risks of the infant's condition to get the state to intervene so he could treat the child over her parent's refusal. No hearing date has been set.
>
> In 2002, Corissa D. Mueller brought her daughter to the emergency department at Saint Luke's Regional Medical Center, Boise, with a 101.3 F temperature, court records state. Emergency physician Richard K. MacDonald, MD, saw the child. Consistent with the hospital's standard of care, he recommended antibiotics and a spinal tap to test for meningitis or other serious bacterial infections, for which the baby showed symptoms, court documents state.
>
> Dr. MacDonald also explained to the mother the risks, including death, of leaving meningitis untreated. He also said the infant's condition could worsen quickly. Mueller, however, refused to authorize the spinal tap. She concluded from her own research that the procedure's risks outweighed the chances that her daughter had meningitis, records show.
>
> Dr. MacDonald called a hospital social worker, who called state Child Protective Services. After he reiterated the risks to the police, the officers took custody of the child, and Dr. MacDonald performed the spinal tap."

This very same scenario happened to Flea when he was a resident at TBFCHITW. We documented the hell out of mom's refusal to let us tap the baby and we left it at that. Hindsight is 20-20, of course, but it appears to Flea that Dr. MacDonald went a tad over the top by calling Child Protective Services.

Happy Passover, Y'all!

1 Reference

Posted on: Mon, Apr 2 2007 9:11 AM | Updated: Mon, Apr 2 2007 9:22 AM | Email This | Clip/Blog This Keep New:

Umpires and Doctors

By Flea

Today is opening day. This morning WBZ radio ran a story of a mathematician from Stevens Tech in Hoboken, NJ, who claims to have created a mathematical model showing that the New York Yankees will take the American League East with 110 wins. Nevertheless, Flea was not comforted.

Today Flea is preoccupied with the comparison between major league umpires and doctors. Once, we heard a radio announcer quip that umpires are expected to be perfect on the day they start their jobs, and to steadily improve thereafter.

This, it seems to Flea, is the same standard to which doctors are held. The only difference between umpires and doctors is that when the former makes a mistake, he is not dragged through lengthy, stressful litigation. Fans may shower him with verbal abuse, but he never receives a hand-delivered letter accusing him of being "negligent, careless, and without skill".

Doctors are human, and humans make errors. We will never be perfect. As long as doctors care for patients, mistakes, errors in judgment, and failures to diagnose will happen. It will not do to suggest simply that we should "stop killing our patients", as if killing patients were the point of the exercise.

The only way to ensure that no bad outcomes will occur is to stop practicing medicine.

But then nobody would get to play ball.

Posted on: Sun, Apr 1 2007 1:43 AM | Updated: Sun, Apr 1 2007 5:54 AM | Email This | Clip/Blog This Keep New:

Flea's Back

By Flea

Pursuing the advice of Ms. Flea, yours truly has been laboring mightily to keep his personal life out of this blog. He needs to deviate off the straight and narrow path briefly for a bit of explanation.

While working out Wednesday morning, Flea felt a sharp pulling sensation in his lower back. Within minutes the left leg in the "S1" distribution began to get weak and numb. To cut to the chase, Flea has a herniated disk. This makes standing difficult, walking painful, and running impossible.

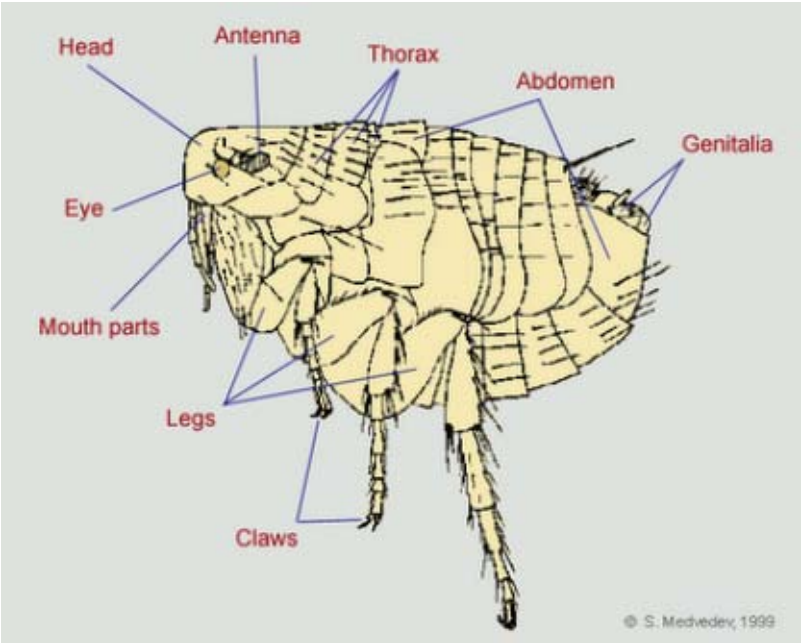
With any luck, physical therapy will start next week. In the meantime we'll try not to become addicted to painkillers. We hear that's a bitch.

Posted on: Sat, Mar 31 2007 11:05 AM | Updated: Sat, Mar 31 2007 11:10 AM | Email This | Clip/Blog This

Keep New:

With Apologies to Gregg Allman

By Flea



Sometimes I feel,
Sometimes I feel,
Like I've been tied to the begging post,
Tied to the begging post,
Tied to the begging post,
Good lord, I feel like I'm dyin'.

Pediatric Grand Rounds 1:26 will be hosted here at Flea on April 8, 2007. Send your submissions to flea_fleablog ATSIGN yahoo DOT com by 8 PM, Saturday night April 7.

Be sure to study up on your anatomy.

Posted on: Fri, Mar 30 2007 3:25 AM | Updated: Fri, Mar 30 2007 3:36 AM | Email This | Clip/Blog This Keep New:

Somebody Show This Man Some Love!

By Flea

This was too precious not to share with you. As the lawyers might say "res ipsa loquitur"

"The Unloved Lawyer

This is a little off topic, but I couldn't resist. Eric Turkowitz, of New York Personal Injury Law Blog fame, was picked up by some doctor blog because of his advice on dealing with good looking physician witnesses. Now I know Eric, and he's one handsome devil himself, so you would think he hangs in the attractive professionals club with those nip and tuck guys and they would lay off their buddy. Not so. Check out how the docs respond to Eric. Between refusing to treat lawyers who sue doctors, and using the pediatricians to poison the minds of their children, it would appear that our beloved physicians are displeased with lawyers. Frankly, I offer them (free of charge) the solution to all their legal woes. Stop killing your patients! Care a little more about whether you're doing the right thing than whether medicaid will only pay $12 for the 30 second treatment so you have to back up 29 patients to make your Mercedes payment. Stop blaming lawyers because you keep killing your patients. We have enough of our own problems. Nuff said."

Nuff said indeed.

Posted on: Wed, Mar 28 2007 8:17 AM | Updated: Wed, Mar 28 2007 8:47 AM | Email This | Clip/Blog This Keep New:

Meet the Turk

By Flea

Flea wishes he hadn't read this after lunch:

Today Flea discovered Eric Turkewitz. Eric is a malpractice lawyer.

First Eric was just a plaintiff's attorney. Then Eric became a plaintiff's attorney with a web site. Now Eric is a plaintiff's attorney with a blog.

Check out this tasty little morsel (acquired via Kevin, MD):

Practice Tip: One Way to Cross-Examine The Attractive Doctor
A recent British study confirmed something most of us all know intuitively:

Juries trying criminal cases are likely to be more lenient when the person in the dock is physically attractive, psychologists say. So **how do you level the playing field if, for example, you have an attractive doctor as a defendant in a medical malpractice case**? And by attractive, I mean not just physically, but someone with good credentials who makes an impressive personal appearance by their ability to speak well. This is important if the patient chose the doctor.

The answer is not to knock them down, but to build them up in opening statements and jury selection (if your jurisdiction allows).

Tell the jury they will like the defendant. After all, your client chose this doctor for surgery, right? Trusted him/her. Kinda like Marcus Welby. Therefore, it stands to reason, the jury will too.

> This does a few things: First, you have been dead honest. It is unlikely the jury expected you to "confess" this thing, but frankly, they will likely see it anyway if defense counsel is even mildly competent. Trying to tar a physician at the outset that your client previously trusted has enormous potential to backfire.
>
> The jury also now has very high expectations for the doctor. **With the bar set so high, any slip-up or contradictory testimony is likely to be viewed in a harsher light**. Assuming you have a solid case to take to trial, this doctor-defendant will also lay out the standards of care (while they still trust him/her) before being confronted with the deviations from care, the sloppy notes, the rushed surgery, failure to read the x-ray, or contradictions from deposition testimony.
>
> And there is something else at play here. **The doctor was trusted, and the trust was betrayed**. Betrayal often unleashes a flood of powerful emotions.
>
> The instinct for confrontation must, at times, be avoided, and saved for those few special moments when the witness, who has now been built up, strays from the straight and narrow. And if that happens, it will have far greater impact than if you had simply tried to trash the doctor from the outset. (bold-type in the original)

Flea is looking forward to being cross-examined by the plaintiff's attorney. He's especially looking forward to those "special moments" when Flea strays from the straight and narrow.

How does Eric Turkewitz look at himself in the mirror in the morning?

His wife and kids look like decent enough people (scroll down on link for picture). Where does Turkewitz find doctors in New York City willing to care for them?

Posted on: Tue, Mar 27 2007 7:32 AM | Updated: Tue, Mar 27 2007 8:55 AM | Email This | Clip/Blog This Keep New:

It's Gettin' Tougher to Do Business Here

By Flea

(via Kevin, MD and White Coat Notes)

It's getting tougher for fleas in Massachusetts. The Massachusetts Medical Society, of which Flea is a member, reports today that "for the 13th consecutive year, the Massachusetts physician practice environment deteriorated. The 2006 rate of decline amounted to 1.6 percent, approximately three times faster than the downwardly revised 0.5 percent decrease in 2005."

The decline in the index was driven mostly by rising liability costs and increased costs of maintaining an office. The latter was driven by non-physician wages, office space, and medical supplies. All increases in costs were significantly greater in Massachusetts than in the country as a whole.

That's why Flea's downsizing. We're looking for smaller, less expensive space. Overall staff costs may also be open for reconsideration.

We've also decided to remain a solo practice. Lean and mean.

Well... not mean.

Posted on: Tue, Mar 27 2007 2:40 AM | Updated: Tue, Mar 27 2007 3:41 AM | Email This | Clip/Blog This Keep New:

Twinkie-the-Kid

By Flea

Pediatric Grand Rounds 1:25 is up at Rob (Goat-Boy) Lamberts' Musings of a Distractible Mind. Rob is, among other things: "An Internist (a 'Flea' as Internists have been nicknamed - the last thing off of a dead person), Pediatrician (A 'Flea' as defined by yours truly), a husband of one, a father of four, a musician," and a lover of ruminant quadripeds.

Rob's one of Flea's favorite bloggers. He's just the kind of voice we need to shake Pediatrics out of its complacency (which we will do just as soon as this television show is over. Promise! okay?)

Flea's pick of the week is actually three picks. Three bloggers all touched on a topic that has long been near and dear to Flea's circulatory system (such as it is): overuse of antibiotics.

Girl, MD, and Dr. John Crippen both saw patients recently whose parents demanded antibiotics for asthma flare-ups. Flea insists that this common occurrance is an iatrogenic problem. That is to say that we docs have been dripping antibiotics on inflamed airways for over fifty years now. Naturally the patients have come to expect it. It's our job to educate our colleagues and our patients as to the distinction between the categories "infection" and "inflammation", and the proper role of antibiotics in cases isolated to the former category. Girl did the right thing and tried to educate her colleague who continues to misapprehend the difference between infection and inflammation. Flea hopes she met with success.

Dr. Crippen did the right thing and tried to educate an incredulous mother. We have no choice but to carry on.

Newcomer Walter at Highlight Health contributes this post on antibiotic over-prescription in acute sinusitis. Flea wonders how much more evidence is required for his colleagues to stop prescribing antibiotics for upper respiratory tract infections.

Next PGR will hosted right here on April 8. More to follow y'all.

1 Reference

Posted on: Mon, Mar 26 2007 3:42 AM | Updated: Mon, Mar 26 2007 8:30 AM | Email This | Clip/Blog This Keep New:

Meet Edwin Leap, M.D.

By Flea

Yesterday, a friend handed me this article by an E.D. doc in South Carolina named Edwin Leap. The article, for the Emergency Medical News, is a sort of new-year's resolution piece. Leap resolves to become brutally honest about medicine in general and E.D. medicine in particular. Here's the money quote:

> "Many of our [E.D.] patients don't belong in a family practice office, much less an emergency

> department. The sooner we address this firmly and politely, the less we will be overwhelmed by volume. Furthermore, a $5 co-payment on Medicaid visits would decrease a lot of the ridiculous things we see. Five dollars for a bug bite? I can get some smokes for that! Forget it. You see, for all of our hand-wringing about the uninsured and poor (and there are a lot of them I am delighted to help), many of the patients who use us for all their health care needs place zero value on our services because Medicaid and EMTALA allow it to be priced at exactly that amount to the patient. Zero."

Leap wrote this in January 2002. Are there more voices like Edwin Leap's out there? And if so, are they being heard?

By the way, Leap has a nice-looking web site and a blog. Flea hadn't read this post carefully when Scalpel linked to it last week, but he should have. It's fairly stunning.

Welcome to the blogroll, comrade Leap!

Posted on: Sun, Mar 25 2007 7:40 AM | Updated: Sun, Mar 25 2007 7:59 AM | Email This | Clip/Blog This Keep New:

Guess This Means He Liked It

By Flea

Flea emailed Roy Richard Grinker to tell him about our review of his book. Here's Grinker's reply:

> "My wife, Joyce, wanted me to email you to say how much she enjoyed your review, and to thank you for the heartwarming things you said about Isabel. My 13 year old, Olivia, also pointed out to me that the photo on your blog is probably not of you (I thought it was an unusual photo for a pediatrician) but rather a member of the Red Hot Chili Peppers."

Strong work, Olivia! Flea wouldn't know Michael Balzary if he fell over him!

Posted on: Fri, Mar 23 2007 4:58 AM | Updated: Fri, Mar 23 2007 5:07 AM | Email This | Clip/Blog This Keep New:

Should We Take the Earth to the Emergency Room?

By Flea

Here's an item that's not quite ready for "Notes from the Lunatic Fringe", but it's a close contender.

> "The planet has a fever," Gore said. "If your baby has a fever, you go to the doctor. If the doctor says you need to intervene here, you don't say, 'Well, I read a science fiction novel that told me it's not a problem.' If the crib's on fire, you don't speculate that the baby is flame retardant. You take action."

Is taking the baby to the doctor for a fever so common as to become cliche? Or is the erstwhile Veep and sometime documentarist drinking Marty Solomon's Kool-Aid?

Folks, before you take the earth to the E.D., call your flea first. He or she will ask you questions like: "Is the earth looking at you? Smiling at you? Is the earth eating well? Does the earth have other symptoms like runny nose, coughing, or a rash?"

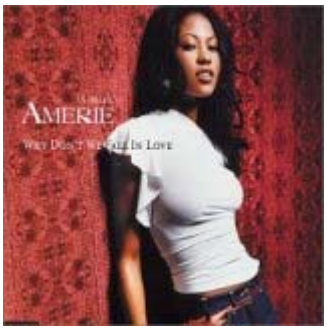
And if the doctor says 'you need to intervene here', please ask why.

1 Reference

Posted on: Thu, Mar 22 2007 9:27 AM | Updated: Thu, Mar 22 2007 9:56 AM | Email This | Clip/Blog This Keep New:

Why Don't We?

By Flea



Click here for link.

> **Many U.S. Adults Do Not Follow Physician Recommendations, Survey Finds** [Mar 16, 2007]
>
> About 27% of U.S. adults said they or immediate family members have not filled prescriptions because they considered the medications unnecessary, according to a recent Wall Street Journal Online/Harris Interactive survey, the Wall Street Journal Online reports. The online survey included responses from adults collected from March 5 through March 7. According to the survey, about one-fifth of respondents said they or immediate family members have sought second opinions, 13% have avoided diagnostic tests, 7% have decided not to undergo surgical procedures and 7% have switched physicians because they considered the recommendations of their physicians overly aggressive. Among respondents who said they or immediate family members did not follow the

> recommendations of their physicians, 89% said they experienced no negative effects, the survey found. *The survey also found that 43% of respondents said they are concerned about overtreatment by physicians*. About 52% of respondents said physicians overtreat patients because of concerns about medical malpractice lawsuits, 45% said "to make more money" and 44% said "to meet patient demands," the survey found (emphasis added).

Flea has been ranting for months about the culture of "over-test, over-diagnose, over-treat, and over-admit". According to the WSJ, it's gotten so bad now that *the patients are noticing*, and apparently some take exception to our behavior. Flea fears that the patients may have it right: Fear of litigation, desire to meet patient demands, and (yes) desire to make money may play a role here.

The patients get it. Why don't we?

(Thanks to Kevin, MD for the tip)

Posted on: Wed, Mar 21 2007 9:10 AM | Updated: Wed, Mar 21 2007 9:22 AM | Email This | Clip/Blog This Keep New:

Cogito Ergo Bloggo

By Flea

Uber-MedBlogger John Crippen of NHS Blog Doctor has tagged Flea with "The Thinking Blog" meme.

Here's the obligatory image tag thingy:

The participation rules are simple:

1. If, and only if, you get tagged, write a post with links to 5 blogs that make you think.

2. Link to this post so that people can easily find the exact origin of the meme.

3. Optional: Proudly display the 'Thinking Blogger Award' with a link to the post that you wrote.

Here's Flea's list, with no regard whatsoever as to whether the chosen blogger has been tagged already. We tag because we think.

1. Autism Diva - Almost lyrical stuff; A gift to the blogosphere.

2. Junkfood Science - We can't believe we'd left her off the blogroll! Off we go to rectify the situation!

3. Musings of a Distractible Mind - Rob makes Flea think about llamas.

4. Respectful Insolence - Flea finds it hard to believe that Orac actually has time to practice medicine. This guy is a veritable *tour de force* of blogging.

5. Signout - One of our favorite new bloggers.

1 Reference

Posted on: Tue, Mar 20 2007 6:52 AM | Updated: Tue, Mar 20 2007 7:14 AM | Email This | Clip/Blog This Keep New:

Unstrange Minds

By Flea

Unstrange Minds: Remapping the World of Autism, by Roy Richard Grinker. New York: Basic Books (2007).

For those of us who care for children, whether it be at home, in the classroom, or in the office, Roy Richard Grinker has done a great service. He has written a book, part personal memoir, part ethnographic study, that will change the way many of us in the English-speaking world think about autism.

Roy Richard Grinker is Professor of Anthropology, Human Sciences and International Affairs at the George Washington University. His family history is compelling: if Grinker had chosen to go to medical school and become a psychiatrist, he would have been the fourth generation psychiatrist in his family! Grinker's great-grandfather Julius, gave up Psychiatry for Neurology, complaining that the patients were too intense for him. His grandfather, the first Roy Richard Grinker, was analyzed by Sigmund Freud in Vienna (to his credit, at no place in the book does our author refer to himself as "Roy Richard Grinker, III", though by all appearances that is his official name). In Jewish circles, this kind of lineage is what we'd call "major *yichus*".

Grinker's major contribution in this book is to demystify the concept of "epidemic" as it applies to the category "autism". In clear and robust language, accessible to the non-academic reader, Grinker explains that autistic people have always been with us. It is only now that we are able to see them because we know how to name the phenomenon.

The star of the book is Grinker's daughter Isabel, now 16 years old. Grinker chronicles the frequently painful details of Isabel's early life, her struggles and her triumphs. By the end of the book, one cannot help falling in love with this remarkable child. And one gains a great deal of admiration for her parents as well, Roy and Joyce Grinker, who navigate waters that in 1991, with respect to autism in the schools, where largely uncharted.

Grinker's obvious gifts as an ethnographer set his book apart from the several "Autism Biographies" currently in print. Some of the most fascinating, and troubling, sections of the book deal with the lives of autistic people in South Korea, India, and South Africa. Flea was compelled to put down Unstrange Minds and utter a quick prayer of thanks that he and his patients live in the United States.

In the course of his discussion of Korea and South Africa, Grinker observes that autistic children in rural communities had better outcomes than did similarly affected children in the cities. By better outcomes, Grinker means that the children in the countryside were better integrated into the economic and social life of the community than were city-dwelling autistics. At first, Flea worried that Grinker had fallen into an old annoying habit of anthropologists to romanticize the primative, or at least simple, way of life - to the detriment of the modern, urbanized way of life. But this is not what Grinker means at all. He merely points out that in rural areas, it is much harder to hide a child with autism, though a parent may want to. Autistics also more easily find jobs and their

places in the community for the simple reason that their contributions, particularly their labor, are so badly *needed* in rural communities.

Grinker hopes that the integration of autistic individuals that has occurred in rural Korea and South Africa will continue and blossom here in the United States. He already sees signs of this happening. Today, Grinker observes a sea-change in attitude toward the presence of persons "on the spectrum" in our community:

> "As the general public learns to understand and appreciate people with autism, the autistic person is no longer strange or foreign. He or she is, instead, unstrange."

Unfortunately, the law of unintended consequences states that any change for the good cannot occur without *some* untoward outcome that is sure to cause some grief. In the case of autism, increased awareness and better epidemiology will sharply increase the demand on schools to provide resources and providers to accommodate children with autism. In relatively well-to-do Montgomery County Maryland, where the Grinker's live, such resources are hard to come by. Grinker retells several uncomfortable stories of doing battle with school administrators over resources for Isabel. How will less well-off school systems handle the onslaught of demand for special-ed services? Flea's guess is that many will fail, whether or not more tax dollars are diverted to the purpose.

Flea cannot help leaving his readers with one small quibble. Grinker, who gets so much right, is dead wrong about Pediatricians. Here is Grinker on the supposed habit of Pediatricians to reassure parents that their child is normal. "Normal, Grinker writes

> "is the word every parent wants to hear. Pediatricians are so well trained to use it that I've wondered if they get bored with it. I realize that in most cases they are right, that new parents often need reassurance... But there is that cynical side of me that imagines new pediatricians attending a training center someplace where they learn how to look sweet, dress in Disney ties, bow ties, or scarves to look just a little ridiculous, and say things like 'He'll be fine' so the hysterical mom will just go home."

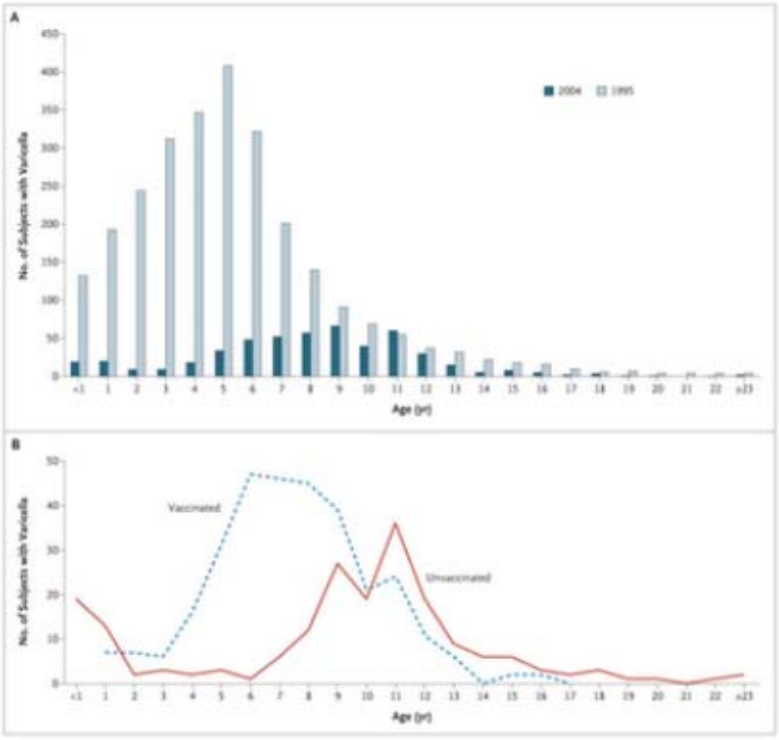
Flea must have been sick the day they taught *Reassurance* in Pediatrics Residency. *Pace* Roy Richard Grinker, fleas today are trained *not* to reassure parents, but rather to increase parental worry by referring developmentally normal children for autism evaluations. The modern flea is exquisitely well-trained to over-test, over-diagnose, over-treat, and over-hospitalize.

The minor quibbles having been noted, Unstrange Minds earns a place on Flea's blogroll. If for no other reason, read it for Isabel.

Posted on: Mon, Mar 19 2007 12:55 AM | Updated: Mon, Mar 19 2007 3:35 AM | Email This | Clip/Blog This Keep New:

The Chicken Pox Vaccine Sucks!

By Flea



Greetings from Antelope Valley!

That's where the Varicella Active Surveillance Project has done another nice piece of epidemiology on chicken pox in the post-Varivax era.

The authors showed that whereas there are 85% fewer reported cases of chicken pox since institution of the vaccine, the peak incidence and severity of illness has shifted to older ages. The authors conclude that vaccine-induced immunity appears to wane over time.

They recommend adding a booster. The ACIP made a similar recommendation last June as well.

No surprise there.

No one asked Flea for his opinion when the Varicella vaccine guidelines were being promulgated, but he wouldn't have recommended making this one mandatory. Not because the vaccine sucks (we didn't know that until recently), but because VZV is a relatively benign self-limited disease of childhood.

2 References

Posted on: Fri, Mar 16 2007 3:32 AM | Updated: Fri, Mar 16 2007 4:31 AM | Email This | Clip/Blog This

Keep New:

Notes From the Lunatic Fringe - Gandhi With Breasts

By Flea

Flea has been going to and fro in the earth, and walking up and down in it.

Well... to tell the truth, Flea was only sitting at his desk and got an email from faithful reader Liz Ditz from I Speak of Dreams. But you get the idea.

Liz found me a truly wondrous creature named Rebecca Lee Roczen, M.D. (a/k/a Rebecca Lee Carley, M.D.)

At Dr. Carley's web site, you will discover "the cause of all diseases as well as how all diseases can be reversed with natural therapies via the Hippocrates Protocol".

If you call Dr. Carley at the number provided at her web site, she will take an extensive history of toxin exposure. Based on your child's history, Dr. Carley recommends a cocktail of "homeopathic nosodes" including colloidal silver. This detoxification restores the child to a "vibration of wellness".

Dr. Carley's license to practice medicine in New York State was revoked in 2004.

According to her own version of events, Dr. Carley was relieved of her license because she believes that vaccines cause disease and she sought to reverse the effects of vaccines in children (source: interview by the Chioropractic Leadership Alliance, linked at Carley's web site).

According to the New York State Board for Professional Medical Conduct, the psychiatrist that examined her found that Dr. Carley suffers from

> "a delusional disorder with the presence of narcissistic and borderline personality traits. [Carley] has delusions of persecution and grandiosity and that she believes that she is being persecuted because she is special".

The examiner went on to say that Carley

> "believes that her husband sodomized their son as part of a satanic ritual because she does not vaccinate and because she cures children with autism. [Carley] believes that her husband was fulfilling the government's role in performing anal penetration on their child and that this penetration sends a surge of energy to the child's brain resulting in the compartmentalization of the brain. [Carley] believes that the government is interested in pursuing all persons who are opposed to vaccinating children, which is part of a global government plot in collusion with the drug industry... [and that] she is being persecuted because she has a special ability to heal autism, attention deficit hyperactivity disorder, cancer and other autoimmune disorders."
>
> Finally, the State Board Documents state that Dr. Carley "refers to herself as 'Ghandi with breasts' as well as having been stripped to the bone and being able to save the world."

What do we make of Rebecca Carley?

We will stipulate that the ejaculations of an insane woman are not necessarily untrue by virtue of her insanity. That is to say, just because the lady's nuts doesn't mean what she's saying isn't true.

Having said that, the material at Carley's web site *is wild freakin' stuff*. Here's a sample:

> "What most people don't know is that the top level mad scientists from Nazi Germany were actually brought to the United States after the war through 'Operation Paperclip', and have been continuing their work to this day in places like Brookhaven labs, Cold Spring Harbor and Plum Island in this author's backyard on Long Island. In 1969 the U.S. military/CIA and Rockefeller directed National Academy of Sciences-National Research Council (NAS-NRC) announced that a research program to explore the feasibility of 'creating a new infective microorganism [HIV] which would be refractory to the immunological and therapeutic processes upon which we depend to maintain our relative freedom from infectious disease' could be completed at a total cost of $10 million. Yes, this is what your tax dollars are going towards, folks."

All right... Carley's a nut *and* the things she says are nutty. Flea fears some parents out there might actually be taking her advice.

And I only alone am escaped to tell thee.

Posted on: Wed, Mar 14 2007 1:53 PM | Updated: Wed, Mar 14 2007 3:40 PM | Email This | Clip/Blog This Keep New:

Flea's Medicine

By Flea

(via HealthBolt)

Flea is addicted to coffee. He can't get into the car in the morning without it. He can't practice medicine without it. He can't speak Portuguese without it.

You could say that Flea loves coffee. Just not enough to have sex with it. That's where we draw the line.

Posted on: Wed, Mar 14 2007 7:58 AM | Updated: Wed, Mar 14 2007 9:44 AM | Email This | Clip/Blog This Keep New:

Goin' Mobile

By Flea

I'm goin' home
And when I wanna go home
I'm goin' mobile
Well, I'm gonna find a home
And we'll see how it feels
Goin' mobile
Keep me movin'

Say hello to Flea's new friend.

After seven years of lugging around a beeper and a phone, Flea has decided to enter the 21st century and get a Blackberry. Now we'll carry one device instead of two. No more struggling to figure out what number the patient left on the machine: it'll be on the phone.

For Flea's patients, instead of calling a voice mailbox and activating a pager, they'll call the Blackberry mailbox instead.

We've been accepting emails for several years now, but now we're going to push it hot and heavy so as to limit the number of phone messages we'll have to answer.

Readers of Flea may ask whether the Blackberry will further intrude on his privacy and his sleep. Thus far, the patients have been remarkably respectful. That is to say, some have not, but the majority have. If the volume of calls and pages becomes burdensome, we'll do something about it.

The point of all of this is to smooth access and communication between the doctor and the patients. Too much of modern medicine is characterized by barriers to communication. We're about breaking down barriers.

Now the only challenge will be to see if the Blackberry and Jill will get along.

Posted on: Tue, Mar 13 2007 2:12 AM | Updated: Tue, Mar 13 2007 2:41 AM | Email This | Clip/Blog This Keep New:

Herder of Cats

By Flea

Pediatric Grand Rounds 1:24 is up at Sam Blackman's Blog, MD.

For those of you who don't know him, Sam is "a third year fellow in a combined pediatric hematology/oncology and pediatric neuro-oncology program. He's a husband, a scientist, a cyclist, a herder of cats, a music-lover, public radio junkie, amateur photographer, and avid reader (among other things). "

Among other things, Sam knows Flea, by which we mean he *really* knows Flea (in the personal as opposed to the Biblical sense).

PGR has for some time developed a fairly strong showing from parent-bloggers. Some of them are quite good, but Flea wishes more of his colleagues would ante up. Otherwise hosts may continue to pull selections from their fellow-flea blogrolls, without permission.

Flea isn't sure there's anything particularly unethical about "post-pulling". This is the way he first appeared in Nick Genes' Grand Rounds (before giving up on the project when it became unwieldy). One week, a host pulled one of our posts and posted at Grand Rounds. It was a great compliment.

Flea's Pick of the Week goes to *uber*-blogger Orac at Respectful Insolence, and his post "The Depths of Antivaccination Lunacy". This one wins not because Orac tips his had to yours truly, but because he writes so much better than Flea and his research is more thorough. Damn him!

Next up is Rob Lamberts at Musings of a Distractible Mind in two weeks. Wake up, y'all: we got some bloggin' to do! Word to the Twinkie!

Posted on: Mon, Mar 12 2007 1:27 AM | Updated: Mon, Mar 12 2007 10:28 AM | Email This | Clip/Blog This Keep New:

The Song of the Cebu

By Flea

Boy is riding with cebu

Into town in his canoe
Sick cebu is rowing and sneezing
achu moo moo achu moo moo
achu moo moo achu moo moo MOO MOO

Flea isn't sure if EMTALA is the sacred cow of medicine, or even the sacred cebu, but Shadowfax the E.D. doc thinks so. M.D.O.D. picked up on this theme and wrote a nice piece on EMTALA's unintended consequences. It's a required read.

My only beef with 911doc's analysis is that it is focused overly on uninsured patients. To be sure, EMTALA created a butt-load of problems related to "care" of the uninsured. But I wish more docs would focus on the unintended effects of EMTALA on *insured* patients.

Here are just a random few in no particular order:

1. A disappearance of the distinctions among the categories "emergent", "urgent", and "non-urgent". Normal people simply don't understand these distinctions. It is our responsibility, including E.D. docs, to educate the folks.

2. Spread of the cult of over-test, over-diagnose, over-treat, and over-admit. If going to the doctor correlates with irrelevant tests and unneccesary drugs, going to the E.D. correlates with these phenomena in a large a serious way. It follows that patients come to believe that the tests and drugs are necessary: after all, a physician did these things!

3. Fragmentation of care. Referrals often get made in the E.D. This should not happen, but it does. Primary care docs make referrals. Got that?

4. Fostering a general misunderstanding as to what it means to be sick. If a problem is bad enough to require all these tests and drugs, the patient must be *really sick*, right?

Posted on: Fri, Mar 9 2007 1:50 AM | Updated: Fri, Mar 9 2007 3:08 AM | Email This | Clip/Blog This Keep New:

Autism Speaks to Flea

By Flea

Yesterday, Flea received a letter from Mark Roithmayr, president of Autism Speaks.

The letter accompanies a "consensus statement" produced by an "expert panel of pediatric gastroenterologists and autism specialists" on the subject of gastrointestinal problems in children with autism.

The consensus statement covers the following GI symptoms: Constipation, diarrhea, reflux, vomiting, and abdominal discomfort. The statement goes on to advise that fleas refer their patients to pediatric gastroenterologists if the patients' symptoms do not respond to initial management by the flea him/herself.

The panel of GI/autism experts then provides a list of examples of possible initial managment strategies, including dietary alterations and stool softeners.

After reading the letter, Flea found himself scratching his head. These are all things Flea *does already*! What the hell does all of this have to do with autism? The conditions and interventions listed by the "panel of experts" are all common presenting complaints that fill Flea's schedule from morning to night (sometimes on weekends). Why then did Roithmayr send a letter instructing Flea how to manage conditions he sees every day and already knows how to treat?

