

## **Bayside Medical Group, Inc.**

**Pediatrics • Family Practice • Travel Medicine • Pediatric Surgery  
Allergy and Immunology • Pediatric Rheumatology**

# **DR. SHENKIN'S GUIDE TO A NEW BABY**

## **Budd N. Shenkin, MD**

**Prior to every visit:** You can download and print handouts and questionnaires for your office visit.  
Be prepared!

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*Before we get started in talking about your baby, here are answers to the top ten questions you may have as the parent of a newborn.*

## **TOP 10 QUESTIONS ABOUT NEWBORNS**

- 1. Does my baby have a cold?** Many, if not most, newborns have a congested nose and frequent sneezing for the first month or so. Unless you see mucus coming from the nose, it's usually not a cold. Unless your baby has difficulty with feeding or sleeping due to nasal congestion, you do not have to use the nasal bulb syringe. In fact, if you use it frequently, you may irritate the nose lining and make the congestion last longer.
- 2. What about my newborn's peeling skin? It looks so dry—should I use lotion?** Peeling is normal and no lotion is necessary, nor will it make any difference.
- 3. Should I worry if my baby is breathing funny?** Well, yes and no. Normal newborn breathing can seem strange. Sometimes they will stop breathing for a second or two and then breathe very quickly for several seconds. Sometimes they sound funny because they snort due to a congested nose (see #1). Sometimes they make a high-pitched whistle when they breathe, due to a flexible wind-pipe (laryngomalacia). However, if you see very fast breathing (more than 70 times a minute) that persists, or if the baby has to work very hard to breathe, or you have worries about his or her breathing, don't hesitate to contact us.
- 4. What if there is oozing or blood when the cord falls off?** A bit of yellowish wet coating at the site of the cord that dries over a few days is normal, as long as the skin around the base of the cord remains a normal color (if it becomes increasingly red, call us immediately). You do not need to use alcohol. A few drops of blood on the diaper as the cord is falling off is also normal. If it bleeds a whole lot (which almost never happens), apply pressure to stop the bleeding and call us. A slightly acrid smell is OK, too.
- 5. How many bowel movements are normal?** Breastfed newborns generally have 3 or more bowel movements per 24 hours by 3 or 4 days of age. Formula fed infants generally have at least 1 bowel movement per 24 hours. But some infants can have up to 20 per day and still be normal. Normal breastfed stool is extremely loose. In an adult, this would be called diarrhea, but it is normal for a newborn. Formula fed stool tends to be more pasty. Any color from bright yellow to green to brown is normal. By age 3 to 6 weeks, the frequency of stool decreases (even once a week for a breastfed infant at this age can be normal as long as it is soft and passes easily).

- 6. Is the discharge from my baby girl's vagina normal?** Yes, it may be clear, white or bloody, and it results from withdrawal from the mother's hormones. You don't have to wipe it away, but you can if you want to (top to bottom).
- 7. Is it normal for my nipples to hurt (for breastfeeding mothers)?** It is normal in the first week to have pain for the first 1-2 seconds of latch on, but if you have pain in the nipples beyond the first second or two, ask us about it. Breastfeeding should feel good.
- 8. Can my baby see me?** A baby's sharpest vision is the distance from the breast to the face. Babies recognize their mother's faces within a short time after birth. They can identify their mother's breast milk smell immediately, and will recognize the voices (and soon the faces) of close family that they heard talking while in the womb, such as fathers or siblings.
- 9. It is normal that my baby lost weight after birth?** Yes, most babies lose weight after birth and this is normal. We will tell you at office visits if we are concerned that the weight loss is too much.
- 10. When should my next appointment be? What should I be concerned about?** Usually 2 days after you leave the hospital, we would like to see you back in the office to check your baby's weight, color, and heart. If your baby has a fever higher than 100.4 rectally (only take the temperature if your baby seems warmer than usual), is irritable, lethargic or not feeding well, call right away. If your baby seems yellow other than the eyes/gums/face (i.e. chest/abdomen/legs), call us during office hours. Also call during the day if your infant is not having normal stools (see #5). Have your baby sleep on the back or side. Make sure that your car seat is correctly installed and used. Call 1-866-SEATCHECK or go to [seatcheck.org](http://seatcheck.org) for a free car seat checkpoint near you.
- 11. Bonus! How can I keep my baby safe from infectious diseases?** The closest people to the baby are you, the parents, so it is from you that diseases are most easily transmitted. Protect yourself and the baby by getting flu immunizations during flu season, and get immunized with Tdap, which protects you and the baby against whooping cough.

