NCMIC

Pediatrics Round Table

Mike Whitmer:

Good afternoon and welcome. Thank you for joining us today. My name is Mike Whitmer. I'm Vice President of Corporate Relations with NCMIC, and I'm going to be moderating today's round table discussion. Before we get started, there's a few housekeeping notes I'd like to review. All listeners are on mute. If you have any questions, please enter them in the questions feature on your go-to webinar menu. We'll be answering questions as time allows at the end of the webinar. If we don't get to your question, please feel free to contact us. We're happy to talk with you and connect you to resources to help.

Mike Whitmer:

Today's webinar is live and being recorded. The recording will be emailed to registered attendees a couple of hours after the program. We'll also post the recording in the resources section of ncmic.com. It takes a bit of time to process the recording and get it posted, so please be patient with us. Our next webinar is September 15th at 2:00 PM Central time. The subject is low back pain, a topic that most chiropractors are interested in. Again, the webinar will be recorded if you can't watch live, so keep an eye out on your email for notifications of that webinar.

Mike Whitmer:

So now I'd like to introduce our guests and start our discussion. Sorry. Pediatric care is a growing niche within the chiropractic profession. Treating children can be such a rewarding experience for doctors, but beyond that, it's a great way for chiropractors to have further impact on the health and wellbeing of their communities. To discuss this huge topic, I'm so happy to be joined today by Drs. Jenny Brocker, Dr. Elise Hewitt, and Dr. Janet Lintala. All three are doctors who have pediatric care as a focus, and in some cases, the focus of their practices.

Mike Whitmer:

Because we have three guests today and all three have lengthy, distinguished CVs, I'd like to go around and have each guest introduce themselves and tell us why they've been involved with pediatric chiropractic. So let's start with Dr. Jenny. Brocker. Dr. Brocker, let's start with the basics, where you practice, went to chiropractic school, and then if you could focus in on the why. Why do you do what you do?

Dr. Jenny Brocker:

Yeah, absolutely. Well, thank you so much for having us today. It's always a pleasure to get to talk about pediatric care. And it is one of my favorite things to do, so I'm excited to be here. I grew up in the Midwest. I'm from Illinois. I attended Palmer Davenport for my chiropractic education, and I graduated in 2007. I'm an '07, too grad. And I moved to Oregon because that's where my husband wanted to live, and was fortunate enough to find a job with Dr. Elise pretty soon after school. And so, I've been in Portland, Oregon in private practice for 14 years.

Dr. Jenny Brocker:

And my love of pediatrics actually started when I was a kid. All I ever wanted to be when I was little, was a doctor who worked with kids. I went to college knowing I was going to work with kids. I went to chiropractic school knowing I was going to work with kids. And it was really for me, just a matter of time until I could find somebody to teach me. So I was lucky to find that really early out of school.

Dr. Jenny Brocker:

I love working with kids. I love being around kids. And one of my most favorite things about working with kids is being able to have a really profound impact on not just one person, but on a group of people by affecting the life of one person. So, when you can take a fussy child and help to give them some peace, you're not just affecting that child. You're also affecting their parents and their siblings and their grandparents, and whoever is coming into contact with that child. And so, it's one of my most favorite things about treating kids. You can really have such a profound impact on a family, on a community, by just changing the life of one child. And that's really where I find the most joy in working with kids.

Mike Whitmer:

Awesome. Thank you so much. Dr. Lintala.

Dr. Janet Lintala:

I live in Beckley, West Virginia, the Southern mountains of our state. And I went to National in Lombard, Illinois, and I had no idea I was going to work with children. I didn't have that vision that Dr. Jenny has. I graduated in December of '94 and one month later, the first of my three sons was born. And I didn't know it at the time, but I was already an autism mother.

Dr. Janet Lintala:

So for 14 years, can you imagine guys, 14 years? I couldn't practice because I didn't realize all the underlying medical issues that went along with autism. They don't sleep. They have tremendous gastrointestinal issues. They have mood and irritability and behavior problems and learning issues. And for many years we didn't know what we were even dealing with. But I threw myself into studying and learning everything I could about autism, and it comes to find out there's a lot of underlying medical conditions that cause all these behaviors and affect their language and their sleep.

Dr. Janet Lintala:

And I began doing free workshops in the community, and soon it grew to be a statewide thing. And finally, there was a lot of demand. And I didn't really have time to have a practice, but I opened a practice to accommodate all these autism families in our state. And so, I really kind of backed into having a mostly pediatric practice, but I've been in practice now for 14 years, so it's kind of even out there, 14 off, 14 on, and I've never looked back. It's really been gratifying to help so many people. I always say, "What heals the child heals the family," with autism anyway. So that's how I got into a pediatric practice.

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Mike Whitmer:

Awesome. Thank you so much. Dr. Hewitt. And before I turn it over to Dr. Hewitt, I do want to note to our listeners that Dr. Hewitt does have to drop off at 3:15 Central time, a little bit over an hour from now. So we're going to get as much from Dr. Hewitt as we possibly can before she has to drop off. So Dr. Hewitt, go ahead and introduce yourself. Thank you.

Dr. Elise Hewitt:

Yes. And I, again, want to just thank you for having us and for NCMIC supporting this panel and talking about pediatric chiropractic care, because it's something that I am so passionate about. And I feel like the only reason all children don't have at least an initial visit with a chiropractor is because the parents don't understand the value of chiropractic care for their child's health. So this will go a really long way to starting to spread the word more.

Dr. Elise Hewitt:

So about me. Let's see. I graduated from Western States a long time ago, back in the eighties, so I've been in practice 34 years now. I grew up on the East Coast, but I live in Portland, stayed out here after going to school. Didn't really know I was going to focus on pediatrics, but I was always drawn to treating children.

Dr. Elise Hewitt:

And finally, when I realized that it was the pediatric patients that really excited me and the adult patients, I was like, "Oh, I have another adult patient I'll treat." I realized I need to go where my heart really lights up. And so, I started to really focus in on pediatrics more and ended up getting my Diplomate Certification in pediatrics. I teach postgrad in pediatrics. My practice is limited to pediatrics, so I only see children, and it has been that way for probably 25 years now. And I specialize in young babies, especially is my favorite patient to treat. What else? I was president of the ACA's Pediatrics Council for 10 years, and I am currently the Program Director for Logan's brand new Master of Science Program in Integrative Pediatrics, which hopefully we'll have time to talk about in a little while, groundbreaking program, first in the country, so I'm really excited about that.

Dr. Elise Hewitt:

And I would just add that it's so filling to treat kids. I feel like it's the only point where we can really change the trajectory in a child, in the family's lives. And imagine having a baby who can't nurse. It's frustrating. The mother can't bond with the baby. They have to feed formula. They're kind of going in that direction versus a mother who is able to nurse, mother and baby bond really well, baby gets all the nutritional benefit from breastfeeding. Those are two completely different directions that child's life could go. And with just our hands and our clinical knowledge and the other tools that we have available to us, we can really make that transition and help that child and that family go into the more positive, helpful life of wellbeing. So that's why I do what I do. My whole goal is to just get more children access to high quality chiropractic care.

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Mike Whitmer:

Great. Thank you very much. And yeah, we definitely want to hear more about that, about that new program at Logan. That's very exciting. So, now that we know a little bit about each of you, I'd like to hear how you grow a pediatric practice. What's worked, maybe what didn't work? Any tips for our listeners there? And I think I'll go ahead and just start with Dr. Lintala.

Dr. Janet Lintala:

Well, again, let me remind people, I have sort of a boutique practice by my choice. Really, I thought about the question, Mike, and I think the more you do for your community, the more you give, the more you show on your website or your Facebook page, you have to show that you have children in your office. But like I said, I started out doing these free informational workshops that I would advertise for people who wanted to learn more about autism and hands-on, step-by-step things that parents could do in the office or at home to help their child feel better, sleep better, so often speak better, learn better, things like that. And naturally, if you're offering a helpful workshop, the content has to be good stuff and you need to give it away. You don't want to try to make money on this activity. But that's how I grew my practice.

Dr. Janet Lintala:

And then, of course, when you do good work, the word gets out. There were certainly lots of pediatricians, hospitals, and residential living places that had no idea what this chiropractor was doing in Beckley, West Virginia. But then over the years, I earned their trust because they saw that I took good care of these patients that we often shared. I was collaborative. You want to have an integrative approach and play well in the sandbox, play well with others and respect what they're doing, even if you don't always agree with it. People practice in different ways. So, pretty soon I had a pretty good referral system coming. And it takes time to build word of mouth, but I find it starts by writing articles and having a good blog going on your Facebook page and doing these free community workshops that you can do in your office if you have the space, and people appreciate that.

