

# THE SCOOP



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Morehouse School of Medicine Pediatrics Residency Program Newsletter



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## FROM THE DIRECTOR A Few Thoughts...

by Dr. Yolanda Wimberly

Well, another interview season has ended. We increased the quality

and quantity of the candidates interviewing for the program this year, once again!

And now, we're looking forward to Match Day in

March to welcome our new members to the family. The Residency Administration is starting to review all evaluations from rotations from the past year and will determine if changes are to be made to the schedule. This is always a daunting but enjoyable task because it gives



us the opportunity to look at the program critically and determine what needs to be dropped, revised, or to continue as is. I commend the residents for their diligent work in critically evaluating the program and providing detailed feedback with solutions. We will send out the semi-annual evaluation analysis to course directors at the end of February and will hold a conference call with them after they receive the analysis. We really appreciate all the hard work everyone put forth and look forward to a great Spring!

## Haiti-Ayiti Cheri

by Dr. Bande Virgil

When the 7.0 magnitude earthquake struck Haiti on January 12, the world watched with sadness and empathy as an already vulnerable part of the world experienced yet another devastating catastrophe. Many of us were touched personally, feeling empathy for the families: mothers, fathers, grandparents, who were lost. We saw the images of injured children crying and felt the need to do something. As pediatricians, what struck an even deeper chord was the health-related issues facing the most vulnerable population of Haiti, the children. As the dust from the rubble settles, and the world attempts to assist Haiti in recovery, the question remains, "What will happen to the children, particularly those younger than two years old?"

The issues facing the children of Haiti after the earthquake are complex. These include PTSD, reliving the horror and uncertainty that comes with natural

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# ADOLESCENT Vaccinations by Dr. Bande Virgil

Adolescent patients, particularly those ages 13-17, are often the silent and forgotten subclass of pediatric medicine. Our vaccination success is not optimal in this

category of pediatric patients. There are many contributing factors that compound this, including less frequent office visits for routine exam. With the introduction in 2005 of vaccines specific for preteens, the landscape of

pediatric vaccinations has become more complex. It is important that we remain abreast of these changes and continue to provide the highest level of care to our adolescent patients. This article provides a brief update on the key vaccinations required for the adolescent population.



**The CDC currently recommends the following vaccines for children ages 13-17 which can be administered as early as 11:**

- Meningococcal conjugate vaccine (MCV4; 1 dose)
- Tetanus, diphtheria, acellular pertussis vaccine (Tdap; 1 dose)
- Quadrivalent human papillomavirus vaccine (for girls) (HPV4; 3 doses) (1).



Advisory Committee on Immunization Practices (ACIP) also recommends that adolescents receive recommended vaccinations that were missed during childhood, in order to “catch them up”;

for example: measles, mumps, rubella vaccine (MMR; 2 doses); hepatitis B vaccine (HepB; 3 doses); and varicella vaccine (VAR; 2 doses); Hepatitis A series, polio series, as well as pneumococcal polysaccharide.

The most recent CDC vaccination data by the National Immunization Survey (NIS) for 2008 suggests that there has been some improvement in receipt of vaccinations for this population of patients, but that there is room for improvement. The report states specifically that coverage increased about 10 percentage points for administration of Tdap and MCV4, reaching about 40% for each vaccine. Additionally, coverage increased about 12 percentage points for girls who received at least one dose of HPV4, to about 37%. In terms of administration of the three recommended doses of HPV4, coverage was about 18%.

Some salient points raised by the NIS CDC vaccine studies include the disparity in vaccination rates among racial/ethnic groups and by socioeconomic group. Specifically, differences were seen in the coverage for HPV among Hispanic females when compared to white; additionally, a higher coverage in teens living in poverty compared with those living at or above the poverty level. With regards to administering Tdap, African Americans had lower coverage than whites; in addition, fewer African Americans had coverage from varicella. Although progress has been made, we must continue the effort to aggressively address this disparity.

