BERKOWITZ'S

Pediatrics

A PRIMARY CARE APPROACH

5th Edition

Carol D. Berkowitz, MD, FAAP

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

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A PRIMARY CARE APPROACH

5th Edition

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Preface

The expansion of immunizations has reduced or eliminated many of the infectious diseases that confronted the children and adolescents for whom pediatric clinicians cared. New and more challenging morbidities, including obesity, violence, and mental health concerns, confront pediatric patients, their families, and their health care professionals. This fifth edition of *Berkowitz's Pediatrics: A Primary Care Approach* examines a series of emerging entities that pediatricians are expected to be knowledgeable about and able to address. The edition also updates information about the ever-changing health care scene. Because we interface with other disciplines and are increasingly working as members of health care teams, we must be equipped to understand the principles of their practices and communicate effectively with them. And lastly, our multicultural society includes children from all parts of the world and from all kinds of families, and we need to be prepared to address their needs.

My thanks to all the contributors and to the staff of the American Academy of Pediatrics, especially Alain Park, Jason Crase, Carrie Peters, Linda Smessaert, and Theresa Wiener, and my assistant, Claudette Hoskins, for all their help.

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Primary Care: Skills and Concepts

CHAPTER 1

Primary Care: Introduction

Julie E. Noble, MD

Primary care is defined as the comprehensive health care that patients receive from the same health care professional over a longitudinal period. The term was first used in the 1960s to designate the role of the primary care physician in response to the abundance of subspecialists and lack of generalists among practicing physicians. It is generally accepted that primary care physicians include pediatricians, family physicians, and internists. In 1966, *The Graduate Education of Physicians: The Report of the Citizens Commission on Graduate Medical Education* (the Millis Committee Report) to the American Medical Association recognized the importance of primary care and recommended a national commitment to educating primary care physicians. Primary care was further defined in 1974 by Charney and Alpert, who separated it into component parts: first contact, longitudinal care, family orientation, and integration of comprehensive care. To understand the depth of primary care, the component parts should be explored.

First contact occurs when a patient arrives for medical care at the office of a primary care physician. The visit includes an intake history, complete physical examination, screening tests appropriate for age, and an assessment of problems with treatment (if indicated). Of great importance is the establishment of the physician-patient relationship. Physicians become the primary medical resource and counselors to these patients and their families and the first contacts when successive medical problems arise.

Longitudinal care, the second component of primary care, implies continuity of care over time. Physicians assume responsibility for issues concerning health and illness. In pediatrics, such care involves monitoring growth and development, following school progress, screening for commonly found disorders, making psychosocial assessments, promoting health, preventing illness with immunizations, and safety counseling programs.

Family orientation is the third component of primary care. Patients must be viewed in the context of their environment and family. Otherwise, practitioners cannot adequately care for patients. In pediatrics, a child's problems become the family's, and the family's problems become the child's. This has become increasingly apparent with the recognition that problems of poverty, drug use, HIV exposure, obesity, teenage pregnancy, and gang involvement directly affect a child's health and quality of life. The psychosocial forces in a particular child's life are intricately interwoven into his or her health care, and the assessment of these forces is an essential component of the primary care of that child. Environmental exposures have a direct effect on a child's health, and a primary care physician must have a knowledge of those environmental threats.

As pediatric medical problems become more complex, many health and educational resources in the community may be used to supplement care. Primary care physicians integrate and coordinate these services in the best interest of patients, thus providing **integration of comprehensive care,** the fourth component of primary care. Working with social service agencies, home care providers, educational agencies, and government agencies, physicians can use multiple resources for the benefit of patients. Understanding the resources of the community is an important part of a primary care physician's education.

Medical Home

When patients select a primary care physician, they have identified a medical home. That home incorporates the physical, psychologic, and social aspects of individual patients into comprehensive health care services, thus meeting the needs of the whole person. This concept of the medical home was first documented by the American Academy of Pediatrics (AAP) in 1967 in the book *Standards of Child Health Care,* which noted that a medical home should be a central source of all the child's medical records. The idea of a medical home developed into a method of providing comprehensive primary care and was successfully implemented in the 1980s by Calvin Sia, MD, FAAP, in Hawaii. He is considered to be the "father" of the medical home. In policy statements published in 1992 and 2002, the AAP defined the characteristics of a medical home to be "accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective." To make that home work for patients, geographic and financial accessibility are key elements. The most important aspect of a home is that it is a place where patients feel cared for.