Mike Whitmer:

All right. Thank you. Any other thoughts, Dr. Brocker, Dr. Hewitt?

Dr. Jenny Brocker:

I would just add that for me, I think it's the most about building relationships with other providers. I started practice when I was pregnant, and so I was seeing a midwife and I would talk to the midwife about what I did. And eventually, that midwife group started sending me patients. And midwives see infants for the first six weeks as long as they're healthy. So a lot of us think about pediatricians, but midwives are a great option as well. And so, it's really just about building relationships, reaching out to people in community who see the same population: lactation consultants, pediatricians, doulas. Families that are getting support in the community are going to be asking for help, and so wherever you can be on the lips of somebody who they're asking for help, they're more likely to end up in your office.

Mike Whitmer:

Absolutely. Dr Hewitt, anything to add?

Dr. Elise Hewitt:

Yeah. I say, too, I think it's all, and you could hear both in Dr. Jenny and Dr. Janet's answers, it's all about education. There's just a lack of education around the purpose and the role of chiropractic care in pediatric health. And so, both internal marketing and external marketing, it's about education. So when I started 34 years ago, I was actually told by someone well-known in our profession, that it wasn't possible to have a pediatric practice, a practice limited to pediatrics, just not possible. There weren't enough patients to support your practice. And my practice has been referral only now for probably 20, 25 years, and I have a waiting list to get in to see me as a new patient, so that was wrong. There's a huge demand for our services. And again, it comes back to education.

Dr. Elise Hewitt:

So one of the things that I did that was super effective, a little more just taking what Jenny said to one more step is, I actually met with an organization of lactation consultants. Just like we have the ACA, they have lactation consultant organizations, and I taught them the role of chiropractic care in infant health. And I let them know what the studies say about safety, first of all, what the studies say about effectiveness for infant conditions. I let them know what our paradigm was, "Why, if you adjust someone should that help nursing?" And then, I just gave them some clues to look for in the history and clues to look for in the exam that would be an indication that this particular baby may benefit from a chiropractic evaluation. And so, it's really simple, 20 minutes-ish, open it up to questions and answers, but, oh my gosh, that built my practice 25, 30 years ago.

Dr. Elise Hewitt:

And something that I still do today, in fact, I just did it yesterday after my new patient that I think is highly, highly effective at internally building your practice. And this works for anybody, but especially if you're in pediatrics, and that is call the family the evening of the day you treated them. So I saw a patient at noon, before I left for the end of my day, I called and checked in with the mother.

Dr. Elise Hewitt:

And this does a number of things. One, it shows you go the extra mile for your patients. How many doctors call their families? It also shows your concern about the patient. And a lot of my patients come in not knowing anything about chiropractic care. They're referred by their pediatrician, their occupational therapist, whatever. They've never been to a chiropractor, and so they're a little deer in the headlights sort of situation. And so, maybe they're a little uncomfortable, a little nervous about what just happened to their baby. And so, I call and check in. I can answer any questions that they have. I can calm down any concerns. If the baby's a little fussy, I can explain that's really normal for a few hours after the first visit, whatever, just nip something in the bud. And I have just found that to go such a long way at developing a strong relationship and trust with the families in my practice.

Mike Whitmer:

Yeah, I've always heard it said that, "People don't care how much until they know how much you care." And I think that that's a great illustration of that.

Dr. Elise Hewitt:

Exactly.

Mike Whitmer:

And another thing that you hit on was education. And that kind of leads into my next question, because I've heard a lot of my friends, family, non-chiropractors, that say that they'd never take their children to a chiropractor because it's dangerous. You crack bones. They don't want that happening on their infant. And some of these people are chiropractic patients themselves, so they understand chiropractic, but they still don't want that for their children. What does the research say about the safety of manual therapies in the pediatric population? Who'd like to go first?

Dr. Elise Hewitt:

So I'll lead off on this one.

Mike Whitmer:

Thank you.

Dr. Elise Hewitt:

I love when this comes up, actually, because I know how safe chiropractic is for kids. And so, I know that their question is based on myth and innuendo, false information that they've heard here and there. So the first thing I like to do is talk about what the studies show. And the latest studies show that chiropractic care, spinal manipulation and chiropractic care for children including infants, is incredibly safe.

Dr. Elise Hewitt:

One of the largest studies that was done was by someone named Angela Todd and her team. They looked at all the literature going back to the initial publication of peer reviewed research. And they looked at the impact of manual therapies on children and the incidents of adverse events. And they found 15 adverse events total, seven of which involved a chiropractor. In the entire history of our profession, there have been seven published case reports involving a chiropractor and manual therapies.

Dr. Elise Hewitt:

And so, if you consider the number of children who see chiropractors, have seen chiropractors in that time period, it's an infinitesimally small chance of adverse events. And so, I talk about that. There are

many others, maybe Janet and Jenny can talk about some other ones. I can if they can't pull them out of the top of their head, because they're always floating around the top of my head.

Dr. Elise Hewitt:

And then, I will talk to them about the myth and where did this idea that it's not safe come from if I have time. And if the parents are interested, I'll talk about the Wilk case and help them to understand where this misinformation comes from, and that their pediatrician learned the myth in their medical school education. And so, it's sort of piece by piece undoing the myth that has been around for such a long time.

Mike Whitmer:

Other thoughts?

Dr. Jenny Brocker:

Well, I'll just add that there-

Mike Whitmer:

Well, I-

Dr. Jenny Brocker:

Oh, sorry. Go ahead. Go ahead, Janet.

Dr. Janet Lintala:

No, I was just going to say, I have sort of a funny personal note to that. I'm married to a medical doctor, and I was sitting in class when the Wilk case was settled and Dr. Winterstein came in and interrupted class to make the announcement personally, where the AMA had this committee on quackery for so many years and they spread this myth that everything was dangerous and horrible. And we actually, when we were engaged, we called our wedding off three times because he wasn't sure he could marry a chiropractor.

Mike Whitmer:

Oh my.

Dr. Janet Lintala:

He knew nothing about it. And then one day, had the miracle cure from chiropractic for something he had injured. But when our baby was born, we had this infant who never slept for more than 20 or 30 minutes out of every 90, 24 hours a day. It's exhausting, just exhausting.

Dr. Elise Hewitt:

Oh my gosh.

Dr. Janet Lintala:

He was so nervous about adjusting our infant. He wanted me not to adjust our son, the newborn. And I already knew from listening to these wonderful instructors we had, that adjustments would be great for his sleep and his colic and everything else that he had. And finally, one night I got up again with the baby, and I was back in bed with him in just a minute. He went, "What did you do?" And I said, "I adjusted him." And he went, "Good for you." And then on his turn next time, he was like, "Can you adjust the baby" It's magic." And it really was helpful for ear infections, colic, sleep, and he just had to see that firsthand for himself. And he knew that I wouldn't injure our infants. So I can't quote a study, but I can say I've put one doctor's mind to rest about adjusting infants.

Dr. Jenny Brocker:

That's fantastic.

Mike Whitmer:

Dr. Brocker?

Dr. Jenny Brocker:

I was just going to add that there are several studies that have to do with the safety of chiropractic care. My favorite is also Angela Todd's. And one of the things that I appreciate the most about the conclusion in Angela's study is that it really highlights the importance of age appropriate modifications and doing a good history and physical exam. And that's really where the risks of any adverse events are minimized to that infinitesimal amount, is really understanding the modifications that need to be made and making them appropriately so that you can. You're not using the same amount of force on an adult as you are on an infant. The contacts are different. There's so many things that are different. But I think that's a really, really important point. And the conclusion of that always is a driving point for me when I talk about that.

Dr. Jenny Brocker:

And I also just wanted to say that if anyone is that's listening would like to read more of the research, the ACA Pediatrics Council, of which I am the current president, does have a research page on our website, acapedscouncil.org. And you can go and it links to the PubMed abstracts for several studies in different categories, which are all broken down on the website. So you have really easy access to finding those studies if you need them or if you want to read them.

Mike Whitmer:

Yeah. Go ahead.

Dr. Elise Hewitt:

And Dr. Brocker, do they need to be a member to access that page?

Dr. Jenny Brocker:

They do not need to be a member, but it's always a good idea to be a member.