One of a couple possibilities present themselves: Either Roithmayr uses the mailing only to raise awareness of autism (as if that were necessary), or he believes fleas are so breathtakingly stupid as to need instruction from Autism Speaks regarding the diagnosis of common GI problems in children.

Flea figures it's the former, but fears the latter.

3 References

Posted on: Wed, Mar 7 2007 1:31 AM | Updated: Wed, Mar 7 2007 4:31 AM | Email This | Clip/Blog This

Keep New:

They Played a Movie at a Malpractice Trial?

By Flea

(via Dr. Charles)

Medical Economics posted an essay by a doctor Anna Maria Voltura regarding her horrific experiences on trial for medical malpractice.

> "I testified in court for four grueling hours. I was well prepared but nevertheless terrified I would say something wrong. I felt the need to repeat what took place over and over again just to make sure the jurors understood the sequence of events. The plaintiff's attorney--attractive, articulate, and dressed in an expensive suit--tried every trick in the book to get me to slip up, to say something she could twist into a lie. Anything she could to make me look inept, inexperienced, evil. Yes, evil. During closing arguments she played a scene of the Lord of the Rings: The Return of the King and equated the doctors in the case to the monsters. I sat there astounded that someone would actually say that I was an evil person wreaking havoc on innocent people behind the guise of a medical license."

Flea wonders if they'll show a film at his malpractice trial. He sure hopes it's this one. If not, this one or this one will do.

By the way, Dr. Voltura emerged victorious from her ordeal. Flea really wishes he'd stop reading malpractice stories with happy endings until after his own trial is over.

Posted on: Tue, Mar 6 2007 1:20 AM | Updated: Tue, Mar 6 2007 1:31 AM | Email This | Clip/Blog This Keep New:

Submit to PGR or the Bunny Gets It!

By Flea

Today is Purim, the Jewish Mardi Gras, sort of. All over the world, Jews are waking up with vicious hangovers, stumbling into shuls, and being assaulted by giant

bunnies wearing tefillin. This has got to stop!

Our only hope is to make contributions to the next issue of Pediatric Grand Rounds. Sam Blackman will be our host on Sunday, March 11th. Please send your contributions to me by e-mailing them to: samuel (dot) blackman (at) gmail (dot) com by Friday March 9th.

Fleas of the World, Unite! You have nothing to lose but your schpilkes!

Posted on: Sat, Mar 3 2007 11:40 PM | Updated: Sat, Mar 3 2007 11:50 PM | Email This | Clip/Blog This Keep New:

Graham Answers His Own Question

By Flea

Posted at Over My Med Body yesterday:

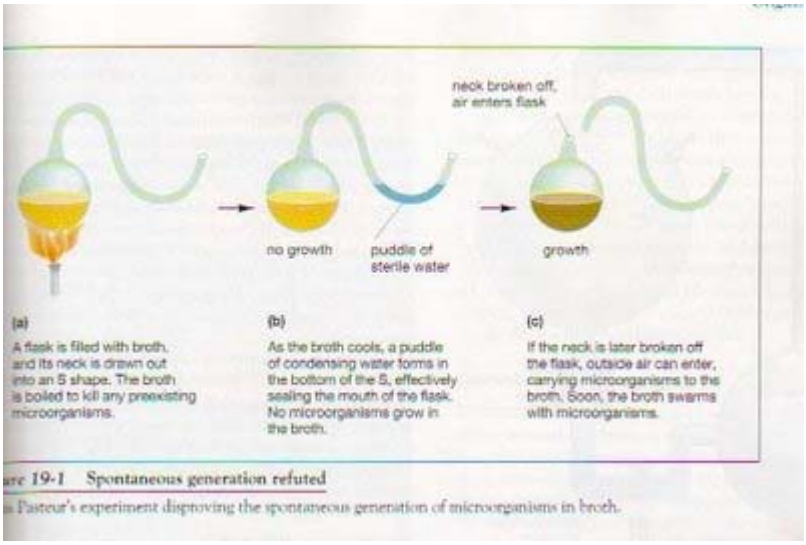
"A call to all the ER docs out there: how do you tactfully, non-insultingly tell patients who come in with minor complaints, “You’re fine, go home, this is not an emergency, you should not come to an ER for a problem like this?” (For example, kid with a cold and low grade temp who is otherwise playful, active, eating and drinking well, with good sats, etc.)

There it is: The question that answers itself!

Posted on: Fri, Mar 2 2007 1:19 AM | Updated: Fri, Mar 2 2007 3:30 AM | Email This | Clip/Blog This Keep New:

Political Advocacy Masquerading as Science

By Flea



Very little irritates Flea more than "scientific studies" that turn out to be nothing more than thinly-veiled political propaganda.

It irritates Flea *even more* when pediatricians perform such studies, or even merely place their imprimatur on them.

Steven Parker, M.D., about whom Flea has posted before, has placed his seal of approval on a real gaper and flamer this time.

In today's post, Parker crows about a "study" performed by the "Every Child Matters Education Fund".

> "A recent study, entitled "Homeland Insecurity," conclusively demonstrates a link between the state tax rate and important indicators of children's health (including low birth weight, neonatal mortality, juvenile incarceration, teen pregnancy, and death)."

The title of the study is a give-away. Readers anticipate, or ought to anticipate, that a document with such a title, having a little fun with the current administration's War on Terror, promises a fair dose of political commentary. Such anticipation will not be disappointed.

The 124-page article can be read as a polemic on the virtues of redistribution of wealth, with a hefty dose of Texas-bashing along the way. Parker comments:

> "Whatever your political leanings, I hope we can all agree that one proper role of government is to protect and enhance the health of our children."

Huh? Flea is no civics major, but he's read the U.S. constitution and he cannot locate the particular "proper role of government" to which Dr. Parker refers.

Here's the point: Parker has every right to sing the praises of the Redistributionist State. Flea is calling him on the carpet for praising a "study" that "conclusively demostrates" something, when Parker knows full well that **correlation is not causation**. His obvious glee with the study's findings appears to dampen Parker's ability to examine critically the evidence presented. That is, *if he actually read the article*.

Posted on: Wed, Feb 28 2007 1:45 PM | Updated: Wed, Feb 28 2007 2:37 PM | Email This | Clip/Blog This Keep New:

Scurvy. Not Just a Disease.

By Flea

Scurvy is: Marc Lawson, Antonio Maria, Yuki Ueno, Adam Hocherman photo by Mr. Ueno

Scurvy. Not Just A Disease.

by Ankur Desai

Scurvy, one of Greeley's rising musical groups, originated early last year in order to play for the first coffee house. Unfortunately, their performance did not go quite as planned. Due to many technical difficulties, the evening was a complete disaster. Scurvy consists of three juniors and one senior. Yuki Ueno on guitar as well as lead vocals, Adam Hocherman on bass guitar and keyboard, Antonio Maria on lead guitar, and Mark Lawson behind the band on the drums. The bands name, which is a disease caused by a deficiency of vitamin C, was coined by former lead singer, Chris Muldoon.

At this year's first coffee house, the band played to an entirely new tune and gave one of the best performances of the night. Despite being the closing act, many people remained to listen to this band which had advertised the previous week. Because of the slam dancing earlier that evening the band was afraid that the power would be cut by Gary if things got too rowdy.

Slam dancing and chants of "Scurvy, Scurvy" persisted as the band played through their entire set. They performed five songs, *Sweet Child O' Mine* and *Knockin' On Heaven's Door* by Guns 'n Roses, *Summer Nights* by Van Halen, *Ride The Wind* by Poison, and *Smelly Like Teen Spirit* by Nirvana.

What are Scurvy's plans for the future? The band hopes to get some payed gigs in order to finance new equipment and you'll be able to see them perform at this coming Earth Day in late April.

A commenter implores Flea to investigate the work of the late C.A.B. Clemetson. Flea has now done this.

Clemetson was an academic OB-GYN who retired with emeritus status from Tulane University in 1991. Two years before his death in 2006, Dr. Clemetson published an article in Medical Hypotheses entitled "Elevated blood histamine caused by vaccinations and Vitamin C deficiency may mimic the shaken baby syndrome".

Clemetson's hypothesis is based on two things: his lifelong interest in the effects of Vitamin C on human metabolism, and a paper he wrote in 1980 demonstrating a relationship between Vitamin C and serum histamine levels.

A simplified version of Clemetson's hypothesis goes like this: Vaccine administration causes, or may cause, massive release of histamine into an infant's blood stream. Among the principal actions of histamine on blood vessels is increased vascular permeability, and perhaps, fragility. Extravasation of blood then occurs in retinas and sub-dural bridging vessels. This gives rise to the pathology that may be mistaken for shaken baby syndrome. Vitamin C may prevent the increases in serum histamine that give rise to vascular injury.

Clemetson argues further that many infants may suffer from a sub-clinical form of Scurvy, the result of severe Vitamin C deficiency. In the presence of smaller concentration of circulating histamine, small blood vessels would leak blood more easily.

That's it in a nutshell. There are two problems with Clemetson's hypothesis:

The first problem derives from what is already known about the effects of histamine on cerebral circulation. Histamine is well known to increase cerebrovascular permeability, but it does not induce blood vessel breakage, leading to observable bleeding.

Second, to Flea's knowledge, there is no such thing as "sub-clinical Scurvy". We will stipulate that there are individuals, including infants, that have sub-optimal Vitamin C levels. Scurvy, on the other hand, is a clinical diagnosis, made on the basis of physical findings. In the absence of physical findings, it's not really kosher to call a

condition "Scurvy".

Even if Clemetson were to jettison the portion of the hypothesis dealing with histamine, the question remains: is there such a thing as Vitamin C deficiency in infants? There is no literature on the subject. In the U.S., where virtually the entire population of infants is either breast-fed or fed standard infant formula, this is a difficult proposition to swallow.

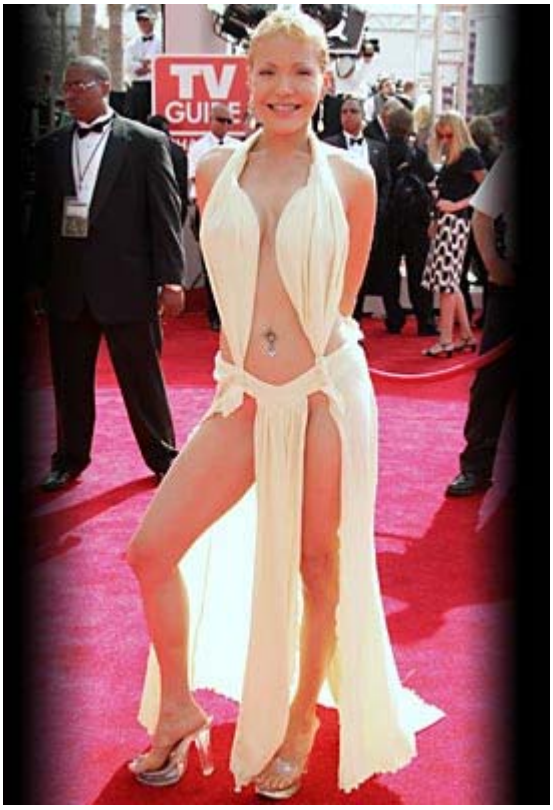
There, we've addressed it.

Nurse, will you show the next crackpot in, please?

Posted on: Tue, Feb 27 2007 1:05 PM | Updated: Tue, Feb 27 2007 6:52 AM | Email This | Clip/Blog This Keep New:

Red Carpet Treatment

By Flea



Check it out!

Pediatric Grand Rounds 1:23 is up at Allergy and Asthma Source.

Lourdes de Asis (not shown at left) is an allergist at Pascack Valley and New York Valley Hospitals in New Jersey. That makes her Flea's Homey. She's also a fellow of the American Academy of Allergy, Asthma, and Immunology and the American College of Allergy, Asthma, and Immunology. *And* she's an assistant clinical professor at the Albert Einstein College of Medicine in the Bronx, so she's *wicked smaht*!

Flea's pick of the week goes to this post by newcomer the doc whisperer. It's about E.D. docs losing their jobs because they are not board-certified. It turns out that 15-years experience *actually doing the job* doesn't cut it any longer. Anyone heard of 'grandfathering'?

Note to self: Must get PGR submissions in on time! Otherwise Flea doesn't get to pick the post he wants to submit!

Second note to self: Must i.d. starlet on red carpet.

Posted on: Sun, Feb 25 2007 5:43 AM | Updated: Sun, Feb 25 2007 6:01 AM | Email This | Clip/Blog This Keep New:

More Notes From the Lunatic Fringe

By Flea

Once again Flea has been going to and fro in the earth, and walking up and down in it. This time he's brought back a particularly tasty little morsel for his readers' consideration.

We have located a woman named Viera Scheibner. An anti-vaccination website describes Dr. Scheibner as "a retired Principal Research Scientist with a doctorate in Natural Sciences." (Actually, she's a micropaleontologist).

Her bio continues:

> "Despite extensive research of orthodox medical research published on vaccines over the past 100 years, [Dr. Scheibner] could find no scientific evidence that these injections of highly noxious substances prevent diseases, quite the contrary, that they increase susceptibility to them, in addition to causing a host of immune disorders and other damage to the body, including the brain. She was forced to conclude that they represent nothing but a medical assault on the immune system... [Dr. Scheibner] is also accepted as expert witness in court cases relating to death and injuries caused by vaccines, such as so-called “shaken baby” syndrome injuries, which like many vaccine injuries can be fatal."

Scare-quotes around the words "shaken baby"? Expert witness in court cases? What's up with that?

Here's what: Scheibner is author of an article entitled Shaken Baby Syndrome Diagnosis on Shaky Ground, published in the Journal of Australasian College of Nutritional & Environmental Medicine, (Vol. 20 No. 2; August 2001)

> "ABSTRACT An epidemic of accusations against parents and baby sitters of shaken baby syndrome is sweeping the developed world. The United States and the United Kingdom are in the forefront of such questionable practice. Brain (mainly subdural, less often subarachnoid) and retinal haemorrhages, retinal detachments, and rib and other bone ‘fractures’ are considered pathognomonic. However, the reality of these injuries is very different and well documented: the vast majority occur after the administration of childhood vaccines and a minority of cases are due to documented birth injuries and pre-eclamptic and eclamptic states of the mothers.
>
> Evidence that vaccines cause brain and retinal haemorrhages and increased fragility of bones, has been published in refereed medical journals. That this has been to a great extent due to the depletion of vitamin C reserves resulting in acute scurvy, has also been published. I refer to such

> articles and demonstrate that there is a viable differential diagnosis available explaining the observed injuries in what is called the Shaken Baby Syndrome (SBS) as non-traumatic injuries, and that the diagnosis of SBS is an incorrect evaluation of the cause of such injuries; it has resulted in unspeakable injustices and suffering for the affected individuals and their families, and deprived the surviving babies of their parental care by replacing it with foster care. It does not reflect well on the justice and medical systems in the developed world which are, sadly, characterised by blindness to the most obvious and victimisation of the innocent. Those who inject babies with great numbers of vaccines within short periods of time in the first months of life, often ignoring the observed serious reactions to the previous lots of vaccines, are not only the accusers of innocent carers, but are not prosecuted or brought to justice; quite to the contrary, they continue injecting babies with toxic cocktails of vaccines and creating further innumerable cases of grievous bodily harm and death."

The "evidence" in refereed medical journals demonstrating that vaccines cause brain and retinal hemorrhages and increased fragility of bones" consists of a single reference to this Lancet article.

What about bones? How do vaccines cause the characteristic bony injuries associated with shaken baby syndrome? Scheibner answers: vaccines cause scurvy. (Honest: Flea is *not making this up*):

> "Vaccines of the kind given to babies as early as at birth and then one month later (hepatitis B vaccine) and DPT, Polio and Hib at 6 to 8 weeks of age, contain a number of toxins. The DPT (three in one vaccine), being the toxoid vaccine, contains pertussis, diphtheria and tetanus toxins which are treated with formaldehyde to decrease their toxicity. However, all of these treated toxins (toxoids) have the ability to revert back to their original toxicity by passage in the injected individuals, as demonstrated by Samore and Siber. These toxins are capable of causing, and they demonstrably cause, serious immunological, vascular and metabolic injuries, of which scurvy is one of many documented mechanisms."

Got it? Flea did a PubMed for vaccine-associated scurvy - couldn't find anything. By the way, here's the link to the abstract of the Samore and Siber article Scheibner cites. It says nothing at all about wild-type conversion of pertussis toxin, and the study was performed in rats.

Scheibner's conclusion? "The practice of accusing innocent carers of injuring vaccine-damaged children should cease forthwith."

And I only alone am escaped to tell thee.

9 References

Posted on: Sat, Feb 24 2007 12:16 PM | Updated: Sat, Feb 24 2007 2:08 PM | Email This | Clip/Blog This Keep New:

What Would Doc Shazam Do?

By Flea

It's a shame that Doc Shazam doesn't work in Flea's neighborhood.

The author of Mr. Hassle's Long Underpants, Doc Shazam is an E.D. doc somewhere in the Rockies. She's hosted her blog since June 2003, and that makes her an old-timer in the med-blog business. She's a biker, a Colt's fan, and a faithful reader of Flea. Now she's paid us a huge compliment.

Please read her post entitled "What would Flea say/do?"

The money quote:

> "Part of my job as an ER doc is to educate. If I can educate patients on proper care at home in order to avoid an ER visit, then I've done a good job..."

Amen, Sister. May the road always rise to meet you.

Posted on: Fri, Feb 23 2007 1:57 PM | Updated: Fri, Feb 23 2007 2:14 PM | Email This | Clip/Blog This Keep New:

Roy Richard Grinker Remaps NPR

By Flea

On February 20, 2007, Madeleine Brand, host of National Public Radio's "Day to Day" program, interviewed Roy Richard Grinker about his new book Unstrange Minds - Remapping the World of Autism.

At 3 minutes 58 seconds into the interview, Brand asks Grinker to explain how "well-educated people who have done their research" believe that some environmental cause such as vaccines causes autism. Listen to Grinker's answer. He dispatches this and all of Brand's questions crisply, confidently, and most important in Flea's view, accurately.

Flea cannot wait to read Unstrange Minds. A review at this blog will surely follow.

1 Reference

Posted on: Thu, Feb 22 2007 2:44 PM | Updated: Thu, Feb 22 2007 3:00 PM | Email This | Clip/Blog This Keep New:

It's Good to Be a Kid

By Flea

Yet more evidence that Pediatricians are running out of things to do: The annual summary of U.S. vital statistics appears in the February number of Pediatrics.

It turns out that disease is taking fewer children, while unintentional injuries, homicide and suicide are becoming more prominent.

The infant mortality rate remains stunningly low at 67.9 per 100,000 live births.

> "More than half of all infant deaths in 2004 were attributable to 5 leading causes: congenital malformations (20%), disorders relating to short gestation and LBW, not elsewhere classified (17%), sudden infant death syndrome (8%), newborn affected by maternal complications of pregnancy (maternal complications) (6%), and unintentional injuries (4%). Final data for 2004 indicate that the order of the leading causes of death changed slightly between 2003 and 2004 as unintentional injuries moved from the sixth to the fifth leading cause."

Of these causes, disorders related to short gestation are being fought mightily and successfully by the Neonatologists. Maternal complications reside in the camp of the Obstetricians.

For children 1-19 years of age, the numbers are even more startling:

> "A total of 25,325 children and adolescents between the ages of 1 and 19 years died in the United States in 2004. The death rate for children aged 1 to 19 years in 2004 was 32.7 per 100,000 population, 0.9% lower than the rate of 33.0 in 2003. Although all of the tabulated age groups between 1 and 19 years of age produced downward mortality trends, the death rates did not decrease by a statistically significant margin for any of the age groups except for 1- to 4-year-olds. For all children aged 1 to 19 years, the first and second leading causes of death in 2004 were unintentional injuries and homicide, respectively. Unintentional injuries accounted for 44.0% of all deaths, and homicide accounted for 10.4% [*suicide, the fourth leading cause of death, accounted for 7.8%*]. The death rate for both of these leading causes did not change between 2003 and 2004. Among the 10 leading causes of death for this age group, the only death rate that decreased significantly between 2003 and 2004 was that for influenza and pneumonia (40%). A significant increase was registered only for suicide (18.2%)."

Only malignant neoplasms, number three on the list of causes of death at 8.5%, stands within reach of pediatricians, pediatric oncologists in this case.

Fleas are no longer needed to prevent deaths in children. That is, unless you believe that pediatricians are uniquely positioned in society to prevent accidents, murders, and suicides. Even if we were to stipulate that this proposition is true, you would have to agree that Pediatrics is a completely different specialty from the one originally conceived in the 1920's.

Posted on: Wed, Feb 21 2007 2:07 PM | Updated: Thu, Feb 22 2007 10:15 AM | Email This | Clip/Blog This Keep New:

Merck Backs Off

By Flea

When Texas became the first state to make HPV vaccination mandatory for girls entering 6th grade, few people realized that the maker of the vaccine, Merck, via a third-party, had lobbied Austin for approval of the plan. It turns out that 20 other states are now considering making the vaccine mandatory, and Merck's fingerprints are all over the place.

When word got out, the public outcry was fairly intense.

Today, Merck did the right thing and backed off.

> "Merck made the decision after groups including the American Academy of Pediatrics said there wasn't enough state funding to pay for the $360 vaccine or public acceptance, said Rick Haupt, director of medical affairs for Merck's vaccine division, in a telephone interview today...

> Merck began its campaign for the vaccine among state lawmakers even before it was approved in June 2006. The company, which is based in Whitehouse Station, New Jersey, decided to stop lobbying states because the focus had shifted to the campaign rather than to preventing cervical cancer, Haupt said.
>
> `Merck's early push was not the way to go,' said Larry Pickering, executive secretary of the advisory committee on immunization practices for the U.S. Centers for Disease Control and Prevention, in Atlanta. 'We want to convince people to use the vaccine because of its benefits.'
>
> 'Immediately implementing school laws is not optimal,'' Pickering said in a telephone interview today. 'We need to gather more data and reevaluate to see whether this kind of approach is necessary.''
>
> The vaccine is Merck's most important new product, capable of generating as much as $3 billion in annual sales, analysts have said. Revenue from Gardasil in the fourth quarter reached $155 million.
>
> 'Many support vaccine use broadly, but don't think this is the right time to engage in a school requirement,'' Haupt said. Merck will continue to lobby to get states to pay for the vaccine through programs for the uninsured and poor, he said.

In other words, even if the vaccine is a good idea (and Flea believes it is), Merck's lobbying turned the public against the whole idea, big time.

Flea understands why girls are the only target population, as they are the ones who get cervical cancer, but he hopes that boys will be vaccinated as well. If nothing else, it provides us with a "teachable moment" with our adolescent male patients.

4 References

Posted on: Tue, Feb 20 2007 1:31 PM | Updated: Tue, Feb 20 2007 1:54 PM | Email This | Clip/Blog This Keep New:

Use of the E.D. by the Non-Emergently Ill

By Flea

Flea's ranting notwithstanding, use of emergency services by non-emergently ill patients in Massachusetts will continue. This piece by Liz Kowalczyk in the Boston Globe proves it.

The crux of the problem is that E.D.s, doctors and insurers have bigger headaches than the problem of non-emergently ill people showing up in the E.D. Listen to Ron Walls, E.D. chairman at Brigham and Women's Hospital in Boston:

> "People with minor problems are easy to take care of; they're quick and uncomplicated and are not high-resource users," said [Walls]. Redirecting patients with routine problems to community health centers, he said, will shorten their waits, but may not provide relief for sicker patients.

The article refers as well to studies that "that it may be cheaper overall to treat patients with minor problems in emergency rooms, which have to stay open anyway, than to pay for a large-scale expansion of primary care services (to see non-emergently ill patients.)"

There you have it. The docs don't mind seeing non-emergently ill patients. They're quick and easy. The State doesn't mind either. It's cheaper for the folks to be seen in the E.D. than for Massachusetts to subsidize community health centers.

The bigger fish being fried by the Commonwealth is the problem of bed-shortage in hospitals for *truly* ill patients. The article did not address the question of how many hospitalized patients truly need hospital level of care. In Pediatrics, this number is smaller than the number actually admitted to hospital.

blueness returning to face

Here's the problem: Overuse of emergency services for non-emergent complaints educates parents and their children that non-emergent conditions require emergency level of care. Thus when a toddler in my practice goes to the E.D. with cold symptoms and gets an I.V. (true story from last night), the parents learn that colds deserve I.V.'s

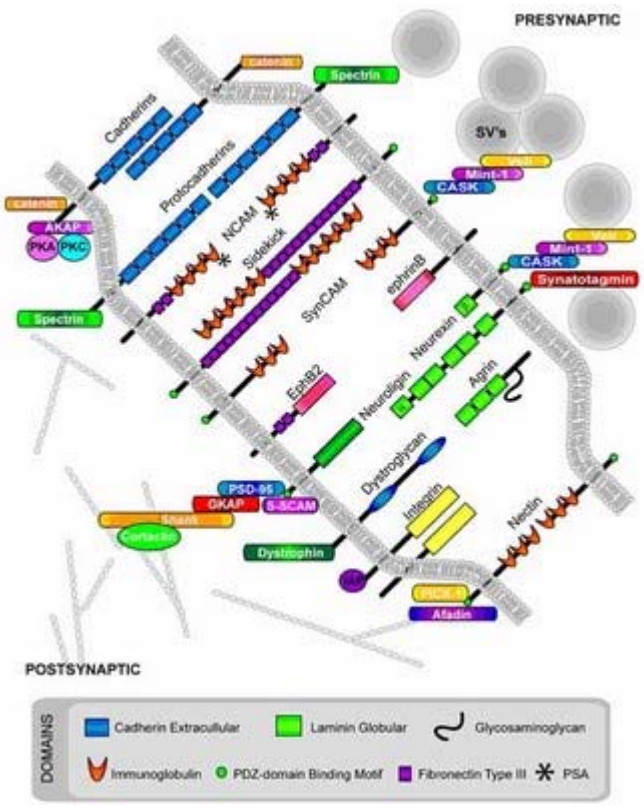
Once the lesson is taught, it's friggin' hard to unlearn. Flea knows that E.D. docs have a lot on their plates. If they can find the strength to do so, could they please help us educate patients not to go to the E.D. for minor complaints?

1 Reference

Posted on: Tue, Feb 20 2007 1:14 AM | Updated: Tue, Feb 20 2007 1:34 AM | Email This | Clip/Blog This Keep New:

Neurexin and Autism

By Flea



Today there's yet more evidence to suggest that autism

is a heritable developmental brain abnormality.

A large-scale multi-center collaboration has resulted in gene-chip data from over 1,000 families with at least two members carrying a diagnosis of autism. By sheer brute force, and lots and lots of money, the gene-chip method has yielded two hot spots. The first is a gene called neurexin 1. Neurexin is a protein that helps guide formation of connections (synapses) between neighboring nerve cells. The other is a poorly defined large stretch of our 11th chromosome.

Reuters Health News reported that the teams involved in the Autism Gene Project "hope that nailing down the genetics of autism will lead to better ways to diagnose it and focus efforts on developing drugs to treat it."

Hold on a second: if autism turns out to be a developmental brain abnormality, as the focus on neurexin appears to suggest, how on earth will diagnosis occur? Blood tests? At what age? Neurexin produces no soluble markers. Mutations could not be detected on Newborn Screening profiles!

What about putative drugs to "treat" neurexin mutations? Neurexin directs synapse formation. Mucking with that, presuming it could be done in a developing brain, is virtually impossible based on the piddly little we understand about structure-function relationships in the brain.

Flea wishes the press wouldn't dangle reports like this in front of their lay readership. It's fascinating science, but it's no good to the folks who pray for autism treatments or cures.

What do you suppose the mercury folks will say about the neurexin story?

Posted on: Mon, Feb 19 2007 3:50 AM | Updated: Mon, Feb 19 2007 6:01 AM | Email This | Clip/Blog This Keep New:

Stupdest is as Stupdest Does

By Flea

Below please find a comment from a reader, left yesterday. Flea waives the editor's prerogative to add "*sic*" in the appropriate places, as doing so would render the comment less, um, coherent.

"Dr.Flea,

Wow you've got to be the worlds stupdest doctor ever and someone shouyld take your medical liscence away."

The comment was made on this post from last May. Perhaps criticism of daycare gets some folks torqued off?

1 Reference

Posted on: Sat, Feb 17 2007 1:30 PM | Updated: Sat, Feb 17 2007 1:43 PM | Email This | Clip/Blog This Keep New:

ADHD linked to Daycare, Health Insurance

By Flea

Exposures to Daycare and Health Insurance and Attention Deficit Hyperactivity Disorder in U.S. Children. Joe M. Braun; Robert S. Kahn, Tanya Froehlich, Peggy Auinger5, Bruce P. Lanphear. Environ Health Perspect. 2006;114(12):1904-1909. ©2006 National Institute of Environmental Health Sciences.

Objective: The purpose of this study was to examine the association of exposures to daycare and health insurance with attention deficit hyperactivity disorder (ADHD).
Methods: Data were obtained from the National Health and Nutrition Examination Survey 1999-2002. Daycare and health insurance exposure was based on parent report; ADHD was defined as having current stimulant medication use and parent report of ADHD diagnosed by a doctor or health professional.
Results: Of 4,704 children 4-15 years of age, 4.2% were reported to have ADHD and stimulant medication use, equivalent to 1.8 million children in the United States. In multivariable analysis, daycare exposure [odds ratio (OR) = 2.4 ; 95% confidence interval (CI) , 1.1-5.1] and health insurance coverage, OR = 18.9 ; 95% CI, 3.7-97.4) were significantly associated with ADHD. Postnatal tobacco smoke exposure was not associated with ADHD (OR = 0.6 ; 95% CI, 0.3-1.3 ; p = 0.22).
Conclusions: We conclude that exposure to daycare attendance and health insurance coverage are risk factors for ADHD in U.S. children.

Okay, okay... So Flea mucked with the text *a little*. But the data shown are all drawn from the actual article. The title and abstract have been amended for purely polemical reasons.

Here's the original abstract from Bruce Lanphear's article (with differences highlighted):

Exposures to Environmental Toxicants and Attention Deficit Hyperactivity Disorder in U.S. Children (same authors and publication info)

"Objective: The purpose of this study was to examine the association of exposures to tobacco smoke and environmental lead with attention deficit hyperactivity disorder (ADHD).
Methods: Data were obtained from the National Health and Nutrition Examination Survey 1999-2002. Prenatal and postnatal tobacco exposure was based on parent report ; lead exposure was measured using blood lead concentration. ADHD was defined as having current stimulant medication use and parent report of ADHD diagnosed by a doctor or health professional.
Results: Of 4,704 children 4-15 years of age, 4.2% were reported to have ADHD and stimulant medication use, equivalent to 1.8 million children in the United States. In multivariable analysis, **prenatal tobacco exposure [odds ratio (OR) = 2.5 ; 95% confidence interval (CI) , 1.2-5.2] and higher blood lead concentration (first vs. fifth quintile, OR = 4.1 ; 95% CI, 1.2-14.0) were significantly associated with ADHD.** Postnatal tobacco smoke exposure was not associated with ADHD (OR = 0.6 ; 95% CI, 0.3-1.3 ; p = 0.22)**. If causally**

linked, these data suggest that prenatal tobacco exposure accounts for 270,000 excess cases of ADHD, and lead exposure accounts for 290,000 excess cases of ADHD in U.S. children.
Conclusions: We conclude that exposure to prenatal tobacco and environmental lead are risk factors for ADHD in U.S. children. "

In other words, Lanphear's group demonstrated that daycare attendance was *just as likely* as blood lead level > 2 mcg/dL to be associated with ADHD. If the child were covered by health insurance, the children in the NHANES cohort were *way more* likely to have ADHD, with an adjusted odds ratio of 18.9 (all the data cited above achieved statistical significance except for post-natal environmental smoke exposure).

In the discussion, Lanphear attempts to explain the daycare association:

> "Presumably, children who attend preschool or child care are more likely to have problem behaviors noted by staff, thus increasing their chance for referral and diagnosis of ADHD by a health professional. Results from the NICHD child care study also suggest that children who are more aggressive and disobedient are more likely to be placed in child care at younger ages and for longer periods of time (NICHD 2003). Regardless of the reason for this finding, staff at these facilities may play an important role in identifying and referring children with behavior problems for early intervention."

Uh-huh? Is that all ya got?

Lanphear doesn't bother to take a crack at the health insurance association. BTW, why isn't *post*-natal ETS associated with ADHD? Your guess is as good as Flea's.

Lanphear also fails to mention that blood lead levels have fallen precipitously over the last thirty years, and yet the apparent prevalence of ADHD appears to be rising even more rapidly. Finally, Lanphear fails to mention that chelation for children with blood lead levels less than 44 mcg/dL has no effect on neuropsychological development. So with average blood lead levels falling asymptotically toward zero in the United States, it's hard to know what Lanphear means to accomplish by pursuing environmental lead exposure.

Last question: Why doesn't Lanphear tell us how many excess cases of ADHD result from daycare and health insurance exposure?

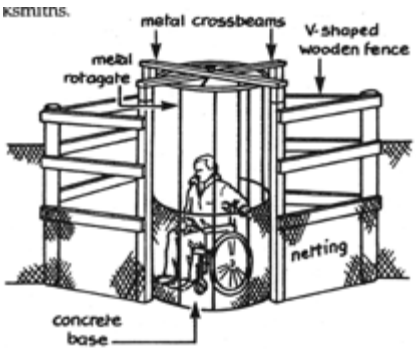
Flea's only askin'.

2 References

Posted on: Wed, Feb 14 2007 10:36 PM | Updated: Wed, Feb 14 2007 10:13 PM | Email This | Clip/Blog This Keep New:

Rota-gate!

By Flea



This newsflash was all over the wires and in Flea's inbox this morning. Flea's mad at himself for failing to predict that RotoTeq would get blamed for cases of intussusception in vaccinated infants. Sure enough, 28 infants, previously given oral doses of RotaTeq, made by Merck, have developed this bowel complication.

As Sam pointed out this morning in his excellent analysis, there is a certain number of infants that will develop intussusception every year, whether they receive the vaccine or not. It turns out that the number of cases reported so far does not exceed the background rate.

And now, a little late, comes Flea's bold prediction: There will more, *lots more* reports of intussusception related to RotaTeq.