Since its implementation in pediatrics in 2004, the medical home model was adopted by the American Academy of Family Physicians and American College of Physicians. Its definition was expanded to include use of electronic information services, population-based management of chronic illness, and continuous quality improvement. The concept has been accepted as a form of high-quality health care. Cost and quality benefits have been well documented. Recognizing these benefits, large corporations with practitioners formed the Patient-Centered Primary Care Collaborative to promote the idea of designated medical homes. As part of that collaborative, the National Committee for Quality Assurance adopted eligibility criteria for a practice to define itself as a medical home. Requirements for the designation include the adoption of health information

technology and decision-support systems, modification of clinical practice patterns, and ensuring continuity of care. With the advent of health care reform in the United States, as part of the effort to control the rising cost of health care, the federal government has endorsed the concept of the medical home model. The Academic Pediatric Association has defined the *family-centered* medial home to delineate the dependency of the child to the family and community in the medical home model.

Role of the Primary Care Pediatrician

As a primary care physician, the role of the pediatrician has not only included the care of acute illnesses and injuries but also the preventive aspects of well-child care with its focus on immunizations, tracking growth and development, and anticipatory guidance. Now there is a renewed emphasis on the importance of the role of the pediatric primary care physician in assessing the psychosocial aspects of pediatric patients. Termed the *new morbidity* by Robert Haggerty, MD, in the 1970s, recognizing these social issues, including family dysfunction; developmental problems, including learning disabilities; and behavioral problems, including emotional disorders, has become a significant part of the role of the physician. In 1993, the AAP stated that pediatricians are obliged to have knowledge of physical and environmental factors and behaviors affecting health, normal variations of behavior and emotional development, risk factors and behaviors affecting physical health, and behavior problems. The focus of the pediatrician should be detection, evaluation, and management, with referrals if needed. Newer morbidities secondary to the increasing complexity of our society were outlined in 2001 by the AAP. These include school problems, mood and anxiety disorders, adolescent suicide and homicide, firearms, school violence, drug and alcohol abuse, HIV, obesity, and the effects of the media on children. Other psychosocial factors such as poverty, homelessness, single-parent families, divorce, working parents, and child care necessitate that pediatricians work with social service agencies to deliver appropriate care to their patients. The role of the primary care physician is continually expanding in an effort to deliver comprehensive care to each patient in a medical home. Often this care is rendered by physician-led teams that include other health care professionals.

Subspecialist Care

Medical knowledge and technology have made amazing advancements in the past several decades. Total knowledge of all fields is impossible for individual physicians. As a result, the role of the subspecialist physician has developed as an adjunct to that of the primary care physician. New fields of subspecialties, such as child abuse pediatrics, have arisen as a response to increased knowledge. Primary care physicians should seek subspecialist consultation when the suspected or known disease process is unusual or complicated, when it demands specialized technology, or when they have little experience with the disease. Generally, subspecialists evaluate patients and concentrate on the organ system or disease process in their area of expertise.

Primary care physicians can use a subspecialist for a consultation or referral. When initiating a consultation, primary care physicians seek advice from the consultant on workup or management of the patient. Consulting physicians assess the patients with a history and physical examination, focusing on their specialty. They then recommend possible additional laboratory tests, offer a diagnosis and treatment plan, and send the patients back to their primary care physicians for coordination of further care.

Use of the subspecialist is termed **secondary care.** For example, an 8-year-old girl with weight loss and persistent abdominal pain has an upper gastrointestinal radiograph series that reveals a duodenal ulcer. She is sent by her primary care physician to a pediatric gastroenterologist for **consultation,** with a request for an endoscopy to allow definitive diagnosis and up-to-date management guidelines. The girl then returns to the primary care physician with recommendations for treatment and further care. Electronic, abbreviated consultations can now be done through an e-consultation system. These consultations give the primary care physician a treatment plan from the subspecialist to implement without a need for the subspecialist to see the patient.

Primary care physicians can also generate a referral to a subspecialist, which differs from a consultation. A **referral** requests that the subspecialist assume complete care of the patient. This transfer of a patient to a tertiary care site establishes a subspecialist as the coordinator of further health care for the patient. For example, a 4-year-old boy with recurrent fevers, hepatosplenomegaly, and blasts on peripheral blood smear is referred to a pediatric oncologist for diagnosis, the latest treatment, and ongoing medical care.