Dr. Elise Hewitt:

I would like to add one more thing on this topic before we move to the next, and it's connected a little bit to what Dr. Jenny just talked about. But not only do we modify our techniques, of course we modify our techniques, but most of the adverse events occurred in patients who had undiagnosed underlying conditions, underlying pathologies of some kind. And so, it's also very, very important that we do a complete and thorough history and a complete and thorough examination before we ever do any manual therapy on a patient, so that we can rule out the presence of underlying conditions that may be contraindications to adjusting.

Mike Whitmer:

Yeah. It's funny. I have a good friend who's a chiropractor, younger than me, and has three young children. And I asked him, "So do you adjust your children?" And he said, "No." He does not because he's not confident-

Mike Whitmer:

No, he does not because he's not confident in his training. Because his focus is athletes and sports and he wasn't comfortable, but he does send his children to a colleague that does specialize in that. That led me to another question. Are rank and file doctors that are practicing and have maybe a sports practice, but they see mostly adults, are they competent to adjust children, pediatrics, newborns?

Dr. Elise Hewitt:

So, doctors of chiropractic in the US are licensed to treat children in every state. So, yes, they've gone through the chiropractic program. That includes education in pediatrics to make them competent to either treat children or recognize when they're not the right person to treat that child and refer on to the provider who is the right person. So, I would say, just like anything, if you have focused most of your practice and your training into sports chiropractic and that's where you feel really comfortable, maybe you don't personally feel as comfortable in pediatrics.

Dr. Elise Hewitt:

Then that's the right choice, is to find someone in your area who does specialize in pediatrics and refer on to that person. Just like I refer all the time if there's someone who needs more nutrition education or management than I can provide, I'll refer to a naturopath. Or if I think an acupuncturist is appropriate or a chiropractic neurologist. If I feel like a child with autism needs to get into that aspect of things more deeply than my knowledge and skills go, I'll refer on. So, I think all chiropractors have the skills needed

to safely adjust kids, but if they're not comfortable in that area then it's easy enough to find someone who specializes in that area.

Mike Whitmer:

Perfect. Other thoughts?

Dr. Jenny Brocker:

I would just add that the reverse, I feel like, is true for me, where I've been in pediatric practice for 14 years, so managing a disc herniation is not my thing anymore. I haven't done that in a long time. I don't do that.

Mike Whitmer:

Makes sense. Yeah.

Dr. Jenny Brocker:

And so the opposite is true for me. I'm sending the adult patients, the parents of the kids who I've now helped, who are asking me, "Who do I see?" Thankfully, we have a group practice here. So, we do have four doctors who are in general practice on the other half of our office, and so it's an easy way for me to send those people to the person who's the most competent to care for their concerns. And I would say that that's true what I think about pediatrics too. If you're not comfortable, like Dr. Elise said, find somebody who is. And the same is true for me. I'm not comfortable treating that, so I'm going to find somebody who is.

Dr. Elise Hewitt:

But I don't think it's necessary to have a special license or certification or anything like that to be able to evaluate and safely treat a child.

Mike Whitmer:

Great point. Thank you. So, I'd like to go back to research a little bit, and we talked about the safety. What does the latest research say about the effectiveness of chiropractic care for specific childhood conditions? Who'd like to start? Dr. Hewitt. I can see you're kind of-

Dr. Elise Hewitt:

I feel like I'm starting all the time. I don't want to be-

Dr. Jenny Brocker:

You're hedging.

Mike Whitmer:

The wheels are grinding.

Dr. Elise Hewitt:

Oh my gosh. So, there has been a lot of research in the last 10 years around chiropractic pediatrics and it's growing as we speak. There's a lot being done at AECC in England. They have a clinic there that is a maternal and child clinic that the students get to work on. So, they publish a lot of papers around that. There's a lot of work in Europe and Scandinavia in pediatrics, a lot of interest in that area because so many kids go to chiropractors there. There's some studies on suboptimal breastfeeding that are looking really positive for chiropractic care of infants who aren't able to nurse properly. One of the studies that was done at AECC looked at infants who were referred to the clinic by either a hospital or a lactation consultant for babies who were having serious nursing issues.

Dr. Elise Hewitt:

And these were very young babies, about five weeks old. And they were treated, I think it was an average of three times over two weeks by the students in the clinic, and almost 80% of the babies were able to exclusively breastfeed after that two week period. And this is something that doesn't normally just resolve on its own. Babies maybe have, in the first couple of days, they can't quite latch and everybody figures it out. But once they're four or five weeks old, if they can't latch, the answer is to give them a bottle. Once they've worked with the lactation consultant and figured out the positioning issues, but if the mechanics aren't working, the suck, swallow, breathe mechanics, then we have to feed that baby so we give them a bottle, because the milk comes out of a bottle more easily than it does from the breast.

Dr. Elise Hewitt:

And I found in my practice, I think Dr. Jenny the same in yours, it's highly effective. In fact, just yesterday, that new patient that I mentioned earlier, two problems came in with mild torticollis and breastfeeding issues. He had a pretty strong latch, but he couldn't maintain it for more than two pulls and he would have to do all this clicking and he would let go. And it was frustrating for mom, frustrating for him. She's having milk supply issues because he's not pulling the milk out and he's partially being bottle fed.

Dr. Elise Hewitt:

So, halfway through the treatment he was getting a little fussy because oftentimes they get hungry as you start to treat them. She started nursing and he did not let go of the breast. He was able to maintain his latch without letting go. He nursed for probably 10 minutes and he never let go. So, I mean, we don't always see a change that quickly, but that's how amazing it is. That it's just as soon as you get the joints moving again, whatever the joints are irritating, that goes away and the whole suck, swallow, breath reflex can kick in and work the way it's supposed to. And I find that 80% number is pretty accurate.

Mike Whitmer:

Other thoughts?

Dr. Jenny Brocker:

Yeah. I mean, I would refer again to the research page, which does have links to a lot of these conditions. I know colic has also been pretty highly studied at AECC, which has been really great. I think that's another infant condition that responds really well to chiropractic care. And that's actually one of my favorite ones to treat because when you can take a really sad fussy baby and give them some comfort and some peace in their bodies, it really changes the dynamic of the whole family, of the baby. It really changes so much so quickly. And like Dr. Lee said, they get better so fast.

Dr. Jenny Brocker:

It really is such a drop in the bucket to a lifetime of discomfort potentially when you can change it that fast. And so that would be the other condition I would say is probably the most highly studied. There are studies on ear infections, on asthma. A lot of the studies that have been done more recently have to do with just manual therapy in general. And so it's not as specific to chiropractic care, which has produced some more interest in the manual aspects of care in general. But all of that stuff is on the research page. So, if you're interested in a particular condition, you can definitely find some of that information there.

Mike Whitmer:

Also, for our listeners, I'll just note that a lot of these resources that we're talking about, we will post on the website with the recording of this webinar. So, you can check there and click through very easily rather than going out and trying to find all these on your own. So, we will post those. Dr. Lintell, any thoughts on that? And especially with your experience with autism, anything there?

Dr. Janet Lintala:

On the effectiveness, right? Of what-

Mike Whitmer:

Yeah. Yeah.

Dr. Janet Lintala:

Okay. So, yes, I was kind of waiting my turn. I was just sitting here.

Mike Whitmer:

All right.

Dr. Janet Lintala:

Typically when a child is on the autism spectrum, of course everyone is different and it's true for children or adults. What I see walk through my door, the most common things, four out of five patients will have these disrupted sleep patterns, traumatic sleep issues. They'll have gastrointestinal dysfunction in the form of constipation, diarrhea, acid reflux, and they have irritability and difficult behaviors. And I'm not going to knock any other profession, but some drugs have been approved for irritability in autism or for this or for that, and I see a matching game go on. I saw it with my own son and I rejected it, and that's why I looked for other answers. If a child can't sleep, instead of saying, "Here. Here's a pill that will make him sleep," or, "Here's a pill that will make him poop or make him behave," why don't we ask, "Why can't he or she sleep? Why can't they poop every day? Why can't they behave?"

Dr. Janet Lintala:

I mean, if a horse is acting out on a trail ride, we don't go, "Hey, is there an antipsychotic approved for irritability in horses?" We stop the trail ride and we listen to their [inaudible 00:32:52]. We check their hooves or we check the bit. But we don't treat our autistic children and adults that way. And chiropractic care, as the ladies on this panel know for sure, it's very effective for gastrointestinal dysfunction and sleep. And a lot of the pain and discomfort from those conditions are driving the difficult behaviors and the irritability. And so if you go to the source... And it's not just adjusting. It's something as simple as a probiotic. A lot of my chiropractic colleagues will go, "How do you get these fussy children settled down?" or, "How do you treat a baby with eczema?" or, "How do you do this?"