Healthy People 2010 established vaccination coverage targets of 90% for adolescents aged 13-15 years. The target is for  $\geq 3$  doses of HepB,  $\geq 2$  doses of MMR,  $\geq 1$  dose of Td or Tdap, and  $\geq 1$  dose of VAR, among those without history of disease. The 2008 NIS survey reports that for the first time, Healthy People 2010 targets were achieved specifically for  $\geq 3$  doses of Hep B and  $\geq 2$  doses of MMR. The results of the NIS study are promising but we have not hit the target on all the vaccinations recommended for this age group. In addition, the disparities noted indicate that work remains to be done.

# FACULTY of the Quarter



## Dr. Taryn Taylor

Dr. Taryn R. Taylor is an Assistant Professor of Pediatrics and Emergency Medicine at Emory University School of Medicine. Board certified in Pediatrics and Pediatric Emergency Medicine, she has served clinically as an attending in the Egleston and Hughes Spalding Emergency Departments since July 2008.

Dr. Taylor received a Bachelor of Arts degree in Biology from Xavier University of Louisiana and a Doctorate of Medicine from Temple University School of Medicine in Philadelphia, Pennsylvania. She completed her residency in Pediatrics and Fellowship in Pediatric Emergency Medicine at Johns Hopkins Hospital, Baltimore, Maryland.

Deeply concerned for the welfare of children during national disasters, Dr. Taylor created an on-line learning module on pediatric emergency preparedness. She is also a member of Georgia 3 Disaster Medical Assistance Team (GA3DMAT), which is part of the National Disaster Medical System (NDMS) Program. This system is a component of the Federal Response Plan to natural and man made disasters with the task of health and medical care in austere environments.

Of equal interest to her, is the wellbeing of young girls. To that end Taylor serves as a board member of Girls On the Run. This non-profit program, designed to prepare girls for a lifetime of self respect and healthy living, targets elementary and middle-school aged girls.

In addition to her responsibilities as physician, teacher, advocate, and mentor, Dr. Taylor is married to Anthony. They share their world with two cats and a dog. She is an avid football fan, and loves to travel.

Volunteering, whether it involves time, effort, or experience, can be one of the most rewarding and humanizing gifts that a person can give. I'm proud to say that the Pediatric Residency Program here at

Morehouse School of Medicine has made volunteerism a priority and a vital part of its core values.



Through a variety of endeavors, Pediatric residents have been contributing their talents throughout the city of Atlanta and

the state of Georgia. They also contribute to international efforts, providing aid to those in need, participating in events that characterize the diverse communities of which we are a significant part.

Residents spend hours and often full days volunteering in unique and imaginative ways. Activities range from making desks for chronically ill children, to tutoring elementary-age students and organizing aid efforts abroad. These are only some of the many efforts residents have undertaken. When asked what helps them decide to whom or where to donate

their spare time, most residents will say, "to whoever needs it" and "wherever I can."

Volunteering not only gives us an occasion to help others, but also the opportunity to become part of the communities we work and live in. By developing mentoring opportunities, assisting with community cleanup projects, or helping out at local junior high school football games, our residents make their presence felt. Their volunteering extends past the hospitals and the various community clinics in which they work around town, into the daily lives of our patients. As a result, our residents often become more accessible to the families they serve.

Similar to other learning opportunities in residency, volunteering teaches valuable lessons that we will carry with us throughout our careers and lives. These distinctive events have given us the occasion to meld our professional lives with our hobbies and leisurely pursuits. At the same time, we make new acquaintances and are exposed to diverse experiences. We learn about some of the individual challenges patients face on a daily basis. We've also taken part in some of the recreational activities and joyful

moments in their lives.

Conversations shared during volunteer experiences and the common bonds created there give us an idea of what our patients face once they're discharged from the hospital or leave a clinic visit. Our volunteer endeavors permit us to understand our patients better and have empathy for their diverse circumstances. This in turn improves our ability to provide comprehensive, reasonable care to them. In addition, getting out into the community gives us firsthand experience with and knowledge of some of the resources that are available to our patients and helps us identify resources that are needed. With this insight, we function better as caregivers, better able to assist gaining patient access to these resources

Participating in the lives of our patients, understanding the things that influence their decisions, and contributing to the ebb and flow of the neighborhoods around us, gives residents a unique view of the intricacies of the communities we serve. The experience of volunteering has at times been humbling as well as gratifying, even on a global scale. These experiences continue to inspire me to enjoy the uniqueness of the people with whom I work and the vibrancy of the places in which we live.