When requesting advice from subspecialists, whether on a consultative or referral basis, primary care physicians should outline specific questions with a probable diagnosis to be addressed by the subspecialist. For example, a consultation requesting evaluation of a child with hematuria is inappropriate. The primary care physician should perform a basic diagnostic evaluation and suggest the most likely diagnosis. The child can then be referred appropriately. For example, a child diagnosed with nephritis should be sent to a pediatric nephrologist, whereas a child diagnosed with Wilms tumor should be sent to a pediatric oncologist.

When primary care physicians and subspecialists function cooperatively and offer 3 levels of care (primary, referral, and consultative), patients receive the highest quality medical care. In general, care provided by subspecialists is characterized as being more expensive and procedure driven. Laboratory studies are ordered with increased frequency by subspecialists, further inflating the cost of medical care. If patients have no longitudinal health care and see multiple practitioners, repeat laboratory studies are often ordered. Primary care is believed to deliver more cost-effective, improved medical care. With the spiraling cost of medical care, there continues to be a nationwide movement to produce more primary care physicians. However, it should be remembered that the role of the subspecialist is an essential supplement to the primary care physician when managing complicated disease. A balance between

generalists and subspecialists needs to be maintained in the education process.

Laboratory Tests

For most conditions, the diagnosis is revealed by the history and physical examination in more than 95% of cases. Thus, good communication skills are a basic tenet of primary care. Patients frequently complain about unnecessary laboratory tests, which increase the cost of medical care, and the prescription of unnecessary medications. To lessen these problems, the primary care physician should use laboratory tests and medications discriminatingly, recognizing their value as well as their potential iatrogenic effects.

In primary care, laboratory tests should be used to help confirm a condition suspected on the basis of the history or physical examination or diagnose a condition that may not be apparent after a thorough history and physical assessment. In pediatrics especially, the value of each test result should be weighed against the inconvenience, discomfort, and possible side effects in children. Tests in at-risk children can also be used as screening tools to prevent disease or to identify a disease early so that treatment can begin and symptoms can be minimized. Laboratory studies can provide a variety of other information, including data to establish a diagnosis, knowledge necessary to select therapy or to monitor a disease, and information about the risk of future disease. Organ function, metabolic activity, and nutritional status can also be assessed, and evidence of neoplastic or infectious disease can be provided. In addition, laboratory studies can be used to identify infectious and therapeutic agents or poisons.

Screening laboratory tests are used when the incidence of an unsuspected condition is high enough in a general population to justify the expense of the test (see Chapter 11). Subclinical conditions, such as anemia, lead poisoning, and hypercholesterolemia, are part of some health maintenance assessments.

Physicians must remember that there is variability in test results and that laboratory error can occur. Laboratory results should always be viewed in the context of the patient. The sensitivity of a test, the ability of the test to detect low levels, and the specificity of a test for the substance being measured must also be considered by the physician when evaluating a test result.

Challenges for the Future

As this edition of *Berkowitz's Pediatrics: A Primary Care Approach* was being written, health care reform was being implemented in the United States. It remains apparent that the role of the primary care physician has increased in importance in health care delivery. Two of the basic tenets of primary care, accessibility and an ongoing relationship with the primary care physician (both of which are reported by patients to be very important), are now recognized as essential components of the medical home. The challenge continues to ensure continuity in health care funding to preserve the continuity of the medical home. Payment reform promises to improve payment to primary care practices and rewards high performance. Through accountable care organizations, as proposed in health care reform, primary care physicians would be the foundation of the organization whose mission is management of the continuum of care and cost as well as to ensure quality of care.

Access to same-day care, which is part of the obligation of the medical home and essential to pediatric patients, can be difficult in the busy schedule of primary care physicians. Practices need to accommodate these visits. Community health centers can provide excellent medical homes for children in families with low income, but these centers can have challenges with accessibility and adequate referral sources. Walk-in immediate medical care clinics and retail clinics have arisen, but episodic visits in a variety of settings do not deliver comprehensive care for the patient, and these short visits may not take into account the entirety of the patient's medical history. This creates a challenge for the primary care physician and medical home to develop a system to integrate the information from these encounters into the comprehensive medical record.

With the advent of hospitalists providing inpatient care, primary care physicians may not be included in in-patient management. They then face a challenge in retrieving important information about the care of their patients.