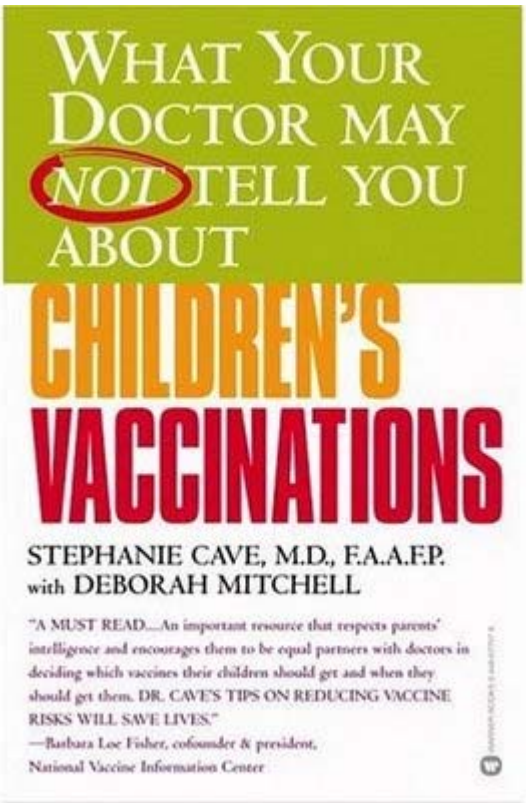
In general Flea is favorably disposed towards an oral Rotavirus vaccine. Rota causes a fair amount of misery every winter, though virtually no children die of diarrheal illness in this country. The morbidity-prevention alone justifies widespread use of the vaccine. The major problem with the vaccine is its expense combined with our state's decision not to pay for it yet. When they do, Flea will hop on board with all six legs.

1 Reference

Posted on: Wed, Feb 14 2007 2:23 AM | Updated: Wed, Feb 14 2007 3:37 AM | Email This | Clip/Blog This Keep New:

Stephanie Cave, Philosopher-Queen

By Flea



What Your Doctor May Not Tell You About Childrens Vacinations, by Stephanie Cave, MD, FAAFP, with Deborah Mitchell. New York: Warner Books (2001)

> "[Socrates] And now, I said, let me show in a figure how far our nature is enlightened or unenlightened: --Behold! human beings living in a underground cave, which has a mouth open towards the light and reaching all along the cave; here they have been from their childhood, and have their legs and necks chained so that they cannot move, and can only see before them, being prevented by the chains from turning round their heads. Above and behind them a fire is blazing at a distance, and between the fire and the prisoners there is a raised way; and you will see, if you look, a low wall built along the way, like the screen which marionette players have in front of them, over which they show the puppets.
>
> [Glaucon] I see."

Plato's Allegory of the Cave comes to teach that Truth is not apprehensible by means human senses alone - We can only come to know Truth via education. According to Plato, the job of the teacher is to point students toward the True and the Good and to encourage students to apprehend these things for themselves.

The world of health and medicine is a particularly dark corner of the cave. The workings of the body, the mysteries of disease and its prevention prove difficult to access via the unaided senses. For this reason we have created academies devoted to the education of medical philospher-kings and queens. Those academies are called "medical schools" and the products of those schools we refer to as "doctors".

One such product of our academy is Stephanie Cave (verbal joke absolutely intended). Dr. Cave has written a book designed to educate the wretched, blinded inhabitants of Plato's cave to understand vaccines and the diseases they are designed to prevent.

What kind of Philosopher-Queen is Stephanie Cave? And what does she come to teach us about childhood vaccines?

Dr. Cave believes with perfect faith that heavy metals cause developmental disorders in children. She believes futher that chelation therapy cures children with ADD, ADHD, and PDD. The following is excerpted from a 2002 interview with Mothering Magazine:

> "MM: Did you find [mercury, aluminum, antimony, and arsenic] across the board in children who exhibited some form of developmental delay?
>
> SC: Yes. The children fell within the autism spectrum, including those with speech and language delay, ADD, ADHD, PDD-NOS (Pervasive Development Disorder Not Otherwise Specified), Asperger's Syndrome, and Autism DSM-IV (*sic*). I feel they are part of the same spectrum because they all seem to improve dramatically when we start treating them metabolically and actually detoxifying the metal. They improved as we did repletion of nutrition and improved bowel-bacteria balance. But when we started pulling metal, all of them started turning around. And the earlier they were treated, the greater the improvement."

According to Dr. Cave, heavy metals are to blame not only for ADHD and PDD, but are responsible as well for certain normal variants of motor development. Here is part of an exchange, taken apparently from a Q&A session with mothers:

> "Q: What causes toe walking? How can you get rid of it?
>
> A (Dr. Cave): Toxins, heavy metals, lack of chemistry, lack of magnesium."

In similar fashion to Flea's new best friend Alix, Dr. Cave predicts in her book that removal of Thimerosal from childhood vaccines will have an enormous beneficial effect on the rates of autism and other developmental disorders. Flea eagerly awaits the next edition of Dr. Cave's book for her assessment of the hoped-for improvement.

Flea got a splitting headache reading Dr. Cave's book. It is a riddled throughout with junk science, junk medicine, and voodoo therapies. The parade of factoids and nonsense fairly dance off the page. A post-length review could not address them all. On one page Dr. Cave states definitively that Vitamin C prevents adverse vaccine reactions. Two pages later she backs off from this claim, adding that Vitamin C "may" prevent adverse reactions. Elsewhere she rehearses the urban legend that oral polio vaccine was responsible for the outbreak of AIDS in San Francisco in the early 1980's.

Dr. Cave also peddles two hoary factoids that have never been adequately rebutted. The first is that an infant's immune system is in some sense "weak". Flea knows of no credible evidence to suggest that an infant cannot handle introduction of proteins and toxoids at early ages. The second is the canard that separating the components of the Measles-Mumps-Rubella vaccine give fewer adverse reactions than giving them together. Again, there is no data whatsoever to support this claim.

It saddens Flea to report that Dr. Cave's book is widely regarded as "balanced". Dr. Cave earns this designation, apparently, because she does not advocate abandoning the vaccine program altogether. If this book is what passes for "balance" in the vaccine debate, we are all in a great deal of trouble.

Finally, Flea derives no joy from informing his faithful readers that Stephanie Cave is no Philosopher-Queen. She leads her readers right back into Plato's cave, where she lovingly places chains back on their legs and necks.

Posted on: Tue, Feb 13 2007 1:51 AM | Updated: Tue, Feb 13 2007 4:51 AM | Email This | Clip/Blog This Keep New:

Repeal EMTALA!

By Flea

Shadowfax, over at Movin' Meat, tries his hand at constitional law. He speculates that the Emergency Medical Treatment and Active Labor act of 1985 (EMTALA) may violate the "Takings Clause" of the 5th Amendment to the Constitution. The post hinges on the following question: Is a physician's labor "property" that the governement cannot commandeer without compensation?

Flea is no lawyer, but the smart money in this dispute is with the government. Unfunded mandates are what the Feds do best. If they want us to see patients with no guarantee we'll be paid for it, they can damn well make us do it.

Flea and Shadowfax agree on one thing: EMTALA needs to be reworked. If congress must repeal it and start again, so be it. Neither of us suggest we ought to return to the days of patient-dumping. We agree that there needs to be greater disincentives for folks to stop off at the ED between stops at Dunkin' Donuts and pre-school.

Of greater importance to Flea, however, is the Prudent Layperson Standard. The PLS can be thought of as a corollary of EMTALA, or as Flea has referred to it, EMTALA's evil spawn.

The PLS states essentially that you are sick enough to be in an emergency department if you show up at one. At least this is the way it has shaken out in practice.

EMTALA and the PLS have caused otherwise sensible folks to seek emergency level of care for non-emergent conditions. When the folks then receive emergency level of care, they learn that non-emergent conditions *deserve* emergency level of care. And they come back for more, this time joined by their friends. Everyone ends up believing that we're sicker than we really are.

Criticisms of EMTALA too often focus on the uninsured who crowd ED waiting rooms. Would that the uninsured waited alone! Unfortunately, they share those waiting rooms with insured patients, and patients on Medicare and Medicaid.

There was a time in recent memory when the expression "the emergency room" was always joined to the expression "rushed to".

EMTALA and the PLS tore these phrases asunder. It's long since time to paste them back together.

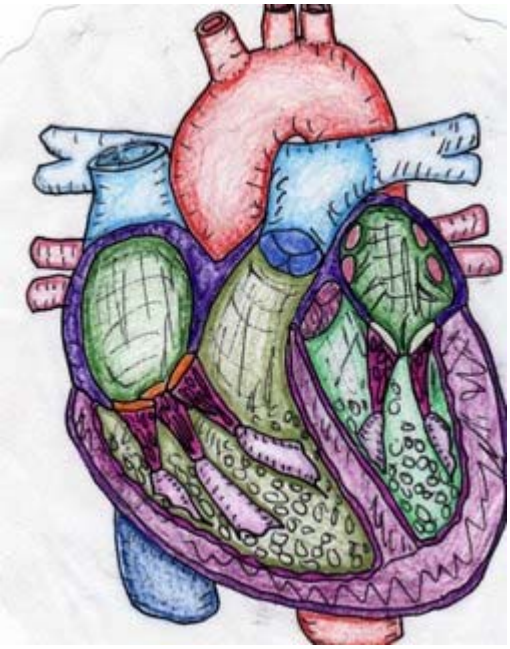
2 References

Posted on: Mon, Feb 12 2007 9:48 AM | Updated: Mon, Feb 12 2007 6:21 AM | Email This Keep New:

Clip/Blog This

Hearts and Minds

By Flea



Pediatric Grand Rounds 1:22 is up at Adventures of an Awesome Mom.

Melissa did an admirable job in her first PGR hosting experience. Flea notices that most of us had the same trouble coming up with thematically-correct posts as per request. So it goes.

Flea's pick of the week goes to the incomparable Kim McAllister at Emergiblog, for her post, "Call 911 He's Dead!" Briefly, the post is Kim's horrific experience, 21 years ago, of a simple febrile seizure in her 20-month old son, and the ordeal of the subsequent E.D. visit.

As per usual, what catches Flea's attention in Kim's post is tangential to the main point of the post: the telephone conversation between the E.D. doc and her son's pediatrician. That an exchange between doctors occurred *at all* is increasingly rare in this day and age, at least in Flea's community. Most notable, the primary care doc determines that Kim's son doesn't need to be hospitalized, given Kim's expertise and judgment, and the relative lack of seriousness of her son's illness.

These days, if mom wanted to be admitted, the child would be admitted. Today's pediatric house officers are trained that "social reasons" such as "worried mom" are perfectly adequate justifications for hospital admission.

Flea disagrees. Hospitalization for problems that do not require hospital level of care educates patients *and doctors* that a particular acute illness is more serious than it really is. The effects of such decisions ripple far beyond the E.D. into the community at large. It's a pernicious development and it should end as soon as possible.

Kim gets it. Why doesn't anybody else?

Posted on: Sun, Feb 11 2007 5:33 AM | Updated: Sun, Feb 11 2007 2:14 AM | Email This Keep New:

Clip/Blog This

Hedge Fun!

By Flea

Say hello to Alix, the author of "med nauseum blog".

Alix's area of expertise is medical research in the consulting industry, according to her profile. Alix says: "Chronic illness is irrefutably a modern scourge that can be reversed through healthy eating, avoiding some types of medication, and safe vaccination. Med Nauseum trolls the most recent literature to bring you research and credible hypotheses about inconvenient cures for chronic illness. Your cure may not be with your doctor but within your control. You just have to be sick of being sick."

Flea knew there was some trick to it. Thanks Alix!

Yesterday (February 8, 2007) on the occasion of release of the CDC's latest data on prevalence of autism among 8-year olds in 2002, Alix pounces:

> "The [autism prevalence] data will get worse through 2010 if they (*sic*) wait until all the kids born in 2002 turn 8 to measure how bad the epidemic got before removing thimerosal from most children's vaccines. That's a pretty big lag in the data - I would call this study a "lagging indicator" of something everyone already knows. They should be looking at kids 3 and older born in 2002 versus 2003 and 2004, but that data is only beginning to come out."

Then Alix places a hedge against her bet that autism rates will drop after removal of Thimerosal. Perhaps it's the vaccines themselves, with or *without* Thimerosal!

> "The sheer number of childhood vaccines is overwhelming in itself, so it's hard to say how much (*sic*) of the neurological problems in children are due to mercury and how much to cumulative vaccine overdose/overload. Three of 4 parents who've tried mercury chelation say it was helpful in their kids though... so that tells us something about how many cases could be due to mercury."

Then Alix makes a prediction. Here's where it gets fun:

> "With further studies like this one, we are still 8 years from beginning to see if rates of autism drop off after removal of mercury from most children's vaccines."

And then, one final hedge:

> "Remember though, that the CDC and WHO have heavily pushed mercury-containing flu shots, and

> especially in the 2006/2007 flu season by marketing to younger populations. That 25 mcg of mercury in flu shots is way over the EPA's safe limit for children. So, conveniently for vaccine manufacturers and the CDC, there is noise in the data which will make it harder to see a dramatic drop-off in autism in kids born in 2003/2004."

Aren't those guys at big pharma and the CDC clever? We won't see the drop-off in autism rates because they will continue to push mercury-containing flu shots!!! (Flea can hear echoes of evil laughter.)

BTW, Flea gives Thimerosal-free flu shots, so, like, whatever.

4 References

Posted on: Fri, Feb 9 2007 1:27 AM | Updated: Fri, Feb 9 2007 8:26 AM | Email This | Clip/Blog This Keep New:

Arthur Caplan Superstar

By Flea

Flea has been a big fan of Arthur Caplan for a long time. Caplan is the Emmanuel and Robert Hart Professor of Bioethics at the University of Pennsylvania and Chairman of the department of Medical Ethics there.

Caplan has long stood, practically alone, as a moderate voice in a sea of raving lunatics posing as bioethicists. Flea doesn't always agree with Caplan, but his reasoning is always sound, his arguments impeccably marshalled, and his speech plain and relatively free of jargon. What's not to like?

Now Caplan weighs in on the Vaccine-Autism "controversy". An anonymous commenter sent a tip on an opinion piece by Caplan in the Philadelphia Inquirer, February 7, 2007. Here's an excerpt:

> "What must it be like to spend a huge amount of time every waking day trying to change public health practice - only to find out that you were wrong?
>
> That is precisely what has happened to the proponents of the theory that mercury in vaccines - contained in the preservative thimerosal, which once was used (and is used no longer) in vaccines - is responsible for a nearly 20-year explosion in autism and other neurological disorders among American children.
>
> This urban legend has had very real - and terrible - consequences. It has led, and continues to lead, many parents to avoid getting their kids and themselves vaccinated against life-threatening diseases. The failure to vaccinate has caused many preventable deaths and avoidable hospitalizations from measles, whooping cough, diphtheria, flu, hepatitis and meningitis. And fear of vaccines puts each one of us at risk that we, our children or grandchildren will become part of a deadly outbreak triggered by someone whose parents avoided getting their child vaccinated for fear

of autism.

Recent research on many fronts in medicine and science has nailed the coffin shut on the mercury-in-vaccines-causes-autism hypothesis. The connection is just not there. Perhaps the key fact, which has garnered little attention, is that thimerosal has been removed from vaccines in this and other countries for many years, with no obvious impact on the incidence of autism. The most recent data point toward a correlation with nothing at all to do with vaccines: the increasing age at which people (particularly men) have children seems to be associated with an increase in autism and other neurological problems.

Still, some of the most fervent anti-vaccine critics cannot let go. They continue to tell devastated parents of children with autism that vaccines are to blame. Others are still out on the lecture circuit peddling books and articles that bash vaccines and invoke mercury as a problem. Still others pepper the Internet with the false message that vaccines and autism do go hand in hand - it is just that the government, or the pharmaceutical companies, or organized medicine, or all of them, are keeping the truth from us all...

Now, with the mercury long out of vaccines, what is there left to say? Why won't the slandering of vaccines as the cause of autism stop? (emphasis added)"

We need more measured, reasonable, forceful voices like that of Arthur Caplan.

After all, who's gonna listen to a flea?

1 Reference

Posted on: Thu, Feb 8 2007 1:16 AM | Updated: Thu, Feb 8 2007 1:38 AM | Email This | Clip/Blog This Keep New:

Awesome PGR Coming Up

By Flea

The upcoming version of Pediatric Grand Rounds will be held over at Adventures of an Awesome (Sometimes) Mother. In honor of Valentine's Day and Congenital Heart Defect Awareness Day (February 14) Awesome Mom plans to host a "heart theme". Please send your submissions to lissa2061 AT yahoo DOT com by 10 PM February 10.

Okay then.

Flea's feelings about Valentine's Day have already been hinted at. Themed rounds also tend not to go over too well at Flea. There is very little chance that a Flea will produce a heart-themed post. He will, however, attempt to produce a heart-*shaped* post.

Posted on: Tue, Feb 6 2007 2:29 AM | Updated: Tue, Feb 6 2007 4:55 AM | Email This | Clip/Blog This Keep New:

The Knack

By Flea

Flea's been seeing a lot of this going around. Could it be an epidemic? Perhaps it should be reported to VAERS?

1 Reference

Posted on: Sun, Feb 4 2007 7:32 AM | Updated: Sun, Feb 4 2007 7:42 AM | Email This | Clip/Blog This Keep New:

Flea-peat

By Flea

The following is a re-post from February 2, 2006. Call it a "Flea-post", or a "Flea-wined", or what you will. Flea's brain is still recovering from noroviremia.

Today, a tiny defenseless creature was wrapped up and dragged out into the cold for no good reason whatsoever.

This newborn, born at term to a first-time mother, was breastfeeding well and was even gaining weight before discharge from the hospital! The family and I had arranged for me to pay a house-call this week. But the discharging pediatrician at the hospital insisted that the baby be seen in my office the next day, for reasons of... well it isn't clear why the baby needs to be seen the next day! In fact, there are *no* evidence-based guidelines that suggest a need for such early follow-up of healthy term infants.

Newborn babies are exquisitely sensitive to sensory stimuli. Unlike us, they are unable to filter unimportant, especially *unpleasant* sensory stimuli, *e.g.* being bundled up and dragged out of the house on a Winter morning. When overstimulated, babies tend to shut down and go to sleep, only to awaken later fussy and feeding poorly.

For this, and other reasons, I prefer to visit newborns at home. But because a doc in a hospital in the big city felt the need to cover her ass for some vague reason (my guess is irrational fear of liability), this baby will be dragged out of the house by a pair of sleepy new parents and exposed to cold, stress, and possible infection by stray microbes in my office.

By the way, is there a dumber holiday than Groundhog Day? Probably yes. My vote goes to Valentine's Day.

2 References

Posted on: Fri, Feb 2 2007 12:52 AM | Updated: Fri, Feb 2 2007 12:58 AM | Email This | Clip/Blog This Keep New:

Flea Down!

By Flea

All things come to an end.

For the first time in almost 7 years, Flea cancelled a session and left work early because of illness.

This time it was gastro. By 2:00 yesterday afternoon it was clear that Flea couldn't sit through an appointment without having to excuse himself to use the bathroom.

Two days earlier, a the mother of a 3 year-old called insisting that if she wasn't seen she would go to the emergency department. Those are "magic words" in Flea's office: No ED - come see Flea. Guess what that precious little morsel had?

Doctors don't get sick, remember? Nonsense. Most often , fleas get sick because parents bring many sick children to be attended to by a physician. Most (not all, *most*) of these kids do not need a doctor.

For these children, it is much more likely that they will transmit their illness to their pediatrician than it is that the pediatrician will be able to make them better sooner.

Posted on: Wed, Jan 31 2007 11:56 PM | Updated: Thu, Feb 1 2007 12:16 AM | Email This | Clip/Blog This Keep New:

Notes from the Lunatic Fringe

By Flea

Flea has been going to and fro in the earth, and walking up and down in it. He's brought back three articles of faith from the anti-vaccination world.

1. There's no such thing as "Herd Immunity".

For a representative sample, consider this exchange between "AnnD" and "breastfeedingmommy" at justmommies.com. First the question:

> "For those of you who have decided not to vaccinate your children, how would you react if every person in your country (or even the world for that matter) just stopped being vaccinated from here on out? Would you be worried about outbreaks of the diseases?"

And the answer:

> "the nonvaxers i know dont believe in herd immunity and many believe it is far less dangerous to get some of the VPDs than it is to get the vaccines for their own personal reasons like family history of neurological problems and things like that. Many dont believe they are very effective anyway. But I dont speak for all just the ones I know that do not vax at all."

2. On his deathbed, Louis Pasteur repudiated the germ theory of disease, saying "the germ is nothing, the Terrain is everything".

Check out this excerpt from the online magazine Organica:

> "With 150 years of hindsight, we are beginning to understand the serious limitations of the germ theory, including the dangers of immunizations, vaccinations and pasteurization."

In other words, with the right combination of clean living and diet rich in macrobiotics, humans can avoid illness from any microbe, come what may.

3. FDR didn't have polio.

Wikipedia has a nice summary of the paper from the Journal of Medical Biography article that got so much press in 2003. Who cares if the diagnosis of polio was wrong? The anti-vaccine crowd, that's who! If our most famous polio victim didn't really have polio at all, it kind of takes the wind out of the sails of some of March of Dimes and Polio Plus, doesn't it?

The authors of the article, it needs to be emphasized, do not know what President Franklin had. They conclude only that the preponderance of evidence favors Gullain-Barre Syndrome.

Hey, what's happenin' in the Clean Worl?

Posted on: Tue, Jan 30 2007 6:48 AM | Updated: Sat, Feb 3 2007 8:27 AM | Email This | Clip/Blog This Keep New:

Because We Care... About Market Share

By Flea

From this month's Pediatric News.

"AAP Takes Stand Against Retail Care

Retail-based clinics are gaining popularity in today's fast-paced world, and pediatricians should take notice.

These commercial enterprises usually are staffed by nurse practitioners, with or without physician oversight, and are located in pharmacies, department stores, and grocery stores. They provide medical care for common illnesses, infectious diseases, and skin conditions and offer diagnostic testing and vaccines.

Although data on their numbers are scarce, a 2006 report by the California HealthCare Foundation estimates that about 150 retail-based clinics are currently in operation in the United States.

The American Academy of Pediatrics (AAP) 'opposes retail-based clinics as an appropriate source of medical care for infants, children, and adolescents and strongly discourages their use,' according to an AAP policy statement published in the December issue of Pediatrics (2006;118:2561–2) The AAP's primary concern is that use of retail-based clinics could compromise the medical home, according to the policy statement.

Dr. James M. Poole, owner of Growing Child Pediatrics in Raleigh, N.C., said that he believes retail clinics, hospital emergency rooms, and urgent care centers already pose a threat to traditional pediatric practice.

'I'm really concerned over the takeover of pediatrics,' Dr. Poole explained in an interview. 'We're *losing major market share*, and it's happening very quickly. … We need to get our patients back.'...

...Dr. [Mark] Reuben suggested that pediatricians develop a clear policy for patients who visit retail-based clinics. *Pediatricians should not answer questions until the patient is seen at the office, and they should not serve as a consultant while their patient is at a retail-based clinic.* (emphasis added)"

Boo friggin' Hoo.

Fleas have no one to blame but themselves for the retail-clinic phenomenon. We triage patients to the ED after hours. We refuse to make ourselves available by phone and email after hours. We educate our patients to the effect that minor illnesses require intervention by a "health care provider".

All these things created an overwhelming demand for medical services that the children of this country **do not**

need. And **now** the AAP has the *chutzpah* to bitch about the advent of retail-based clinics!

Especially pernicious is Dr. Reuben's suggestion that fleas refuse to speak to the nurse-practitioner seeing his patient off-site. That is perfectly rotten idea. Never, *under any circumstances* should a doctor worthy of the name refuse to take a call from a colleague treating his patient.

Is the AAP "Dedicated to the health of all children" as they claim on their logo, or are they dedicated to maintaining our market share?

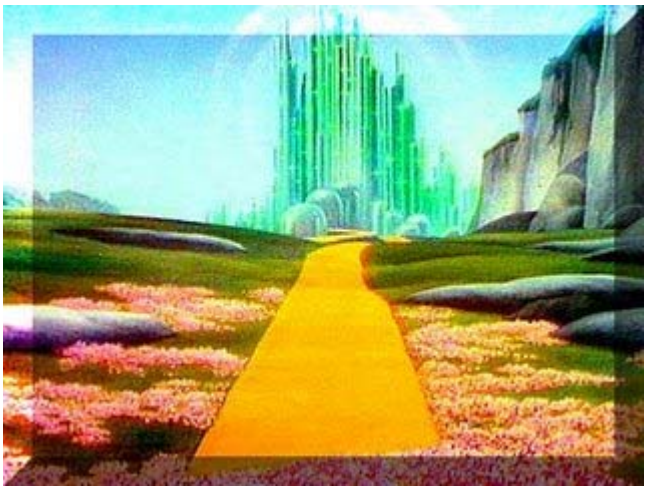
You get one guess.

1 Reference

Posted on: Mon, Jan 29 2007 1:25 AM | Updated: Mon, Jan 29 2007 10:50 AM | Email This | Clip/Blog This Keep New:

Pay No Attention to That Man Behind the Curtain

By Flea



Pediatric Grand Rounds 1:21 is up over at Unintelligent Design.

The pseudonymous Clark Bartram is the founder of Pediatric Grand Rounds. He is a hospitalist in a big friggin' medical center somewhere in the U.S.A. In other words, Clark inhabits the *sick* world. Skepticism is Clark's area of interest and expertise, as evidenced by his extensive side-bar.

Now, you simply have to read Clark's PGR. After you finish it, decide for yourself whether Clark has or has not been hitting the wacky weed.

Flea's pick of the week goes to this post by Dad of Cameron over at Autism Street, on the subject of "Poor Mercury Excretors".

Do'C and others have done yeoman's work exploring and exposing the junk science poop that has been flung about in the autism world of late. Keep up the good work!

The look and feel of Autism Street is awesome. It's a pleasure to read.

Posted on: Sun, Jan 28 2007 11:18 AM | Updated: Sun, Jan 28 2007 11:47 AM | Email This | Clip/Blog This Keep New:

Best, Flea

By Flea

Flea turns one today.

To observe the occasion, we present the posts that best represent the writing that has appeared here since January 27, 2006. They are also listed in the side-bar under the heading "Best Flea".

"Wanna Bet?" deals with the risks a flea absorbs while trying to practice good medicine in the presence of the 800-lb gorilla named "Malpractice".

"When the Kids Leave Home and the Dog Dies" is Flea's first, and so far only post dealing directly with abortion.

"Who's Your Daddy?" deals with what genetic counselors call "misattribution of paternity". The deeper issue explored is a physician's fascination with the soft underbelly of society that is revealed to us daily, whether we like it or not.

"Media Events" describes two public service educational opportunities that will never occur because Flea would get in too much trouble if he even *tried* doing them!

"Three Wishes" represents a theme that consumed this blog for a fair portion of the year: overuse of emergency services by non-emergently-ill patients.

"Dear Prudence" explores EMTALA, the Emergency Treatment and Labor Act of 1985, it's evil spawn, the "prudent layperson standard", and the pernicious effect this pair has had on medicine generally, and pediatrics in particular.

"So You Wanna Be a Doctor?" is an exchange of emails with a reader who is trying to get into Med School.

"Mamash Reggae" is so far our only music review.

In "True Confessions", Flea rages against the saccharine-sweet, milquetoast-y crap that most pediatricians write for the "benefit" of parents.

Among Flea's obsessions, baseball looms large. "Why They Play Baseball" is our favorite baseball column this year.

"*L'affaire Tomate*" consumed way too much of our time this past Summer. "Reality Test" is Flea's post-mortem on the whole mess.

Flea tries not to attack fellow bloggers at this site, but on one occasion, the temptation to jump all over Vince Ianelli at Pediatrics.about.com became too great. "Angry Blues" was the result.

"Beyond the Precautionary Principle" explores some possible explanations for our unfortunate habit of refusing to accept the good news that the world is an increasingly safe and healthy place.

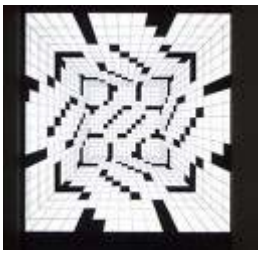
Thanks for visiting. Have (another) safe and healthy year!

Posted on: Sat, Jan 27 2007 4:41 PM | Updated: Sat, Jan 27 2007 7:45 AM | Email This Keep New:

Clip/Blog This

Flea's Addiction

By Flea



Hi. My name is Flea. I'm a crossword puzzle addict.

[*audience responds: "Hi Flea"*]

My grandmother turned me on to crossword puzzles. She was probably an addict too. Only back then they never talked about it that way. It was just "Nana's little problem" and we left it at that. Nana showed me how to do them. I was 8 years old.

By the time I was a Sophomore in High School I solved my first New York Times puzzle. [For those unfamiliar with addict lingo, "solved" means completed, **correctly**]. Instead of listening to my AP Calculus teacher, I was solving. I did lousy on the AP exam. Had to re-take Calculus in college.

As a Freshman in college I completed a "Monday" puzzle in 5 minutes, 10 seconds. ["Monday puzzles" are the easiest of the week, or at least they were back in the 80's]. I was so fast, a roommate of mine used to say I didn't look like I was solving a puzzle, it looked like I was just filling in letters in boxes. To a puzzle addict, hearing something like that is better than sex.

Do I need to mention the "pen vs. pencil" controversy? There is no controversy, in fact. There is only one device suitable for puzzle-solving, and that is the ball-point pen.

I would buy the New York Times just for the puzzle. No headlines, no sports, no Op-Ed. Puzzle. I knew exactly where it would be, inside the last page of section C. Did the puzzle, threw the rest of the paper away.

Later on, my parents gave me a "gift" of a Times subscription. Were they "enabling" me? Who knows? They only wanted me to be happy.

A photographer from the Times came to my med school one day and photographed us in class. I'm pictured in the middle with my forehead in my left palm, right hand out of sight. My family thought I was sleeping. I was doing the puzzle.

Then I hit bottom. The first and only priority of the day was the puzzle. Everything after that was superfluous. One day, I had an epiphany: I had to quit. I *needed* to quit.

Flea hasn't done a 15x15 crossword puzzle in over 10 years. We allow ourselves to look over Ms. Flea's shoulder while she does the puzzle on line (as a purist, Flea would *never* solve a puzzle this way), but so far we've been able to resist the temptation to get back into it. Miss it? Sure. But those days are over. Flea can't go back.

Doctors and crossword puzzles go together like, what? Doctors and golf. It's part of our genetic make-up. But some of us simply can't handle it like others can. For some, it's just an amusement, no big deal. For those of us with addictive personalities, it's just like anything else you get addicted to.

Still, sometimes Flea has a little argument with himself: We can do just one puzzle, can't we? See if we still "have it"? Yeah, right. Can't think that way. Just put the paper down and back slowly away from the breakfast table...

Posted on: Wed, Jan 24 2007 10:44 PM | Updated: Wed, Jan 24 2007 11:11 PM | Email This | Clip/Blog This Keep New:

Signout is Dangerous

By Flea

Grand Rounds 3:18

When Flea was learning to be a flea at TBFCHITW, he learned two lessons regarding the transfer of information and duties between residents, also known as "signout".

Lesson one - Anything can be signed out: Lumbar puncture, discharge summary dictation, telling a parent their child has died. *Anything*. Note that *can* does not equal *should*. Before you leave for the day, it's preferable to do heinous tasks rather than fob them off on your colleagues.

Lesson two - Signout is dangerous. Transfer of information, like translation, is fraught with difficulties. Important, even crucial points of history may be minimized or ignored altogether. Physical exam findings are hard to reproduce in one dimension. Try it some time. There is no substitute for actually *being* with a patient, taking a history yourself and examining the patient yourself. When you leave, you take your history and your physical exam with you. What you leave behind is signout. It's difficult to take good care of patients with signout alone.

Signout strikes Flea as an apt name for a medical blog. At best what you get in the medical blogosphere are word-pictures (and in some cases, real pictures) of this parallel universe we inhabit. You can't really know us until you hang a stethoscope around your neck, don a white coat, knock on a patient's door, and enter. The eponymous Dr. Signout does a terrific job unpacking this world for the general reader. She paints particularly pretty word pictures.

Signout was also brave enough to take on Nick Genes' Grand Rounds assignment. Flea demurred when Nick asked us last year. Grand Rounds has grown too large and unwieldy for Flea to read it through. The idea of banging one out here was more than Flea could handle with a full-time solo practice, two arms, two legs, two Terminators, a long-suffering wife, and 24 hours in the day.

Still, Signout does an admirable job. She has a terrific ear and a facility with writing that will serve her well.

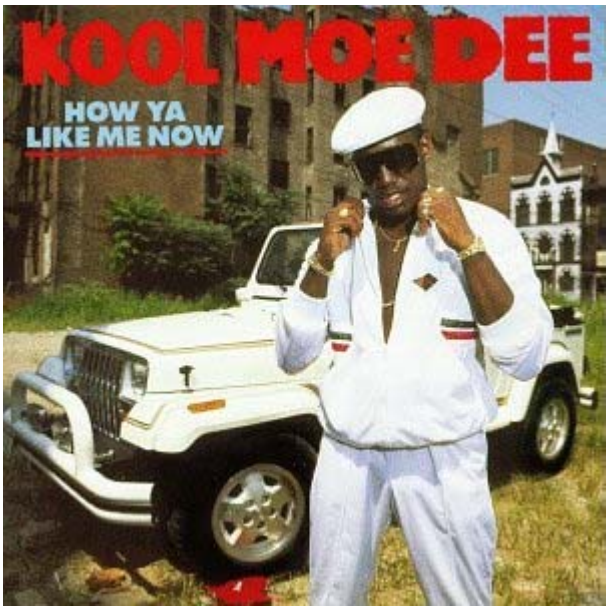
We're telling you all this because Signout asked us over the weekend to make a submission and we gratefully complied.

2 References

Posted on: Tue, Jan 23 2007 6:59 AM | Updated: Wed, Jan 24 2007 1:25 AM | Email This | Clip/Blog This Keep New:

How Ya Like Flea Now?

By Flea



Having switched to New Blogger when they came out of beta, Flea finally changed to the new and improved template. It's the same thing, only different.

In so doing, many of the links had to be moved manually from the old version of Flea. Our apologizes if any link fell off the blogroll during the move. Let us know.

Posted on: Tue, Jan 23 2007 2:19 AM | Updated: Tue, Jan 23 2007 2:53 AM | Email This | Clip/Blog This Keep New:

The Tenpenny Opera

By Flea

Submitted for your approval.

The link brings you to a video by Sherri J. Tenpenny, D.O. entitled "Vaccines...the benefits...the risks...the choices". Dr. Tenpenny describes herself as board-certified in Osteopathy and Emergency Medicine. To listen to her own account of her career, it appears that she has done very little either Osteopathy or ED work for several years. Instead, at the time of the lecture in 2004, Dr. Tenpenny claims to have spent over 6000 hours researching vaccines and vaccine-preventable diseases.