## Haiti-Ayiti Cheri Continued from the cover

disaster, loss of family, destruction of their schools, homes, and shelters. Prior to the earthquake, respiratory infections, malaria, tuberculosis, and HIV/AIDS were the leading causes of death for children in Haiti. According to the World Health Organization (WHO), as of 2005, the under-five mortality rate per 1,000 live births among educated Haitian mothers was 65.2. For mothers with the lowest level of education, the rate was doubled: 122. This is staggering when compared to the United States where, in 2004, the probability of dying at younger than five years of age was 8 per 1,000 live births.

It is clear from this data that, after addressing acute trauma in post-earthquake Haiti, mitigating the effects

of infection will be essential, particularly for young children.

In an effort to address feeding issues in particular, UNICEF, the World Health Organization (WHO), and the World Food Programme (WFP) have called for the exclusive breast-feeding of all children younger than six months of age, and complementary feeding with breast milk into the second year of life for older children. A recent joint statement report cited as high risk, those children who are not breast

fed. The report also stated that key recovery management should identify these children early. This includes the 1 million of Haiti's 8 million children who are orphans. The report also encourages "re-lactation" for those children who have already been weaned off breast feeding.

This is critical in a nation where 80% of the people did not have access to clean water before the earthquake.

This can be accomplished through the use of informal community structures to prioritize mothers with young infants for food and shelter. This is critical in a nation where 80% of the people did not have access to clean water before the earthquake. An advantage for Haitian children however, is that most children in Haiti are at least partially breast fed by their mothers.

Ideally, other culturally appropriate interventions in Haiti's recovery should be similarly configured without compromising care. Organizations that have long-standing commitments to the nation and community building in Haiti should take the lead to ensure the greatest measure of success moving forward. \*"Haiti my darling"— affectionate Creole term used by Haitians referring to the motherland

# TRANSITIONING FROM MEDICAL SCHOOL to Residency

by Dr. Constance Enmon



The word nervous does not begin to describe how I felt on the first day of my residency training. I remember stepping off the elevator onto the third floor of Dekalb Medical Center to begin my term nursery rotation. Before I even stepped foot in the nursery, a woman frantically ran up to me saying, “Please help me. My niece is not breathing!” I was so thankful that a nurse was in the hallway with me at the time. We both ran to the room, only to find a healthy, pink newborn with periodic breathing. My first morning as an intern turned out to be quite intense, but my first night was even more so. I had the pleasure of having my first call on July 1st. Nurses who were veterans in their field paged me, asking me (as if I were a veteran, too) how I would handle specific patients’ needs. It was definitely an eye-opening experience. I was thankful for my supportive senior resident!

The transition from medical school to residency is analogous to learning how to swim. Initially you prefer to walk around in the shallow end. Then someone decides to pick you up and throw you in the deep end. As you quickly find a way to come up for air, you become an expert at treading water. Before you know it, you are swimming on your own. You even begin to try different techniques to improve your stroke.

Initially, going from the shallow to the deep end can be

overwhelming. At the beginning of your residency, you learn that you are responsible for the lives of others in a way you hadn’t realized in your experience in medical school. That responsibility is what most separates our experience in medical school from residency. The difference between the experience we have in medical school and actual residency is frightening. However, as in learning to swim in the deep end, your expertise continues to develop. Your comfort with

the level of your responsibility grows with time and the acquisition of knowledge and experience: the more patients you have taken care of, the more you acclimate to that responsibility.

When you go home after work each day, you continue to expand your knowledgebase through reading. The work experience allows you to compare what you learn in textbooks to what actually happens. You evaluate research articles

and decide whether or not they pertain to your patient population—to determine what is best for each individual patient.

What’s the best part of the transition? You are finally doing what you spent years (and a considerable financial investment) preparing for. Hopefully you’re in a field that you absolutely love. Pediatrics has always been a dream of mine. Now that I’m here, living that dream, I can honestly say that the journey thus far has been both enjoyable and rewarding. I am definitely excited to continue my journey.

Before I even stepped foot in the nursery, a woman frantically ran up to me saying, “Please help me. My niece is not breathing!”