Medical care reform incorporates accountability, demonstration of quality of care, and standards of medical practice into the medical home model. These have increased the oversight and bureaucracy of medical care exponentially. This business of medicine with redundant oversight of medical care has put a tremendous burden of administrative activities in the lap of the primary care physician. There is a significant challenge to physicians to provide care while answering to administrative structures.

The biggest challenge to pediatric primary care physicians has always been to ensure the future of health care funding to provide access and availability in a medical home of health care to all children. The Patient Protection and Affordable Care Act will provide health coverage for nearly all children, but in a multi-payer, market-driven health care system, there will remain significant challenges. There continue to be a multitude of programs, varying in each state, to pay for children's health care. Families will move among payers, disrupting continuity of care. Universal health care for children is being advocated. Without a national plan for financing, children's health care will continue to be variable, leading to disparities in children's health.

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CHAPTER 2

Child Advocacy

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CASE STUDY

A 15-year-old boy is brought to the emergency department with a gunshot wound to his left leg. He says he was hanging out at the park with his friends when a random car drove by and shots were fired. Though he denies being in a gang, his mother expresses concerns in a conversation with the social worker. His physical examination reveals a gunshot wound to his left lower leg, with intact sensation, movement, and pulses in the left foot, and no other signs of injury. A radiograph shows a fractured left tibia, and he is admitted for orthopedic surgical treatment.

Questions

1. What does it mean to be a child advocate?
2. Aside from caring for individual patients, how can pediatricians promote the well-being of their communities?
3. What is the role of pediatricians in child advocacy?
4. What are the levels of advocacy?
5. How do pediatricians implement advocacy?

An advocate is someone who speaks on behalf of a person or cause. No group in our society has a greater need for advocates than children. Children are ill equipped to face the many threats to their health; they cannot obtain their own health insurance, access available social services, or even take themselves to the doctor when sick. Children also have no voice in our society. They cannot vote, donate money to political campaigns, or speak publicly to advance their interests. The word *advocate* is derived from a Latin root meaning "one who has been called to another's aid." From the beginnings of pediatrics as an independent branch of medicine, pediatricians have answered this call to advocate for the health and well-being of children.

The father of American pediatrics, Abraham Jacobi, MD, spent his career in the late 1800s and early 1900s advocating for children through legislation in New York and Washington, DC. He was a great teacher of pediatrics, introducing the discipline into academic medicine, but truly believed that physicians needed to be involved in public policy. Another founder of American pediatrics, Job Lewis Smith, MD, recognized the need for a clean water supply and decent housing to decrease the high infant mortality rate of his time. He worked through public advocacy to improve conditions not only for his patients but for children in general. The American Academy of Pediatrics (AAP) was founded on federal advocacy principles. In June 1921, the Sheppard-Towner Act on maternal and child health legislation was introduced into Congress. It was the first involvement of the federal government on behalf of children and provided federal matching funds to states for services for pregnant women and new mothers. The American Medical Association (AMA), worried that the legislation would lead to socialized medicine, condemned the act, while the AMA Section on Diseases of Children supported the legislation. When the act was up for reauthorization in 1930 and the AMA still opposed it, the pediatric group left the AMA and founded the AAP. This organization has been advocating for children ever since.

The New Morbidity

Advocacy has become increasingly important because the new morbidities in pediatric medicine are related to community forces. As our society has become more complicated, major health concerns have become even more intertwined with the environments in which children are involved. Child health outcomes improved dramatically in the 1900s with the development of vaccines, antibiotics, and new and improved surgical care to treat the classic morbidities of infectious disease, infant mortality, poor nutrition, epidemics, overcrowding, and chronic disease. But there emerged new morbidities that were negatively affecting child health outcomes. These morbidities of the 1960s to 1980s, as described by Robert Haggerty, MD, included family dysfunction, learning disabilities, emotional disorders, and educational problems. In the 1980s to 2000s, Judith Palfrey, MD, documented new challenges for pediatricians: social disarray, political ennui, the sequelae of high-tech care, and new epidemics of violence, AIDS, cocaine, and homelessness. The newest morbidities of the 21st century include the increased prevalence of childhood obesity, the rise in certain mental health issues, and significant health disparities among cultural and socioeconomic groups.

Though there has been improvement in recent years, many children in America continue to face challenges in obtaining access to quality health care. Over the past several decades, government programs like Medicaid and the Children's Health Insurance Program have expanded the availability of health care to children of limited financial means. As of 2012, there were still 6.6 million children younger than 18 years with no health insurance coverage, representing 8.9% of that population. Among children in poverty the

uninsured rate was 12.9%, versus 7.7% for children not in poverty. Racial and ethnic minorities were also more likely to be uninsured, with Hispanic children having the highest rate at 14.1%. Roughly one-third of all children were receiving coverage from public insurance programs.