Dr. Janet Lintala:

And I start launching in about infant probiotics and they go, "Yeah, yeah, yeah, probiotics. But really, how do you treat them?" It's like people don't hear the simplest solutions. We need to start with the basics. A car needs oil and gas to run, and they're worried about waxing it or putting on accessories after market or something. And I think chiropractors look at the whole patient. We ask, "What is the root of this problem, and what are the different layers of things that I can do to help support this appropriately?" So, in autism we never say we treat autism. That's a no no. We don't treat autism. But we support good gastrointestinal function. They often have immune dysfunction too. So, we support the immune system. We support the brain. We support everything with our care. And we have a lot of tools in our toolbox. We don't just have a prescription pad. And I'm not against prescriptions, but they need to be used later on for things that we don't treat like anxiety or suicidal tendencies or infections or things like that.

Dr. Janet Lintala:

So, I find chiropractic care, the entire scope of our practice, really wonderful at supporting the autism population. And I have always said, I think chiropractors can own this because no one else wants to. They just want to, I'm kind of rude, I'm a cranky autism mom, I say, they want to find the shut up dose for the child. And I think they want to find it for the parents too. "Here. Take this prescription. Go fill it. Shut up and go away." And I'm being [inaudible 00:35:07] kind doctors out there that we've dealt with, but in general they just would like us to settle down and go away quickly. And it's really not quite that

simple. And I think chiropractors take the time. We build that relationship. We communicate. We use all the tools. We ask why. We get to the root of the problem. And I think that's our gift to the autism world. And I really think chiropractic has a lot to offer if anyone would like to focus on autism in their practice.

Mike Whitmer:

All right. Thank you very much.

Dr. Janet Lintala:

I was on my soapbox there.

Mike Whitmer:

Yeah. That's perfect. Thank you. So, when we look at the pediatric chiropractic as a specialty, where do you think this specialty of pediatric chiropractic could or should be in 10 years?

Dr. Jenny Brocker:

Ooh, I'll start with that.

Mike Whitmer:

Thank you, Dr. Brecker.

Dr. Jenny Brocker:

One of my dreams for the profession is to be in more integrative settings, to have chiropractors in PICUs and NICUs in hospital systems, doing rotations with pediatric residents, having residencies where we have conversations with pediatricians who are going through residencies as well to really bridge all of the spokes on the healthcare wheel to make sure that we're providing the most complete care for these patients. So, that's my number one thing, is that I really would like to see more integration into the full healthcare system and more easy cooperation between health professionals that treat kids. And I would also love to see more international cooperation. I think with all of the studies that are going on in Denmark and in England at AECC, I think we have so much opportunity to really become a little bit more internationally cooperative and pool the resources of our specialty to really push it forward. So, I would also really love to see that.

Mike Whitmer:

Other thoughts?

Dr. Janet Lintala:

You heard my soapbox, but I think that in 10 years I would love to see, when someone's child is diagnosed with autism, instead of just going, "Oh, I need an IEP and a speech therapist and a

psychologist and an occupational therapist," that they go, "I also need a chiropractor because they really have a handle on this supporting autism well." So, that's where I am.

Mike Whitmer:

Thank you. Dr. Hewitt?

Dr. Elise Hewitt:

I've always thought that every pediatrician should have a chiropractor in their office. They should practice together. And when a baby comes in for their two week PKU check, they should get a chiropractic evaluation as well. Because why wait until they're older than two weeks to get all the joints working properly and address all of the needs from our chiropractic perspective? Which by the way includes more than just adjusting, of course. All of the other tools that we use as well. I think I feel like medicine and chiropractic, they dovetail really well together. Medicine is there for crisis care and chiropractic is there for more quality of life issues. And I was talking about, we fit together really well. Like this. There's medicine and there's chiropractic. We fill in the gaps in each other's toolbox. And so I think that's obvious in no more place than pediatrics. And of course everything that Janet and Jenny talked about. Integration is the future, I think, of chiropractic care.

Dr. Elise Hewitt:

I've always also felt that none of us, no one practitioner, has the answer for any child's full healthcare needs. It's impossible to know everything you need to know to address all of the broad range of healthcare needs for anybody. And so I think it's important that we all work together, understand each other's strengths and how we can balance each other. And so I think integrating into hospitals is key. Integrating into multidisciplinary clinics. A lot of that has to do with our education and having our education and our skills recognized outside of our profession. But I've been in this profession now for 35 years and when I started, pediatrics wasn't really a topic on the table at all. And now we've got pediatrics councils and pediatrics certifications and we have research in pediatrics. There's so much about pediatrics now that didn't even exist. And so 10 years from now, we could be so far integrated into pediatric health and wellness that I get really excited about it.

Mike Whitmer:

Well, it's very exciting. And Dr. Hewitt, I'd like to take that a step further. So, if I'm a doctor listening to this webinar, are there any resources and educational opportunities for me to enhance my skills treating pediatric patients or even resources to help me build this part of my practice? And we mentioned earlier the new program that you are the founding director at Logan. So, I wanted to go down that a little bit and talk about some of the educational opportunities.

Dr. Elise Hewitt:

Yeah. Let me step back for a second just talk about the history of education in our profession, and then I'll get to the master's program. Because it's important to understand, I think, where we came from to

understand the role of the master's program in our profession. Because of the Wilk case and all of the politics around that, or not the Wilk case, but because of the committee on quackery and all of the politics that we've had to swim against, we didn't have access to university education back in the day. And so doctors of chiropractic who wanted to specialize got together themselves and created educational programs in sports injuries or pediatrics or what have you. They created boards. They created exams and they created certification programs. And so those are the diplomate certification programs that we know now. And there are something like 12 or 14 different diplomate specialty certifications in chiropractic.

Dr. Elise Hewitt:

And they're great. The education is great. The exams are done to the best of their abilities. The problem is, there's no outside certification. There's no outside oversight to these programs so that someone outside of our profession doesn't know the quality. We know the quality, but outside of the profession there's no way to know what the quality of that certification was. So, now fast forward 30, 40 years, we now have access to university education. And so there are now master's programs in sports injuries and nutrition and several other chiropractic related topics. We've never had one for pediatrics before. But in about two weeks, we will have our first master of science program in integrative pediatrics that's available to chiropractors. The first in the United States, that is. There is one in England that's been around for quite a while. The focus of that one is on research and creating experts who will go on and do research in pediatrics.

Dr. Elise Hewitt:

This program, Logan's program, the focus is clinical. So, it's for the practicing doctor of chiropractic, how to increase their skills and knowledge base to really become experts at taking care of pediatric patients. And the advantage of this master's program is that it has received accreditation through the Department of Education, through their arm of accreditation, which is called HLC, Higher Learning Commission. So, it now has outside accreditation and validation of the educational program itself. So, someone who graduates with a master's degree now can take that master's degree and go to a hospital and work in pediatrics. They can go to a multidisciplinary clinic and work in pediatrics. They can go on to teach pediatrics at the university level. They can go on to do research in pediatrics. So, it's a stepping stone to a lot of things that our diplomate programs never opened doors for us to.

Dr. Elise Hewitt:

So, with that said, I think it's important to understand the role of both because we still definitely have a place for diplomate programs. Not everybody is going to want to do a master's program. It involves more commitment, more education and more monetary commitment. So, each doctor has to decide what is it that they want to get out of their education. But I'll tell you a little bit about the master's program to help maybe with that decision. So, the master's program is, as I said, it's clinically focused. It's evidence-based. It's 36 credit hours given over two years. And so that's roughly a half time program. It takes about 18 hours of student input per week to complete the program. It covers everything from A

to Z. Basically it's designed to take the education that you received in chiropractic school and modify it to the pediatric patient.

Dr. Elise Hewitt:

So, it covers fundamentals of pediatric chiropractic. It covers pediatric development, pediatric diagnostic imaging, of course, technique courses, cranial extremity, and spinal technique. It covers pediatric nutrition, pediatric neurology, case management. There are four different case management courses that each build on each other. Evidence-informed practice in pediatrics is another course. So, it covers pretty much everything you need to know to be able to take care of any age patient that walks into your office or is carried into your office.

Mike Whitmer:

All right. Thank you very much. Sounds like it. We actually had a question submitted from our listeners if we could prompt you to talk more about that program. So-

Dr. Elise Hewitt:

It's very exciting. I mean, faculty for the program is incredible. I searched far and wide around the world and found the most amazing pediatric specialists in their...