PROGRAM COORDINATORS Corner  
by Rashida Elliott

On January 11, 2010 we concluded our interviews with many impressive applicants from all over the world. We received and reviewed over 700 applicants and selected and interviewed 46 medical students to potentially join our program. The quality of the applicant pool will force us to make some difficult decisions when selecting applicants for our six available residency slots.

We will be eagerly anticipating the final results on Match Day. Match Day will take place on March 18, 2010, from 12 pm-3 pm and will be held at the Louis W. Sullivan National Center for Primary Care (NCPC) auditorium on the main campus of Morehouse School of Medicine.

I would like to thank all the faculty, staff, and preceptors for participating in the interview process and providing your feedback. If your schedule prohibited you from participating this year, there is always next year!

# SPOTLIGHT ON ACGME COMPETENCIES: Patient Care

by Dr. Sandra Moore

In each issue of the MSM Pediatric newsletter, we focus on a core competency requirement for resident training.



This quarter, we will highlight Patient Care. According to the ACGME, “Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.

Patient care is the cornerstone of being a physician. We all pride ourselves on delivering care enhanced by the latest research evidence. We take into consideration the needs of the patient. Patient care all starts with gathering essential and accurate information about the patient so that we can determine what the diagnosis is and the best course of treatment. We must be able to interview patients and families about the particulars of the medical condition for which they seek care, with specific attention to behavioral, psychosocial, environmental, and family unit correlates of disease. Based on the history taken and the physical (H & P), residents are expected to make informed diagnostic and therapeutic decisions and to develop and carry out management plans.

As faculty members and preceptors, we must model exemplary behavior for the residents to follow. We must evaluate through direct observation, using a structured approach with appropriate evaluators that correspond to the individual setting. Currently this is done for inpatient and continuity clinic, but we encourage all preceptors to document this at least once on the rotation. Residents are encouraged to bring evaluation forms created by the residency program for preceptors to complete. Forms are also available online at [msmpeds.com](http://msmpeds.com).

Here are some tips for helping the residents with patient care skills:

- ♦ Demonstrate medical interviewing skills at least once on your rotation, especially for PGY—1. This helps the residents understand more clearly what specific information they should be obtaining during the interview, which may be particular to that rotation.
- ♦ Ensure that you ask residents about a patient/family psychosocial environment which may influence the diagnosis or treatment plan.
- ♦ Directly observe and document a resident’s History and Physical Examination (H & P) skill. You can use the forms created specifically for this purpose if you want to document this observation formally.
- ♦ Give residents immediate feedback after an observed interaction. Let the resident know what he or she did well and what needed to be improved.
- ♦ Based on the resident’s H & P, ask the resident to list a differential diagnosis in order of most-likely to least-likely.
- ♦ Ask the resident what the first-line treatment would be, based on the differential. Also ask what other factors, based on the individual family, they should consider when developing a treatment plan (e.g.: does the family agree with the diagnosis, are they likely to follow the treatment plan, can they afford treatment, can they return for follow-up, etc.)
- ♦ Communicate early with the residents if you have concerns about their patient care. At a minimum, provide verbal feedback at mid-rotation.
- ♦ If you have ongoing concerns about a resident’s communication and patient care skills, contact the residency program directly.
- ♦ Last, but most importantly, complete your evaluation of the resident and return it to the residency program. This enables the resident and program to know how well the resident is doing.

We hope this article has been helpful for you. We will continue to bring information about the six ACGME core competencies to the forefront. If you have an idea or topic about the competencies that you would like to see discussed in our newsletter, please email Dr. Sandra E. Moore, Associate Residency Program Director at [smoore@msm.edu](mailto:smoore@msm.edu).

# OPERATION BOARD REVIEW

by Dr. Chevon Brooks



Our board review course is in full swing. 9 months and counting for those taking the 2010 ABP board examination in October 2010. Take this quiz and look at page for the question breakdown and answers. The goal is to take 1-1.5 minutes for each question. Start your timers...