It's a fascinating lecture, though a little long at 2 hours, 52 minutes. Dr. Tenpenny discusses many of the risks, many of the choices, but precious few of the benefits associated with vaccines. In fact, by the 2-hour mark it is fairly clear that Dr. Tenpenny would prefer that Americans not vaccinate their children at all.

Presented here are several classic anti-vaccination arguments: Vaccines are not solely responsible for the elimination of infectious diseases (Dr. Tenpenny argues explicitly that Smallpox would have vanished on its own

without the vaccine); Vaccines are not as safe and effective as conventional doctors are willing to discuss; And the potential for harm from vaccines is in many cases greater than the risk from the relevant diseases.

It is this last point on which Flea wishes to focus, because therein lies the crux of the debate over universal vaccination programs. What one will not hear from Dr. Tenpenny is any discussion of relative risk: What's more likely, morbidity and mortality from a vaccine-preventable disease (VPD), or morbidity and mortality from vaccines?

She is pretty good at rehearsing the low numbers of reported deaths from VPD's, but rather bad at quantifying the numbers of individuals harmed by various vaccines.

For example, regarding the Hepatitis B vaccine (Dr. Tenpenny's avowed nemesis), we are told that basically only drug-abusing prostitutes get the disease, but that the vaccine causes autoimmune diseases.

Dr. Tenpenny's best discussion of VPDs centers on Diptheria, Tetanus, and Pertussis. She gives a terrific overview of all three diseases including their pathophysiology and the mechanism of action of the relevant vaccines. At great length she argues that none of these VPDs are particularly harmful, but that the DPT vaccine caused serious complications. That DPT vaccine is no longer widely administered does not disrupt the thread of Tenpenny's argument.

Perhaps the most remarkable segment of the video comprises the few minutes Dr. Tenpenny spends on Hib. She admits that morbidity and mortality related to the disease has largely disappeared since introduction of the vaccine. "The Bad News" about Hib, however, is one report (Autoimmunity. 2002 Jul;35(4):247-53) showing an increased rate of Type I diabetes in Finland. Furthermore, Tenpenny argues that a decrease in invasive Hib disease has led to an increase in invasive pneumococcal disease, making a pneumococcal vaccine "necessary".

And what *about* the hepta-valent pneumococcal vaccine (PCV-7, or Prevnar)? Dr. Tenpenny tells us only that there's a fair amount of aluminum in each vaccine and that the teratogenic and carcinogenic potential of the vaccine has never been established.

Regarding the chicken pox vaccine, Dr. Tenpenny tells us that disease is mild, everybody gets it, and that the efficacy of the vaccine is fairly lousy.

One recurrent theme in the talk deserves mention. Dr. Tenpenny goes on at length about "molecular mimicry". This is the theory that excess disease-specific antibodies with nothing to do will likely attack our own bodies, resulting in immune diseases. Indeed, we know from the pathophysiology of Rheumatic Fever that antibody cross-reactivity can give rise to disease. Dr. Tenpenny argues that since the phenomenon exists, it must exist in the case of vaccine-induced antibodies.

The doctor presents no such evidence because none exists.

One more annoying feature of the video: Dr. Tenpenny appears to speak before an audience. There is a stage festooned with flower-pots, and there's a screen for slides. But the audience, if there is one, is silent - nary a cough or sneeze in three hours. At several junctures Dr. Tenpenny tells jokes that elicit no laughs. Flea suspects there is, in fact, no audience.

Unfortunately, there is indeed an audience in the community and they are paying rapt attention. We owe this audience a discussion of relative risks. Otherwise we might as well give talks to empty rooms ourselves.

Posted on: Mon, Jan 22 2007 5:22 AM | Updated: Tue, Jan 23 2007 1:04 AM | Email This | Clip/Blog This Keep New:

A Bolt From the Blue

By Flea

Thanks to Bryan Vartabedian for turning Flea onto Healthbolt.

Healthbolt is the brainchild of Wade Meredith, a self-described troupe comedian from the Kansas City suburbs. Naturally, readers of Flea are going to ask: can a professional funny-man do a health blog? Wade answers:

"We're talking about good health, bad health, nutrition, technology, gadgets and gear. We keep a triathlete, a DDS, a PhD, an MD, a fat jogger and a Smart-ass on staff. We want to play longer and harder and have more fun doing it."

Any blog with a smart-ass on staff is worth a look.

Flea suggests these two posts:

First, Wade tries to put a real, manageable perspective on the number of lives saved by the African Measles Initiative. It's an article that the ladies over at Mothering.com really ought to read. Of course, they'd probably argue that hygeine and sanitation, not vaccines, saved the lives of all those African kids.

For example, see this discussion comment from "Angela"

> "I don't see (vaccines) as a luxury. I (sadly) see the sanitation, running water, sewers, and electricity as the luxuries. They are what give us a different profile than other places in the world. Not vaccines.
>
> My children have the luxury of access to healthy food, clean water, and sanitation systems to remove the waste without contaminating the water supply.
>
> I do think that vaccines have some level of effectiveness, BUT I think they come at a price. Look at the rise in chronic disease.
>
> -Angela"

Next, check out this stunner about "generic drugs" at Wal-Mart. Wade suggests that the discount chain is selling patented drugs under "private label" arrangements. In other words, Wade suggests that Wal-Mart sells drugs that are not generic equivalents, but the *exact same products* bearing the Wal-Mart label. It's highly-speculative, completely un-sourced, and exactly the kind of thing that the blogosphere was made for. Now it's up to the rest of us to do some digging and see if it's true. Anybody have a mass-spectrometer Flea can borrow?

Posted on: Sun, Jan 21 2007 12:34 AM | Updated: Sun, Jan 21 2007 1:14 AM | Email This | Clip/Blog This Keep New:

Holy Crap! Flea Won!

By Flea

Due to unforseen circumstances including some heavy drinking and drugging over at Medgadget.com, Flea has been chosen Best New Medical Blog.

The last time Flea looked, we were in the process of having our narrow fanny spanked by a med student in Hungary who started his blog, ScienceRoll, two months ago. turns out that Mr. Meskó garnered the most votes (by more than 300 the last time we checked). Now it seems the judges pulled a electoral college special and gave the nod to Flea.

A thousand thanks to those who voted for Flea, and to my good friend Dr. Dork, who nominated this blog. Special thanks to Ms. Flea for tolerating (mostly) this obsession. (Love You!)

Blessed is the Lord our God, Sovereign of the universe, Who gives us life, Who sustains us, and Who brings us to this day.

2 References

Posted on: Fri, Jan 19 2007 5:51 AM | Updated: Fri, Jan 19 2007 6:09 AM | Email This | Clip/Blog This Keep New:

La Bête Noire of Pediatrics

By Flea

Were it not for ear infections, most of us fleas in primary care would be out of a job. To be more precise, were it not for *fear* of ear infections, most of us fleas in primary care would be out of a job.

Just yesterday Flea paid a house call to an 8-month old who had been pulling at her ears (she was teething). What if instead, the girl had had a non-infected-looking effusion? Some (many?) fleas would have handed the parents a script for Amoxicillin (some fleas would have handed them a script for Azithromycin, but that is a matter for another day!) Why? This is a perfectly happy, peppy kid who pulls at her ears! What would happen, if we left fluid in her middle ear space for while? Would she go deaf? Would she become language delayed? For the last 40 years or so, most of fleadom, in fact most of the world, believed something dire would come to pass if this child were not antibiosed.

And so it was until Jack Paradise and colleagues at Children's Hospital of Pittsburgh began asking if middle ear effusions were really as big a deal as all that. As early as 1981, Paradise began evaluating the literature on middle ear effusions. He found that the data... well... there wasn't much, and the existing data sucked.

Fifteen years ago, Paradise and colleagues began following a group of kids from Pittsburgh from birth to age 12. Many of these kids got ear infections and had fluid behind their ears. Paradise et al. wanted to know if the ear fluid prevented these kids from acquiring speech and learning correctly.

That study is now ended. Here's the verdict: There appears to be no association between early ear infections and later impairments of speech, language, and cognitive development.

So is that it? Do we pack up our otoscopes and go into real estate?

Not so fast. Science and culture tend to run on different schedules. Even in the presence of the definitive study on the subject, Flea figures his colleagues will continue poking holes in tympanic membranes for a long time to come. What's more (and here's where Flea's colleagues threaten to beat him with blunt objects), ear infections pay the bills. Consciously or uncosciously, fleas will continue to take good care of our hot little bête noire. After all, she's been good to us.

1 Reference

Posted on: Fri, Jan 19 2007 1:23 AM | Updated: Fri, Jan 19 2007 5:46 AM | Email This | Clip/Blog This Keep New:

Sandy Follows the Money

By Flea

Flea's daddy taught him a long time ago: if folks are doing stuff that doesn't make sense to you, follow the money and it'll all make sense.

Flea has negotiated managed care contracts with several HMOs that require him to manage obesity as a disease. We are required to track body-mass index (BMI) for every child starting at age 2. For children with BMI's above a certain level, we are required to make some kind of intervention. If we don't, the payors withhold money from us.

The payors themselves take cues from the U.S. Department of Health and Human Services.

The problem with managing obesity as a disease is three-fold. First, we lack reliable methods to screen children for obesity risk-factors later in life. Second, even if we did have reliable screening tools, we lack evidence-based medicine to guide us in managing obesity. Finally, there are significant potential harms that can be done to patients by telling them they're too fat.

So why are the HHS and the HMOs asking us to do something that makes no sense?

Follow the money.

That's what Sandy Szwarc did at Junkfood Science. Sandy asked how come such a great effort is being exerted on behalf of the obesity problem when we have no idea how to proceed? She discovered that the energy driving most obesity initiatives is the same thing that greases the wheels of the capitalist machine.

> [M]ore than $800 million was funding these initiatives, most of which focused on increasing physical activity and improving diets, directed at 4.6 million children each year. Eight out of ten programs specifically targeted kids over 6 years of age and 20% were aimed at infants, toddlers and pre-schoolers. Fat children were targeted in 2/3 of the programs and the largest segment of participants were low-income. *While the programs appear altruistic, two-thirds admitted their programs were created to support their marketing and corporate branding, and 100% were developing products and services using the child obesity issue*. The largest motivating factor (admitted by 20% of the organizations) for initiating their programs was 'increasing public perception of a health care crisis.' (emphasis added)"

Flea will acknowledge that obesity is a (you'll pardon the expression) a big problem. But no problem was ever solved through an initiative that enjoins us to do anything for the sake of doing *something*.

For the record, Flea's got no problem with making money. He'd like to make lots and lots of it. We draw the line at being told how to practice medicine without evidence-basis, for the sole purpose that someone *else* can make a buck.

Posted on: Thu, Jan 18 2007 2:47 AM | Updated: Thu, Jan 18 2007 3:40 AM | Email This | Clip/Blog This Keep New:

Oh Great, Just What Flea Needed to Hear!

By Flea

A doc describes the effect of a malpractice case on the doctor himself. It isn't clear from this piece if the doc himself has ever been sued:

> *A trial may or may not require the presence of the physician in the courtroom, but absence from the trial may lead the jury to feel that the physician is uncaring and aloof, and certainly might give the jury an impression that the physician would not wish to convey.*
>
> *Under such pressures, most physicians choose to attend their trials. Their presence in the courtroom removes the doctor from the office, creates havoc with his practice and can devastate him financially. Staff must still be paid, lest they move on to greener pastures. And the patients still have needs. Who will treat them while the trial continues? And when can the doctor see his or her patients?*
>
> *In this case, this may require the physician, already fatigued by the stress of the trial and time in court, to see patients at night and on the weekends — if his loyal staff and patients are agreeable to such an arrangement.*
>
> *If the physician has a spouse and children, the stress of such a change in his or her life can create terrible difficulties, further magnifying the pressures created by the trial.*

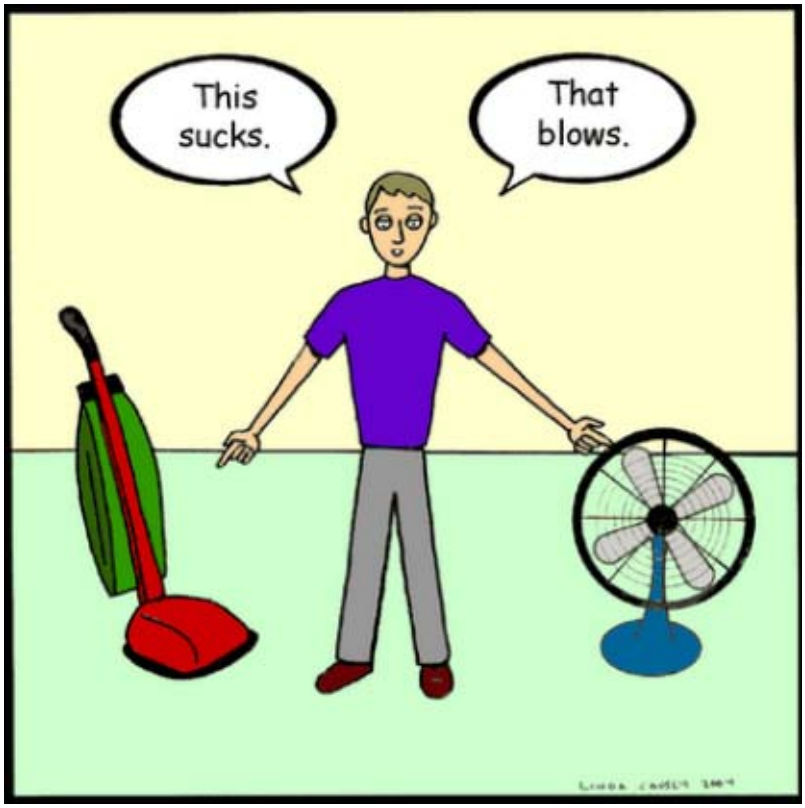
Oh good! Flea was starting to worry! His trial date is coming up.

(via Kevin, MD)

Posted on: Wed, Jan 17 2007 8:03 AM | Updated: Wed, Jan 17 2007 8:12 AM | Email This | Clip/Blog This Keep New:

Do We Just Suck?

By Flea



Flea's final patient of the day was due for her MMR vaccine. At the end of the visit, her mother told me she didn't want to give it until she had "done more research". This has become an increasingly common expression in Flea's office.

What kind of research are the folks doing?

Shinga and others have noted that Google searches of vaccine-related search terms return many anti-vaccination web sites. Most of the *non*-anti-vaccination sites do a pretty poor job of answering the accusations that are often hurled at the vaccine program.

Some parents read books on the subject. Unfortunately, such books tend to scare them off vaccines. A couple recently refused 12-month vaccines for their child after reading "What Your Doctor May Not Tell You About Children's Vaccinations". Flea has ordered this book from Amazon and plans to review it here shortly.

Is it Flea's perfervid imagination, or are the folks in the "anti" camp doing a better job of getting their message out?

Or do we just suck at getting *ours* out?

Posted on: Mon, Jan 15 2007 10:37 AM | Updated: Mon, Jan 15 2007 10:58 AM | Email This | Clip/Blog This Keep New:

The First Casualty

By Flea

Pediatric Grand Rounds 1:20 is hosted this week by relative-newcomer Bryan Vartabedian of Parenting Solved. Bryan is a Pediatric Gastroenterologist at Texas Children's in Houston.

Flea really likes Bryan's stuff. He's helping unpack the madness and idiocy that characterizes so much of the parenting world. And unlike some of our fellow flea-bloggers, Bryan isn't afraid to unburden himself of a professional opinion and call it like he sees it.

Speaking of madness and idiocy, Flea's pick of the week goes to Sandy (Can I buy a vowel?) Szwarc of Junkfood Science. Sandy is Flea's new hero. She does what all responsible med-bloggers *should* do more often (present company included). Sandy looks at media reporting and public advocacy on health issues. She scrutinizes the original papers on which the media reporting and policy decisions are based. Then Sandy asks the crucial question: Does the evidence presented justify the conclusions reached by the media and public policy advocates? More often than not, when it comes to wars against obesity and environmental toxins, truth is the first casualty.

Check out Sandy's post on the lunacy surrounding elemental mercury in thermometers. You go, girl!

Flea's only bone to pick with Ms. Szwarc is her overuse of scare-quotes around the word "obesity". Flea understands that the war on obesity is being waged on the basis of WMD-that-were-never-found, but no one doubts that *there is such a thing as obesity*! Perhaps the stigma associated with the word ought to go away, but first we need to examine critically the "data" that leads public policy advocates to wage the war in the first place. For this, we owe Sandy Szwarc and Junkfood Science our thanks.

1 Reference

Posted on: Sun, Jan 14 2007 1:22 AM | Updated: Sun, Jan 14 2007 2:00 AM | Email This | Clip/Blog This Keep New:

Detail Flea!

By Flea

And you thought Flea had too much time on his hands:

The guys at eDrugSearch.com (and Flea can only assume that they are *guys*) have developed a roster of "The All-Pharma Cheerleading Squad — current pro cheerleaders who double (and undoubtedly receive double takes) as pharma reps."

This "project" was erected from a study reported in the New York Times a while back, showing that pharmaceutical houses often recruit detail women from college cheerleading squads.

> "Cheerleaders -- known for "their athleticism, postage-stamp skirts and persuasive enthusiasm" -- have "many qualities the drug industry looks for in its sales force," the Times reports. T. Lynn Williamson, an advisor for cheerleaders at the University of Kentucky, said pharmaceutical companies looking for recruits "don't ask what the major is. Exaggerated motions, exaggerated smiles, exaggerated enthusiasm - they learn those things, and they can get people to do what they want."

Flea gets detailed very infrequently. This is probably because the history of visits from pharma detail people has not resulted in alterations in his "prescribing behavior". That is to say, he's not persuaded by "the pitch". Pharma sales departments are able to track prescribing behavior, so if a doc isn't seduced, the company directs its efforts elsewhere.

All Flea wants to know is, how come GlaxoSmithKlein never sent Tawny (shown above) to his office?

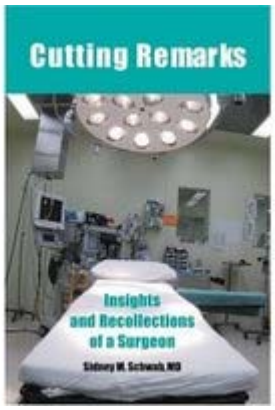
(Thanks to Kevin, MD, for the tip)

3 References

Posted on: Sat, Jan 13 2007 11:42 AM | Updated: Sat, Jan 13 2007 11:57 AM | Email This | Clip/Blog This Keep New:

Sucking (Wounds) in the Seventies

By Flea



Cutting Remarks: Insights and Recollections of a Surgeon, by Sidney M. Schwab, MD, FACS. North Atlantic Books/Frog, Ltd., $15.95, 228 pp. paperback

Passing through residency is like losing your virginity. It may go well or badly, but in either case you're never the same afterwards.

The most dramatic deflowering of a surgical resident I ever witnessed happened to my med-school classmate Brian. I had left school to earn a Ph.D. Brian continued into residency and was serving as a chief resident when I showed up on the wards after a four-year hiatus.

Brian had been a friend. We partied together. We played in a garage cover band. I watched him get married. He fixed me up with a hot photographer friend of his (she would become the love of my life and the mother of my

children).

Now Brian was a surgeon, and I was a flea-in-training. Our relationship reduced to my following Brian around the wards, waiting for my turn to report on a patient I was covering. I was required to spit out a ton of information rapid-fire, preferably in one breath. I wanted to impress my friend so badly my brain seized up and I tripped over my words. Without looking up from his notes, Brian extended two fingers and described a rolling motion in the air, slowly but insistently. The gesture said “C’mon Flea, I haven’t got all day, get on with it, man!” He might as well have put down his clipboard and punched me in the stomach.

Now comes Sidney M. Schwab, a retired surgeon, to give an account of the power of surgical residency to turn an eager fresh-faced med student in to a gaping, flaming jerk. Of course, surgical residency is designed to produce *surgeons*, not jerks, but based on the results, it is often hard to tell whether it is not the other way around. Not that Schwab is a jerk by any means. It’s a miracle that he emerged from residency (plus two years in Vietnam) with an intact sense of humor.

“Cutting Remarks” is a memoir of Schwab’s years at the University of California, San Francisco general surgery program, during the 1970's. That program led Schwab through several Bay Area hospitals, some no longer standing. The book is organized into three sections that roughly mirror the stages of surgical training. Along the way he offers vignettes of colleagues and mentors, some of them very funny, some a touch mean-spirited. One wonders if the author had score-settling in mind when he sat down to write.

Sid Schwab writes like a nice guy, but that’s not to say he writes particularly well. Some of the passages seem to have been dictated into a tape recorder before being transcribed. I tried reading some of them aloud, and discovered they made more sense spoken rather than read. Schwab is not a writer, and he readily admits as much in his forward:

> *Someone said writing is easy: you just sit down at a typewriter and open a vein. As I’ve been in the business of preventing bleeding, this may not work out well. You wouldn’t want John Updike taking out your gall bladder.*

Schwab is at his best describing details of surgical procedures and the intricacies of surgical pathology. I re-learned a ton of anatomy that I had long-since forgotten. Schwab’s vivid stories of operations gone awry are fast-paced and engrossing. Unfortunately, he’s not as deft at describing people. Schwab’s descriptions of friends and colleagues leave the reader wanting to know more about them.

The subtitle of the book promises insights as well as recollections. Unfortunately the latter outweigh the former. There are tidbits of insight here and there, such as when the mature Dr. Schwab admits that surgeons and internists often misunderstand one another, but that’s about as deep as it gets.

I realize “Cutting Remarks” was meant to focus on the UCSF training program, but I wanted to hear more about Schwab’s two years in the service in Vietnam. It’s simply impossible to believe that he could have returned and picked up where he left off without having been changed in some important sense. Two years and a Purple Heart

deserve more than four pages in a book of this length!

Surgeons and surgeons-in-training will love “Cutting Remarks”. Fleas like me will learn a thing or two and will be entertained by some of the stories. But although Dr. Schwab takes pains to define technical terms and explain physiology in a way a lay person could understand, I’m not sure the general public will take to this book.

Give Sid Schwab credit for one thing: he gave this book to a flea to review. That took guts. Hey, he’s a surgeon!

Posted on: Thu, May 25 2006 5:00 AM | Updated: Sun, Apr 15 2007 12:40 PM | Email This | Clip/Blog This Keep New:

Mamash Reggae

By Flea

Youth - Matisyahu, JDub/Or/Epic (March 2006)

In October, 2004, Ms. Flea caught a notice in a Boston paper advertising an act called "Matisyahu, the Chassidic Reggae Superstar". We went to his web site and listened to some sample clips. It sounded like *real* Reggae.

"Okay, *this* I gotta see!", I said. I was more interested in the type of crowd that would show up than I was in the music itself.

Matisyahu was the opening act. His band starts playing a low grumbling Reggae groove. Then he walks out in a black caftan, full beard, kippah, tzitzis, the works. He picks up the mic, sways for a minute, and sings.

"Hashem, sifatai tiftach, oo'fee yagid t'hilatecha" - Lord, open up my lips and my mouth shall declare Your Praise. These are the opening words of the *Shemonah Esrei* the core 18 prayers that Jews are enjoined to say three times every day.

I get it.

Then the band rips into an old Bob Marley tune. It's *really* good. These guys are *real* musicians, playing real *Reggae*. The front man happens to be a Lubavitcher Chasid. And he's *selling* the material. I can't believe what I'm seeing.

Born Matthew Miller, the 26 year-old Matisyahu's work is classic guitar-based "Dub" Reggae, in a *melange* with Rap, and Chassidic *niggun* (tunes without words). To call Matisyahu's music *sui generis* doesn't go far enough. This stuff is *genius*.

Reggae is a natural choice for a musically-talented intensely-religious Jewish kid from New York. For the last 30 years, Reggae has been the most unapologetically religious musical form that simultaneously attracts a non-religious audience. In fact, Matisyahu's music is wildly popular on alternative and college rock and reggae programs.

Sure enough, the crowd that came to see Matisyahu turned out to be a surreal mix of college kids and orthodox young people. The kids loved the show. The *frum* people were more restrained.

Matisyahu's success clearly caught the eye of the major players in the industry. Last year Epic signed him, and

Youth, Matisyahu's third album, is the result.

With a top-shelf label and top-drawer producers, the Matisyahu has produced a polished product that sounds great. You can't help but *shep nachas* for the boy. He's **arrived**.

But *Youth* is disappointing. It is a thoroughly standard, prosaic Reggae record that any Reggae band could have turned out this year. For all the flash and sparkle that good production brings to the product, it lacks the *ruach* (spirit) of the first album *Arise...Shake Off the Dust* (2004), and the energy of Matisyahu's live performances captured well by the second collection *Live at Stubbs* (2005). *Youth* isn't, for want of a better word, *Jewish* enough.

That's not to say there isn't anything worth mention on this album. "Time of Your Song" and "WP" are both autobiographical, the latter being an *homage* to the artist's home town, White Plains, New York. Lyrically and musically these are the strongest tracks. "Unique is My Dove" sounds like a love song, and it is, except the title is drawn from the Bible's Song of Songs, and the imagery, though erotic enough for the contemporary audience, is actually a metaphor for the love affair between God and His people.

The title track (here's where I keep it Pediatric), is a rock anthem, in which the author exhorts his listeners to assert themselves in life: "Pound your fist on the table and make your demand", but adding the warning "You better make the right move". The right move, in this case, would be to choose the path of righteousness.

Matisyahu's strength has always been his ability to tap into his young audience's primal yearning for "higher ground". This generation of kids, up to their eyeballs in portable electronic devices and sexual stimulation around every corner, positively screams for authenticity, for something *mamash* (real). And they find it in Matisyahu.

My hope for him is that, if *Youth* succeeds , that Epic will allow Matisyahu to return the studio and create a collection with the creativity of *Arise* and the power of *Live at Stubbs*, but with the production values of *Youth*.

One Love, y'all.

Posted on: Wed, May 10 2006 1:09 AM | Updated: Sun, Apr 15 2007 12:40 PM | Email This | Clip/Blog This Keep New:

Display items within the last All Items Display

Hotkeys: **j** - next article **k** - previous article **m** - collapse/expand left pane **s** - next sub **f** - next folder **A** - read all **n** - toggle keep new **o** - open article **O** - open article in background **r** - refresh left pane

Home | About | Help | Languages | Services | Privacy Policy | Terms of Service | Contact Us | We're Hiring!
Copyright © 2007 IAC Search & Media. All rights reserved.

Partner Sites: Citysearch | CollegeHumor | Pronto | LiveDaily | Ballard Designs | Alsto's | Sally Foster | Expedia | Hotels | Hotwire

Dear Dr. Flea,

My name is Allison, and I have been reading your blog for a few months now (I found it through Grand Rounds) and I've been impressed with your writing and your intellect.

I know that it's your blog and not mine, but I was wondering if you would ever be willing to write a post about how prospective patients should interview pediatricians to see what's a good fit.

My own experience finding doctors has been hit-and-miss. I believe most doctors, while highly educated, aren't particularly scientific in reasoning, and I am. I want my doctors to be scientific in reasoning (perhaps that's my problem in the first place?) So I've struggled to find docs for myself that answer questions, seem reasonable, etc.

Your comments about autism, about fear in your patients' parents, etc. are so clearly well thought out and well informed. You've taken your role to heart, and I don't know if you started out this wise or experience has taught you much, but I'm glad for your blog.

I was wondering if you would be willing to use your blog as a forum to discuss/think about/explain how to find a pediatrician who, for example:

a) believes there's no scientific evidence connecting vaccines and autism,
b) believes that there's no scientific evidence connecting the rise in ADHD/ADD and some actual neurological/neurophysiological issue, etc.

Bluntly, how do I ask a doc "you don't believe autism is caused by vaccines, do you?" in a way where I can a straight answer? How do I do so without coming across like a lunatic? If I say "there's no autism epidemic" have I just made it impossible to get good care? How do I find out if my pediatrician is going to want to medicate my child when I think some extra structure, discipline, and sleep is best? How do I find a doc who is willing to question how some tests and treatments are performed--instead of doing what seems the simplest for case management?

Again, I know it's impolite to try and push someone else's blog in a given direction--it is your blog, afterall, but perhaps my suggestion will set off an idea that you've already kicked around. In any case, I wanted to thank you for your blog, and I wanted you to know that

you have one more fan, so much so that I would even like your take on how to find a flea like you.

Best of luck to you, and I hope your hate mail does not outweigh your fan mail.

Sincerely,

Allison

--

Dear Allison,

Thank you for your questions and for your kind words.

You wondered whether I started out wise or whether experience taught me. I appreciate that you considered the first option, but I'm afraid any "wisdom" that I share here was acquired the hard way, by experience. Working solo has forced me to examine critically everything I do, from management of strep throat to billing procedures. I would not have had the opportunity to think about what I do if I were still working for somebody else.

Regarding "scientific reasoning": Doctors are taught to think like doctors in medical school, and then we actually practice medicine and forget all about scientific reasoning. Please forgive the cliche, but the practice of medicine is more art than science. A lot of the energy I expend every day is directed not at the bodies of children but at the hearts and minds of their parents. The reasoning is scientific, the delivery is not.

Now to the answers to your specific questions:

Any time you are choosing a pediatrician, it makes sense to talk to

him or her before deciding to switch over the care of your children. For new parents, I recommend having the discussion before the third trimester, babies sometimes arrive before their due dates (the last "pre-natal consult" I did was for a boy who was 4 days old when the parents met with me. He arrived at 34 weeks).

If the pediatrician cannot or will not meet with you, or if he charges you money for the visit, I recommend you look elsewhere. This is a doctor who doesn't want your business.

When you do get to speak to the pediatrician, if you have direct questions, ask them. Don't worry about sounding like a lunatic. I have encountered plenty of real lunatics in practice, and you are certainly not one of them. Ask your questions directly.

You will be reassured to know that most (all?) of us feel as you do about vaccines, so you should feel no reluctance to ask the doctor's opinion about them. We're used to such questions from parents who have doubts about vaccines, or who don't want to vaccinate at all. I answer them the same way I'd answer you, directly and honestly.

Regarding ADHD, it is the case, unfortunately, that many pediatricians have drunk deeply from the vat of Kool-Aid. It doesn't hurt to ask a doctor in an open-ended fashion "what do you think about ADHD?" You may be surprised at the answers you get.

If you want to find a pediatrician "who is willing to question how some tests and treatments are performed--instead of doing what seems the simplest for case management", ask him how he treats reflux in an infant. If he asks a detailed history, performs a thorough physical exam, and suggests "anti-gravity" methods first, he's your man. If you get an immediate referral to a pediatric gastroenterologist, throw your notes over your head and run screaming from the room.

Hope this helps,

best,

Flea

Add starShareEmail (Updated)Add tags

May 9, 2006 9:09 AM

Aexcellent Aexamples of Maedical Blogging

from drfleablog by Flea

Grand Rounds 2:33 is up at Aetiology.

Dr. Tara Smith, a microbiologist at the University of Iowa, plates a tasty colony from the medical culture you can't resist!

Check out Paper Mask and his idea for a pS (probability of survival monitor). Do surgeons Down Under have too much time on their hands or what? Just ask Barbados Butterfly.

As usual, the fleas are rather poorly represented, meaning Dr. Bartram, Neonatal Doc, Graham, Phil Gordon,

yours truly and that's all she wrote!

Doctor Andy is a Pediatric Allergist. Does he count?

Add starShareEmail (Updated)Add tags

May 7, 2006 5:01 PM

Pediatric Grand Rounds 1:2

from drfleablog by Flea

Laaaa-dies and Gentlemen! I direct your attention to Clark Bartram's Unintelligent Design, where pedie and pedie-like bloggers of all shapes and sizes convene for the second-ever Pediatric Grand Rounds!

I particularly liked Selkie's posts on home birthing. See also Tara Smith of Aetiology on a particularly nasty drowning hazard.

Strong work, brother flea!

Add starShareEmail (Updated)Add tags

May 7, 2006 11:01 AM

When Daycare Calls - Part I

from drfleablog by Flea

This mom called me from her office. She had just been called by her daycare provider. It seems her 11 month old boy had some kind of rash on his abdomen. The daycare

provider told the mom to come right away and pick the boy up. He would not be permitted back in the daycare until I saw the boy and determined whether or not the boy represented an infectious risk to his mates.

The mother worked in Boston, some 13 miles from her child's daycare center. She was forced to leave early, pick up her perfectly happy and playful baby, and bring him to my office. Sure enough, he had a pink bumpy rash on his belly, nothing else.

This was not the first time the mother was asked to leave work, remove her child from daycare, and come to my office for basically no reason. Mom was upset and so was I. I called the daycare center and spoke to the director.

"Hello, this is Dr. Flea. Ms. Ticktoff is in my office with her baby. I believe you told her she couldn't bring him back until I saw him. Why did you do that?"

"Well, we're not doctors here. We can't tell what this rash is or if he's infectious."

"Yes, but you have common sense, don't you? You don't need to be a doctor to tell if a child isn't well. You don't need a doctor to tell if a child is scratching an itchy rash, anybody can do that!"

"It's just our policy here. We have to have mom pick up the child and bring him to a doctor."

I didn't pursue the argument further, as I sensed I had already plumbed the furthest depths of this poor woman's intelligence.

Since when did it become the flea's job to determine who was well enough to be in daycare and who needed to stay home? There was a time not so long ago when that job was performed by **parents**, most of whom are *not* doctors. And don't I, the doctor, get to participate in the decision as to whether a child is sick enough to be seen in my office?

I have made a rule that mom should pick up the child if compelled to do so, *then* call me if she sees fit. Based on our subsequent conversation we will decide jointly whether I need to see the child.

I'll be damned if these decisions are going to be made *for me* by feckless daycare providers.

Add starShareEmail (Updated)Add tags

May 4, 2006 5:53 AM

Numbers 11:23-24

from drfleablog by Flea

Hashem said to Moses, "Is the hand of Hashem limited? Now you will see whether My word comes to pass or not!" Moses left and spoke the words of Hashem to the people: and he gathered seventy men from among the elders of the people and had them stand around the Tent."

The people Israel have been wandering in the wilderness for some time, eating nothing but manna, which falls from heaven every morning. Some folks are starting to complain. Moses despairs and essentially offers his resignation before Hashem. Moses' crisis of the moment is a crisis of leadership. He has come to realize that he alone cannot serve as Hashem's conduit on earth.

Hashem, realizing this, says to Moses "Is My hand limited (heb. *tiktzar* = shortened, abridged)?" In other words, "Moses, do you think My reach is so short that I am unable to touch anybody else in the community?" Moses then gathers seventy elders around the tabernacle, and Hashem rests his spirit on them as well (v 11:25).