It is clear that these significant issues affecting child health cannot be adequately dealt with on an individual basis but require advocacy on a community or national scale to improve child health outcomes and life for children.

Community Pediatrics

Community pediatrics has developed as the vehicle to implement advocacy. Robert Haggerty, MD, first originated the concept in 1968 in an article published in the *New England Journal of Medicine.* In his work as department chair of pediatrics at the University of Rochester, NY, he developed an extensive advocacy agenda for the children of the community of Rochester. Subsequently, the AAP published a policy statement from its Committee on Community Health Services, "The Pediatrician's Role in Community Pediatrics." The policy delineates 5 components of community pediatrics: a *perspective* from the individual patient to all the children in the community; a *recognition* that family, education, society, culture, spirituality, economy, environment, and politics all affect the health of children; a *synthesis* of clinical practice and public health principles directed to providing health care to a child and promoting the health of all children; a *commitment* to collaborate with the community to optimize health care for all children, especially disadvantaged children; and an *integral part* of the role of the pediatrician. All of these components are recommended as a part of pediatric practice, and training in advocacy has been instituted in pediatric training programs. Examples of potential involvement in the community include serving as a board member, developing health agendas, working with an existing organization to design and fund a community service project, and being a source of information for the community on child health issues.

Levels of Advocacy

Every pediatrician functions as a child advocate on a daily basis. With every patient encounter, the pediatrician advocates for care in the best interest of the patient. This first level of advocacy includes treating the *individual's* immediate medical needs, performing screening tests, giving anticipatory guidance, and coordinating referrals as needed. The pediatrician may step beyond direct medical care to advance the welfare of the child, for example, by writing letters to help a patient obtain social services or visiting a patient's school for an Individual Education Plan meeting. The second level of advocacy is *community* advocacy. Pediatricians are an integral part of the community, and the community directly affects the health of their patients. Thus, pediatricians have a responsibility to improve conditions in their community to benefit children. To do this, they must be familiar with the services that are available for children. They can develop relationships with child care centers, schools, community coalitions, city governments, and local organizations to advocate for the best interests of children. On a *state* level, pediatricians can work to improve health care resources or develop policies to help and protect children. Opportunities for involvement include working on legislation, budgets, regulations, and initiatives or working with the executive branch of local and state government. The next level of advocacy would be the *federal* level, at which pediatricians can be involved with their senators and representatives lobbying for child health issues. Pediatricians may also be involved in testifying before a congressional subcommittee. The final level of advocacy is the *international* level. For example, pediatricians may decide to work with the World Health Organization to improve immunizations for all children worldwide. Global child health is now a focus of many advocacy training programs.

Becoming a Child Advocate

To become an effective child advocate, pediatricians must first identify an issue that they want to change or set a goal to improve the lives of children. The more specific the issue or goal, the easier it is to develop a solution. Ideas often come from clinical practice, where repeatedly engaging in individual advocacy efforts on behalf of patients with the same problems suggests the need for a larger solution. The first step is to obtain background information about the problem and to collect objective data that supports the need for change, then to define the nature of the problem and the affected population in clear and precise terms.

Community Projects

Pediatricians may find that the issue would be best addressed through a community advocacy project. In developing such a project, relationship with the community is of the utmost importance, and pediatricians should endeavor to become familiar with the community as a whole. Community exploration, potentially as simple as walking or driving through the community and looking around, can reveal areas of need, such as dilapidated housing or unsafe streets. Equally important is the discovery of the community's assets, institutions such as churches, schools, and banks, which give the community strength and could provide support and counsel for the project. Pediatricians should view themselves as members of the community, acting from within and in collaboration with the community, rather than as outsiders bringing about change externally.

The next step is to develop an intervention. After the possible solutions are considered, pediatricians should collaborate with community stakeholders to develop and implement the solution that is the most practical. Having credibility in the community makes the task of collaboration much easier. Everyone is more effective working with others, but collaboration necessitates the ability to compromise and be flexible in implementation plans. Larger projects may require funding, and grants may be sought from advocacy organizations, the government, or even local businesses. Data should be collected during the intervention to monitor the success of the project. If the project is successful, its methods may be adopted by child advocates in other communities.