1. A 6-week-old boy has had progressively worsening projectile vomiting for 2 weeks. He is afebrile and has no diarrhea. Blood gas analysis is most likely to show:

	pH	pCO <sub>2</sub>	CO <sub>2</sub>
A.	7.27	55	32
B.	7.47	50	32
C.	7.47	30	15
D.	7.27	30	32
E.	7.40	50	32

2. Low complement C3 levels are seen in:
- A. Focal segmental glomerulonephritis
  - B. Minimal change nephritic syndrome
  - C. Chronic pyelonephritis
  - D. Acute poststreptococcal glomerulonephritis
  - E. Alport syndrome
3. You are examining a 20-month-old girl who has diarrhea and failure to thrive. Her CBC, ESR, chemistry panel are unremarkable. Stool is negative for reducing sugars but positive for neutral fats, a 72-hour fecal fat collection shows a coefficient of absorption of 45% (normal, >93%), with a normal alpha-1-antitrypsin result. Of the following, these findings are most consistent with:
- A. Celiac disease
  - B. Milk protein allergy
  - C. Hirschsprung disease
  - D. Crohn's disease
  - E. Cystic fibrosis

4. For the past 6 weeks, a 4 year old boy has had painless, bright red rectal bleeding associated with bowel movements. Examination of the abdomen and anus reveals normal findings. The rectal vault is empty, and no blood is noted on gross inspection. Of the following, the next best step in management would be:
- A. Stool culture
  - B. CT of the abdomen
  - C. Barium enema
  - D. Colonoscopy
  - E. Meckel's scan

## ANSWERS

1. This question describes an infant with projectile vomiting without signs of acute gastroenteritis and it wants you to give the acid-base results.

**Plan of attack:** write in the margin the acid-base disturbance associated with pyloric stenosis= hypochloremic hypokalemic metabolic alkalosis, then find the answer which matches. This child is vomiting, so he is losing a lot of hydrogen ions or acid, leaving him in alkalosis. With alkalosis, there would be a high pH (normal pH 7.35- 7.45), this eliminates answers A, C, and E. Now you're left with answers B and D. You will have an excess of bicarbonate ions, resulting in high CO<sub>2</sub> level. As long as volume contraction from vomiting is also present, the kidney is unable to correct the alkalosis by increasing urinary bicarbonate excretion (contraction alkalosis). Answers B and D both have the same CO<sub>2</sub> level. Respiratory compensation with increased pCO<sub>2</sub> is usually present (normal pCO<sub>2</sub> 35- 45), leaving answer B as the correct answer.

**Board tip:** It would probably have taken longer to consider each answer choice rather than matching your information about pyloric stenosis with the answer choices. Write your answer down first before reading answer choices is better strategy. You must know the normal ranges of common laboratory values.

2. This is a recall question on glomerulonephritides.

**Plan of attack:** List what you know and

compare it to the answer choices. Most glomerulonephritides are immune complex diseases with both immune complexes and complement C3 in the glomeruli. However, only 3 conditions are associated with low circulating C3 levels: postinfectious glomerulonephritis, systemic lupus erythematosus (SLE), and membranoproliferative glomerulonephritis. In acute poststreptococcal glomerulonephritis, complement C3 is low for up to 8 weeks but always returns to normal. This should be documented to confirm diagnosis. If C3 is still low, membranoproliferative glomerulonephritis or lupus nephritis should be suspected.

3. This question describes a toddler with diarrhea and failure to thrive, secondary to malabsorption. Stool studies are given as clues to the type of malabsorption.

**Plan of attack:** The key to this question is the laboratory findings.

- The stool is negative for reducing sugars, so she probably does not have carbohydrate malabsorption.
- A protein-losing enteropathy (PLE) can be due to damage to the intestinal lining or impediment to lymphatic or venous flow. Albumin can't be measured in the stool since it is not intact in gut excretion. Alpha-1-antitrypsin (AAT) is used as a marker for increased gut permeability to protein since it is a serum protein with similar molecular weight as albumin and resistant to digestive breakdown; therefore fecal AAT is used as a screening test for PLE. In cystic fibrosis, the defect is not in the gut mucosal lining, so there is no PLE.
- This child has normal fecal AAT, so eliminate choices A and D since these do present with PLE and abnormal fecal AAT. Eliminate choice C- Hirschsprung disease presents with constipation, not diarrhea and it usually doesn't involve the small intestine. (A very uncommon presentation for Hirschsprung disease is hypoproteinemia from PLE- there are very few absolutes in medicine, don't you love that!)
- **CORRECT ANSWER IS B-** Cystic fibrosis includes fat malabsorption. This child has elevated fecal fats and decreased fecal fat absorption.
- Shortcut to the answer- zero in that fat malabsorption was the only abnormal; protein and carbohydrate absorption were normal.