These verses of Torah come to teach that the Torah of Moses is not the Torah of Moses *alone*. It is *our* Torah, the community's Torah, to learn and study.

--

Last night I received two pages at 11:23 and 11:24. It's unusual for me to awakened from sleep by a page, and even more unusual to be awakened by two simultaneous pages. It's even yet *more* unusual that the reason for both pages should be identical (crying baby).

Why the timing of the pages drove me to the Torah, I don't really know. In any case it shouldn't matter. The tradition teaches that it is meritorious to study Torah *li'shma*, for it's own sake. In other words, you don't need a reason. Words of Torah are their own reward.

Me, I seem to need more of a push to open the Book. Two Numbers, 11:23 and 11:24,

did the trick this morning.
Add starShareEmail (Updated)Add tags

May 3, 2006 7:53 AM

My Windex

from drfleablog by Flea

Yesterday I saw a 9 month-old for a well-child check. On exam she had vaginal labial adhesions. Essentially the labia minora (small lips) are fused together. This is common in girls under 6 years of age, and most often gives no symptoms whatsoever. However, a significant percentage of these kids get urinary tract infections, so adhesions should probably be treated.

I was taught that the way to treat labial adhesions was to apply an estrogen cream once per day until the fusion opens. This can take several weeks. I wondered if there were alternative therapies to topical estrogen, or if I could even watch and wait.

I went back to my other bible, Nelson's Textbook of Pediatrics. To my surprise and delight, Nelson's says you can use polysporin or bacitracin ointment nightly for one week!

This is too good to be true: Yet *another* application for my favorite first-aid ointment? Neosporin really is my Windex (please follow the link if you don't get the reference). How many other applications for this stuff exist out there in the world? I know, but I'm not telling.

My lips, as it were, are sealed!
Add starShareEmail (Updated)Add tags

May 2, 2006 2:53 PM

Unprofessional

from drfleablog by Flea

An Item From Flea's "Thin Skin File".

This comment appeared in my post on communication breakdown among physicians:

Anonymous said...
Could you please state where in Massachusetts you practice? As a parent advocate for children with autism I want to make sure not to refer any child to a physician who is so unprofessional to have a blog such as this.
2:35 PM, April 30, 2006

It's not the first nasty comment I've gotten, but it's the one that has bothered me the most.

Thanks to the magic of Tracksy, I can determine that "anon 2:35" visited me from Manchester, NH for the first time on April 24, and for the last time (thankfully) 10 minutes after leaving her *billet-doux*.

What is it, exactly, that agitates my anonymous interlocutor? The only clue, if there is one, comes from the self-designation as "a parent advocate for children with autism".

Does anon object to my autism posts? Does she object to my linking to my favorite contrarian autism blogs (in the side bar)? Or is it simply that I use this God-send of a medium to speak my mind clearly and forthrightly about things I believe to be true? Clearly, anon is angry. I infer this from the promise not to make referrals to me.

What about anon's use of the word "unprofessional"? I've noticed that folks with limited vocabularies often use the term "unprofessional" when they wish to insult a doctor with whom they have a beef. True, it's a bad word in my community, one that is roughly equivalent to the word "unethical" when used in the correct context.

What types of behavior would appear *professional* to a parent advocate for children

with autism?

I suppose I could behave more like a flea?

Not gonna happen.
Add starShareEmail (Updated)Add tags

May 2, 2006 11:53 AM

See You in the Funny Papers!

from drfleablog by Flea

After a misadventure with his hosting company, Scott, over at Polite Dissent has finally got up Grand Rounds 2:32.

Scott is the the pseudonym of a family physician in the Midwestern United States. He started collecting comics at an early age and kept it up through college and medical school. During a long stint with the Air Force in the Middle East, his girlfriend (now wife) kept picking up his favorite titles. When he returned in 2002, he had a big pile of comics waiting for him.

Nick's full bio for Scott can be found at MedScape, here.
Add starShareEmail (Updated)Add tags

Apr 29, 2006 6:47 PM

What We Have Here is a Failure to Communicate

from drfleablog by Flea

I almost drove off the road today.

My car radio played an ad for a nearby medical center. The ad featured a bunch of (ostensibly) physician voices finishing each other's sentences.

Then a serene male voice interrupts, asking us to "imagine a hospital where *doctors actually talk to one another*!"

Uh-oh... If advertising copy-writers have figured out that docs don't communicate any more, that can only mean that the marketing consultants have figured it out. And if the marketing consultants have figured it out, that can only mean that the *patients* have figured it out too!

The other day, I called a gastroenterologist regarding a letter he had sent me about a boy in whom I had suspected Crohn's Disease. I drew blood work in my office and then I had a local radiologist perform an upper GI series with small bowel follow-through. The study was highly suspicious for Crohn's. My GI colleague confirmed the diagnosis on biopsy.

In his letter, however, the gastroenterologist failed to mention any of the work-up that I had performed, and stated matter-of-factly that **he** had made the diagnosis.

In a collegial manner, I offered that at best the diagnosis was a joint effort.

My colleague's reply was "My goodness, I didn't think you guys (i.e., you fleas) actually *read* these letters!"

To which I wanted to reply (but didn't) "Then why the f*** do you write them?"

I know that somewhere in the world there is a community of physicians that actually call one another on the phone and chat about patients. I suspect there are even emergency department physicians who call fleas when their patients show up unexpectedly!

Sadly, I don't live in that world.

I'm stranded on a cartoon cliche island.
Add starShareEmail (Updated)Add tags

Apr 26, 2006 11:38 AM

Oh, Cruel Fate, Why Dost Thou Mock Me?!

from drfleablog by Flea

Received in the mail this morning:

Dear Dr. Flea,

Good news. We were able to suceessfully move to dismiss this case due to the fact that the plaintiff failed to timely disclose an expert to support her case. If there is no appeal filed within the next 30 days, the case will be officially over.

Actually, **not** good news. This letter is not from *my* lawyer, it's from a lawyer representing a doc in New Hampshire. I had agreed to act as an expert witness in defense of a fellow flea. This guy is off the hook. I am not.

I have fantasized so many times about receiving a "good news" letter or phone call from my *own* lawyer. In fact, I have received many phone calls that began "I have good news for you, Flea", to which I would respond "The case has been dismissed, right?", only to be told that we succeeded in obtaining an expert witness or some such piece of less-than-truly-good news. I have politely requested that he refrain from beginning such phone calls in this manner, unless the news is that the cases against me actually *have* been dismissed!

It appears that the good news I fantasize about will not be forthcoming. I will have to slog through these things to their conclusions.

I'm confident that I will afford myself of the opportunity to blog about my malpractice suits in the future. For now, I will observe to the Flea-faithful that the basis of both

suits is that I am a **blithering idiot**. My defense is that I am *not* a blithering idiot. Sounds like a stroll in the park, huh?

We'll see.

Add starShareEmail (Updated)Add tags

Apr 25, 2006 7:37 AM

So, You Wanna be a Doctor?

from drfleablog by Flea

The following is the text of an e-mail I received from a reader. With his permission, I have agreed to reproduce it with my reply, making appropriate changes to protect his anonymity.

"Flea",

I wanted to take a moment to encourage you to continue posting on your blog. I appreciate your take on the field of medicine, and the number of entries that you post.

I have been doing everything in my power to make it into the medical field. However, I have a few issues with my record from years and years ago that make it hard for me to enter medical school. For this reason, I've enlisted in the U.S. Navy as a corpsman and hope to build upon the skills I already have to eventually earn my M.D.

I can imagine you receive a multitude of emails, but if I do get a response, I was curious as to any advice you could offer a person in my situation as to the feelings you experience about your job several years into it. What advice do you have for a person

trying to make it to where you are? What are the issues you face from day to day? Would you ever do anything different if you had to do it all over?

Thanks in advance,

A Sailor

Dear Sailor,

Thank you for your service to our country. The least I can do for you is to answer your questions thoroughly and honestly.

First, if you are psyched enough, you *will* be a doctor. It may take many years of hard work and sacrifice. You may need to attend an "off-shore" medical school, but if you want it badly enough, you can be a doctor in this country.

Once you have all your credentials in order, apply to medical school *every year*. Apply to as many of them as you have a reasonable opportunity to attend. Interview at as many schools as will permit you. If you are ever 'wait-listed', ask for a second interview. If admissions officers at schools give you specific advice as to what you need to do to make yourself a more viable candidate, take that advice seriously.

What issues do I face day to day? Well, have you been reading your Flea lately?

I don't write much about the joys of practice (bitching is more fun, if not positively therapeutic), but I assure you that there *are* joys. Every morning I welcome new life into the world, and I don't have to get all that blood and gore on my hands in the process! In the office I get to clown around and generally act like an idiot, and get *paid* for it!

I also don't write much about "the costs of doing business", but I assure you that there are costs as well. Nothing good comes without sacrifice, financial and otherwise.

You didn't ask me specifically about practice setting, but this deserves some comment. I've worked for someone else and I've been a solo practitioner/sole proprietor and solo is better. I have had to examine critically everything I do, from billing procedures to the managment of Group A beta-hemolytic streptococcal pharyngitis (strep throat). I believe doing so has made me a better doctor.

Finally, as much as I bitch and moan about it, **there is no other job I would rather do than be a pediatrician**. Every morning when I wake up, after expressing gratitude for having opened my eyes and for the gift of my family, I thank the Almighty for the privilege of serving my community as a pediatrician.

That's a partial answer to your third question. Would I do anything differently? Certainly. I spent four years in graduate school earning a Ph.D. and three years in a sub-specialty fellowship in addition to four years of medical school and three years of pediatrics residency. I did not become gainfully employed until I was 36 years old. My advice to you, especially as you will be coming late to the table as I did, is to get to the business of doctoring as soon as you finish residency.

And try blogging. It's cool!

best,

Flea
Add starShareEmail (Updated)Add tags

Apr 25, 2006 6:36 AM

Grand Rounds at Health Business Blog

from drfleablog by Flea

This week's edition of Grand Rounds, volume 2:31, is hosted by David E. Williams over at Health Business Blog.

David is co-founder of MedPharma Partners LLC, strategy consultant to pharma, biotech, device, and technology enabled healthcare services industries. He used to work for the consulting firms BCG and LEK. David earned an MBA from Harvard Business School after his BA at Wesleyan (the one in Connecticut, I assume).

One of my favorite posts is also one of Dave's faves, from the cleverly-titled "ChronicBabe". This chick is crazy! Flea don't even go to bed with a band-aid on!

Also be sure to check out Tara Smith's post on the genetics of obesity over at Aetiology.

Finally, Deborah Serani tells it to us straight about stress.
Add starShareEmail (Updated)Add tags

Apr 24, 2006 10:30 AM

Up, You Mighty Fleas!

from drfleablog by Flea

I'm pleased to provide a link to the first-ever pediatric grand rounds, up over at Clark Bartram's excellent blog, Unintelligent Design.

Clark is a pediatric hospitalist in Nashville, Tennessee, and a skeptic
"who tends to avoid acceptance of anything without cold hard facts to back it up. I attempt to approach all aspects of life with as a scientist, not making up my mind until I've examined the evidence. I would love to share this world with ghosts, aliens, subluxations, and other supernatural phenomena but I'm still waiting for the proof. SUM ERGO COGITO"

Clark is a polymath, whose interests range from debunking junk science to deconstructing infomercials. And he manages to "keep it pediatric".

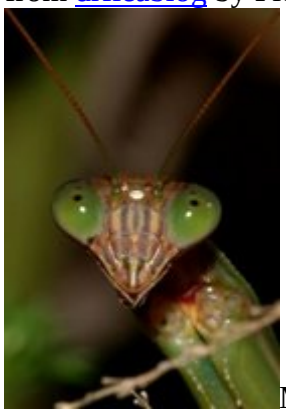
I am, therefore I think indeed!

Up, you mighty Fleas!
Add starShareEmail (Updated)Add tags

Apr 23, 2006 7:31 AM

Bugs in the System

from drfleablog by Flea

 My beeper woke me up at 1:05 AM today. I was grateful to hear the voice of a young mom in my practice.

"Great," I thought, "This mom *gets it*. She's going to call me with a concern rather than freak out and race to the Emergency Department!"

My joy was short lived. Our conversation went something like this:

"Hi, this is Dr. Flea."

"Dr. Flea, (baby, 15 months old) is, like, having a lot of trouble breathing. She got what looked like a mosquito bite on her face. Now she's, like, bright red... Hold on a minute, the ambulance is here. Can you call me back in, like, five minutes?"

"You called 911 and *then* called me? (Mom), I'm not going to call you back. I can't help you if you've already called 911 and the ambulance is already there!"

Allow me to clarify: My patients know *not* to call me first in a "911 situation" (child not breathing, turning blue, seizure that doesn't stop in one minute, multiple traumatic injuries, etc.) This mother, however, has a history of mis-using the emergency department, although I'm not aware of her ever having called 911.

I've tried very hard to educate these very young (and very "limited") parents as to how to access medical care in an urgent situation. Last Christmas eve I paid a house call hoping to forestall an E.D. visit over the holiday (the child was fine). About two weeks ago, mom brought baby back to the E.D. for another non-emergency. In a follow-up phone call with her, I reminded her to call me if she was contemplating going to the E.D. I suppose that's what was going through her mind when she paged me after calling 911.

This morning I spoke to the E.D. doc who saw her last night. I called him, he did not call me. He told me baby looked like a rose. When she was getting ready to leave the E.D. at 3 AM he asked the family if he should call me.

"It's not the family's decision!" I burst out, "I want you to call me *whenever my patients*

show up in your E.D.!

"It's just that a lot of docs don't want to be bothered at night..."

"I don't *care* what other docs want! I want to be called whenever one of my patients shows up there!!! Not so long ago it would have been *unthinkable* not to speak to the patient's doctor!"

Clearly, there are still a few bugs in the system. I need to work on educating my patients as to proper use of the emergency services, and E.D's need to improve physician-physician communication.

Or am **I** the bug?

Add starShareEmail (Updated)Add tags

Apr 22, 2006 4:31 PM

Docked in Brockton

from drfleablog by Flea

BOSTON (April 20)-- The state Board of Medicine yesterday suspended the license of a Brockton doctor accused of giving his two children unneeded medical treatments and providing hundreds of painkiller prescriptions to his addicted wife. The board suspended Dr. Joseph Dullea, 42, a pediatrician who worked at Caritas Good Samaritan Medical Center in Brockton and had visiting privileges at Brockton Hospital. After the board's action, Dullea was fired by Caritas Good Samaritan Practice Corp., and suspended from the medical staff at Caritas Good Samaritan Medical Center, the hospital said in a statement...

...The board alleged that Dullea gave, or allowed his wife to give, medically unneeded treatments to his children, including intravenous treatment and administering the drug Ipecac, a first aid drug that induces vomiting. No more specifics were given in the allegations."

This story is particularly painful for me. I know Joe Dullea. I know him to be a perfectly sane and decent man who is married to a woman who suffers from mental illness. Joe loves his wife, and he loves his children. And Dr. Dullea loves his patients. But Joe has made some perfectly terrible choices. I get no joy from saying so, but I believe Joe deserves to lose his licence for what he did.

And yet, what is that I read in the paper? In addition to writing fraudulent prescriptions for his wife, it is alleged that Joe gave "unneeded treatments to his children", including syrup of Ipecac and IV fluid treatments.

I will stipulate that these allegations are true. Dr. Dullea did *indeed* give his children emetics and IV fluids that they did not need.

I have worked in the same space where Dr. Dullea worked. I know where we kept the sample bottles of Ipecac that we distributed to new parents. At one end of our office was a treatment room where we administered IV fluid to vomiting children. I confess to leading more than one child to the treatment room and starting intravenous lines.

The overwhelming majority of them did not require IV fluids. Most were mildly or moderately dehydrated. We rationalized starting the IV's by telling ourselves we were preventing unneccessary E.D. visits and unneccessary hospital admissions. Today I realize that the treatments I administered in Dr. Dullea's office were quite unneccessary as well. We administered IV's in the office because we were *extremely* well reimbursed for doing so.

Today I feel that not very much distance separates me from Joe Dullea. Only because I administered unneeded treatments to children who weren't mine, I get to keep my licence.

Add starShareEmail (Updated)Add tags

Apr 20, 2006 10:32 AM

Zofran the Magnificent

from drfleablog by Flea

Flea is mad.

First of all, I can't figure out how to activate my on-line access to the New England Journal of Medicine.

Second, I'm jazzed by this article, looking at use of Ondansetron (Zofran) in children presenting to emergency departments with acute gastroenteritis.

The background of this study is one that is familiar to readers of Flea: too many non-emergently ill children are being brought to emergency departments. Too many parents present to E.D.s expecting intravenous hydration for their children, and too many E.D. docs are obliging them. The purpose of the study, with the best of intentions, was to see if there were some safe, effective medicinal means of avoiding having to place an IV.

There is not one thing about this study that I like. In no particular order, my beefs are:

Support: GlaxoSmithKline, the maker of Zofran, co-sponsored the study along with NIH.

Study population: Patients included in the study were children with vomiting and diarrhea and mild-to-moderate dehydration. According to Cincinnati gastroenteritis guidelines, IV hydration is indicated for severely dehydrated children only, or for children with long-term on-going fluid losses. Severely dehydrated children were excluded from this study. In short, the study population should not have been considered for IV rehydration at all!

Study Intervention: When I was a resident, we needed to page the anesthesiologist covering the "pain service" if we wanted to order Zofran for our inpatients, *including* oncology patients! Now we're studying the use of this (still) very expensive drug to outpatients who don't really need it. In the study, after the drug or placebo was administered, the treating physician could decide whether to administer IV fluids, to patients in whom IV rehydration was not indicated!

Outcome Measure: The outcome measure was the number of times a child vomited during oral rehydration. Children are supposed to vomit during the course of acute gastroenteritis! The point is to continue taking fluids in, not to count puking episodes.

I will assume for the sake of argument that the statistics and the "number to treat"

analyses are fine. The point is that this study should never have been done in the first place. The premise on which it is based is false.

A study I'd like to see would aim to evaluate the effectiveness of an intervention designed to keep mild-to-moderately dehydrated children away from from the emergency department.

I won't hold my breath. Now that the NEJM has decided that these kids belong in the E.D., it's gospel.

Add starShareEmail (Updated)Add tags

Apr 18, 2006 2:30 AM

It's Over...

from drfleablog by Flea

Grand Rounds 2:30 is up over at Fat Doctor. This one is singing!

BigMamaDoc is a
"famine-resistant doctor, wife, mom, cynic and active daydreamer. Blogging for 15 minutes each morning to better avoid starting my day."

She's got wonderful stuff - Check it out!

BMD introduces us to a new blogger, Ged, at Cricoid Pressure. Ged promises to write fictionalized accounts of experiences in a (pediatric? we can hope!) intensive care unit.

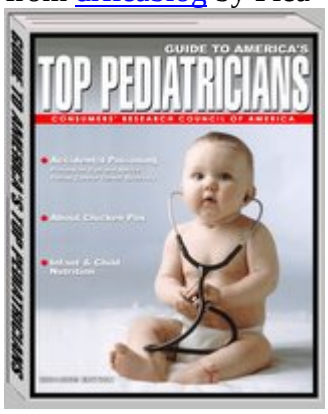
And we meet Megan, a pediatrician, at her family's blog Johnsonville (I get it, like the 'Brats) Megan raised her hand yesterday and volunteered that she is *indeed* a flea-blogger. Congratulations and welcome!

Add starShareEmail (Updated)Add tags

Apr 17, 2006 1:32 PM

Where are the Fleas?

from drfleablog by Flea



Clark Bartram, over at Unintelligent Design, suggested that we fleas try to start our own pediatric blog carnival.

It sounds like a great idea, except... where the heck are all the flea-bloggers?

I have combed Blogspot Search and Google Blog Search in a nearly vain attempt to find pediatricians in the blogosphere **who actually write about what they do for a living**. I found a 20-something who shares a blog with his roommates, one of whom happens to be a pediatrician. I've found a dude who lightly dusts his blog with stuff about his job in between posts about the Cincinnati Reds and his (other) religious faith. I found a couple more *truly* bizarre blogs written by pediatricians that have absolutely *nothing* to do with pediatrics *whatsoever*.

Then I found Jackie Anderson over at Point and Shoot. Jackie is a pediatrics resident but that means she'll be a flea real soon! Jackie writes about her kittens a little too much, but she shows promise. Check out this post on our favorite fleshy lobe, the uvula.

Finally, a truly rare phenomenon: a single-issue pediatrics blog! Michael Scaccia, MD, FAAP, blogs at The Healthy Child, a site devoted to childhood nutrition and excercise. I hope Dr. Scaccia spreads his tiny flea wings at least a little.

So if there are other flea-bloggers out there, or if you know of any, please let me know. It's lonely out here!

Add starShareEmail (Updated)Add tags

Apr 15, 2006 7:31 PM

Ear Infections Get Better

from drfleablog by Flea

The other day I saw a 9 month-old girl for a sick visit. She had fever for three days, runny nose, poor sleep and poor feeding.

Her mother told me "You know, I wonder what took her so long: her sister had her first ear infection at 6 months of age!"

I examined the baby. She didn't appear ill. I even got her to smile briefly at me. But she did *indeed* have a middle ear infection, *two* in fact.

[A brief digression - I do not refer to acute bilateral otitis media as a "double ear infection". I object to the term because it seems to suggest that two infected ears is twice as bad as one. I'm not so sure. And I've never encountered a child with "double ears".]

Now a confession.

I didn't tell the mother what I saw. Here's why: I knew that if I told her both ears were infected, I would not be able to convince mom to watch and wait to see if it got better without antibiotics. This mom had "grown up" in a practice that routinely treats ear infections upon diagnosis. I know this because her former pediatrician is a friend of mine. I also knew I would see the baby the next day, as mom was bringing in her 7 year-old for a well-child check up. If the baby was still sick I would offer to take a look and write a prescription. For the time being I recommended "comfort medicines" (Motrin and Tylenol) and plenty of fluids.

The next day, mom showed up as expected with the baby. And these are the words she said to me: "She (the baby) is 100 times better". In fact, she looked pretty good to me as well.

Now, how'd the baby get better without antibiotics?

It's a rhetorical question. *Most* children with ear infections heal spontaneously without antibiotics. That is not to say that I do not treat children with ear infections. I recommend pain medications, and sometimes write prescriptions for analgesic ear drops, or, in appropriate contexts, even codeine. Sometimes I recommend decongestants, although I'm wary of the agitation and sleeplessness they can cause.

If the child does not get better in 24-48 hours, or gets worse, I prescribe an antibiotic.

I almost never look in the ears of well children. I refrain for three reasons. First, it's painful. Second, the ear drums are likely to appear normal. Third and final, if they are not normal I am not likely to write a prescription for an asymptomatic child.

I know of colleagues who *do* diagnose ear infections in asymptomatic children. Every time I hear the phrase "we didn't even know she had an ear infection", I lose a little more of my remaining hair. Symptoms are necessary for a diagnosis of acute otitis media. No symptoms, no bug killer.

Here's the bottom line folks: Most ear complaints do not require the attention of a physician. They certainly do not merit visits to the emergency room! An "ear" is not an emergency.

And two ears do not constitute a "double emergency".

Add starShareEmail (Updated)Add tags

Apr 14, 2006 3:30 PM

Roomful of Fleas

from drfleablog by Flea

Yesterday I wasted an entire morning meeting with a bunch of my fellow fleas to discuss "quality improvement initiatives".

The group I belong to is a consortium of doctors that negotiates contracts with third-party payors. In exchange for better reimbursements we promise to do "disease management" for a number of conditions including asthma, obesity, and ADHD. We were meeting to congratulate ourselves on how well we were keeping the youth of Massachusetts thin, well-behaved, and breathing freely.

The highlight of the morning was the presentation on ADHD. According to the flea who gave the presentation, approximately 10% of the children in our practices suffer

from it, so we best get them on central nervous system stimulants.

I raised my hand. I wanted to know if the speaker could help me explain the neurobiological basis of ADHD to my patients. I mean, is there such a thing as a deficiency of central nervous system stimulation?

Fortunately, one of my favorite fleas, Dr. Fonzie, got called on first. Dr. Fonzie is a developmental pediatrician. He's been seeing kids with ADHD for 20 years. The Fonz pointed out that "co-morbidities" such as depression, learning-disabilities, and conduct disorders are common and that "pure ADHD" is the exception. He worried that we fleas in the community might not have the time and energy to sort out these things. He suggested that children we are tempted to put on Ritalin should see a developmental pediatrician first.

The Fonz is cool. He's right.

During the coffee break I sat down with Dr. Fonzie and thanked him for sparing me the embarrassment of asking a bitchy question in front of my peers and for raising such an important point about co-morbidities. Then the Fonz gave me a brief history of the management of ADHD.

It seems that there was a turf battle over ADHD between neurologists and psychiatrists about 20 years ago. The neurologists lost. This is a shame, according to Dr. Fonzie, since neurologists draw a distinction between "primary" and "secondary" ADHD. Primary ADHD is what might be called "pure" ADHD, without co-morbidities. Secondary ADHD refers to signs and symptoms of the disorder that are caused by other things. Psychiatrists, according to the Fonz, tend to view ADHD as Ritalin-deficiency, period.

Dr. Fonzie is also a fan of early intervention. He believes the data from the autism literature suggest that intervention in the third or fourth year of life can have a huge impact on the lives of children with autism. The Fonz suspects that the same may be true for ADHD.

"Hang on a second", I interrupted. "Do you mean you'd treat a three year-old with central nervous system stimulants?"

"I would and I have", he replied, "I can identify a three year-old with primary ADHD when he walks into my office".

All of a sudden Dr. Fonzie seemed a whole lot less cool. Three year-olds on Ritalin?

I've blogged on ADHD before here and here. After reading Sami Timimi's book, I'm increasingly convinced that our descendants in this field will consider us to be knuckle-dragging cave-dwellers on account of our handling of childhood inattention and hyperactivity.

While I'm still alive, I've resolved to work hard to try and figure out why "problem kids" are the way they are, before slapping them on stimulants. I'll keep on referring them to developmental pediatricians. I'm just glad Dr. Fonzie works very far away from me.

Add starShareEmail (Updated)Add tags

Apr 11, 2006 5:57 PM

Aetiology

from drfleablog by Flea

Here's a shout out to Dr. Tara C. Smith and her blog, Aetiology. I rediscovered her over at this week's Grand Rounds.

Dr. Smith is an assistant professor of Epidemiology at the University of Iowa in Iowa City. She writes for The Panda's Thumb and is the founder of Iowa Citizens for Science. She lives in rural Iowa with her husband and 2 young children.

There are lots of reasons to like her, not least her writing, which is excellent. She's a Yalie (class of 1998), and well, she's kinda... ya know... smart!

Add starShareEmail (Updated)Add tags

Apr 11, 2006 8:57 AM

Don't Worry, Be Happy

from drfleablog by Flea

Grand Rounds 2:29 is up at Anxiety, Addiction, and Depression Treatments. Flea was working too hard yesterday and forgot to mail in his submission until 10 minutes after the deadline!

I wish I could tell you more about the author of this blog, but I couldn't find any at the site.

Maybe it's the guy with the scary-looking crab tattoo.

Add starShareEmail (Updated)Add tags

Apr 10, 2006 6:57 PM

Riding the Short Bus

from drfleablog by Flea

I was awakened last night by the beeper on my bedstand.

It was a mom in my practice calling. I recognized her name, but I didn't recognize the name of the child she mentioned in her message. It turns out she had given birth to her second baby six days prior, at a hospital far away from where I practice.

She was calling from her cell phone while on the way to the emergency department at a local hospital. She had been told to do this by a doctor from the practice that saw the baby in the hospital. It seems that mom was worried about the yellow color of the baby's skin. Instead of calling me, she called the other doctor instead.

It seems that the new baby had a bilirubin level of 9 mg/dL at two days of life. This is not a very high level. It is not enough to require "the blue lights" (phototherapy), and it certainly isn't enough to keep a newborn in the hospital. Indeed the baby was discharged from the hospital shortly thereafter.

Four days later the mom was still worried about the yellow color, so she called back the doctor she saw in the hospital (I'm not sure why she hadn't been calling me this whole time, and in retrospect, I wish she had). This doctor instructed the mom to bring the baby to the outpatient lab to have a blood test for bilirubin drawn again. This time, the test came back at 12 mg/dL. For six days of age in an exclusively breast-fed baby, this is not cause for concern either. The baby had been nursing very well and was making wet diapers. And mom was an experienced nurser, having nursed her first daughter for a year.

Mom called the office of the doctor on call and asked her what she should do. This doctor, not one she had ever met, told her to take the baby to an emergency room. "It's a liability issue", he told her.

"It's a liability issue"

Translation: "I don't know you lady, and I'm afraid you might sue me some day, so I better cover my ass and tell you to go to an emergency room."

That's when mom called me. I told her not to worry and suggested she turn the car around and head home. She thanked me profusely.

I called her back this morning. The baby was still nursing well and didn't look so yellow any more. We set up an appointment for later this week.

I could not be more disappointed in the behavior of the flea this mom spoke to last night. He was in possession of all the relevant facts and *still* he referred this nervous young mother to an emergency department in the middle of the night so as remove any smidgeon of a doubt that he could possibly get sued some day.

In my guest blogger post at This Makes Me Sick, called "Driving the Yellow Bus", I characterized universal bilirubin screening protocols as nothing but CYA maneuvers on an institutional scale. But I've got an even *tastier* characterization for *this* flea. He's riding the short bus.

Add starShareEmail (Updated)Add tags

Apr 7, 2006 3:35 PM

New! Green Poop Dispenser!

from drfleablog by Flea

Recently I blogged on my families' obsession with green poop.

More recently, I was turned on to an evil little web site called Tracksy. This site allows you to find out who's been visiting your site and how they got there. I like it a lot.

In four short days of tracking Flea on Tracksy, I have noticed no fewer than 20 visits to my St. Paddy's Day post by way of Google searches. It is by far the most commonly visited page as a result of such a search. I wonder, how many more folks are searching for green poop insights every day but *not* visiting me? That's a scary thought.

One more disturbing thing I found: Someone went to google searching "women having sex with dogs", and came up with this post of mine (which, as you may recall, has to do with sex, and mentions dogs, but has nothing to do with women and the latter *ensemble*, as it were).

To tell the truth, I'm less disturbed by the fact that someone performed such a search than I am by the fact that he went to the second page of results and followed the link to the Flea!

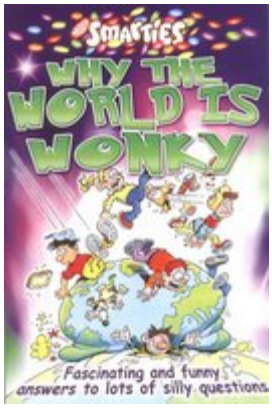
By the way, I simply adore Google Images. Where else can you find a photo of a green poop dispenser (see above) in a fraction of a second?

Add starShareEmail (Updated)Add tags

Apr 6, 2006 7:35 AM

Wonky Wonky World

from drfleablog by Flea



My friend David Williams over at Health Business Blog is hosting the lastest installment of Health Wonk Review. This is a biweekly compendium of the best of the health policy blogs.

David is co-founder of MedPharma Partners LLC. He is a strategy consultant to pharma, biotech, device, and technology enabled healthcare services industries.

Go ahead and have a visit.

Add starShareEmail (Updated)Add tags

Apr 5, 2006 3:35 PM

Flea vs. Sieve

from drfleablog by Flea

Five o'clock in the morning I'm staggering into the kitchen when my beeper, clipped to my boxers, starts vibrating. I replaced the battery the other day, so fully charged the sensation of being paged is a bit like being poked with a cattle prod.

It was a call from Dr. Sieve at the local emergency department. Recall that Dr. J, his boss, had agreed to tell her staff to call me whenever one of my patients showed up at her place. It seems a 3 month-old patient of mine was brought by his parents because of fever and fussiness. The parents hadn't called me during the night. Already I'm

annoyed.

He rattles off a series of vitals and laboratory results (including RSV swab and chest x-ray), no exam. "Did you examine the patient?" I ask him. "What did she look like?". It turns out she has runny nose and cough. This is an infant with fever with a source (as opposed to fever without a source). He has given 50 mg/Kg of Ceftriaxone and wants to send her home. I'm relieved.

Two hours later I'm in the locker room at the gym and my beeper goes off again. It seems Dr. Sieve doesn't like how fast the baby is breathing, in the 40 breaths per minute range (not abnormal for an infant), and now he wants to admit her. I stuff my gym clothes back in the bag. It's a five-minute drive to the hospital.

"I'm on my way". I tell him.

In the E.D. I find the smiling happy baby being examined by a fresh-faced young resident who tells me he is there to admit the baby. I shake his hand, tell him he probably won't need to do that, and I say goodbye to him and to the hospital's Portuguese interpreter who is accompanying him. I examine this smiling, happy baby and speak to the parents briefly.

I greet Dr. Sieve, shake his hand and tell him I don't believe the baby is sick enough to be in the hospital. I go back and talk to the parents about taking care of the sick baby, when to call, and how to "emergency page" me if necessary. I turns out they don't know how.

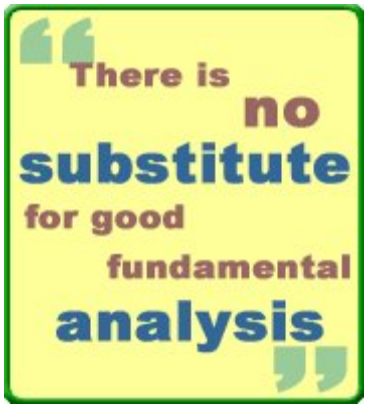
So this one is a save. Score Flea 1, Sieve 0.

Add starShareEmail (Updated)Add tags

Apr 4, 2006 1:35 PM

Accept No Substitutes

from drfleablog by Flea



Attention True Believers!

There is no autism epidemic.

Repeat after me: "There is no autism epidemic".

Paul Shattuck from the University of Wisconsin, Madison published a study in this month's number of Pediatrics entitled *"The Contribution of Diagnostic Substitution to the Growing Administrative Prevalence of Autism in US Special Education"*.

It turns out that applications for special education services because of autism increased as applications for learning disabilities and mental retardation decreased.

Whereas this is not slam-dunk incontrovertible "evidence of absence" of a rise in autism, it is nevertheless compelling analysis. At the very least we can draw two conclusions from this study: we don't know for sure if the prevalence of autism has increased over time; and even if we did know it for sure (and we do not), the magnitude of the increase is no where near what the true believers say it is.

In the same issue, a commentary from Craig Newschaffer ofJohns Hopkins tries to poke as many holes in Shattuck's analysis as possible, but to little effect.