*Congratulations! Enjoy your baby!*

## INTRODUCTION

One of the best parts about being a pediatrician is caring for a newborn baby and his or her family. It is an exciting time, the beginning of a long journey in which the initial tentativeness of new parents gradually turns into confident competence.

In this pamphlet I have tried to get us on the right path together by covering some pertinent points for the first weeks of life, and also some of the months that follow. There will be, I hope, some discussions here that interest you, and there might well be some points with which you disagree, and still others that you wish I had added. I hope that you will feel free to bring all of these subjects up with us—we learn a lot from our patients.

We have also put a lot of effort into constructing a web site that introduces you to Bayside, and gives you a great deal of information on your child and pediatrics. We also have forms and handouts on the website for many of the well visit appointments you make. You can go online and start your visit before you actually come to the office. This is a real advantage—you can read and write in a more relaxed atmosphere where you can think, and you can make your actual visit go faster. Check it out: [www.baysidemed.com](http://www.baysidemed.com).

## SECTION 1: THE BASIC GUIDE

### I. General Principles of Child-Rearing During the Early Days

#### A. RELY ON YOURSELF

Your first baby brings a lot of unfamiliar responsibilities, requirements, requests, schedules, and feelings. As with other new times in your life, you have a lot of learning and readjustment to do. If I were restricted to only one sentence of advice in this situation, I think that it would be this: *Rely on yourself*. Friends and relatives can be helpful, books can give good hints, and we pediatricians can help to steer you away from trouble. But no one will ever know your child as well as you do, nor care about him or her so much—and so many things are really questions of common sense, anyway.

I don't mean to minimize the importance of getting advice or calling for help, and after all, giving help and advice is our job. But I think that you should use us and baby books (especially *Taking Care of Your Child*—see the section on books) to support your care of the baby, not to replace your judgment. It is very important that you not get bogged down by feeling that others would do it better, or that the

opinions of others are necessarily better than you own. Each baby is amazingly different and so is each mother and father, and most of the time you are the ones in the best position to find an appropriate solution for a problem.

*And remember this:* learning to take care of a baby is not a Ph.D. course; there are plenty of excellent parents with little education at all. So, hitting the books in preparation for a new tyke is not mandatory. Instead, work on patience, perseverance, understanding, and endurance!

## **B. THE BALANCE OF CARING**

Infants are helpless and need to be cared for, and we parents have not only a capacity to care for these little kids of ours, but even a need to do it. Most times our capacity and their need match up, more or less, and with some shifting here and there, a workable situation can be achieved. But sometimes there is an imbalance, and then something has to be done.

The most common imbalance consists of a very demanding baby and a mother and father whose capacity is exceeded. A baby with colic can drive anyone to distraction, or a very energetic baby can be very difficult for a mother who needs a lot of sleep and a hard-working father who can't really get into caring for a little baby. Or maybe there is a single parent. These situations can quickly become impossible.

Solutions here can be difficult, but the first step is clear: *identify the problem*. The baby is demanding more than you are able to give. That is not a sin. It doesn't mean that you are bad parents. It is just a situation that happens. I know I just got finished telling you to rely on yourselves, but in this situation don't be afraid to call for help. Come in and talk to us. Try hard to get someone to babysit a screaming infant a few times a week. We can work on this problem and eventually it will pass. Our task will be to minimize the damage to the family unit in the meantime.

A less common imbalance is the reverse situation, where the mother and father are all primed to give the best, most loving and most attentive care the planet has ever seen, and what do they get? A sleeper! Sixteen hours a day, the kid saws Z's. You drum your fingers, you come in to look, you are tempted to wake her up to play. (I know—most of you are saying, "I should have such a problem!" But just wait a few years—this is what the "empty nest" syndrome is all about.) Still no response. A quick meal, diaper change, and back to the sack. You want to give, to be parents, and she is happy on her own. You get

frustrated. You worry, is there something wrong with my baby? Is she retarded? Will she be as lazy as Uncle Louie?