Dr. Elise Hewitt:

The most amazing pediatric specialists in their specific area. Dr. Brocker, actually, is one of the faculty members teaching several of the courses in the program. The faculty is amazing, and not only are they experts in their area in pediatrics, in chiropractic, and their specialty, but they're amazing educators. They're really excited about their students moving forward and learning all of this and bettering the profession. I really see the program, not only as a stepping stone for doctors of chiropractic to be able to help and reach more children, but also for these graduates to then carry the mantle forward of our specialty and bring us into the next 10 years and move us into that world of integrative pediatric healthcare.

Mike Whitmer:

Great, thank you. Any other thoughts from Dr. Brocker or Dr. Lintala?

Dr. Jenny Brocker:

Well, I would just add that for those that are... As Dr. Elise mentioned, the master's program is one option, and it does take a really deep dive into pediatric care. If you don't, excuse me, have the financial or time commitment that is required to do the master's or just don't need the master's level coursework, the ACA Pediatrics Council is also in development with a new diploma program that's going to be mostly online and able to be accessed at any time for people. We're estimating it's going to take about two years to complete, as well, and there will be some in person required meetings to attend in order to really fulfill the hands-on part of what to learn with pediatrics. The council's super excited

about being able to put this together for people as another option to some really high quality pediatric education. We're hoping the first cohort will start sometime in the early part of 2023, but we don't have that totally set yet.

Dr. Jenny Brocker:

The Council website will have all kinds of information on that as we come available, and then I also would just mention for anybody who just wants to learn more in general about pediatric care and not necessarily commit to any sort of program, that the Council is always... that we have an annual conference every year where we try to have a hands-on piece presentation on adjusting, extremity adjusting, cranial work, something to just help supplement your practice in pediatrics and then any additional information we can provide from the experts. That education is usually, like I said, once a year. We just had ours at Logan, actually, in July, which was awesome. We're working on our plans for next year.

Dr. Jenny Brocker:

We also have community meetings for the Council where we can talk to each other about what we're doing and ask questions of each other. I think the more that the pediatric provider community can come together and work together and talk together and brainstorm together, the better off the specialty is, so those are also options for just learning more from each other as we move forward in our profession.

Mike Whitmer:

Okay.

Dr. Elise Hewitt:

I'd like to add to something important that I forgot to say about the Logan program. That it is mostly online, as well, and it's asynchronously delivered, meaning you can work around your own schedule to work with the material at your own pace, rather than having to sit down for a lecture at a certain time. There are two hands-on sessions where the students all come together on the Logan campus once a year to work on all the hands-on aspects of the program.

Mike Whitmer:

Okay, great. Dr. Lintala, did you have something?

Dr. Janet Lintala:

I do.

Mike Whitmer:

All right, thank you.

Dr. Janet Lintala:

It's really not quite so much about, specifically, chiropractic, but it's about if people want to learn more about the underlying medical issues of autism.

Mike Whitmer:

Great.

Dr. Janet Lintala:

Tons of information about the other things, sensory, speech, all that, but for the medical issues, and you want something that's evidence based, there is a conference, it's open to all types of healthcare specialties, called the Medical Academy of Pediatric Special Needs. They have one conference in the spring on, I think, the East Coast, and the other one's in the fall on the West Coast. I may have that backwards, but just excellent. I would go for the entire time and just immerse yourself in the science. It's a lot. It's like trying to take a sip from a fire hydrant when you're new to it. You need to go quite a few times to really get a grasp on this, but it's wonderful in that it's evidence based, and they're offering hands-on things that you can take home and use in your practice. That's my addition.

Mike Whitmer:

All right, thank you.

Dr. Elise Hewitt:

I'd say, too, there are smaller things. There's textbooks. There's the textbook Chiropractic Pediatrics or Pediatric Chiropractic. I always forget which it is. The new edition actually just came out, the third edition, last month, and it's a hefty textbook. I think it's available as a Kindle, but there's a lot of great information in there if you just are the kind of person who wants to sift through and read up on all aspects of pediatric chiropractic care. There's actually a new chapter I just authored in there on chiropractic management of babies with suboptimal breastfeeding, so a whole chapter in there if that's something that you're interested in. That's a great textbook.

Dr. Elise Hewitt:

There's the Journal of Chiropractic Medicine. Actually, the ACA Pediatrics Council is a society member of the JCM, Journal of Chiropractic Medicine, so they publish articles whenever they're available on pediatric chiropractic. Actually, I believe you get a subscription to that included in your membership if you're an ACA Pediatrics Council member. Dr. Janet, I know you're being humble, but she has a wonderful textbook, or not textbook, a wonderful book on treating children with autism that has just a tremendous amount of great tips in there for parents, but also for doctors of chiropractic, as well. Just wanted to put a plug in for her on that one.

Mike Whitmer:

All right, thank you. Okay. Let's go back. We talked about conditions that respond well to chiropractic treatment in the research. Okay? What are some other examples of pediatric conditions that respond well to chiropractic care that, maybe, haven't hit the research yet? Anything come to mind?

Dr. Elise Hewitt:

Well, I'd say, if we're going to be honest, we need more research on every topic in chiropractic. I'm not happy with the research on any of our topics yet because we just need more. With that said, you guys can go ahead and answer the question, but I feel like every condition could fall under that category as of now.

Mike Whitmer:

Yeah, yeah.

Dr. Janet Lintala:

Well, I see a lot of children and adults with immune dysfunction. There's a few different types specifically on the autism spectrum, but it also applies to anyone with a GI system because the bulk of the immune system is located in and along the gut. I just find that the proper support of gastrointestinal health imbalance, digestive enzymes, probiotics, vitamin D3, so just some simple things. I have dramatic cases, tons of them, where kids come in who are dependent upon inhalers or who are in the hospital five times every winter with pneumonia and bronchitis or just constantly sick. Or the cycle of ear infections that we see in so many kids these days and acid reflux. How many of us have kids that come in, and they're on every drug there is for acid reflux?

Dr. Janet Lintala:

I cannot say enough about proper support of the gastrointestinal system and then what falls out of the picture from that. They don't have to be autistic for this, and they can be adults, too. People catch fewer calls. I mean, I don't ever take a child off their inhaler or try to treat asthma or anything like that, but they just start coming back to their follow up visits every so many months and go, "Wow, he doesn't need his inhaler anymore," or, "She hasn't been in the hospital this fall." It's just shocking what a few simple things in your support plan can do for somebody. Especially on the spectrum, it's like magic for sleep and mood, and sometimes we just see language pouring out of people. I don't claim ever. I don't promise that, but it's just shocking over the years what something as simple as proper and simple GI support.

Dr. Janet Lintala:

People come in, and their kids are on 25 different supplements. You're on all those supplements because you're missing something foundational. You're missing something basic and simple here and some appropriate testing. I've had chiropractors tell me, "What do you mean you run stool tests and urine tests and organics, acid tests and things like that?" Some functional medicine testing can give you

a lot of insight into the metabolic problems that people are having and just some simple nutritional support in your office. I will just say it is shocking and gratifying how you can help people feel better. Food sensitivities often are responsible for a range of shadowy, vague symptoms and conditions, and just really getting to the bottom of some simple things that start in the GI system, I think, it really helps people feel better.

Mike Whitmer:

Thank you. Dr. Brocker, anything to add?

Dr. Jenny Brocker:

I would say that one thing that I think it would be really cool to see more research on that I don't think there is a lot on right now is the really simple musculoskeletal stuff that you see in really little kids, and especially babies, as they're developing those musculoskeletal skills. Asymmetrical crawling patterns, asymmetrical gait patterns, those are hugely responsive to chiropractic care and can definitely affect the way that child is going to grow and move in their future. I think sometimes in pediatrics, we get a little bit... we get so focused on the non-musculoskeletal aspects and the conditions that are presenting non-musculoskeletally that we forget that our bread and butter is the musculoskeletal system and that there are things that babies can have that are very musculoskeletal and we can help with very quickly.

Mike Whitmer:

All right, thank you. I'm going to take that a little bit further because we did get a question from our listeners. It says, "Even though we have research on many conditions, such as colic, we still cannot say we are treating those conditions that are not directly related to the spine. How do you communicate this to the patient's parents, a medical doctor?" Or I guess I'm reading that as, how do you explain this to other parties, the parent, medical doctors, as for where the chiropractic profession stands on treating conditions, such as autism, colic, and breastfeeding needs? Then when you're documenting, do you usually only record the codes for segmental and somatic dysfunction? That's a big question. Who'd like to start?