At the bottom of Newschaffer's commentary, the editor of Pediatrics delivers the following stinger:

Editor's note: I am always hoping that we can find an explanation for the rising incidence of "autism."

Amen, brother.

Thanks to Orac for the tip.

Add starShareEmail (Updated)Add tags

Apr 4, 2006 3:08 AM

I Have to Pee I Have to Pee!

from drfleablog by Flea

[Title courtesy of my younger son]

Grand Rounds 2:28 is up at UroStream. Keagirl is

"...convinced that I am a frustrated veterinarian at heart. However, my unfortunate allergies to most rodents, felines and equines led me to the wonderful world of human medicine and the ever humorous field of urology."

This week's format is a classic H&P. Well done!

Add starShareEmail (Updated)Add tags

Apr 3, 2006 9:08 PM

Re-tagged

from drfleablog by Flea

I've been tagged again.

This time, autism-blogger "Dad of Cameron" over at Autism Street got me. As I only just engaged in this exercise three days ago, I should have politely refused, but I can't turn down flattery:

Because I find his comments and blog interesting, and because it certainly wouldn't hurt to have a few extra links floating around to pediatrician who is also quite the

critical thinker, and also because Orac didn't tag him, I tag Dr. Flea.

Okay, then. At the risk of alienating all four loyal readers, here goes:

Where was I one year ago?

Precisely where I am right now.

Where was I five years ago?

I was a salaried doc on the South Shore of Massachusetts, working for a practice with 2.5 full-time equivalent MD's, two full-time NP's, and a full-time PA. The organizing principle of this practice was "make a lot of money". I learned a lot about how I would not run a pediatrics practice when I left, which I did one year later.

Where was I ten years ago?

I was a second-year pediatrics resident at the "best freakin' Children's Hospital in the whole wide world". I was learning that I had better be very glad I was where I was, because the community outside our walls was populated by yahoos, assassins, and other fleas who cannot be trusted with the care of the children of Massachusetts. Four years later I would become one of those yahoos, assassins and other fleas.

And now, please forgive me, fellow bloggers: I'm not going to tag anybody at this point. Enough is enough.

Add starShareEmail (Updated)Add tags

Apr 3, 2006 8:08 AM

Hope Springs Eternal

from drfleablog by Flea

A straggling few got up to go in deep despair. The rest
Clung to that hope which springs eternal in the human breast;
They thought, "If only Casey could but get a whack at that—

We'd put up even money now, with Casey at the bat.

The morning after daylight savings time began, my alarm woke me up in pre-dawn darkness again. I had been getting used to driving to work with at least a little sunlight. The seasonal affective disorder was starting to go away. And then, boom, back to darkness.

Oh sure, we got to play outside an hour later. We also were fortunate to have spectacularly beautiful weather in New England this weekend. But mornings will continue to be dark and depressing for a few more weeks.

And then I turned on the radio. How could I have forgotten? There is hope after all. It's spring, the fields are ready, the tickets are sold (most of them), the teams have left Florida and Arizona. And every team is in first place. It doesn't get any better than this.

It's Opening Day.

Contrary to popular belief, baseball is *not* a children's game. Playing the game, and even watching, requires patience, anticipation, and a whole lot of standing around doing *nothing*. The ball is actually in play for only a couple of minutes over the course of a 9-inning game.

Well, you don't actually do *nothing* during the interstices of the game. It's the standing around, or sitting around as the case may be, that makes the experience of watching baseball special. That's when you talk, shout at the players and the umpires, buy popcorn and hot dogs, drink beer, and most of all, talk baseball.

Baseball is all about talk. It's reminiscences of baseball games witnessed, favorite players, strategies. Or sometimes you just kick back and remember how damned lucky you are that it's baseball season again and you are blessed with the privelege of experiencing it again.

Man, it doesn't *get* any better than this.

Play ball!

Add starShareEmail (Updated)Add tags

Apr 2, 2006 6:09 AM

Where'd They Find Volunteers?

from drfleablog by Flea

I got this off of Reuters Health News this morning:

"US researchers said on Saturday they had transformed immature cells from men's testicles into powerful stem cells, which they then coaxed into becoming nerve, heart and bone cells.
Their work has not been assessed by standard peer-review processes, but was presented at a meeting of stem cell researchers in Valencia, Spain. If other researchers can duplicate their efforts, the study offers a possible new source of valuable stem cells."

Most normal bloggers are going to ask all the right questions about lack of peer-review, financial incentives, and recent cloning scandals.

I can't get past the volunteers:

"Silva's team took cells from the testes of men aged 26 to 50 years old."

I'm not sure there is a financial incentive "powerful enough" to get me to sign up for *this* particular study!

Add starShareEmail (Updated)Add tags

Mar 31, 2006 12:47 PM

Tag, I'm It!

from drfleablog by Flea

I've been tagged by Kim, over at Emergiblog (okay, she dared me - not true tag, I suppose - the adult version, perhaps?)

Here goes:

Four Jobs I've Had in My Life

1. Pediatrician
2. Professional Student
3. Cashier in an Ice Cream Joint
4. Attendant at an Aquarium

Four Movies I Could Watch Over and Over

1. Raising Arizona (1987) - dir. Joel Coen. Ostensibly a comedy, I regard this film as a serious work of art. It is a brilliantly incisive and poignant commentary on the state of parenthood in the U.S. And of course, it's *screamingly* funny.
2. Crimes and Misdemeanors (1989) - dir. Woody Allen. Allen's best film. It asks all the right questions, particularly "Is there a moral order to the universe?". Woody gives the wrong answer, but I forgive him. It's a *great* film.
3. The Jerk (1979) - dir. Carl Reiner. Quite possibly the funniest motion picture ever placed on celluloid.
4. Casablanca (1942) - dir. Michael Curtiz. Quite possibly the best motion picture *period*. Here's lookin' at you, kid.

Four Web Sites I Visit Regularly

1. NHS Blog Doctor - Dr. Crippen is who I would be if I were a tiny bit older, angrier, and more British.
2. MyYahoo! - My homepage - news, weather, and sports instantaneously.
3. Medem - to pick up messages from my patients.
4. New York Yankees page at MLB.com - Wait 'til *this* year, baby!

Four Favorite Foods

1. Coffee
2. Mushrooms
3. Carrot Cake
4. Fries

Four Places I Would Rather Be Right Now

1. The Kotel Ma'arivi - Jerusalem
2. Governador Valadares, M.G.
3. Step Beach, Nantucket
4. Yankee Stadium

Four Most Wonderful Places I've Ever Been (I cheated a little)

1. Aureole
2. Bouley
3. The Four Seasons
4. Great Bay

Four Books I Could Read Over and Over

1. Charlotte's Web, by E.B. White - Quite possibly the best children's book ever written.
2. The Wind in the Willows, by Kenneth Grahame - The second best?
3. James and the Giant Peach, by Roald Dahl - *Anything* by Dahl, really.
4. Fahrenheit 451 - ditto for Ray Bradbury.

Four Songs I Could Listen To Every Day

1. Steamroller (1970) James Taylor, off "Sweet Baby James". This white boy's introduction to 12-bar blues. Originally conceived as a "joke song", Steamroller became an audience favorite at JT concerts.
2. Rock 'n Roll Band (1976) Boston, off the eponymous album. Centers on the classic rock motif "boy makes it big playing his guitar". Perhaps the greatest musical climax and denoument in the history of rock 'n roll.
3. Statesboro Blues (1971), off "The Allman Brothers at Fillmore East". Play this song next to my deathbed. If I don't start movin', cart me off.
4. Hideaway (1966), of Bluesbreakers with Eric Clapton. EC was 15 or 16 years old when he recorded this instrumental with John Mayall. I've listened to it a million times and it *still* gives me the chills.

Four Reasons I Blog

1. I can't say this stuff at my *real* web site.
2. I can't say this some of this stuff *in public*!
3. I can't say some of this stuff at the dinner table.

4. I need to practice my writing.

Four People to Tag

1. Dr. John Crippen
2. Barbados Butterfly
3. Aggravated DocSurg
4. Neonatal Doc

Add starShareEmail (Updated)Add tags

Mar 30, 2006 7:57 AM

Dunkin' Dirty Little Secret

from drfleablog by Flea

Most of the moms in my practice pour coffee for Dunkin' Donuts. It's not a great job, but it's one of the only jobs they can get. There are several reasons for this, but the essential reason is that DD's doesn't ask them about their immigration status. Most of my mom's are not in this country legally.

That is not to say they waded across the Rio Grande or were smuggled across the Mexican border in a container truck. None of them, in fact, *came here* illegally. They merely obtained tourist visas in their home country (Brazil), moved their families and all their possessions to the U.S., and out-stayed the terms of their visas. At this point they transmogrified from "documented aliens" to "undocumented aliens" - from legal to illegal.

Now, according to the Border Protection, Antiterrorism, and Illegal Immigration Control Act of 2005 (HR 4437) passed last December in the House of Representatives, Dunkin' Donuts is in a whole heap of trouble for keeping undocumented aliens on the payrolls.

What did Dunkin' Donuts do? Absolutely nothing. The donut king will continue to employ undocumented workers with impunity for the foreseeable future.

Why? Because DD's dirty little secret is that they cannot stay in business without illegal aliens. Conservative protestations to the contrary are simply not credible. Consider the testimony of Ana (not her real name), a new mom I saw in my office

yesterday.

"I've worked in Dunkin' Donuts for five years. In that time I worked with at most 20 Americans. They were basically very stupid high school students who after one week would still ask me how to make a coffee. They did not stay very long. And a Brazilian can pour four coffees in the time it takes an American to pour one."

Our elected officials will continue to pat themselves on the back and crow to their constituents about how tough they are on illegal immigration. Without enforcement, however, my Brazilian moms will keep coming to the U.S. to get jobs.

This flea has mixed feelings about this whole deal. I want to protect the borders as much as the next conservative Republican. I'm offended that I work my ass off, take no days off, one week vacation per year to pay taxes that fund health benefits for the children I care for in my practice. It's as if I'm paying myself!

On the other hand, I love Dunkin' Donuts coffee. I mean I *really* love Dunkin' Donuts coffee. And these moms? Not that this should matter in an immigration debate, but these ladies are among the most beautiful specimens of femaledom on God's green earth.

Not that this matters ;)
Add starShareEmail (Updated)Add tags

Mar 30, 2006 3:57 AM

Oh My God, They Printed Every Word!

from drfleablog by Flea

My "guest blogger piece", Driving the Yellow Bus, is up at This Makes Me Sick.

This is a "single-issue" blog devoted to medical malpractice.

Wow! My name in print!

"Good things are gonna to start happening to me now!"
Add starShareEmail (Updated)Add tags

Mar 29, 2006 2:41 PM

Speaking of Trisha

from drfleablog by Flea

The aforementioned Dr. Greenhalgh has a go at the now infamous 1998 Lancet paper by Andrew Wakefield and colleagues that sparked the autism-MMR kerfuffle.

In conclusion, the Wakefield study was scientifically flawed on numerous counts. I am surprised that neither the editor nor the reviewers spotted these flaws when the paper was submitted. Had they done so, the public would have been saved the confusion and anxiety caused by false credibility conveyed by publication of the study in this prestigious journal.

Via NHS Blog Doctor.
Add starShareEmail (Updated)Add tags

Mar 29, 2006 12:42 PM

How to Read a Paper

from drfleablog by Flea

A bunch of folks came over to my blog and got into an argument. It was just a silly post about a silly man on a mission and all the trouble he's caused. I didn't mean to start a fire. It's hard to know what to do in these situations. Do I tell everybody the party's over, time to go home? Do I dial 911?

I'm trying to be a gracious host, but it hasn't been easy. After a couple fruitless attempts at participation, and some more at humor, I gave up.

Now I'd rather light a, um... er.... candle than curse the darkness. I might suggest that all of us, professional and layperson alike, learn how to read critically the medical literature.

In 1997, the BMJ published 10-part mini-course called "How to Read a Paper" by Trisha Greenhalgh, a senior lecturer at the University College London Medical School and Royal Free Hospital School of Medicine.

It's a terrific introduction for the non-specialist. It's an even better refresher course for fleas with Ph.D's like me.

Add starShareEmail (Updated)Add tags

Mar 27, 2006 6:42 PM

On Her Majesty's Medical Service

from drfleablog by Flea

© Reuters

This week, Grand Rounds (2:27) is being hosted by Dr. John Crippen of NHS Blog Doctor.

Dr. Crippen is one of this flea's favorite bloggers. I've been reading him since long before I decided to take the plunge myself.

Dr. Crippen is an internist in the National Health Service in the U.K. He is married with four teenage children. He sees a full schedule worth of patients every day and nevertheless manages to find the time to become one of the most prolific contributors to the medical blogosphere.

Crippen's got *great* stuff. I suggest you visit there early and often.
Add starShareEmail (Updated)Add tags

Mar 26, 2006 3:36 PM

Dear Prudence

from drfleablog by Flea

On an early Spring morning in 1970, a man gets up from the toilet after having relieved his bowels, gazes into the bowl, and seeing blood in the water, runs screaming from the bathroom, straight to his garage, jumps into his car and drives off.

He brings himself to the emergency department of his local hospital, sure he is bleeding to death from his rear end.

There, an examination and a series of tests shows the bleeding was caused by external hemorrhoids. Relieved in more ways than one, the man returns home and writes a large check to his family house of worship.

Six week later, he receives a gigantic bill from the hospital. It seems his insurance company does not agree that hemorrhoids are an emergency and therefore will not pay for emergency level of care.

Such stories were quite common in the U.S. until passage in 1985 of EMTALA, the *Emergency Medical Treatment and Labor Act of 1985,* a provision that would later be passed under The Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). According to EMTALA, an emergency is defined as

(i) A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in--

(A) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
(B) Serious impairment to bodily functions; or
(C) Serious dysfunction of any bodily organ or part; or

(ii) With respect to a pregnant woman who is having contractions--

(A) That there is inadequate time to effect a safe transfer to another hospital before delivery; or

(B) That transfer may pose a threat to the health or safety of the woman or the unborn child.

Sounds great, but it begs the question: how do you know what whether the blood in the bowl constitutes an emergency? One man's emergency is another man's no-biggie.

To help solve the question of what constitutes an emergency under EMTALA, several states adopted what is today know as the "Prudent Layperson's Standard" (PLS). According to PLS, an emergency

is any medical condition of recent onset and severity, including but not limited to severe pain, that would lead to a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of

such a nature that failure to obtain immediate medical care could result in:

• *Placing the patient's health in serious jeopardy*
• *Serious impairment to bodily functions or*
• *Serious dysfunction of any bodily organ or part*

As a result, poor saps like our fellow with the bleeding tushie were no longer getting stuck with even *bigger* pains in the rear end.

But as with so many good pieces of legislation, EMTALA and the PLS have given rise to a consequence that may have been anticipated, but certainly could not have been intended: Emergency rooms began to fill up with folks who are not emergently ill. Why? Because a "prudent layperson possessing an average knowledge of medicine and health" hasn't got the faintest glimmer of an idea as to what constitutes an emergency medical condition!

According to the PLS, emergency medical conditions include:

- Fever at any age
- Ear Infections
- Sore Throat
- Thrush
- Green Poop
- Don't recognize the name of doctor on call
- Need a prescription refill

In order to avoid running afoul of EMTALA, insurance companies are forced to pay $900 for an emergency department visit from a 1 week old with green poop.

There is no solution that will solve the problem completely, but there are half-measures. Fleas like me can educate parents as to what constitutes an emergency. I provide a hand-out, written in 8th-grade English and Portuguese, that details the signs and symptoms that constitute a medical or surgical emergency.

Fleas like me can insist that their patients *call them* before heading off to the E.D. By asking screening questions and providing advice over the phone, I can forestall almost all non-emergent E.D. visits by my patients.

Respondents who have patiently read through this uncharacteristically long post will respond that patient histories cannot be trusted, or that the "safe thing" to do is to refer patients to the E.D.

I have argued before and I will continue to do so until the blueness returns to my little flea face- Inappropriate use of emergency services educates parents to the effect that *all* acute illnesses in their children require not only the ministrations of a physician, but

even emergency level of care.

In this flea's opinion, such an education distorts and confuses our understanding of the difference between wellness and illness. As a result, **we have come to regard our essentially healthy children as essentially *sick* children**, one sniffle away from certain doom.

If that's the world y'all want, you're welcome to it.

Add starShareEmail (Updated)Add tags

Mar 23, 2006 6:36 PM

Sweet Asymmetry

from drfleablog by Flea

Karen (not her real name) came to visit my office about 4 months ago for a "pre-natal consult". Essentially this was an opportunity for this expectant mother to check me out and decide if she wanted me to be her soon-to-be-born daughter's pediatrician.

During the course of our meeting, Karen told me that she had recently been treated for breast cancer.

Karen's fiance, soon to be her husband, had discovered a lump in her right breast during love-making. After marriage, lumpectomy and radiation therapy, Karen became pregnant. As her pregnancy progressed, her left breast began to grow, as breasts do during pregnancy, but the breast that had been irradiated hadn't. Up to this point in the conversation, I kept my eyes locked on Karen's.

"Feel free to look", she said. And I did. Sure enough one breast was noticeably larger than the other.

After the baby was born, I visited the family at their home. The labor and delivery had gone well, though the otherwise healthy baby girl was born with an extra digit on one

hand (it would later be removed by a plastic surgeon). Karen was struggling to breastfeed her daughter with her one functioning breast. I gave Karen the number of a lactation consultant and hoped for the best.

Today Karen brought her daughter to the office for a one month well-child check. The lactation consultant had given Karen lots of good tips and troubleshooting advice and breastfeeding began to go very well. Karen was now exclusively breastfeeding her daughter with one breast. The baby had gained weight very well. Mom was positively ecstatic.

"You have a great story to tell", I told her, "and I hope you tell it someday".

"I plan to", she told me. "I definitely will".

Add starShareEmail (Updated)Add tags

Mar 22, 2006 11:31 AM

Not Exactly Molotov-Ribbentrop

from drfleablog by Flea

I just met with the chief of Pediatric Emergency Services of our local hospital.

I invited her (I'll call her "Dr. J") to discuss various "issues" that I had with the care my patients receive in her Emergency Department.

What we emerged with was not exactly a Hitler-Stalin-type non-aggression pact, but it was a start.

I opened by thanking her for coming to my office at lunch time and asking forgiveness for eating my veggie roll-up in her presence. Then I got down to business.

I asked her point blank if she cared whether she saw non-emergently ill kids in the

E.D. or not. She gave no reply. I went on, coming back to the question twice more. Finally I waited in silence until she answered my question "Do you care whether the kids you see in the E.D. are emergently ill or not?"

Finally she answered, "I guess I don't care either way."

I should have ended the meeting there. I should have stood up, shaken hands and wished her a good day. From that point on I would make no progress with her.

As long as E.D. docs remain indifferent as to the acuity of illness that presents to them, folks are going to continue to use E.D.'s like doctors' offices. And there isn't a thing a flea like me can do to stop it.

As for the current climate of over-test, over-diagnose, over-treat, and over-admit, I had to concede that "over-fill-in-the-blank" is the currently the community standard of care, due only in part to the E.D.s but due principally to my fellow fleas. As I am the only deviator from the community standard of care, by definition they are right and I am wrong.

Dr. J *did* tell me that she asks every parent if they called the pediatrician before coming to the E.D. I was pleased to hear this, but I seriously doubt that her entire staff does this. Asking the question has the effect of educating the parent to the effect that calling the flea is something they *should* do before heading for the E.D.

There was a small glint of sunlight at the end of the meeting. Dr. J agreed to inform her staff that Dr. Flea wishes to be called whenever one of my patients presents to the E.D. in order to be involved with making a treatment plan. Her only reservation was "what if you don't agree with the E.D. doc's plan?" I assured her we could cross that particular bridge whenever. For now it'll be enough to be called *at all*.

At the end of the meeting I was left with a firmer conviction of something that I only suspected before, that I am the only damned flea in this community who gives a hoot as to where his patients receive care.

That's a shame.

Add starShareEmail (Updated)Add tags

Mar 22, 2006 4:41 AM

Sweet Anonymity

from drfleablog by Flea

Something bad's going on at Geek Nurse.

The following was posted at 1504, Kiwi time:

Owing to concerns raised by staff and management, GN's archive has been removed from public display.Thank you to all those that took part.

What happened?

Is Rich, PaedsRN, done with blogging? And if so, why? Too much truth?

Once again I'm glad I chose to go anonymous. If it's dangerous in New Zealand it's downright *deadly* in the U.S.!

Add starShareEmail (Updated)Add tags

Mar 21, 2006 3:52 PM

Thanks, Bobby!

from drfleablog by Flea

The Thimerosal-Autism story will not die. When I say that a patient asks me about thimerosal *every day*, I am not exaggerating. Here is today's installment, in the form of an email from a mom.

Hi Dr.Flea ,

My son, XX, is 18 months old and he'll be coming in for his DTAP shot next week. I understand that up til now his shots haven't contained Thimerisol (*sic*), but that this one will.

I hear a lot of things about thimerisol and autism, some say with much conviction that there's a direct link, others say with equal conviction that there is not.

I'd like to err on the side of caution, so I spoke with (your nurse) about whether I could obtain a DTAP shot that did not contain thimerisol and she gave me a number for a Glaxo Smith Kline rep, but the number was out of service.

Would you be able to obtain the vaccination for me, or point me in the right direction? Also do you have any idea how much the shot would cost and whether or not it would be covered by our insurance?

I appreciate any assistance you can provide. Sincerely, (mom)

Here is my reply to this mother:

Hello (mom),

I want to be as clear about this as I can. There is *no* controversy surrounding Thimerosal. There is scientific evidence and there is hysteria. The scientific evidence suggests that there is no link between thimerosal in vaccines and autism or any bad

outcome whatsover!

The hysteria is driven by celebrities such as Bobby Kennedy, Jr., who wrote an article at Salon.com a few months back about thimerosal. Then there was the book called "Evidence of Harm". Though the book pretends to be an even-handed look at the "controversy", the title betrays its bias.

It's true that our DTaP has a tiny bit of thimerosal in it, but it is best characterized as a trace amount, not enough to work as a preservative. But even if it had a large enough amount to act as a preservative, I would not expect it to harm your child.

I would not recommend anything for your children that I would not give to my own, or to myself for that matter.

We've never tried to obtain thimerosal-free DTaP, so I would not know where to start ordering it. In Massachusetts, I get paid for administering vaccine, but not for the cost of the vial itself, as the State buys it for me.

In my opinion, it's a safe vaccine. Nevertheless, if you choose not to give him the DTaP, I will stand by your decision.

best,

Flea
Thanks, Bobby. Thanks very much indeed.
Add starShareEmail (Updated)Add tags

Mar 21, 2006 4:55 AM

Healthy, But a Little Concerned

from drfleablog by Flea

Grand Rounds is up over at Health Concerns.

Elisa Camahort is the sole proprietor and Queen Bee of Worker Bees, a marketing consulting firm. She's also politically active, blogging for the Santa Clara County Democratic Party.

Elisa is the co-founder and President of Marketing & Events for BlogHer, an online network and organization committed to providing an opportuity for education, exposure and community to women bloggers.

Elisa actually read and commented on the posts she received. I appreciate that kind of depth and attention!

She kindly provides a link to us early on (before the back-row crowd falls asleep!). My only concern is that she characterizes "Black Bag" as an anti-E.D. diatribe. There is a single clause in one sentence referring to care in our local E.D.

Could it be that I've gotten a reputation as an "E.D. Basher" from these two posts?
Add starShareEmail (Updated)Add tags

Mar 19, 2006 6:32 AM

Black Bag

from drfleablog by Flea

I received two emergency pages yesterday, Saturday.

The first was from the inpatient pediatrics ward at the hospital. A 5 month-old of mine had been admitted the night before for "dehydration". As per usual, he had had a "line and labs" including a complete blood count and a blood culture.

It seems the mother, a 17 year-old high school student, didn't want me to be the pediatrician any more. Mom and baby had come to the office the day before. Her insurance was a type of Medicaid that I am not permitted to accept (it's long and complicated to explain - suffice to say I'd accept it if they'd let me). We have told this young mother on numerous occasions that she needs to call MassHealth and change the child's insurance designation, but she failed to do so. We told her this in two languages, including Portuguese, her native tongue, and on more than one occasion gave her the opportunity to call MassHealth from our office.

When she arrived Friday, we told her she could pay us $50 for the visit. This, by the way, is less than my "usual and customary fee", but is slightly more than MassHealth pays me for a typical "sick visit". Mom told my secretary she didn't have $50, and that she was going to the emergency department. The E.D. doctors then did what E.D. doctors do, including admit the child overnight for "observation". The attending pediatrician assigned to the case does not take new medicaid patients, and only one doctor in his practice speaks Portuguese (and badly, at that).

The second page I got was from the Brazilian mother of a 10 month-old former 34 week premie. He had been sick on and off for three weeks, but now he was febrile and coughing. Mom was concerned and (saying the Magic Words) wanted to know if she should take him to the hospital. I picked up my black bag and left for her house.

This family lives 28 miles from me, but MapQuest got me there without a problem. He was laying on his mother's bed, unhappy but non-distressed and non-toxic appearing. I got him to smile briefly and play with my stethoscope. These were two very positive signs. An infant who smiles and plays may be sick, but he is not *sick*. Already I know this is a child who does not need to be admitted to hospital.

His chest was retracting a bit and he had gentle wheezes throughout his lungs. I went back into my black bag and pulled out a cannister of albuterol and a spacer with mask. With mom's help I gave him two puffs. Ten minutes later, his chest was much clearer. I went back to my bag for a script pad and wrote two prescriptions, one for albuterol and another for the spacer. I hoped (not aloud) that MassHealth would cover the latter, as it is a medical device and not a medicine *per se*.

With all the junk I have to deal with at work, not least a large, stupid governmental insurance system, there are so few opportunities for me to do something that makes me feel like a real doctor.

Obrigada, Doctor. Muito obrigada, mom said as I was leaving.

De nada, senhora. Por isso eu sou medico. This is why I'm a doctor.

Add starShareEmail (Updated)Add tags

Mar 17, 2006 8:58 AM

Green Poop

from drfleablog by Flea

My office is located in a community with a very large Brazilian-born, Portuguese-speaking population. Approximately 30% percent of the parents in my practice are Brazilian, and a large number of these speak little or no English.

Taking care of this population has been a challenge, not least because I needed to learn to speak Portuguese after the age of 40. The human brain loses a great deal of its natural ability to learn another language by age 10. But I've been blessed with what Ms. Flea calls "a language thing". I picked up Portuguese fairly quickly.

Learning to speak Portuguese has afforded me insights into the minds of folks I otherwise would never have gotten to know. What I learned is that, at bottom, Brazilians and Americans are not as different as you might think. This is particularly so with regard to their worries about their children.

There is, however, some variation with respect to the variety of worries that trouble Brazilian parent. For example, intestinal parasites are terribly common in Brazil. Virtually all children with access to medical care are treated with antihelminthics on a yearly basis. In the minds of Brazilian parents, any complaint referrable to the abdomen is *vermes* (worms) until proven otherwise. This is not an unreasonable assumption. In Brazil it's likely to be true.

There is one obsession, however, that is shared by Brazilians and Americans alike: *green poop*. Nothing drives parents as crazy as the appearance of the color green in a baby's diaper. All across the country, new moms and dads are running screaming from the nurseries, all on account of green poop.

I confess I don't get it.

I have fielded so many green poop calls in the last several years that I'm considering

starting a single-issue blog on the subject.

Green poop, or *coco verde* to my Brazilian parents, is normal. The green pigment is produced in the liver, stored in the gallbladder, and secreted into the intestines in the course of normal digestion. Most of the green pigment is reabsorbed, unless the poop travels fast through the gastrointestinal tract. The faster the poop moves, the greener it will be. It's more typical in breast-fed babies where transit times are shorter.

I like green poop. It's a sign of health. I prefer it much more than the alternative.

Happy St. Patrick's Day.
Add starShareEmail (Updated)Add tags

Mar 16, 2006 8:53 AM

Bonk!

from drfleablog by Flea

My patients have been bonking their heads a lot lately. I wonder if I should be worried.

Head bonks happen with great frequency. This is due, in large part, to the peculiar anatomy of the cranium.

Little kids have big heads. Whereas an adult head diameter (crown to chin) may measure 1/10 to 1/12 of his total height, the ratio in toddlers is closer to 1/3 to 1/4. It is not surprising, therefore, that this is the first part of the body to strike the ground. And

their heads strike the ground with alarming frequency.

The reason we've been able to survive lo these many millenia despite being born with ridiculously large heads is that the baby brain is tethered with a much greater degree of elasticity than the adult brain. If you or I bang our squash as hard as the kids do, it would 'ring the bell' but good.

When I get a 'head bonk' call, I typically ask a number of screening questions. I need to know if the child lost consciousness. I ask if the skin is broken and bleeding. I ask about vomiting and state of consciousness. If any of these answers are affirmative, I ask the parents to bring the child immediately or triage them to an emergency room.

Yesterday, at grand rounds, a neurosurgeon presented the case of a 4 year-old head bonk, with no loss of consciousness, no vomiting, and no bleeding cut. The parents brought her to the E.D. because they were concerned about the bump. In the waiting room she *did* lose consciousness and was run back to the crash room. A CT revealed an parietal skull fracture and an epidural hematoma (broken head and internal bleeding in the head). The clot was evacuated emergently and the girl survived. Had she stayed home she probably would have died.

This is an example of the infamous "talk and die" syndrome that we're taught about in medical school but never hope to see. It's scary and appears to be unavoidable. That is, unless you triage *every* head bonk to the E.D.

I trust the child's pediatrician made a large contribution to his local house of worship after this event, not only for the life of the child, but also for the lawsuit which almost certainly would have ensued, but didn't.

Fifteen minutes ago, before I sat down to type this post, I received a call from the father of a 4 month-old former 32 week twin who fell down the stairs. He has no obvious trauma apart from a small bump on one side of his head. Dad gave all the 'right' answers to the questions I asked.

I will hit the orange "publish post" button and say a quick prayer.

Add starShareEmail (Updated)Add tags

Mar 14, 2006 7:56 AM

This Just In: Teens Take Risks!

from drfleablog by Flea

That was some meeting the AAAAI held in Miami last week!

Thousands of allergists from around the world converge in South Florida to discuss the most important issues in diagnosis and management of allergy and immunology, and the only interesting thing the Reuter's stringer could find was this?

It turns out... (wait a minute, I have to stop and take some deep breaths: I'm hyperventilating here... there, I'm better). It turns out that **teens take risks**!

"A substantial number of teenagers with food allergies admit to "risk-taking" behavior such as not reading food labels or knowingly eating foods labeled "may contain" allergens, a survey shows.

The poll of 174 food-allergic individuals whose average age was 16 years also shows that many of them do not always carry self-injectable epinephrine -- the medication that is immediately needed in the case of a severe allergic reaction.

Whether or not they pack their EpiPens depends largely on where they are going, who they will be with, and how convenient it is to carry it. If the purse is small or the clothes tight-fighting, odds are they won't carry it."

Be still my beating heart!

I know my colleague Dr. Andy was in Miami: surely there was some research or therapy discussed more newsworthy than this!

As with many risk-taking behaviors, many teens "get the message" only after something bad happens. As physicians and parents, we pray that when the "teachable moment" happens, the child is alive and unhurt.

That doesn't relieve parents and fleas from the responsibility of reminding kids early and often that the world can be a dangerous place.

Add starShareEmail (Updated)Add tags

Mar 14, 2006 7:56 AM

Kiwi Confidential

from drfleablog by Flea

Grand Rounds 2:25 is up at Geek Nurse. Rich, RN, is a self-described "PICU RN, self-taught geek in various IT disciplines, wannabe cartoonist."

And he's from New Zealand!

Add starShareEmail (Updated)Add tags

Mar 12, 2006 1:14 PM

Three Wishes

from drfleablog by Flea

This morning I had the strangest experience.

Rummaging through the kitchen for some coffee, I stumbled across a dusty jar of Colombian Colcafe. I couldn't tell how long it had been there, but it appeared positively ancient.

I can't resist Colcafe, a fantastic brew that I find impossible to make too strong. Surely it would retain it's characteristic smoothness and flavor after, what, *2,000 years*?

I struggled mightily to open the thing, and in so doing, tripped on a Matchbox car, sending me and the precious jar of coffee flying.

When the latter struck the ground, the top sprang off and out popped not ground coffee, but the doctor pictured here at the left.

He dispensed with the introductions and got straight to the three wishes thing.

"I get *anything* I wish for?", I asked incredulously.

"Don't be a putz", my new friend admonished me, "This is a medical blog, so let's keep it topical, *capisce*?"

I decided to go the genie-doctor fellow one better and wish for three things related to emergency medical care:

1. **I wish E.D. doctors would learn to say "You don't need to be here"**.

Surely this would be an easy one. It's a verbal trick, a piece of cake for a genie. When a kid shows up in the E.D., and he's not emergently ill, the docs could see him, take a

history, perform an appropriate exam and testing (if they must), and decide if he is emergently ill. If he is not, the docs will tell the parents that the child doesn't require emergency level of care. They would explain why this is the case. The family would leave the E.D. healthier and wiser.

2. **I wish E.D. doctors would practice "watchful waiting".**

So this 3 year-old walks into an emergency room, see, and the doctor takes a history and a physical and notices he has otitis media. The E.D. doc calls the child's pediatrician, and together the two of them decide to watch the child off antibiotics for a couple of days. Sure enough, in 2 days the child is dramatically better using only appropriate analgesics.

This is no joke. This happens in real life. Just not in emergency departments.

3. **I wish E.D. doctors would not draw blood when doing so is not indicated.**

A fully-immunized child with a fever and an obvious viral source does not require a complete blood count and a blood culture. I'm astounded that this seemingly unremarkable piece of medical reasoning requires the intervention of a genie.

"Your wish is my command, master".

I woke up with a vicious headache, and no coffee to dull the pain, either.

Add starShareEmail (Updated)Add tags

Mar 10, 2006 8:53 AM

Corporeal Punishment?

from drfleablog by Flea

I recently posted about a 2 year-old boy brought to the emergency department with vomiting and diarrhea. An intravenous line was placed and fluids were given, though neither were indicated in his case.

It turns out that serum electrolytes, a complete blood count and blood culture were also sent. This puzzled me. The patient had no fever at presentation, though mom gave a history of fever 3 days prior to the E.D. visit.

As per the Cincinnati Clinical Practice guidelines linked above, no testing whatsover was required to work-up or manage this patient. Why then were all these tests done?

This isn't defensive medicine. This certainly isn't evidence-based medicine. It's not even cookbook medicine.