**Board tip:** Highlight, circle, or underline phrases in the question stem which will key you into the answer choices or could change your answer choice, e.g. "except", "most likely", "the next best step". Overlooking this could mean lost points since there will probably be a wrong answer choice which could also fit this criteria.

4. This question has a 4 year old boy with painless rectal bleeding and you have to pick the best next step in management. First, you must diagnosis the correct disorder.

**Plan of attack:** The most common causes of hematochezia in this age group in order of frequency: anal fissure, juvenile polyp, infectious diarrhea, lymphonodular hyperplasia, IBD, HSP, Meckel's diverticulum, peptic ulcer, HUS, vascular malformations. Since the patient has a normal GU exam where no anal fissures were found, the next most common cause is juvenile polyps. Juvenile polyps are diagnosed by colonoscopy.

**Distractors:** We all probably wanted to zone into meckel's scan since we're all classically taught that Meckel's diverticulum causes "painless rectal bleeding". However, Meckel's is usually seen under 2 years old.

**Board tip:** Know most common presentations of disorders and conditions by age group.

**POSITIVE VISUALIZATION:** Visualize yourself at the board exam breezing through the exam then opening your mailbox to find your score report with a high pass! Good luck!



# THE HOME Visit

by Dr. Ruby S. Thomas

I recently did a public health rotation and it exposed me to an aspect of medicine that is nearly nonexistent in the world of modern medicine...the home visit.



In the past, when transportation was less easily available, there were few telephones, no internet and fewer established hospitals, home visits were routinely performed by physicians. Being

in someone's home gives you invaluable information about their resources and habits. In this day and age however, physicians are seeing 30 or more patients daily in their practices. Some also have hospital and nursery duties as well, so that leaves little to no time for visits to a patient's home. There are however other professionals whose job it is to perform these tasks. Various programs are available through the state of Georgia that allow those infants or children at high risk for adverse outcomes (infants of adolescent parents for example) to be visited at their homes by a professional. These individuals are usually nurses and are able to give anticipatory guidance tailored to the needs of the patient. For example, they

are able to see the person's home, to see what their sleeping arrangements are and counsel about co sleeping or to observe them mix formula and thus prevent malnutrition or failure to thrive. They may also be able to see what options for grocery shopping are available and able to counsel patients on options for eating healthier to aid in preventing childhood obesity. As doctors, we tend to focus on the clinical and problem solving aspects of medicine, when there are other important social and economic factors play a major role in the lives of patients and their families. The use of these home visiting programs available through the Children's First programs in Georgia may be an adjunctive tool to reach your patients and their families and do a better job of fulfilling some of their needs. In a recent article in the Archives of Pediatric and Adolescent Medicine, a study showed that those infants whose mothers participated in a home visiting program had better long term outcomes at five years. There are resources available for our atients outside of what we can offer in our offices. It may help address some of the disparities of health care that are so obvious in our society today.

# RESIDENT of the Quarter



## Dr. Fredly Bataille

Originally from Brooklyn, NY, Dr. Bataille completed his undergraduate studies in Anthropology and Pre-medicine at New York University in 2000. Then went onto do research in Insulin signaling and Diabetes via a Research Training Grant at the National Institutes of Health and Columbia University from 2000 to 2003. He then went on to receive his doctorate degree from Morehouse School of Medicine in 2007, where he is currently a Third Year Co-Chief in the department of Pediatrics. Dr. Bataille is a newlywed, and father of a young son. His hobbies and interest include sports, volunteering and spending time with his family. His future plans are to join a General Pediatric & Adolescent Medicine practice in Atlanta, GA upon completion of Pediatric residency.



The Morehouse School of Medicine Community Pediatric Residency Program and Children's Healthcare of Atlanta, Hughes Spalding participated in the Crossroads Newspapers Health Expo at Mall at Stonecrest on Saturday, January 30, 2010.



2010-2011  
Chief Resident  
Congratulations

DR. PRAGYA VERMA