Dr. Elise Hewitt:

I'll start on that. I guess, I'll answer the last part first. I've always felt like it's pretty important to include both the somatic dysfunction listings or findings diagnoses along with the larger condition diagnoses because if those don't get entered into the system, then we won't be shown to address those conditions. If I don't put suboptimal breastfeeding as a diagnosis, then nobody who's looking at data that comes out of the system is going to know that chiropractors treat babies with suboptimal breastfeeding. How I'm treating them, how I'm treating that suboptimal breastfeeding, just because the diagnosis is there doesn't mean that I'm treating it with only one thing. I'm treating it with a range of things.

Dr. Elise Hewitt:

I may be talking to the mom about changing their diet so the baby is less gassy. I may be talking to the mom about positioning. I may be adjusting the baby's spine and doing cranial work on that baby to normalize whatever dysfunction is happening that's not allowing the suck, swallow, breathe reflex to function properly. That would be a diagnostic finding or diagnosis also, the joint dysfunction, but so is the condition, whether it's colic or suboptimal breastfeeding or asthma. Then the way I explain it to people is... I mean, there are a lot of different ways we can talk about it. Do we know exactly what's happening in the body when I worked on that baby yesterday, and all of a sudden, he's able to latch on in a way that he couldn't before? Nobody knows yet.

Dr. Elise Hewitt:

There are a lot of great scientists who are working on that right now, but to me, it's like a black box. There's the intervention. There's this baby with symptoms. Let me back up. There's a symptom. Then there's this intervention, and something happens in the black box. Then out comes an outcome. I'm dying to know what happens in the black box, but we don't know that right now. You know what? I'm a clinician, so what's really important to me is to know that if I have a patient who comes in with this condition, and I do this thing, the outcome is going to be this. Someday we're going to learn what's happening in the black box, but from a clinical perspective, what matters is, does the intervention have the outcome that I intend or that I expect? That's one way to explain it to, say, a medical doctor who's more used to thinking in those terms.

Mike Whitmer:

Great. Any other thoughts? Dr. Lintala, I am interested in any thoughts you'd have on this with autism because you had mentioned earlier, "Well, we can't say we're treating autism," so what are your thoughts?

Dr. Janet Lintala:

Yeah. If you put that on your website or your social media that you're treating autism, that will get yanked down really quickly because it's just not allowed. When I decided to have a focus on autism, and I don't advertise that I specialize in pediatrics or specialize in autism, it's just, that's what I do, I took the time to speak with my board. Our regulations and scope of practice vary from state to state, so I always encourage people to speak with their board. Sometimes for NCMIC, part of my talks, I'm asked to focus on risk reduction, so one, understand what your scope is. Some very good advice that I always pass on in my talks is the language that we use when speaking with doctors or writing an article or speaking with parents. I often joke, I treat nothing, and I support everything.

Dr. Janet Lintala:

I don't even claim to treat GI dysfunction or dysbiosis or yeast infection or anything like that, unless I have a lab result that says they have a yeast infection. I support GI balance and health, and I support a balanced microbiome. I support neurological health. I support the immune system. I support a healthy

response to inflammation. I treat nothing, and I support everything. Watch your language. Unfortunately, I have a cash practice. It's just me, so I don't bill insurance or Medicare, Medicaid. I can't help with any of the coding questions, but just the language when you speak with the families or speak with other professionals. I always reassure the professionals, I'm not going to step on their toes, but for autism, there's a lot of risks involved. You just have to support everything. You also have to be able to refer, and that's probably a separate question that we'll get to.

Mike Whitmer:

Yeah. Actually next one.

Dr. Janet Lintala:

Yeah. Those appropriate referrals are very important, and I'm sure with a general pediatric practice or a specialty one, there's going to be some referrals that the other doctors would like to talk about, too.

Mike Whitmer:

Dr. Brocker anything to add?

Dr. Jenny Brocker:

Not really. I think that really covers the crux of it. I think that it's, of course, nobody really knows what we're doing, but what we can see, like Dr. Elise said, is that, clinically, we have the experience to be able to say what we do has shown to help and with very little risk. I think that's the important piece to talk about always, is minimal risk and possible reward.

Mike Whitmer:

Right. Let's go on, and this does get to the referral issue. The question is, when treating pediatric patients, when should they be referred to an MD for various common conditions? Who'd like to start? I know, Dr. Lintala, you've got some thoughts.

Dr. Janet Lintala:

Well, I don't treat common conditions though, so I mean...

Mike Whitmer:

True, true.

Dr. Janet Lintala:

I see some different things, so I don't know if you want me to go first or not. Know what the risks are in your patient population. In my risk population, there's lots of anxiety. They have higher rates of depression and suicidal thoughts and ideations, and you cannot miss that referral. You just can't mind read, so it's better to over call it than under call it. I have a little list here. Severe self injuring behavior.

Now, a lot of times self injuring behavior is pain behavior from a painful gut condition. They're prone to ulcers and inflammation, and if they can't communicate that to you, it comes out as aggression or irritability or self injuring. The American Pediatric Council, I don't know if I named that right, long ago came out with a management of autism spectrum disorders paper, and they say that these difficult behaviors can be a sign of gastrointestinal distress. That you shouldn't reach for that antipsychotic first thing, but people tend to ignore that.

Dr. Janet Lintala:

They have a great need for developmental optometry. I refer more than half my practice to a developmental optometrist because vision is one of the five senses. Okay? I always explain to parents that your child's brain probably isn't handling the constant input of sensory information that comes from our five senses, and that includes our two eyes. They're giving separate information to the brain, and if they don't coordinate that, they're very clumsy, or they can't read, or they can't do their homework. Their eyes fatigue, and they become a behavior problem in the class, or a class clown, or they're dangerous behind the wheel. Any of my teens that want to drive, I insist they go to the developmental optometrist. I call it my miracle referral. It's always good to look under that rock with people, anyone with sensory issues, whether they're autistic or not.

Dr. Janet Lintala:

If you're, sort of, the first person on the scene with a new autism diagnosis or a suspected case of autism, and the team hasn't been built yet, autism needs to have a village. You need to have a real collaborative integrative team. Sometimes it's baffling. The pediatricians will go, "He'll talk when he's ready," and they miss that early referral, that birth to three. They miss those three years completely, and then at three, they go, "Oh, there's a problem. She's not talking." Then they try to start referring, but you can refer to these services. In some states, like Alaska, it's Easterseals, they might not have birth to three. Just find out what's available for your patient population.

Dr. Janet Lintala:

If the pediatrician refuses, you can, in my state anyway, make the referral for speech therapy, occupational therapy, sensory work with the occupational therapist. Feeding therapy is a big one. A lot of these children just gag and spit up and have acid reflux, especially the infants, and they may need a feeding therapist, a toddler or a young child might. It's for the sensory aspects of feeding a lot of times. They're gagging because they're overwhelmed by the texture or the smell or the taste of the food, and it's nothing mechanical that's wrong. It's more they have to overcome these sensory issues, so there's a lot of referrals for the autism population.

Dr. Janet Lintala:

I have never, yet, sent one person to be scoped or have anything invasive into their GI system, and that's the first thing, often, pediatricians seem to do. I just have never had the need to do that. With proper GI support, a lot of those things, most of them, just fall out of the picture, and we don't need to sedate a child or strap them down and scope them or anything like that. I'm not saying that it's not a good study

when you need it. I'm just saying a lot of doctors go for that big gun first thing, and you don't have to do that. That's not a referral that I've ever had to make, so I'm going to point out what referral I don't make, I guess. Just the psychiatric issues, you really have to stay on top of the psychiatric issues.

Mike Whitmer:

Yeah. Dr. Hewitt or Dr. Brocker, other thoughts on referrals?

Dr. Elise Hewitt:

Yeah. I would say, I mean, just to throw a couple specifics out there, if I'm examining a baby, and I suspect developmental dysplasia of the hip, for example, I'm going to refer to a pediatric orthopedist so that baby can get an ultrasound and that can be handled early when it's easily treatable. If I have a patient that I'm concerned is losing the battle, as I say to parents a lot of times when they have an illness, upper respiratory infection or a lower respiratory infection or some something where their immune system is starting to get overwhelmed, I'll refer them to their pediatrician to see if antibiotics would be appropriate in...

Dr. Elise Hewitt:

Get overwhelmed, I'll refer them to their pediatrician to see if antibiotics would be appropriate in that case. I mean, basically I think it's important to understand our role and know what the role of medical doctors is. And we are primary care providers, essentially and so we are also musculoskeletal specialists, so we should get referrals from other people for their musculoskeletal concerns, other practitioners. But if I need a pulmonologist or a cardiologist or an orthopedist, I'm going to refer to those as needed, on a case-by-case basis.

