

ON THE LEARNING CURVE

Pediatric Workforce Issues

While attending the recent American Academy of Pediatrics National Conference and Exhibition in Boston, I heard a presentation regarding pediatric workforce issues. It occurred to me that this would be a very useful topic for young physicians to be aware of, as our present situations are affected by the state of the workforce and our future careers will be affected by policies currently being enacted.

Workforce issues touch all aspects of our professional lives, including topics such as the availability of part-time work, diversity of the workforce, geographic distribution of pediatricians (general and subspecialist), and training and licensing.

As an example, the presentation I attended discussed reentry into the workforce after extended absence (greater than a year). This happens for various reasons, including but not limited to family, illness, alternative interests, and dissatisfaction with career.

Male and female, young and old physi-

cians take extended breaks from clinical work. Unfortunately, the mechanisms for preparing to reenter the pediatric workforce are largely haphazard, and many barriers exist. There are a few formal reentry training programs, but they may be hard to get to and expensive. There is no real guidance regarding the best way to get back up to speed. This is a topic currently under study by many health professional groups, including the American Academy of Pediatrics (AAP) and the American Medical Association (AMA), with the hope of affecting workforce policy.

Another recent example of an essential workforce issue is a policy statement released by the AAP, "Enhancing the Diversity of the Pediatric Workforce" (Pediatrics 2007;119:833-7). This policy statement addresses the importance of developing a diverse pediatric workforce, not only addressing race and ethnicity but also encouraging diversity of "language, national origin, religion, sexual orientation and physical disability." A

number of policy recommendations are made in this statement designed to encourage an increasingly diverse workforce in order to provide better, more easily accessible, and more culturally appropriate care to our patients. Discussion of other AAP workforce issues can be found at its Web site (www.aap.org/copw).

Graduate medical education (GME) is an important aspect of workforce development as well. Obviously, the type and amount of training that residents receive on various topics affect the future workforce; for example, a focus on advocacy may encourage more residents to enter less traditional pediatric careers. GME policies and regulations can play a role in encouraging residents to enter either primary care or subspecialties, and incentive programs can encourage geographic distribution to underserved areas. Increased options for part-time work during residency may further encourage a more diverse workforce.

As young physicians who will be affected by workforce changes and policies, we should be sure we have input into these decisions. At a local level, you can be involved within your workplace or community to effect change in areas such as

benefits for part-time employees and access to subspecialists. Additionally, many national organizations are working on workforce policy. For example, the AAP has committees on pediatric workforce and pediatric education, and sections on residents and young physicians (among many others). The AMA has a council on medical education and also has sections for various subgroups, including residents, young physicians, and women physicians. The Academic Pediatric Association also has a number of relevant special interest groups.

All of these organizations, and most other professional organizations, are eager for young physician input, and would welcome involvement.

Remember, decisions made regarding the pediatric workforce today will affect your practice for many years to come! ■

DR. BEERS is an assistant professor of pediatrics at Children's National Medical Center in Washington, D.C. She also is a member of the PEDIATRIC NEWS editorial advisory board and the American Academy of Pediatrics Committee on Residency Scholarships. Write to Dr. Beers at our editorial offices, pdnews@elsevier.com.



BY LEE SAVIO BEERS, M.D.

Free Drug Samples Are of Concern in Pediatric Population

BY SHARON WORCESTER
Southeast Bureau

Free drug samples not only do little to equalize medication access in the pediatric population, but they also may pose safety concerns in young patients, results of a recent study show.

The practice of providing free drug samples to children in nonurgent situations should be carefully reconsidered—and perhaps abandoned, the investigators concluded (Pediatrics 2008;122:736-42).

Study author Dr. Sarah L. Cutrona of Harvard Medical School, Boston, and her colleagues said the findings, which were based on nationally representative longitudinal survey data from 10,295 United States residents under age 18 years from the Agency for Healthcare Research and Quality 2004 Medical Expenditure Panel Survey, show that free drug samples tend to go to children with the best access to health care, not to those with the greatest financial need.

About 5% of the children in the survey received at least one free drug sample in 2004, and 10% of the children who received a prescription medication received a free drug sample that year.

On multivariate analyses, routine health care access, defined

for the study as three or more provider visits in 2004, was found to be associated with the receipt of free samples, but insurance status and family income was not found to play a role in determining which children received samples.

That is, poor children, defined as those from families with incomes less than 200% of the federal poverty level, were no more likely to receive free samples than were those from families with incomes of 400% of the poverty level or greater (3.8% vs. 5.9%; odds ratio, 0.78), and those who were uninsured for part or all of the year were no more likely to receive samples than were those who were insured for the entire year (4.5% vs. 5.1%; OR, 1.05).

In addition, Hispanic and non-white children were much less likely to receive free samples, compared with non-Hispanic white children (2.4% and 3.5%, respectively, vs. 6.2%; OR, 0.51 and 0.72, respectively).

Factors indicative of health care access also were associated with free sample receipt. For example, among those who received more free samples were those who had more visits to medical or dental providers (OR, 1.77 for two vs. one visit; OR,

3.25 for three or more vs. one visit), those who used office-based primary care vs. those with no usual site of care (OR, 1.52), and those who received more medications in 2004 were more likely to receive free samples (OR, 1.06 for incremental increase of one drug).

The high prevalence of drug sample use among pediatric pa-



'Does the availability of free samples influence a physician's overall prescription pattern?'

DR. FASSLER

tients also is of concern because the 15 most frequently distributed sample drugs in 2004 included two schedule II controlled medications (Strattera and Adderall). In addition, these two drugs, along with two others (Elidel and Advair) required a new or revised black box warning between 2004 and 2007. Elidel, for example, added a warning against use of the drug in children under age 2 years, yet the survey data indicate that nearly 38,200 children under age 2 years received free samples of this medication.

Although the findings suggest

that doctors make a sincere effort to provide free samples to needy children who arrive in the office, system-wide barriers to health care access appear to prevent the most disadvantaged children from benefiting from these efforts, Dr. Cutrona and her associates said.

For example, the findings—like those from a recently published national physician survey—indicate that physicians who practice in hospital or clinic settings, and who thus treat greater proportions of poor and uninsured patients, are much less likely than those in group or solo practices to receive free samples to provide to patients.

"If, as our study indicates, free samples fail to improve equality of medication access on a national scale, then their continued presence in family medicine and pediatric practices across the country may be difficult to justify," Dr. Cutrona and her associates commented.

The study—the first to look at free drug sample practices in the pediatric population—is an interesting and helpful study that draws attention to the widespread practice, Dr. David Fassler, clinical professor of psychiatry at the University of Vermont, Burlington, said in an interview.

"The authors raise legitimate

questions about the potential safety of current practices with respect to free samples. In particular, they report that controlled substances and treatments not generally considered "first line" were included in the list of medications most commonly distributed as free samples.

"Of particular concern, they also note that a significant number of very young children (under 2 years of age) received samples of medications which are specifically contraindicated for this age group," Dr. Fassler said.

However, based on the methodology employed, the study raises more questions than it answers, he said.

"For example, did the kids actually take the medication received as a free sample?"

"Did the families subsequently receive a prescription for ongoing treatment?"

"Does the availability of free samples influence a physician's overall prescription pattern?"

"The authors have opened an interesting avenue of inquiry. I expect these and other questions will be addressed in subsequent studies," he added.

The authors stated they had no financial relationships relevant to this study.

Dr. Fassler said he had no conflicts of interest with respect to this issue. ■