It's punishing children for being sick.

Add starShareEmail (Updated)Add tags

Mar 8, 2006 2:01 PM

Welcome Scan Man

from drfleablog by Flea

Scan Man is a radiologist in Tamil Nadu, India. His new blog is up and it's off to a good start. The graphic design is elegant as well.

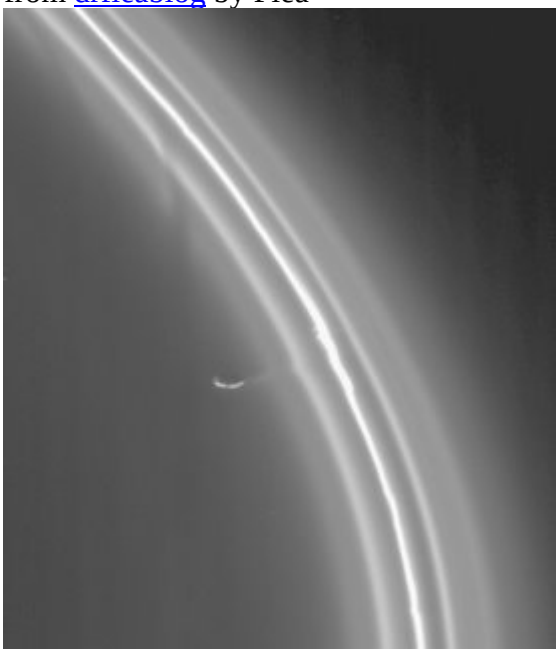
See his first major post, on the sad story of abortion on-demand in India.

Add starShareEmail (Updated)Add tags

Mar 8, 2006 7:57 AM

Mercury Attacks!

from drfleablog by Flea



Prometheus, over at Photon in the Darkness, writes a scathing critique a paper from the International Journal of Toxicology purporting to provide evidence of the "Mercury Causes Autism" hypothesis.

"In a nutshell, the Holmes et al "study" compared the mercury in the "first baby haircut" hair of 94 autistic children and 45 "neurotypical" controls. Disregarding so

many procedural, technical and analytical flaws that they almost defy counting, the "data" they came up were these: Autistic children's hair mercury levels: 0.47 ppm (+/- 0.28 ppm) Control children's hair mercury levels: 3.63 ppm (+/- 3.65 ppm). Now, Holmes (a radiation oncologist who was in "alternative" medical practice at the time), Blaxill (an MBA) and Haley (a somewhat conflicted PhD chemist) concluded that, since the autstic children had lower hair mercury than the controls, that autistic children were unable to excrete mercury.

Huh?!?"

Huh indeed.

Check it out here.
Add starShareEmail (Updated)Add tags

Mar 7, 2006 10:12 AM

No, I Won't Hurt Your Child, Even If You Ask Me To

from drfleablog by Flea

Several of my fellow bloggers devote a large chunk of bandwith discussing over-use of diagnostic tests. Kevin, M.D, has written about it here and here recently.

I have a wholly different problem. In the last 24 hours, I have been asked by three different sets of parents to perform unneccessary tests on their children.

The mother of a 2 year-old recently returned from Peru, asked me to perform a lead (Pb) test on him. The mother has heard a lot on the news about Pb lately (see here for example), and she's nervous. She grew up in Peru and she knows the pollution is bad there. The boy was perfectly happy and playful - his normal self.

A father of a 3 year-old asked me to "authorize him to do a blood test" because his son, who was recently treated from Group A Streptococcal Pharyngitis (strep throat) has a swollen submandibular lymph node. The boy has no fever, no sore throat, has a good appetite, and is sleeping well. The lymph node was not particularly swollen, and was not painful to touch.

Last evening a mother of a 2 year-old with a viral gastroenteritis called me. She wanted something to be done because she didn't have anybody to take care of her sick child. Based on what she told me, the child was well-hydrated and was taking good fluids by mouth.

The first mother was reassured by my explanation that it was unlikely that her boy had Pb poisoning. Furthermore, I told her the Pb test would be very unlikely to produce any information that would be useful to us in terms of therapy. Finally I explained that the test would hurt, and I didn't want to hurt her boy.

I explained to the second father (in lay terms) that this was a reactive lymph node, and that there was no blood test I knew of that would help diagnose what the was causing it. The father became angry and said he would get on a plane and take the boy home to Brazil to find out what was wrong. I explained that I did not want to hurt the boy unncessarily.

At about 10 PM last night the emergency room called me to tell me the boy with gastroenteritis was there. He appeared well-hydrated to the staff. An IV was placed, according to the ER doc, because the mother wanted it done. I wrote a letter to the mother this morning, discharging her from my practice.

You may call it "defensive medicine". You may call it "keeping the customer happy". I call it "hurting kids only because parents ask us to". Others may call it "structural violence" - I dunno, I found the drawing at Google Images and the phrase sounded compelling.

Add starShareEmail (Updated)Add tags

Mar 7, 2006 4:12 AM

Put Down That Soduku and Pay Attention!

from drfleablog by Flea

Grand Rounds is up at Emergiblog. Kim, RN has done a spectacular job. Check it out.

BTW, where *does* she find those pictures?
Add starShareEmail (Updated)Add tags

Mar 4, 2006 4:13 PM

Media Events

from drfleablog by Flea

How do I get parents to stop taking their kid's temperatures every 5 minutes?

I explain patiently that in a fully-immunized 6-month old, the absolute magnitude of fever is not nearly as important as the child's appearance. Nevertheless, parents in my

community obsessively poke thermometers in their children's orifices if the cherubs so much as pass some smelly wind.

I've given out 10,000 handouts. I've counseled hundreds of new parents. I've written articles at my website.

Now it's serious.

I'm going to stage a **media event**.

I'm going to alert all the local television stations. I'm going to invite all parents of 6+monthers to donate their thermometers. We're going to line the thermometers up on the ground in the parking lot behind my office. Then I'll rent a steamroller and, with the cameras running, drive that baby over the thermometers, massively crushing every last little digital plastic nasty into a million bits!

Maybe *that'll* get their attention!

While I'm at it, here's an idea for a media event designed to advertise the benefits of Neosporin in the treatment of acute bacterial conjunctivitis.

[By the way, before sitting down to write this post, I placed two dabs of the stuff in the nose-side corner of each eye, just as I recommend to parents. I have not yet gone blind]

With the same local television cameras running, with a flourish I place a dollop of goop in each eye, whereupon a Lexus LS430 pulls up, driven by my father-in-law wearing a chauffer's uniform. He opens the back door for me and we drive off into the sunset.

For fun, we also cooked up an alternative Neosporin media event. After applying the drug, I scream, grab my chest and fall to the ground. Then my wife pulls up in her Volkswagon Passat Wagon (with all wheel drive!). She and her best friend dash from the front seats, both wearing white nurse's uniforms complete with white hat. They roll

me onto a stretcher and toss me in the back seat. Finally, my lovely wife, from the driver's seat, places one of those temporary police lights on the roof and tears out of the parking lot, horns blaring.

All right officer, I'll come quietly.
Add starShareEmail (Updated)Add tags

Mar 2, 2006 7:13 PM

Did You Know You're Afflicted?

from drfleablog by Flea

My older son asked me this before I put him to bed tonight. He had no reply when I asked him to explain what he meant. It turns out he was only trying out a new word he learned today.

Then it occurred to me that this is a question people ask one other all the time. Worse, we ask the question with regard to each other's *children*.

"Your daughter has been poking at her ear. You should bring her to the doctor and see if she has an ear infection."

"Did you know your son is very hyper? You should have him checked out for ADHD."

"I've notice your daughter has pretty nasty temper tantrums. Have you talked to your pediatrician about this?"

"My child was diagnosed with scarlet fever. My doctor says her friends should be checked out to make sure they don't have it."

I shouldn't mind such talk. It generates a lot of business for me. As long as mothers and fathers continue to say these things, I'll be able to afford college for both my children!

When I was growing up, parents believed that their children were essentially healthy. That is to say, it was an element of our *essence* that we were healthy, normal people. We'd get sick, we'd get hurt, but our parents expected that we'd get better and go back to being our essentially healthy selves. We didn't go to the doctor very much.

Since then, the prevailing attitude toward our children has been turned upside down. Today children are regarded as essentially *sick*, or potentially sick. Many parents today believe their children are forever teetering on the brink of certain doom.

This trend has been good for pediatricians. Our offices are full of children who *don't need to be there*. Pediatricians have little incentive to disabuse parents of the myth that their children are essentially sick. We'll stay in business as long as folks continue asking each other if they knew they were afflicted.

Then there are some notable exceptions. Yesterday I met with a mother who is transferring her two boys into my practice. She had recently discovered she had breast cancer. She had undergone lumpectomy and sentinel node biopsy (two such nodes were positive). She had only that day received a central line to deliver chemotherapy drugs. She is 36 years old.

Never once in our long discussion did this mother use the words "survivor" or "victim". She did not describe her predicament as a "battle" that she was "fighting". This is a young, vibrant woman. She is a home-school teacher. She is a wife and a daughter. She is a descendent of famous rabbis.

She knows she is afflicted.

But she is not a sick person. She is an essentially healthy person who has breast cancer. It goes without saying that her children, in her eyes, are healthy people.

Add starShareEmail (Updated)Add tags

Mar 1, 2006 1:54 PM

Some Doc Amputated This Man's Finger

from drfleablog by Flea

The man in the center of the photo is Ronnie Lott, a member of the NFL Hall of Fame.

This is only photograph I could find that clearly shows that the distal segment of the fifth digit (the tip of the pinky) on Lott's left hand is missing.

It seems that in 1985 Lott, playing for the San Francisco 49ers, caught his pinky in the mask of another player and badly broke the finger. Team doctors told him he would miss the rest of the season. Lott asked instead if the tip of the finger could be amputated. He found a surgeon who would do the operation. Lott did not miss a single game for the rest of the season.

I was reminded of the doctors who amputated Lott's finger when a commenter at Moof's site remarked that "[a] true caregiver stands by her clients' own choices."

I wondered, does "standing by a client's choice" mean doctors should do what patients ask us to do, even if we disapprove of their decisions? Lott wanted the tip of his finger cut off. Does being a "true caregiver" entail doing the amputation?

I once participated in a genetic counseling session with a family from India. The pregnant mother had Marfan Syndrome. The parents were *not* there to ask about the likelihood that their unborn child would be affected. They already knew the risk was 50%. They came to learn the sex of the unborn baby. In their culture, girls with genetic diseases are very hard to marry off. The mother herself had fetched a very low bride-price because of her condition. If the baby turned out to be female, the family wanted to abort.

The geneticist explained amniocentesis to the family "who understood and asked appropriate questions" (for the uninitiated, that's documentation jargon).

Later I asked the geneticist why she didn't simply tell the family that abortion for the purposes of gender selection wasn't something that we did here in this country.

She replied that we "just have to understand their way of looking at the world" or

words to that effect.

So my question is, does standing by your patients' decisions mean helping them do things you object to, like amputating a finger that does not need to amputated, or facilitating an abortion for parents who'd really prefer a boy?

I hope not. We have a name for folks who do unsavory stuff for money.
Add starShareEmail (Updated)Add tags

Feb 28, 2006 7:14 AM

Who's Your Daddy?

from drfleablog by Flea

"He went to his mama
He covered his head
He told his mum what his father had said
His mother she laughed, she said
Go man, go
Your daddy ain't your daddy, but your daddy don't know"

About once or twice a year I have to refer parents to a genetic counselor. This happens after a child is born with a genetic illness, such as Cystic Fibrosis or (most recently in my practice) an inborn error of metabolism.

A genetic counselor will perform testing on parents and will then give advice as to the couple's chances of conceiving a second child with the same disorder. For example, in the case of Cystic Fibrosis, a classic Mendelian recessive disorder, the odds are 25%

that another child will be born with CF. The odds are 50% the next child will be a carrier.

But sometimes the genetic counselor obtains information that the parents might not want to know, specifically that paternity has been incorrectly attributed. That's a fancy way of saying that "your daddy ain't your daddy but your daddy don't know". The actual incidence of this phenomenon is not known. The smallest estimate is 1%, the highest 30%. Most genetic counselors will tell you they believe paternity attribution errors occur in about 5% of consults.

Putting aside for the moment the ethical questions that this raises for the genetic counselor, I want to explore our feelings about this situation.

My own initial reaction to such stories is to blush. I feel embarrassment for the mother, sympathy for the geneticist, pathos for the 'father'. What I don't feel, and this is what I want to explore, is *outrage*.

Why am I not outraged? In most cases, this finding represents evidence that a crime has been committed! Adultery is still a crime in Massachusetts, but though it is considered grounds for divorce, it is never prosecuted. At the very least, most of my fellow citizens consider adultery to be a very bad thing. Most of us feel that violations of trust and loyalty, to say nothing of violation of marriage vows, are bad things.

Or do we?

Joseph Conrad, who wrote more eloquently in his second language than most of us do in our first, described a phenomenon he called "the fascination of the abomination". We have a two-faced nature, one that we show to the world, and another that we know only in the heart of darkness (or the blogosphere?). We are attracted powerfully to abominations (car crashes, for example). Man's better nature can only hope to contain his heart of darkness, he cannot eliminate it.

So it is with infidelity. We recoil from it even as we are fascinated by it. Many of us do it (present flea excluded). The rest of know we should express outrage, but we can't. Half of our brain is *rooting* for the mom, and feeling *schadenfreude* for the dad.

My moral confusion over "incorrect attribution of paternity" is a symptom of the cultural disease I wrote about here.

Anybody know a good doctor?

Add starShareEmail (Updated)Add tags

Feb 26, 2006 10:34 AM

When the Kids Leave Home and the Dog Dies

from drfleablog by Flea

The title of this post is the punch-line to an old joke that hooks on the question "When does life begin?"

The joke is funny because it drives straight to the heart of some of the fundamental questions that arise from the abortion debate.

For pro-lifers, the humor comes from the complete unexpectedness of the answer, and from the ridiculous contrast with the concept of life beginning at conception.

For pro-choicers, it's funny because it plays with the concept of responsibility for our children that they value so highly.

For both sides, the touch of canine humor relieves a fair bit of tension.

Of course, there's nothing funny about the abortion debate at all, and it's about to get a whole lot less funny. The legislature of the state of South Dakota this week approved a bill that would for all intents and purposes ban abortion in that state. Exceptions would be made for threats to the mother's life.

Pro-lifers argue that if life begins at conception, then induced abortion is murder. The pro-choice objection to this argument is that life does not in fact begin at conception, it begins when the fetus becomes able to live on its own (the age of quickening) outside of his mother. If this is so, it becomes permissible to terminate a pregnancy without committing murder. According to *Roe vs. Wade*, states may regulate and even prohibit abortion after the commencement of the third trimester of pregnancy, at which time, by legal definition at least, the infant can live outside of his mother. Prior to the third trimester, wide latitude is given to pregnant women and their doctors to abort if they so choose. Even after the start of the third trimester, however, *Roe* permits abortion to preserve the life or health of the mother.

A difficulty in this pro-choice argument arises when you consider that a newborn is completely helpless. Though she is able to breathe and eat outside her mother's body, she will surely die if not fed and cared for. A newborn is in fact *less* able to live outside her mother's body than she is to live inside it.

Pro-choicers argue that the interior of a woman's body lies within her sphere of privacy. She is therefore granted the right of complete autonomy over the life of her unborn baby just as she has complete autonomy over the rest of her body. The author of *Roe*, the late Mr. Justice Harry Blackmun, argued that the right to privacy in matters related to pregnancy was protected by the fourth amendment to the Constitution that guaranteed freedom from unreasonable searches and seizures.

In his dissent, the late Mr. Justice William Rehnquist (later Chief Justice of the United States) disagreed.
"A transaction resulting in an operation such as this [i.e., abortion] is not 'private' in the ordinary usage of that word. Nor is the 'privacy' that the Court finds here even a distant relative of the freedom from searches and seizures protected by the Fourth Amendment to the Constitution, which the Court has referred to as embodying a right to privacy."

In other words, Justice Rehnquist was unable to associate abortion with a condition of "privacy" in the usual sense of the word. Indeed, even pro-choicers would have to admit that pregnancy is substantively different from other medical conditions, say uterine cancer for example.

I suppose it's obvious at this point that I find the pro-life arguments more persuasive. There are other pro-choice arguments that could be aired and refuted, such as separation of church and state, but these are beyond the scope of this post.

For me, the abortion debate has been more than a debate regarding the question of when life begins.

It's a debate about *sex*.

Abortion on demand is central to a culture that values sexual relations between men and women more highly than it values children and their upbringing. If suddenly all American men and women stopped having sex with each other, and children were conceived by artificial means only, *Roe* and the arguments over it would become instant irrelevancies.

By the time we find ourselves arguing about murder and rights to privacy, it's too late. We need to engage in open, honest, philosophical debate about sex and its consequences *before* the lights go out.

Add starShareEmail (Updated)Add tags

Feb 26, 2006 10:34 AM

Wanna Bet?

from drfleablog by Flea

The most common reason fleas like me get sued is the missed diagnosis of meningitis, according to ProMutual Group, my malpractice insurance carrier.

Let us consider the case of the young child with fever and no other sign of illness. No runny nose, no cough, no vomiting and diarrhea, no pain on urination. Could this child have meningitis?

Children between 6 months and three years old are the toughest diagnostic cases because they don't show classic signs of meningitis, and yet the risk of developing the illness in an otherwise well-appearing child with a fever is very low. The most generous estimate is that there is a 1/2,500 chance such a child with high fever has meningitis.

Is it possible to do other tests to help you decide whether this child needs a spinal tap and admission to hospital? Yes, a doctor can draw a complete blood count and obtain urine, either by having the child pee in a cup or by sticking a catheter in the child's urethra into her bladder. The doctor could also swab the child's nose and throat and check for viruses or strep.

But these tests are painful and traumatic for small children, not to mention expensive and (in some cases) difficult to perform correctly. If the child appears well (smiles appropriately, interacts with caregivers, no signs of dehydration, no trouble breathing), and if the family and physician can communicate easily with one another, a physician may choose to watch and wait.

But if he does so, he takes a 1/2,500 risk that he's wrong and the child will turn out to have meningitis and become very ill.

One in 2,500 sounds like pretty good odds, and they are. I, as a male flea, have a much better chance of developing prostate cancer. My odds of being killed in a car accident are about as good. I may just as well choose to keep the lines of communication open with this family, send the child home with no tests, and have them call me if she gets worse.

But there is a confounding factor here that may change my decision making: threat of malpractice. Every decsion I make as a flea can be thought of as a bet that I won't get sued.

Imagine a die with 2,500 sides, all numbered. I ask you to pick a number between 1 and 2,500. I roll the die. If any number other than your number comes up, I pay you $1. If your number comes up, you pay me $2,500. Do you take the bet?

The answer is 'no', you don't. Here's why:

The game I proposed is designed to illustrate a principle of "non-linearity of a utility curve". From a mathematical standpoint, you are perfectly justified to take the bet: the odds are 2,500:1 that you'll win a dollar. But what does a dollar matter to you? It will matter to you *a whole lot more* if you lose $2,500! In other words, it is much *much* more painful for you to lose $2,500 than it is pleasurable to win $1.

This principle holds if the odds are 1/2,500, 1/10,000, or 1/1,000,000! For a rational actor, the paltry amount of money you stand to win is nothing compared to the enormous amount you stand to lose. Therefore the rational decision is *never* to take the bet.

So it is with the workup of fever in a well-appearing 6-36 month old child. A doc is likely to win the bet that the child doesn't have meningitis, but she is not willing to endure the pain (to the child as well as to her) if she's wrong. Being sued for malpractice sucks. No one wants it to happen to them.

So why do I take this bet every day?

I do it because for me the pain, anxiety, and expense involved for me and for the family is too great in the face of slim odds. The bad outcome I face in the presence of a febrile 6-36 month old is fever phobia, overuse of medical services (including emergency services), fear of doctors, and most of all inculcation of the mistaken belief that children are essentially sick people, forever at the threshold of a life-threatening illness.

Bad stuff happens in life despite a physician's best efforts to prevent them. The two bad outcomes for which I have been sued came out of nowhere and blind-sided me. I

learned from these experiences that in principle bad outcomes cannot be completely prevented.

Good medicine demands taking bets against getting sued.

Add starShareEmail (Updated)Add tags

Feb 24, 2006 6:34 AM

Boys and Girls Shorts, Half Off

from drfleablog by Flea

For several months now, news reports have surfaced that several major retailers in the U.S. would soon begin providing health care clinics.

Last October, the Wall Street Journal reported that Wal-Mart, the nation's largest retailer, planned to open in-store health clinics. Services provided would include strep-throat tests, sports physicals and flu shots.

Payors like the idea, as Wal-Mart would bill a fraction of the cost of an emergency department visit, and clinics would be staffed by nurse-practitioners, who are reimbursed at lower rates than physicians.

Doctors are understandably ticked off about the idea, primarily because of the potential loss of market share. They are saying the right things however, such as "serious illnesses can look non-serious", etc.

This flea thinks it's a fabulous idea. Overuse of medical services is one of the major problems in American health care delivery, and no one gives a damn about it as long as the money keeps flowing.

Simple stuff like athlete's foot, conjunctivitis, and strep throat don't belong in a pediatrician's office. Better to put it in aisle 6, between feminine hygeine products and shaving paraphenalia

Add starShareEmail (Updated)Add tags

Feb 22, 2006 2:34 PM

Lead or Gold - II

from drfleablog by Flea

Bad news from Rhode Island.

It turns out that the state has prevailed in its lawsuit against three paint companies. The suit alleged that these companies created a "public health nuisance" in Rhode Island, by manufacturing paint containing lead.

Lead was banned from paint in 1978.

Nevertheless, the state wants the paint manufacturers to pay for the cost of abating remaining housing units containing lead paint.

Shares of Sherwin Williams fell 15 percent, and NL Industries fell 7.6 percent by the time of this posting.

Last June, DuPont Co. settled with Rhode Island by agreeing to pay several million dollars to the nonprofit group Children's Health Forum for lead paint remediation, public education, and compliance programs in Rhode Island.

The state brought in doctors as 'expert witnesses' to testify as to the dangers of lead poisoning.

Somehow, the state convinced a jury that paint companies went on making paint when

they knew of lead's dangers.

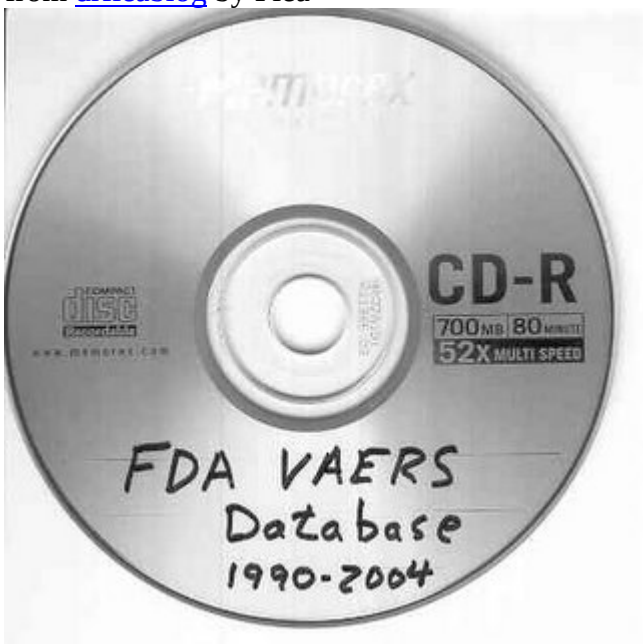
All this is going on while blood lead levels fall precipitously throughout the population, including in Rhode Island.

Who says alchemy went out with the dark ages?
Add starShareEmail (Updated)Add tags

Feb 22, 2006 10:35 AM

VAERS and Litigation

from drfleablog by Flea



Did you know that anybody can report an adverse reaction to a vaccine?

I didn't. But it seems suspiciously like a bunch of lawyers have figured this out for themselves. And doing so has helped them a great deal in vaccine-related litigation.

The suggestion that the VAERS database might have been tampered with was hinted at first by A Photon in the Darkness in July 2005 (or earlier - it appears to be a re-post).

It turns out the Photon was not suffering from a bout of cynicism. This month, Medpundit , Orac , and Overlawyered all noticed a study published in this month's number of Pediatrics . As I am a subscriber, I got a hold of the full text. The article documents an astronomical increase in the number of litigation-related 'adverse

reactions' that have been reported to the VAERS. It seems that when the authors searched the VAERS database for the words "lawyer", "legal", "attorney" or the substring "litigat", they found an explosion hits beginning in 2001. A large percentage of the litigation-related hits were linked to the word "thimerosal". These findings, and others, suggest strongly that the VAERS database has been infiltrated by those seeking to enrich themselves at the expense of vaccine manufacturers.

As the authors point out, in all likelihood their findings *under*estimate the number of bogus complaints filed in the VAERS, since it is not necessary to tell the system *why* you are making a report.

Let this be a shout out to those who follow the so-called 'vaccine controversy' carefully. Just because your source of information is the government, doesn't mean the data are worth a hill of beans.

Add starShareEmail (Updated)Add tags

Feb 21, 2006 8:29 AM

You Mean They Could Get Hurt?

from drfleablog by Flea

Honestly, I don't know what the editors of Pediatrics were thinking!

The February 2006 number includes a study by physicians at York University in Toronto, demonstrating that hockey-playing children get hurt when body checking is permitted.

It seems that in Ontario, where checking is permitted in the under-14 leagues, boys are nearly twice as likely to suffer checking-related injuries than boys in Quebec, where checking is not permitted.

A simply breathtaking finding, no?

The authors gratefully acknowledge funding from the Canadian Hospitals Injury Reporting and Prevention Program at The Hospital for Sick Children in Toronto. I'm sure the CHIRPP feels it's money was well spent.

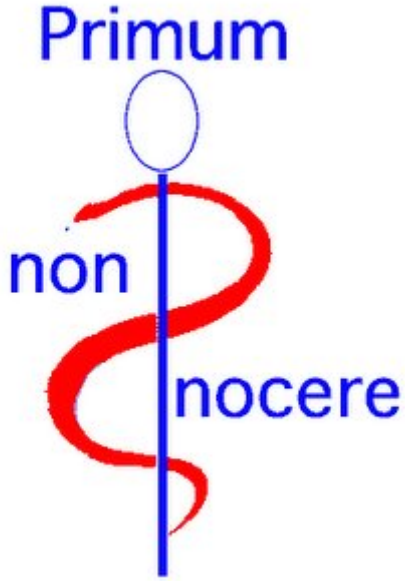
BTW, I derive no joy from pointing out that the hockey player hitting the ice is P.J. Axelsson of the Boston Bruins. The Bruins are having a lousy season.

Add starShareEmail (Updated)Add tags

Feb 21, 2006 8:29 AM

Not My Job

from drfleablog by Flea



What follows is *not* a brief regarding the death penalty.

I wish only to observe that two physicians have refused to participate in an execution in the state of California.

The request for the participation from an anesthesiologist seems silly in any case. In California, where the mode of execution is lethal injection, it isn't at all clear to this flea why an M.D. would be required to ensure that the condemned felt no pain.

Is a doctor necessary to certify that the condemned person has died? Clearly not. As my colleague Dr. Crippen has pointed out, non-physicians are fully capable of making a determination of death.

As to the question of whether a physician should participate in any capacity in an

execution, I side with the American Medical Association, who has deemed such participation unethical.

We're not in the death business, after all. We're in the life business.
Add starShareEmail (Updated)Add tags

Feb 20, 2006 6:29 AM

What Would We Do Without Misunderstanding-Experts?

from drfleablog by Flea

This headline from Reuters Health Service caught me attention today:

"Autism surrounded by misunderstanding-experts"

It's a report from the annual meeting of the American Academy for the Advancement of Science (AAAS), that is being held in St. Louis, MO this week. The AAAS is the organization that publishes the journal Science, the premier general-interest academic scientific journal in the U.S.

Annual meetings of this kind are usually attended by tens of thousands of participants, accompanied by an equal number of exhibitors (people trying to sell you stuff). The agenda usually includes hundreds of symposia and poster sessions, so many that one must consult a guide the size of a phone book to decide what to see and hear.

Not surprisingly, the symposium on autism caught the attention of Maggie Fox, the stringer from Reuters.

Ms. Fox relates how Dr. Laurent Mottron, from Montreal, claimed that most people with autism are more intelligent than previously believed, based on standard intelligence testing. That's encouraging news. The problem remains figuring out how to help autistic people harness that intelligence so that they can more effectively navigate through the world.

In similar fashion, Morton Gernsbacher from the University of Wisconsin-Madison challenged the theory that autistics lack a "theory of mind". As with intelligence testing, the wrong metrics are being used to study autistic people's minds. This too is encouraging, but what are we to do with the insight? How will we help autistics to make meaningful human connections?

An anti-climax was delivered by Dr. Judith Grether, an epidemiologist working for the state of California. Dr. Grether questioned the now commonplace assertion that we are in the midst of an **autism epidemic**. Unfortunately, it appears that Dr. Grether pulled some punches. At least according to Maggie Fox, Grether didn't mention diagnosis creep or observation bias. Grether would only say it's impossible to know if there are more cases of autism today because of our uncertainty as to how many true cases there were *in the past*.

The *denoument*, delivered by Dr. Irving Gottesman from the University of Minnesota, drove yet another nail in the coffin of the vaccine/autism 'controversy'.

As in a lousy horror movie, this thing keeps coming back from the dead. Parents continue to ask me about "things they've heard" about vaccines and autism.

Thank goodness I can now refer these parents to misunderstanding-experts to set them straight.

Add starShareEmail (Updated)Add tags

Feb 19, 2006 2:30 PM

An Attempt to Head Off Debate

from drfleablog by Flea

The circumcision debate has once again reared its... er... ugly head.

It seems a divorced couple in Chicago have gotten their names in the paper over a dispute as to whether their 8-year old will be circumcised. The mother's claim is that two of the boy's physicians have recommended a circumcision for medical reasons. The father has successfully blocked the procedure in court, claiming it is an "unnecessary amputation" that will cause the boy physical and emotional harm. Nothing will happen until the father gets the chance to plead his case in public.

According to "legal experts", there is no legal precedent in the U.S. concerning circumcision and the decision-making process surrounding it. The current regime honors the "best-interest of the child" standard.

The Flea is troubled by the whole thing. I don't wish to debate the medical pros and cons of the procedure. I am concerned here only with the effect this debate will have on two faith communities, Jews and Muslims.

I belong to the first community. Both my boys were circumcised (as I was) according to the dictates of Jewish law. Ritual circumcision, like the passover seder is a custom that Jews of all backgrounds and levels of observance take with the utmost seriousness. American jurisprudential precedent is not going to change the level commitment. All this negative attention, however, can only be bad for the Jews.

The logic works like this:

1. Circumcision is barbaric.
2. Jews perform circumcisions.
3. Jews are barbarians.

Jews have been down this road before. It's just that we've never been down this road in my lifetime in the country where I live.

American Muslims, on the other hand, are *very much* on that road right now in this country. If there were any community that could do without more negative attention, it's them.

As this chapter in the saga unfolds, I hope that the "pro" side will refrain from over-interpreting data that supports its position. And I hope that those who would use the occasion to bash Jews and Muslims will remain silent.

Add starShareEmail (Updated)Add tags

Feb 18, 2006 8:30 PM

Call the Mind Police!

from drfleablog by Flea

R.C. is a 17 month-old boy who's had a few more visits to the Emergency Department than your average toddler.

When he was 4 months old, his father tripped with the baby in his arms while trying to climb over the dog gate in his kitchen. Both father and son were injured, the son more seriously. The baby broke his femur, mid-shaft. He was casted and made a complete recovery.

A few months later, his mother placed him in his carseat, un-strapped, and placed the carseat on the counter-top in her kitchen. Moments later the boy pitched himself out onto the floor. He suffered only minor bruises.

This weekend, the mother called me to tell me that the father got bleach in the boy's eye. It seems the dad, a florist, had been cleaning out buckets and splashed the boy in the face. Dad called 911 this time. The boy's eyes were thoroughly flushed and he was discharged from the Emergency Department in good condition. The next day he developed a chemical conjunctivitis, but otherwise appears well.

In isolation, none of these events would have caused me to raise an eyebrow. But *three in 17 months*? Now, I'm starting to worry about what's going on here.

I've known these parents since they came to my office for a pre-natal consultation. The two of them can be described usefully, in our politically-correct parlance, as *limited*. In a less enlightened era you'd say they were just bone stupid.

Stupidity isn't a crime, but child abuse is.

Chapter 119, section 51A of the Massachusetts General Laws mandates me, as a health-care provider to file a report with the Department of Social Services when in my

"*professional capacity [I] have reasonable cause to believe that a child under the age of eighteen years is suffering physical or emotional injury resulting from abuse inflicted upon him which causes harm or substantial risk of harm to the child's health or welfare including sexual abuse, or from neglect, including malnutrition, or who is*

determined to be physically dependent upon an addictive drug at birth."

I should stress that I am a *mandated* reporter. In fact, *anyone* can "file a 51A" in Massachusetts, anonymously and without fear of retribution. After the accusation is made, DSS investigators descend on the home of the accused, and attempt to determine if abuse or neglect has taken place. The statute does not delineate the penalties incurred from not reporting abuse or neglect, but there are several "urban legends" about doctors who failed to file.

In residency, we were taught to file a 51A if we merely *suspect* abuse or neglect. An attorney once advised me to file if abuse were in the differential diagnosis of a child's injuries ("*But*, I argued to no avail, *abuse is in the differential diagnosis of* ***every*** *traumatic injury*!")

In American law, the subjective state of a person's mind is often legally relevant. For example, if you assault another person *with the intent to kill him*, the penalties to which you are liable are more severe than if you had no such intent. In most states, if you assault someone of a different race, religion, or sexual orientation because you *hate the difference*, you are subject to harsher penalties than if you simply assault him because he dissed you.

But I am unable to think of a crime or misdemeanor the commission of which requires the perpetrator's brain to adopt a specific subjective state, whereupon the subject *fails* to act on that subjective state.

But such is the mandate of the 51A. Now that suspicion regarding R.C.'s parents has sneaked into my brain, I am mandated by law to activate the social service machine. If I don't, the "Mind Police" may come knocking at my door.

George Orwell, may his memory be for a blessing, must be rolling in his grave.

Add starShareEmail (Updated)Add tags

Feb 16, 2006 5:54 AM

Is That Your Picture?

from drfleablog by Flea

Ummmm... Well, no actually it isn't. To my surprise (and to some perverse delight), Red State Moron tells me that a certain Michael Balzary (pictured on the right), bassist for the Red Hot Chili Peppers, has already adopted the moniker "Flea".