Dr. Elise Hewitt:

Just yesterday I had a six year old who had fallen off the monkey bars at the playground, or... No. The day before she'd fallen off monkey bars. But yesterday, the day before my treatment yesterday, she fell off a trampoline and had some arm pain that for like half an hour that day. This isn't why they brought her in to see me, but I started to ask more questions about it, and really... and she was doing handstands; she's a gymnast. She was doing handstands, but it was bothering her a little bit and it turns out I am sure that she broke her distal forearm, whether it's her ulna or radius or both, we don't have the films yet.But mom didn't think it was a big deal because this girl's paint tolerance is pretty high and she was not making a big deal out of it.

Dr. Elise Hewitt:

And so I think our role is to pick up things like that. I'm a primary care specialist and then get the testing and assuming that there is indeed a fracture, I'll be sending the child to a pediatric orthopedist, following that.

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Dr. Elise Hewitt:

So, like I said, I feel like our care integrates well with medical doctors, medicine in general. And it's just a matter of knowing where their resources are and our resources are and working together that way.

Mike Whitmer:

Yeah. Dr. Brocker, anything to add?

Dr. Jenny Brocker:

Yeah. I would just add that, kind of stepping back to the first time you're seeing a patient and going through that history and physical exam, if there's something that is highlighted on that history and physical exam that is concerning to you in any way, that's the time to refer them to somebody, to have that evaluated more fully. And that's where, again, sort of referring back to those safety studies, that's how we can provide the most safe and effective care is to really do a thorough job and make sure that any concerns that come up with the history or any concerns that come up with the physical exam are getting referred to the appropriate places. And to not always assume that your patients, your pediatric patients, have a pediatrician already when they see you. Sometimes you're going to be the first person to see that baby or that child in a long time, and so just being aware of what other providers they have and then being thorough in your exam to make sure that you're catching things that you need to be catching and referring.

Mike Whitmer:

All right. Thank you. Another one from the audience; I've got two here, so I'm going to kind of mash them up. So, "Who is the contact person for the ACA pediatric diplomate?" They're looking to become a part of the cohort in 2023. And then the other one, along those lines is, "I'm a member of the ACA. Is there a separate thing to join for pediatric membership?"

Dr. Jenny Brocker:

Oh, I can answer that.

Mike Whitmer:

I thought so, Dr. Brocker.

Dr. Jenny Brocker:

So I would be the person to contact about the Diplomate Program, actually. In this initial phase, we're collecting interested parties, kind of putting them on a template wait list until we have more information. So, you can send me an email at Dr. Jenny, D-R-J-E-N-N-Y@portlandchiropracticgroup.com, and I will forward you onto the list of interested people and you'll be contacted once we have more information about registration and when the cohorts are starting, and so forth.

Dr. Jenny Brocker:

And to answer the second part of that question, you do have a separate application to join the Pediatrics Council. You do have to be an ACA member in order to join an ACA specialty council. If you go to the ACA website, there's a place under membership where it talks about specialty councils, and you can access it membership application from there.

Dr. Jenny Brocker:

You can also go to the Pediatrics council website, acapedscouncil.org, and there is a membership tab that will take you also to the membership application. And that just gets sent back to the ACA and they will put that on a list for us to get you as a new member.

Mike Whitmer:

Okay. Thank you.

Dr. Elise Hewitt:

And I bet you email Dr. Jenny and she'd send you the link, too.

Mike Whitmer:

The whole thing, yeah. And Dr. Hewitt, we are at quarter after the hour, so I know you have to drop off so let me take this opportunity to thank you so much. It's been a pleasure having you.

Dr. Elise Hewitt:

Oh, thank you so much for including me. This has just been wonderful and I really enjoyed the conversation.

Mike Whitmer:

All right. So-

Dr. Elise Hewitt:

I'll have to do it again sometime.

Mike Whitmer:

You bet. You bet. So you can go ahead and drop off. I do have a few more questions, if Dr. Brocker and Dr. Lintala are up for it, so we'll move on. All right. Thank you, Dr. Hewitt.

Dr. Elise Hewitt:

Bye-bye. Thanks, everybody.

Mike Whitmer:

All right. So this one I think is interesting. "Been practicing since '82, don't see many young children. Any tips on getting babies and toddlers to relax and tolerate being touched?"

Dr. Jenny Brocker:

You know, I would say that first and foremost, babies, especially, are some of the most intuitive beings on the planet and that if you are giving off an energy of uncomfortableness, if you're uncomfortable with treating them, they're going to pick up on that and they're not going to be excited about it. So, I would say first and foremost is always for you to be in a space that is calm and comfortable and for you to be in a space where you can put your hands on that baby and feel confident and feel comfortable with what you're doing. So I would always say that's the first place I always start.

Dr. Jenny Brocker:

If beyond that, being in pediatric practice is a lot of really quick thinking and a lot of creative thinking all the time, because kids do not follow directions all the time.

Mike Whitmer:

Really?

Dr. Jenny Brocker:

And sometimes you have to be pretty creative on how you're doing things. So, if I have a really fussy baby that I find that I can't work with or work through their fussiness... or, I would say more often the issue for me is that I can feel that the parents' energy is changing based on the fact that their baby is laying there crying, it doesn't usually bother me because I know that I'm helping them but sometimes I'll feel that the parents are getting very anxious about how much their baby is crying. And so I'll just have the parents hold them. Usually if the parents are holding them, especially if mom's there and she has the ability to nurse the baby while we're working on them, that's a really easy way to keep babies still and calm, but using the parents as much as possible.

Dr. Jenny Brocker:

For older kids who maybe don't want to sit still, I'll have the parent lay down on the adjusting table, have the child lay on top of the parent, and that way the parent can kind of help corral them a little bit. I have done several cranial treatments walking behind a child in circles around my table, because that's what they want to do and that's how they're letting me touch their head so that's what I'm going to do.

Dr. Jenny Brocker:

So I would just say a lot of it is just being creative in the moment, but using the parents as much as possible to provide comfort is the easiest way, I would say, to get them to be as cooperative as they are going to be in that moment.

Mike Whitmer:

Yeah. Dr. Lintala, I would think that this would be quite the issue in a practice where your focus is children with autism so, any thoughts?

Dr. Janet Lintala:

It is. I tell people when I teach, I said, "Don't meet them at the door and get in their face and go, 'Hey, buddy. How you doing?' and pound them on the back." This is a population that we don't touch right away. They don't transition well so trying to interact right when they come through the door is not the best thing. That's not where you're going to bond.

Dr. Janet Lintala:

I have a Thomas the Train Engine table that is the magic breaker and all the little kids head over there and you can start playing trains with them and things like that. Sometimes there are patients you will never be able to touch. They're just so sensitive to things.

Dr. Janet Lintala:

I think Dr. Jenny's right, the parents are often key. And then having the parents hold them, starting with sensory things like a nice sensory brush or a little bit of massage. They often crave sensory; they're sensory seekers, they're not all sensory avoiders. And it's just really building a trust and it may not happen on the first or second visit, but you just get them happy to show up at your office. And so part of that is understanding that they do have sensory issues.

Dr. Janet Lintala:

Whenever we do any work around the office, the paint is zero VOC paint with no odor. When I did have office help, we didn't wear scented shampoo or hairspray or powder or perfumes. We don't play music in our office, the patient can play their music. We don't have incense or scented candles. Even the cleaning staff has unscented, fragrance free cleaning products. That really is a huge deal with the autism population. Having some fidgets that they can play with, a little vibrating teddy bear is really wonderful; they often like that vibrating teddy bear, it's soothing.

Dr. Janet Lintala:

So I would say probably letting them transition before you really try to interact with them. Use the parents. And then the key is the sensory issues. They're either going to be sensory seekers or sensory avoiders and there are little sensory hacks that you can use to touch them.

Mike Whitmer:

Dr. Lintala, this next question, you kind of answered that from the perspective of your practice focusing on autism. But Dr. Brocker, I want to put this to you because I think it's a kind of an important question. Going back to what you were saying about the energy in your office and with you and how children

respond to this, so the question is: "Do you recommend any office decor or toys to make the office more kid friendly?" And I'm looking at your wall behind you, so I think the answer is yes.

Dr. Jenny Brocker:

Yeah. I was just going to do a little bit of show and tell. So this is one of our pediatric treatment rooms.

Mike Whitmer:

Nice.