Legislative Advocacy

Though initially daunting for physicians without political expertise, involvement in the legislative process is often the only way to effect a desired change for children's health. Information about the content and progress of existing bills is readily available online, and legislators can be contacted by letter, e-mail, or phone to offer a position. It is helpful to become familiar with the process by which a bill becomes a law at the state and federal levels; the identities of the important players change as a bill progresses through various subcommittees and committees and ultimately to a floor vote.

Pediatricians may also arrange to meet with a legislator or staff member at a district or capital office to discuss their position personally. In the dual role of scientist and healer, pediatricians are in a unique position to inspire the heart and the mind. It is important to state the problem clearly and explain why a new law is the solution, to present well-researched facts that support the position, and to stick to layman's terms, avoiding medical jargon whenever possible. Pediatricians should minimize the appearance of self-interest by focusing on how the proposal will help children, rather than how it will benefit the profession. It may also help to connect with the legislator by sharing a story about a patient encountered in practice who has been affected by the problem, especially if the patient is a constituent of the legislator (though the patient's identity must never be discussed without his or her consent). Leaving behind a concise fact sheet summarizing the position and pertinent background information will help ensure that the position is not forgotten when the legislator is considering the issue at a later date.

Pediatricians should be prepared to encounter opposition from some legislators and avoid responding with angry statements that would alienate a legislator. Effective advocacy requires building relationships with legislators over the long term, and a legislator who opposes a position one year may be a potential supporter the next year, when the political climate changes, or may be a potential ally on another important issue. There are a number of other pitfalls to avoid, such as making or agreeing with partisan statements or claiming to represent an organization like the AAP or an institution like a university without authorization. When asked a question they do not know the answer to, pediatricians should avoid guessing and should instead offer to do further research and contact the legislator with the requested information.

When developing a new legislative proposal from scratch, the challenge is to remember that although the factors contributing to child health may be numerous and complex, legislative proposals must by nature be concrete and limited. It may be best to start small and work for incremental change. The first step is to identify a clear and, if possible, measurable objective and define the target population. Other important information to know when drafting a proposal includes what the potential funding sources would be (if applicable) and which government agencies might be involved in implementation or enforcement. Pediatricians should partner with one or more legislators early on, as some of the finer points of the legislative process will be outside the experience of the average pediatrician, and because a bill must be sponsored by a legislator to be considered for passage. Building a coalition of support within the community, involving important stakeholders such as politicians, businesspeople, other health care professionals, educators, and parents, will help the bill gain political support.

Opposition should be expected, and potential sources of opposition should be identified in advance. If opposition from a powerful interest group is anticipated, it may help to meet with a representative of that group to explain the proposal. Potential arguments might include ways in which the proposal is really in the group's self-interest, the moral imperative to help children, or that opposing an initiative to benefit children might generate negative publicity. Compromising on aspects of the proposal should be considered, when doing so might turn an enemy into an ally. When facing intractable opposition from powerful interests, pediatricians and supporters should recruit even stronger allies into their coalition.

The process of turning a policy idea into real legislation may be lengthy. A bill may have to be reintroduced repeatedly over several years before achieving passage. Once a bill becomes a law, advocates must continue working to ensure that the bill is reauthorized when applicable and that regulatory processes develop favorably. Physicians who are recognized as experts in child health policy will be called on to testify before committees in Congress or the state legislature on policy issues affecting children.

Media Advocacy

The media, including newspapers, magazines, radio, television, and the Internet, are extremely influential in our society. News stories about child health and welfare may not always be written from a child-friendly point of view. Pediatricians play an important role in providing the media with better information and a different angle on a story. For instance, a pediatrician reading a newspaper story about a child who exhibited signs of autism spectrum disorder (ASD) shortly after his 1-year physical might write a letter to the editor discussing the lack of scientific evidence for a connection between vaccinations and ASD. Over time pediatricians can develop relationships with local journalists, who can then turn to them for information when covering child health stories.

A directed media campaign may also be a key element in an advocacy project. At the community level, the media can help spread ideas, notify the public of events, and bring out potential allies and coalition members. When advocating for legislation, pediatricians can use the media to reach legislators directly and, equally important, to reach thousands of the legislators' constituents all at once, who may in turn help pressure their legislators for change. In such situations, it is essential to plan a media strategy ahead of time by determining the most important target audience, selecting the appropriate types of media to approach, crafting a message appropriate to those media, and preparing thoughtfully for encounters with journalists.