Alas, cruel Fate! Why dost thou mock me?!

Do I duck for cover under my desk until the threat of copyright infringement lawsuit passes?

Do I curse the darkness... or light a candle?

So I ripped off Balzary's pic from Wikipedia.

By the way, I chose this other picture here because of the phrase "Give it Away".

Against my better judgment, I embroiled myself yesterday in "comment-section shouting match" with a bunch of other anonymous and semi-anonymous commenters. The venue was Kevin, M.D.'s fine blog. The subject was defensive medicine.

You could say I got my little bass-playing tatoo'ed fanny smacked. Check it out. One of my "interlocutors" accused me of "giving it away" to "sodomite lawyers" (his words, not mine), because I refuse to practice defensive medicine. My personal forays into the legal world will no doubt occupy plenty of cyberspace at this blog in the future.

Meanwhile, Rock on, Flea.
Add starShareEmail (Updated)Add tags

Feb 16, 2006 5:54 AM

My Mother, the Forger - II

from drfleablog by Flea

A few weeks ago I posted a story about a mother in my practice who had stolen a "school excuse form" from my office and had been forging my name in order to avoid being penalized by the school for her son missing too many school days.

It seems mom got busted. The school confronted her about it and she was forced to fess up.

She called the office today and spoke to my nurse.

Mom has decided to leave my practice because she's so embarrassed about the whole thing. I can't say I blame her.

So it turns out I'll never get the chance to investigate this thing further. Was the mother getting some kind of secondary gain from keeping her only child at home with her? Was she lonely?

Was the boy having trouble at school? Maybe he was being harrassed by a bully?

I'm hoping the truth is that the mom just got tired of calling my office and asking for excuse notes. That explanation would allow me to vent my frustration at the school systems that choose not to trust parents.

Instead I'm afraid that I missed a chance to do some good for this family.
Add starShareEmail (Updated)Add tags

Feb 15, 2006 7:17 AM

Nature vs. Nurture?

from drfleablog by Flea

An anonymous commenter sent me this link to a debate in the British Journal of Psychiatry. At issue is the resolution "ADHD is best understood as a cultural construct". In the affirmative we have Dr. Sami Timimi, author of *Pathological Child Psychiatry and the Medicalization of Childhood*. The rebuttal is written by Professor Eric Taylor, a child psychiatrist practicing in London.

I urge readers to examine the arguments for themselves. I have a few observations.

Drs. Timimi and Taylor appear to agree more than they disagree. Both contend that cultural or "environmental" influences are essential to the creation of the category we call ADHD. Both acknowledge that genetic variability gives rise to individuals with different personalities, strengths and weaknesses.

As to the fundamental question "Are children with ADHD born or made?", Timimi and Taylor part company.

Timimi argues that 'the immaturity of children is a biological fact, but the ways in which this immaturity is understood and made meaningful is a fact of culture'. The cultural touchstones singled out by Timimi include 'loss of extended family support, mother blame..., pressure on schools, a breakdown in the moral authority of adults, parents being put in a double bind on the question of discipline, family life being busy and hyperactive, and a market economy value system that emphasises individuality, competitiveness, and independence.' Finally there is the profit-dependent pharmaceutical industry', and last but not least, 'a high-status profession [i.e., we fleas] looking for new roles...'.

Taylor counters that hyperactivity (he avoids the expression 'ADHD' for some reason) is neither cultural nor genetic: it arises from a combination of the two. He underscores the empiric observation that severely hyperactive children are at risk for poor outcomes later in life. Finally, Taylor observes that ADHD in the U.S. is both over-diagnosed and under-diagnosed, whereas in the U.K. he believes it to be mainly underdiagnosed. The severely affected children are potentially saved from bad outcomes with treatment.

From my vantage point in private pediatric practice, Dr. Timimi has the better argument. Particularly poignant is his observation that facile diagnostic categories such as ADHD discourage families and fleas from doing the hard work of solving difficult problems. Nothing good is easy.

In a previous post, I quoted a literature review by Lydia Furman in which she observed that ADHD has no known neurobiological basis. It is rather a constellation of symptoms that are characteristic of a number of well-described conditions, including, this flea would add, normal childhood behavior.

Add starShareEmail (Updated)Add tags

Feb 14, 2006 3:36 AM

Is That Love?

from drfleablog by Flea

You've left my ring by the soap
Now is that love?
You cleaned me out you could say broke
Now is that love?
The better better better it gets
The more these girls forget
That that is love.
Difford/Tillbrook - "Is that Love?"

I haven't eaten recently, so I'm confident I can get through some brief reflections on Valentine's Day without becoming physically ill.

- D.W. is 14 months old, the son of single mother, living at home with her parents, and a father I've never met. Mom and dad were never really going out anyway. She just got pregnant and that was it. D.W. has never seen his father, as far as I know.
- H.M. is a newborn. Mom and dad work at Pizzeria Uno. He's a Brazilian cook. She's an American waitress. He doesn't speak English. She doesn't speak Portuguese. I suppose they speak the "international language", *pizza*.
- S.G. is the child of an unmarried Chinese couple. Dad is a student. Mom, who speaks no English, is unemployed. Shortly after S.G. was born, her father sent her to China to be cared for by his mother.

I acknowledge that stable, committed relationships based on love are not guaranteed to every couple on this planet, including those who choose to have children, or end up with children without meaning to have them. Many of the parents in my practice have gotten the relationship part down pat- it's the stability and committment they have trouble with. Too many of them aren't even *trying*.

And now, as if to mock these unhappy couples, we have this travesty of a day ostensibly dedicated to the romantic ideal.

Do we need any more evidence that the great majority of Americans have no idea at all what love is?

Add starShareEmail (Updated)Add tags

Feb 13, 2006 11:24 AM

Pickin' Up the Pieces

from drfleablog by Flea

Today, this flea received a tasty little tidbit from ProMutual Group, my malpractice insurance carrier. It was a report entitled "Failure to Diagnose: Putting the Pieces Together". It is a risk management review of closed claims involving ProMutual between 2002 and 2004. Naturally, I skipped the introduction and turned immediately to the Pediatrics section.

As I expected, "failure to diagnose" is the most frequent and costly allegation in

Pediatrics. It turns out that ProMutual closed a mere 58 pediatric cases between 2002 and 2004. Of these, 1/3 were failure to diagnose cases. The document acknowledges that "pediatricians are at lower risk for claim and loss than some other specialties", but then it makes the following startling assertion:

"Because a child's life - or long-term health - may be in jeopardy *even when the clinical presentation does not automatically lead one to that conclusion*, it is incumbent upon pediatricians and, indeed upon all other physicians, *to maintain a high index of suspicion for the worst possibility*, to do appropriate testing to rule it out, and to document the process and the thinking that led to its acceptance or rejection as the final diagnosis." (emphasis mine)

I'm sorry, ProMutual, I cannot practice medicine this way. Let me give the most trivial of examples.

The worst that a child with a fever could have is sepsis or leukemia. I simply *cannot* maintain a high index of suspicion and do appropriate testing to rule out sepsis and leukemia (i.e., draw a complete blood count and blood culture) on every one of my patients with fever, without regard to the patient's clinical appearance.

That's worse than defensive medicine. It's bad medicine. If I must practice my profession badly in order to practice it at all, I'll quit medicine and go to law school.

Add starShareEmail (Updated)Add tags

Feb 12, 2006 7:25 AM

The Flu Story You Probably Won't Read

from drfleablog by Flea

Every flu season has a theme, or a story around which the majority of news coverage revolves. Once the theme is established, the media tend to stick with it, regardless of the final outcome of flu season.

During the 2003-2004 season, the theme centered on pediatric influenza. Prior to Thanksgiving, 2003, five youngsters died of influenza in the state of Colorado. What followed can be described fairly as a panic. At the height of the panic, telephone calls to this flea's office came at rate of 60 per hour. After each of my families had called me

for at least the second time, parents from *other doctors' practices* began calling, looking for vaccine. Largely as a result of these deaths, the CDC began reporting pediatric flu deaths in the 2004-2005 season.

In 2004-2005, the theme was the vaccine shortage caused by the unexpected shutdown of Chiron Corporation's flu vaccine operation on the eve of vaccination season. The run on vaccine that followed resulted in long lines outside of pharmacies and shopping malls. The signature story of the year centered on the tragic death of Marie Franklin, who died of head injuries suffered in a fall caused in part from standing in line for five hours waiting for flu vaccine.

This year, the theme was avian flu. And the theme is likely to remain thus until next year.

That would be a shame, because the *real story* is that this has been an **extraordinarily mild flu season**. According to the CDC's weekly flu report, nationwide cases of influenza peaked in the last week of December, 2005, and have been declining steadily since. Even at its peak, the number of reported cases was approximately one fourth of the total in recent years.

Happily, a few responsible news outlets have found the strength to pull their heads out of the guano long enough to report the good news about this year's flu season. All appeared in local or regional outlets.

- Angela Stewart, in the Newark (N.J.) Star-Ledger, filed this report on February 10.
- Linda Lamb, writing for The (Columbia, SC) State, filed this piece on February 9.
- Dayna Brown, in the Journal Star (Peoria, IL) filed this on February 9.
- Jessica Cervantez, posted this at the web site of KTRE-TV, Lufkin/Nagadoches, TX. By the way, Ms. Cervantez's bio indicates that she joined the television station in 2002 and that this is her first job. Perhaps these ladies are hungrier for good stories than their more experienced colleagues?

The flea eagerly awaits the day that the major outlets pick up the story. When they do, we can thank a few hard-working cub reporters for breaking it down for them.

Add starShareEmail (Updated)Add tags

Feb 11, 2006 5:25 PM

Good News in a Black Box?

from drfleablog by Flea

David Williams over at Health Business Blog alerted me to a stunning piece of news. It seems that a Food and Drug Administration panel of advisors has recommended a "Black Box" warning for ADHD drugs. The majority of these medications are central nervous system stimulants. There have been a number of reports of cardiovascular deaths in patients taking some of these medicines. The reports this flea read did not specify whether any of the deaths or injuries occurred in children.

Last year, Canada briefly pulled Adderall XR from the market, but reversed it's decision when it turned out that there was insufficient evidence to link adverse events with the drug.

In this flea's opinion, the FDA has been too quick to slap warnings on drugs or to pull them altogether. A few years back, pediatricians lost Cisapride, a terrific prokinetic agent for the treatment of intractable gastroesophageal reflux, after reports of serious cardiac arrhythmias and deaths in a small handful of patients. Again, it isn't clear how many, if any, were children.

This time, for a change I found myself cheering for the FDA! Nevertheless, the panel's recommendations may not be taken up by the agency as a whole. The celebration may be premature.

If there were ever a time to end this love affair with stimulant medications, this would be it. Anything that makes parents less anxious to demand these medications from me is a good thing.

Add starShareEmail (Updated)Add tags

Feb 10, 2006 5:25 AM

Rhode Island's Heavy Metal Problem

from drfleablog by Flea

The state of Rhode Island has a problem with heavy metal. In February, 2003, the heavy-metal band Great White played the Station nightclub in West Warwick, RI. At the end of a set, the band's manager set off a planned pyrotechnics display that accidently triggered a fire. One hundred patrons were killed and 200 more were injured. The legal proceedings continue three years later.

But this juriprudential disaster is nothing compared to the lawsuit currently pending between the RI state attorney general and four housepaint manufacturers. The heavy metal in question here is lead.

The suit alleges that lead paint, banned in the U.S. in 1977, continues to pose a "public health nuisance" to Rhode Island. The state is asking for the paint companies to pay for the clean-up of remaining housing stock that contains layers of lead paint. The case was sent to a jury yesterday.

The problem with this lawsuit, and cases similar to it, is that environmental lead is disappearing from the environment. Blood lead levels in our children have fallen dramatically in the last 25 years. These findings are well documented in the National Health and Nutrition Examination Survey (NHANES).

In my own practice, over 90% of my one-year olds have *undetectable* blood lead levels. Of my patients born in New England, there is not a single patient with a blood lead level above the "level of concern", 10 mcg/dL.

At the same time, lawsuits related to environmental lead are increasing as the total mass of lead in the environment decreases.

In 1995, a woman named Nancy Hallaway wrote a book called "Turning Lead into Gold". Ostensibly, it is the story of how her twins were diagnosed with ADHD, and her subsequent linking of this diagnosis to high blood lead levels.

Ms. Hallaway completely missed the irony in her book's title. She and others have been turning lead into gold for years. I suspect they will continue to do so long after the last traces of environmental lead have been cleaned up.

Add starShareEmail (Updated)Add tags

Feb 9, 2006 5:22 AM

Doctors Don't Get Sick

from drfleablog by Flea

Says who?

Doctors get sick. Some doctors get sick *a lot*. Most folks believe that exposure to all those sick people boosts a doctor's immunity. It's bunk.

This is the same mythology that causes parents to believe they are doing their infants a favor by putting them in day care.

"Isn't it good for her to get sick, doctor?"

"No."

"What do you mean, doctor? If she gets sick now, won't it build up her immune system?"

I try to explain, patiently. There are over 200 varieties of the most common cold virus. If a child were to contract a cold at a frequency of once every two weeks, she would be a junior in college before she caught them all. And that's just *one type* of virus. There are several others.

This flea is testing that proposition in a big way. Since entering primary care 5 1/2 years ago, I have contracted an acute illness with a frequency of approximately once every 3 weeks. That's an average of 14 times per year. If your math is as bad as mine,

I'll do the calculation for you: that makes **77** acute illnesses in the last 5.5 years.

The latest came on yesterday.

I've tried everything to prevent this. I wash my hands like a maniac before and after every patient. I try to get 8 hours of sleep. I try to exercise at least 4 days per week. I try to eat well. I keep plenty of Neosporin on hand.

Recently I began taking megadoses of Vitamin C. I take an Airborne every day. All the latter does for me is give me terrible bloating and gas.

I cannot afford to take sick days, as I am a solo practitioner. If I don't work, I don't get paid and the patients don't get seen. As you might imagine, it does not inspire confidence in parents to visit a pediatrician who appears ill himself. Therefore I must medicate myself heavily so as to appear to feel much better than I actually do.

I confess that some days I am able to muster less than my usual dose of sympathy for a family who drags a child to my office for a sick visit, kicking and screaming, when the child clearly feels better than I do.

I want to tell these parents the truth. "Look, I feel like crap and *I'm working* for heaven's sake! Take the child home and give him some TLC. That's what he *really* needs!"

One day, perhaps, I'll get up the nerve.

Add starShareEmail (Updated)Add tags

Feb 8, 2006 5:23 AM

Lydia Furman, Vox Clamantis in Deserto

from drfleablog by Flea

This month, the Journal of Child Neurology published an impressive review article on the Attention Deficit with Hyperactivity Disorder (ADHD). The author is Lydia Furman, MD, from the Department of Pediatrics at Case Western Reserve University, Cleveland, Ohio. Furman carefully reviews the current literature on the characterization, diagnosis, and management of ADHD. She finds that ADHD as a diagnosis stands on shaky ground at best. Furman's conclusions are so stunning, and so contrary to the *zeitgeist*, that they bear reproducing here at some length.

"[A]fter careful review of the evidence available, it is not obvious that ADHD is either a disease or a neurobehavioral condition. ADHD is a collection of symptoms, namely, inattention, impulsivity, and overactivity, that overlaps with other major and minor mental health conditions. No diagnostic test confirms the diagnosis of ADHD, and no investigative study has identified an etiology for ADHD. Screening tools and diagnostic criteria are not validated."

Then, as if destruction of the entire ADHD edifice were not enough, Dr. Furman goes on to speculate as why the myth of "ADHD as disease" will not die.

"There are extraordinary societal and financial pressures that lead to the diagnosis of ADHD and the use of stimulant medications in school-aged children with behavioral difficulties. These include (1) inadequate availability and funding of both mental health services and educational testing resources, (2) a change in 1991 that led to the inclusion of ADHD as a reimbursable diagnosis for educational disability services under the Individuals with Disabilities Educational Act, (3) a strong marketing effort by the pharmaceutical industry for use of stimulant medications (eg, the funding of Children withAttention Deficit Disorder [CHADD], a parent support group for ADHD), and (4) economic pressures on families for both parents to work longer hours, leaving less time for approaches that require "talking therapy," making a "quick fix" involving medication and "med checks" more desirable."

And finally, the voice of reason delivers the *coup de grace*:

"Every child deserves to be cared for as an individual. Prudent and thoughtful

evaluation of symptoms, including educational, psychiatric, or psychologic, and family assessment begin the process of understanding the individual child's difficulties and needs and of deciding which interventions will be most helpful to the child. Children deserve our "best shot"even in the face of resource scarcity, not a "one size fits all" approach. Certainly, many practitioners might disagree with this minority viewpoint, but the care of children can only benefit, one hopes, from transparent dialogue about challenging clinical problems."

Bravo, Dr. Furman! Well said.

Add starShareEmail (Updated)Add tags

Feb 7, 2006 7:42 AM

The Plague

from drfleablog by Flea

"[The]...pandemic is going to happen. For the American public in particular, I think it will be horrific." - Dr. Greg Poland, Mayo Clinic

My phone fairly rings off the hook. Desperate parents demanding to know where they can find medication. Why won't I write a prescription?

Then the existential questions begin to come in: Why weren't we prepared for this? Don't we have a Department of Homeland Security? What are we paying taxes for?

Then I receive the phone call every parent dreads. It's from the school nurse. My kid's **got it**.

"Someone is going to have to come pick him up because I found some lice in his hair."

Oh good God, NO!!! How could this happen to us?

Please forgive me for making light of the fuss about bird flu. The truth is that planning for the latter has been quite good, in my opinion. The calls to my office demanding prescriptions for Tamiflu have been thankfully few.

What concerns me more is the fuss being made over head lice. To hear some parents talk about this, you'd think the plague *had indeed* arrived! Lord knows how flipped out folks will get when the next mysterious pathogen comes round (think SARS).

For the record, especially for those who followed the link in this paragraph, "pediculosis" is not an *infection*, it's an *infestation*. No one ever died of head lice. No one even got particularly sick from it. The worst that can happen is you could get a superficial skin infection from scratching too much. For that you can use my secret remedy.

The treatments are fairly benign and can be purchased over-the-counter. We used Hair Clean 1-2-3 for my son. He handled the whole thing quite nicely.

By the way, the photo is an image of *The Plague at Ashdod* by Poussin. It hangs in the Louvre.

Add starShareEmail (Updated)Add tags

Feb 6, 2006 7:54 AM

Mannish Flea

from drfleablog by Flea
That wasn't so bad.

I fired my secretary this morning.

At the risk of boring both my devoted readers, the issue was health insurance. He gets health insurance at his other job. He insisted that I give him health insurance as well. I disagreed.

That and he was a lousy secretary.

So there it is: the Flea fired his first employee! Maybe there's a little man inside the tiny arthropod... Nah! I'm still a flea.

I'm gonna go home tonight, put on some blues, kick back all six legs and pour me a shot of somethin' fine.

Add starShareEmail (Updated)Add tags

Feb 5, 2006 5:54 AM

Why I Blog

from drfleablog by Dr. Flea

<-- Here's the *real* reason I blog. It's Neosporin. For those of you unfamiliar with the stuff, it's a triple-antibiotic ointment, consisting of Bacitracin, Polymixin B, and Neomycin. There are several generic versions, or store brands.

I'm crazy about Neosporin. No really, I mean I have this crazy infatuation with an over-the-counter antibiotic. It's my Windex. I recommend it for just about anything that appears on the skin of my patients that doesn't look like eczema or or classic candidal diaper rash or any other non-scary-looking skin condition I can't identify. If there is broken skin, in addition to whatever I recommend, I recommend Neosporin. It really seems to speed healing and prevent deeper soft-tissue infections.

One day, I checked out the ingredients for Neosporin Ophthalmic Ointment (for eyes). To treat bacterial conjunctivitis, you need a prescription for this stuff, but not for the OTC version. I was surpised to find that the ingredients were essentially identical to those in the OTC version. How come you can put one in the eyes and the other you can't?

The answer, for all intents and purposes, is that you *can* put Neosporin in the eye. The only difference between the prescription-strength, and the non-prescription strength is a bunch of inert ingredients (see below) and a guarantee of purity.

But regarding purity, how likely is this stuff to become contaminated? Very very unlikely. It's a *mixture of three antibiotics* for pete's sake!

What about the "inactive ingredients" (cocoa butter, cottonseed oil, olive oil, sodium pyruvate, vitamin E, and white petrolatum). You don't want to put those in your eye, do you? Well, it turns out you can do this too. If you don't like the idea of cocoa butter and those oils, you can use the 'generic' brands, such as CVS. These contain only petrolatum, as in the prescription-strength ophthalmic preparation.

I have been recommending this for bacterial conjunctivitis for years. I have found it to be safe and effective.

The problem is that the label says you shouldn't put in your eye, and the pharmacist will tell you the same.

Here's the bottom line: conjunctivitis generates a lot of business for fleas like me and for pharmaceutical companies (for example, see Vigamox and Ocuflox.) It wastes enormous amount of time on the part of childcare providers, parents, and pediatricians.

The reason I blog is because I can whisper this in the ears of my patients, but I feel I cannot tell the world, for fear of a backlash, or worse, litigation. If a child should somehow be injured, and I recommended an "off-label" indication for an OTC drug, and the label explicit says I shouldn't have made such a recommendation, I'm screwed.

But come on, people! This is Neosporin!

Add starShareEmail (Updated)Add tags

Feb 4, 2006 8:21 PM

Fireflea

from drfleablog by Dr. Flea

I have to fire my secretary.

I don't wish to upload here a litany of grievances against one stinky employee. I mean to explore the lengths to which a flea must go in order to stand up and act like a man.

The stereotypical pediatrician is a nice guy. He wears cute ties. Fuzzy creatures dangle from his stethoscope. He tells jokes and plays with toys on the floor with patients. He tends to smile and bow before those physicians higher than he on the evolutionary scale. In other words, he's a flea (see also, nebish).

The problem is that this particular flea is also the boss. Bosses need to do unpleasant things like pay bills and fire people.

As I've never fired anybody before, I asked friends for advice. I visited web sites. Still I'm afraid the worst-case scenarios are going to play out: He'll raise a fuss; He'll get violent; Or worse, he'll *sue* me.

I don't know how long it will take me to prepare for this, but it will happen this week.

Wish me luck.
Add starShareEmail (Updated)Add tags

Feb 3, 2006 2:10 PM

Ain't No Big Deal

from drfleablog by Dr. Flea
If I lose my baby or miss a meal/
I'll get me another, ain't no big deal/
I said I'll get me another, ain't no big deal
Robert Cray

Against my better judgment, I am going to ignore the admonition of my friend Dr. Crippen and comment on a post he left this morning at NHS Doctor Blog. Dr. Crippen was kind enough to recognize my new effort here. I make this contribution only as a gesture of respect to Dr. C, not to create an argument.

The subject is sex education in the schools.

I have no problem with sex education *per se*. It is only that there is an item in the curriculum that is absent and I wish it were there.

I wish the children would be taught that the decision to have sex early in life has consequences. Sex with numerous partners has consequences. The consequences I am referring to are not unwanted pregnancies and sexually-transmitted diseases. What is at stake here is the devaluation of the sexual bond.

For too many young people today, sex is simply "no big deal". When something as important as sex becomes no big deal, it is nigh impossible to make it a big deal again.

What will happen when these young people enter long-term stable, loving relationships? I fear that they will miss something crucial, and that is the magic and power that the sexual bond brings to the union of two people.

As a pediatrician, my advice to young people is to keep it in their knickers. And not because I'm concerned about pregnancy or STDs. I'm concerned about their happiness.
Add starShareEmail (Updated)Add tags

Feb 2, 2006 6:31 AM

Stay Inside, For Heaven's Sake!

from drfleablog by Dr. Flea

Today, a tiny defenseless creature was wrapped up and dragged out into the cold for no good reason whatsoever.

This newborn, born at term to a first-time mother, was breastfeeding well and was even gaining weight before discharge from the hospital! The family and I had arranged for me to pay a house-call this week. But the discharging pediatrician at the hospital insisted that the baby be seen in my office the next day, for reasons of... well it isn't clear why the baby needs to be seen the next day! In fact, there are *no* evidence-based guidelines that suggest a need for such early follow-up of healthy term infants.

Newborn babies are exquisitely sensitive to sensory stimuli. Unlike us, they are unable to filter unimportant, especially *unpleasant* sensory stimuli, *e.g.* being bundled up and dragged out of the house on a Winter morning. When overstimulated, babies tend to shut down and go to sleep, only to awaken later fussy and feeding poorly.

For this, and other reasons, I prefer to visit newborns at home. But because a doc in a hospital in the big city felt the need to cover her ass for some vague reason (my guess is irrational fear of liability), this baby will be dragged out of the house by a pair of sleepy new parents and exposed to cold, stress, and possible infection by stray microbes in my office.

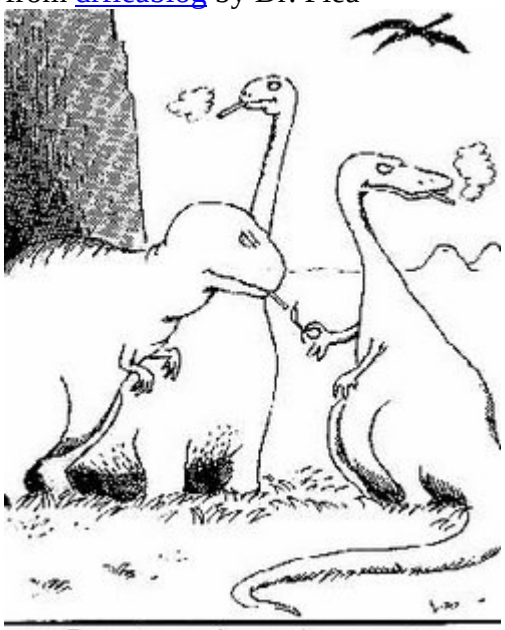
By the way, is there a dumber holiday than Groundhog Day? Probably yes. My vote goes to Valentine's Day.

Add starShareEmail (Updated)Add tags

Feb 1, 2006 12:30 PM

Saving the Dinosaur

from drfleablog by Dr. Flea



The real reason dinosaurs became extinct

One of my colleagues refers to Pediatrics as the "Dinosaur of Medicine". What he means is that, after a mere 150 years on earth, the primary care pediatrician is finding himself unfit for survival.

Advances in Public Health, Epidemiology, and Medicine (in that order) are responsible for leaving pediatricians with little to do. Clean water sources, reliable and plentiful food supplies, washable clothing, indoor plumbing, vaccines, and medical-technological advances have gradually eliminated diseases that kept the pediatrician of 100 years ago busy. Today's pediatric residents learn about protein-calorie malnutrition, epidemic diarrheal illnesses, Typhus, and Smallpox (to provide a small sample) but they will never see them in their professional lifetimes.

But fleas are survivors. Now that our erstwhile enemies are gone, we must *create* enemies to fight, lest we drift into oblivion.

Thank goodness for that cranial sinus the anatomists call "the middle ear"! Thank goodness it occasionally fills with pus! Because of you, middle ear, I will live to fight another day!

Thank Heaven for "failure of executive function", whatever that is! Thank Heaven my preferred provider organization pays me to "manage" the disease they call ADHD!

Now I can see well children in my office and code 99214's without guilt or fear of audit!

And thank the Lord for the Autism Spectrum Disorder! Fervently we pray for the day when all Your children, the odd ones as well as the not-so-odd ones, shall gather together under the shelter of "pervasive developmental disorder, all-inclusive type"!

I *will* survive.

Add starShareEmail (Updated)Add tags

Jan 31, 2006 12:30 PM

My Mother, the Forger

from drfleablog by Dr. Flea

My office received a fax today from a school nurse. The fax contained a photocopy of one of our standard "school excuse" forms, filled out in handwriting I did not recognize.

It seems a mother in my practice has acquired a blank form and has been using it to excuse her 10 year-old boy from school. According to the nurse, this mother has sent the school similar forms on several occasions. On each of these forms, my name is written out long-hand. There is no forged signature.

I have two opinions on this subject. First, I'm unhappy that the mother has been filling out these forms on her own, particularly as I would have excused her child on her behalf after discussing the matter with her. I am only secondarily concerned that this mother might be keeping her child out of school for some other reason. Either mother or son or both may be benefitting from some "secondary gain" by his staying home. This may be worth investigating.

On the other hand, I'm unhappy that I am compelled by my State to excuse children from school a) with whom I do not live and b) (in some cases) whom I do not know very well.

There was a time in the not so distant past of human history when parents were permitted to excuse their own children from school. The presumption was that parents were smart enough to know, without the assistance of a physician, that their children were sick enough to stay home from school. Today, schools distrust parents so much that they transfer what is properly a *parental* responsibility to pediatricians.

Schools treat *both* parents and pediatricians like fleas. It's an offensive, wasteful practice, and it should stop.

Add starShareEmail (Updated)Add tags

Jan 30, 2006 12:40 PM

Good News...Really!

from drfleablog by Dr. Flea
An anonymous contributor wonders why some parents are so worried about autism in their children. Many parents worry that late appearance of certain developmental milestones may signal autism.

The Flea himself remembers worrying when his first child did not develop a social smile at eight weeks of age. The fear is understandable, but it is unfortunate to say the least. The fear is a symptom of a more serious disease.

The disease is our inability to accommodate ourselves to good news. The good news is that American children are blessed. Statistically speaking, American children are the healthiest human beings who ever lived.

Three hundred years ago, American parents could expect some or all of their children to die before reaching maturity. If they lived, many suffered terribly from disease and deprivation.

Humans are conditioned to live in a dangerous and deadly world. We have developed a natural anxiety, to help us prepare and deal with saber tooth tigers, infant deaths, and other horrors of daily life.

Today, there are no more saber tooth tigers and virtually all our children survive infancy. But we have not lost our anxiety. We appear to *need something to worry about*, so we grasp any and all opportunities to worry we can find. In the absence of real dangers, our anxiety no longer serves us well. At best, we become simply vigilant.

Many become unnecessarily worried about non-worrisome things. At worst, we become silly.

Fear of Autism is one of many "worries of the moment". This too will pass, and something else will replace it.

I'm a flea, but I'm not callous. I see first hand the pain suffered by parents of autistic children in my practice. Fortunately, contrary to popular opinion, true autism is very rare. Most of the things we're worried about never happen.

For a book-length discussion of our primal instincts, and how they serve us ill in modern times, see Mean Genes, by Terry Burnham and Jay Phelan.

Add starShareEmail (Updated)Add tags

Jan 30, 2006 5:39 AM

My Dog Has Flea

from drfleablog by Dr. Flea

Flea wishes a very happy Year of the Dog to all my Chinese friends and colleagues! People born this year are said to embody the warmth and loyalty that characterizes our canine friends.

I'm pleased and gratified to be launching Flea on the eve of the Year of the Dog. What an auspicious sign!

Add starShareEmail (Updated)Add tags

Jan 30, 2006 5:39 AM

Pediatricians and Other Cavedwellers

from drfleablog by Dr. Flea

One hundred years ago, pediatricians would cut baby's gums with scalpels in order to "release" erupting teeth. The 'best science of the day' suggested that gum cutting could prevent serious illness and even death among infants.

Three hundred years ago, blood-letting was a common therapy for many ailments. On his deathbed, president George Washington was attended to by the finest physicians in the country. According to their own accounts, Washington was 'bled' numerous times before he finally succumbed. No doubt the volume of blood Washington lost hastened his death.

Thank Heavens those days are over, right? From our perspective, physicians 100 and 300 years ago were a bunch of cavedwellers. But they didn't think of themselves that way. To the contrary, physicians of every era tend to believe that they know just about everything there is to know about the human body, the diseases that afflict it, and how to treat them.

But to future generations of physicians, docs practicing today will surely generate the same slack-jawed disbelief with which we regard the gum-cutters and blood-letters.

This flea predicts that at least three common practices among pediatricians will be regarded by future generations as barbaric, or nearly so:

1. Our (over)treatment of acute ear infections with antibiotics.
2. Our (over)diagnosis and 'treatment' of autism spectrum disorders.
3. Our management of ADHD.

Add starShareEmail (Updated)Add tags

Jan 30, 2006 5:39 AM

Could It Be Autism?

from drfleablog by Flea
I received an email from the father of a 9-day old baby girl. Dad is concerned because his baby does not make eye contact with him or follow him when he moves. This is the second time this father expressed this concern to the flea. The first time was when the baby was 4 days old. (It is not normal for a baby to "fix and follow" until at least 2 months of age).

A few weeks ago, the mother of a 7 month-old boy withdrew him from my practice because she felt I was not paying adequate attention to her concerns about her son's development. It seems his head circumference had grown from the 25th percentile to the 75th percentile since birth. Mom had heard that such rapid growth could be a "red flag" for autism. I had already referred this baby to a developmental pediatrician because of mom and dad's concern over the baby's difficulty getting to sleep. On the basis of no fewer than 5 well-child visits to my office, my impression was that this baby's development was normal.

Then in the mail today, I received a complimentary copy of Could It Be Autism?, subtitled "A parent's guide to the first signs and next steps". A quick skim of the volume suggests that it is not the bomb-throwing, doctor-hating, vaccine-blaming diatribe I was expecting. Instead, it is a book-length pamphlet counseling parents to look closely for the absence of particular developmental milestones. If those milestones do not appear at the expected times, the parents are warned not to permit their pediatrician to say "let's wait and see". Instead, intensive developmental evaluations should ensue, lest valuable time for early intervention be wasted.

I'm quite sure this flea will have more to say about explosion of autism diagnoses in the last 10 years.

For now, suffice to say that my concern about this book is that it will be read by the parents described above. These parents, and thousands like them, are spending far too much time looking for something wrong with their children, and far too little time simply loving them, enjoying them, and being grateful for them.

Add starShareEmail (Updated)Add tags

Jan 30, 2006 5:39 AM

Everyone Else is Doing It, So What the Heck?

from drfleablog by Flea
It occurred to me the other day that I am one of the few human beings left on earth who

does *not yet* have a blog. Rather than suffer one more embarrassing moment at a cocktail party, I figured I'd give it a whirl.

Not a few of my physician colleagues have also launched themselves into the blogosphere. I resisted for some time because of liability concerns. For this and other reasons, I decided that if I were going to start blogging, I would have to do so anonymously.

A word about the name of the blog: The first time I heard the term 'flea' applied to a doctor I was in medical school. The anesthesia resident I was shadowing called everyone a flea who wasn't a surgeon or an anesthesiologist. As he knew that I was going to be a pediatrician, it was his way of letting me know our respective places in the pecking order.

Now I pick up my flea designation and pin it on as a badge of honor.

I am Flea. Hear me roar.