Dr. Jenny Brocker:

You can see we have a beach mural on the wall back here. On the door, we have a series of alphabet letters that go up and around. In the corner where you can't see over here, we have a bookshelf with various toys that are loud and obnoxious and very distracting. And we have some books that we keep on hand and we have stuffed animals everywhere.

Dr. Jenny Brocker:

And we have, in our office, two dedicated pediatric treatment rooms, and so that's why we get to decorate them how we want. The other room has a big mural of trees that are of different seasons. And so I do recommend making, if you plan to treat a lot of kids, make your space friendly to them. They will know as soon as they walk in the door whether or not they want to stay and hang out with you. And a lot of times the toys are the key to that and being able to sort of break the ice a little bit and get down on the floor.

Dr. Jenny Brocker:

And I can't tell you how many times I've sat on the floor and treated somebody because we're looking at a toy or we're looking at a book and that's where they're going to sit and be cooperative, so that's where I'm going to sit and do my job. So I do really recommend if you want to have a space that is very kid friendly on their level and something that they can walk in and be excited about.

Dr. Jenny Brocker:

I just had a little girl who's three years old today come in and she walked in the door and she went, "Wow, this place is really fun,"-

Mike Whitmer:

Which is what you want.

Dr. Jenny Brocker:

I didn't even do anything yet. So she was already like, "All right. I can get down with this place." So, yeah.

Mike Whitmer:

And that makes sense. So that patient is already kind of relaxed because this is a fun environment and she's responding to that. So, that's great.

Dr. Jenny Brocker:

Exactly.

Dr. Janet Lintala:

Jenny, do you wear a white coat or the stethoscope around your neck? Because I find a lot of patients have white coat anxiety.

Mike Whitmer:

Oh, interesting.

Dr. Janet Lintala:

So...

Dr. Jenny Brocker:

No, I do not. In fact, nobody in our office does. We do have our equipment kind of tucked away in case we do need to use it for something. I would also say that the first question I get a lot of times from kids who are a little bit older, if this is their first visit, is, "Am I going to get shots here?" And I can always really positively say, "No. I actually don't even know how to do that, so that's not what we're going to do here." And so that always kind of immediately gives them a little bit of relaxation. Like, "Okay, this is a doctor who's not going to give me a shot. Awesome. I'm down for that." So, creating that environment does really help."

Mike Whitmer:

Yeah.

Dr. Janet Lintala:

Yeah. I have some parents who say, "We can't call you doctor. If they hear the doctor, the D word, my child will not come through the door." And so I am not big on that either. I'll always say, "Well, they can call me Miss Janet, or just Janet, or..." Because some parents want them to call you something to show respect and so I'm Miss Janet, just trying to get it easy.

Dr. Janet Lintala:

But I even decorate my office to look like a living room instead of a doctor's office, so these fun colors. This is my kitchen. Obviously I don't see patients in my kitchen. But, yeah. I think you're you're right. The kids need to relax and feel that atmosphere when they walk in.

Mike Whitmer:

Yeah. We've got a few more minutes. I did want to interject one thing about this, when we're talking about office setup and fun things in the office. And Dr. Brocker, you said you've got equipment tucked away. And this is where my insurance guy hat comes on, and risk and supervising children while in the office so that they're not messing around with things that could injure them. Any thoughts on that?

Dr. Jenny Brocker:

Yeah, absolutely. That is something that we put a lot of thought into, especially when we switched to electronic health records. Prior to 2000, I think we switched in 2013 to EHR, and prior to that, we just had paper charts that we brought in the room and we just had a writing utensil. But now we're trying to access computer files and things like that, so we were very thoughtful about how we implemented that. We don't have any computer stations in the treatment rooms. We use mobile devices to be able to document all of our EHR stuff. We don't have any equipment in the room that moves on its own. So, for example, our tables are stationary. We don't have any high lows in the office, so there's no risk of kids getting fingers stuck in places. We do have tables with drop pieces so we're always really careful to let parents know, "Don't pull on this handle here."

Dr. Jenny Brocker:

And then we do have our equipment up on a high shelf that kids are not able to reach. And anything that really is not meant for them is up on that high shelf, so we do try to keep everything really tucked away.

Dr. Jenny Brocker:

We have outlet covers on all of the outlets in the treatment rooms, so everything is covered that way. So we really do try to minimize the risk to kids with the equipment in the office by making sure that it's not reachable for them.

Mike Whitmer:

Yeah. Okay. Dr. Lintala, any thoughts there?

Dr. Janet Lintala:

I agree. When we took our children... my son had difficult behaviors when he was young, he doesn't now, but it was hard to go into a doctor's office that had a lot of little fancy... I mean, some people decorate their office a lot. They just have all their equipment out or their jars of swabs and things. I was doing my best to control my child, but you get this, "Can you control your child," thing.

Dr. Janet Lintala:

So I always said, "I'm not going to have that kind of office. Nothing." I mean, I don't get upset if they're... I mean, they're going to be flipping the light switches and doing the window shade and we try to keep things up and out of their reach, but I just flat out don't have a lot of knick-knack, fragile things in my

office. Anything that's put on the wall is wired to the wall. They can't get it off, because they will bounce around on the couches and try to pull the picture frames off the wall.

Dr. Janet Lintala:

I mean, some of these kids, when they're treatment naive, are real active, shall we say. Overactive. But, yeah. You just have to have a kid friendly office. The outlet covers I agree with. Nothing sharp, nothing...

Mike Whitmer:

Yeah.

Dr. Janet Lintala:

They'll even get into your office space and get on your computer if you don't have that locked up. So, we're kind of big on locks. The half door that we can reach in and get it but they can't, and things like that.

Mike Whitmer:

Yeah. Okay. One more question and then... this is quick because we're almost out of time. "When does a pediatric patient become and need referred to an adult practice?" So, where's that line? Is it preteen? Tweens? What do you think about that?

Dr. Jenny Brocker:

Yeah. So for me, pediatrics is really not as much of an age definition as it is an abilities definition. So when I think about special needs children, especially neurologically atypical kids who have potentially some developmental or some intellectual delays, they may still be on the level intellectually of a child, even though they're in the body of a 26 year old, for example. And so I try to be really cautious about referring those people out of my treatment room, unless I just really can't physically do my job for them anymore.

Dr. Jenny Brocker:

So, I currently have a patient who has some significant intellectual disabilities that's 26 and he and I do great together and I have been treating him for a while, so I know his history really well.

Dr. Jenny Brocker:

I would say outside of that, I usually leave that up to the patient, for the most part. Every once in a while you'll get a 13 or 14 year old boy who's really hit his growth spurt and has gotten just kind of physically too big for me to do an adequate job doing the treatments that I want to be doing. And in those cases, we'll refer them to the other side of the office. But a lot of times you'll get kids in that middle adolescent age group that just don't want to get treated in the kid room anymore. They want it-

Mike Whitmer:

Yeah. Your mural is great for little kids.

Dr. Jenny Brocker:

Exactly, exactly.

Mike Whitmer:

But there comes a point when you're like-

Dr. Jenny Brocker:

So, yeah. So I always leave it up to them. Like if I'm comfortable treating them, they can come to me for as long as they want. If I say, "You've height and weighted out of my ability level. I'm going to send you over to the other side of the office," sometimes that happens.

Dr. Jenny Brocker:

But I do have a handful of college kids that still come back and want to see me, so... and that's fine for me. It doesn't matter to me, as long as for me, I know that I'm still providing them with good, quality care. As long as I can do that, I don't care. But, yeah. Those would be my sort of criteria for that.

Mike Whitmer:

Dr. Lintala?

Dr. Janet Lintala:

I'm cradle to grave, so-

Mike Whitmer:

Okay. All right.

Dr. Janet Lintala:

... patients grow up, learn to drive, go to college. I have a lot of residential living patients around the state that are in their forties, fifties, sixties. Any age responds to what we do.

Mike Whitmer:

Okay. All right.

Mike Whitmer:

We're out of time. Thank you so much, Dr. Brocker, Dr. Lintala. This has been a lot of fun talking through this. I've really enjoyed it and I appreciate you.

Pediatrics Round Table

Mike Whitmer:

Just real quick, a reminder. Our next webinar is September 15th at 2:00 PM Central Time. The topic is low back pain. I hope you can join us. And if you are interested in resources from NCMIC, including these webinars, check out our resources page on ncmic.com. You can also keep up with new resources from NCMIC by following us on social media on Facebook, Twitter, LinkedIn, and Instagram.

Mike Whitmer:

Once again, thank you Drs. Brocker and Lintala. I really appreciate it. And thanks everybody for listening. Until next time, thank you very much.

Dr. Jenny Brocker:

Thank you.