Some babies are just quiet. Once again, identify the problem. The baby is demanding less than you want, and perhaps need, to give. This doesn't make him or her a bad baby, nor you bad parents. Once again, it is possible that we can be of some help in this situation, so don't let the fact that the baby isn't "sick" prevent you from coming in. To understand and care for a baby like this can be very demanding of your patience, if you want to give "active" mothering and fathering. Just as in the opposite imbalance, you will have to learn to manage the situation a little more consciously and less automatically than in most cases. The key lies in recognizing the problem.

### **C. BENIGN SELFISHNESS**

This leads us to a third principle that I call "benign selfishness." If you keep yourselves in good shape—physically, mentally, and in your relationship—your child will likely turn out well, too. There really is no point in being a martyr. So, for instance, it is a good idea for the primary caretaker (usually the mother, as we all know) to set up a regular babysitting arrangement, so that she will know that for a certain period every week she will be able to take some time for herself, not just to do errands, but to enjoy herself. Looking forward to those long Thursday afternoons can keep your head above water the rest of the week, and it is important for your self-esteem and survival to have things that really mean something to you, in addition to taking care of your baby.

It is also important for father and mother to have time together to be more than just father and mother. A child can bind two people together in a sense of family, but it is important not to lose what it was that drew you together initially. To spend time together without the miniature chaperon requires planning and perseverance, and I heartily endorse both.

### **D. LOVING YOUR BABY**

Loving your child is such a deep feeling that I think it must be an instinct. That doesn't mean that we don't get annoyed with our kids and depressed at their demands, but basically, deep down, you can probably feel for them in a way that is deeper than your feelings for anyone else. If you don't see this in yourself and it worries you, talk to us about it. But when you do get that feeling deep down that you love your baby, trust it.

You don't have to do anything special to prove your love—to yourself, to us, to your parents, or to anyone. If friends or relatives tell you that you are spoiling him by comforting him so often, don't listen to them!

Many people wonder, should you pick up a baby when he is crying and wants to be held, or is it better to let him “cry it out.” They don't want him to be spoiled, after all. Most mothers and fathers have the instinct to pick the crying baby up; I think that you should trust this instinct, and pick him or her up. Why? Because in the first year, a baby learns whether or not he can trust the world to be nice to him and respond to him. He also gets used to feeling a certain way, satisfied and comforted on the one hand, or frustrated on the other. If he or she learns to feel satisfied, and gets used to it, then later on, unconsciously, he or she will take whatever steps necessary to reproduce that same feeling. These are the people with their “sunny side up.” These are the people who are kind to others, friendly and well-behaved, because you were nice to him. (At least, let's hope so.) Interestingly, these are the children who are also “tough.” When they fall down on the playground and come to you crying, these are the children who need only a pat or two, and the tears dry up and back they go to the gang. It is as though they learned how to be comforted, and just use that skill to be stronger people.

On the other hand, trust yourself to let him cry for a few minutes now and then. You deserve your shower, and even though you love him, the world wasn't made to order just for him!

Growing and maturing to the point where you can really do what is best for your child, hugging and kissing when appropriate and correcting when necessary—this is the challenge of parenthood. Loving your baby is your most important gift. If you love him, he will come to love himself, and he will be a good human being, and later on a good parent to your grandchildren. This formulation is no doubt too simple, but at the most basic level, it is probably true.

Actually, I think that many people come to the point where they grow to love their children more than they love themselves in some ways. Some parents in the past have chosen to die, literally, so that their children might live. Most of us are set less extreme tasks, but many times we wind up doing a better job for our kids than we do for ourselves. Being a responsible parent represents the finest sort of growth, and for many of us nothing else is quite so fulfilling and maturing.

## II. The First Weeks of Life

During the first few days take some time to be very quiet and alone with your baby. This goes for both mother and father. Make the room

dark and quiet, hold the baby in your arms, sit back a little and close your eyes. Contact the baby by feel, just the way he or she is contacting you. It is hard to put ourselves in the baby's place, for we can't remember what it was like when we were so little, but we can feel when the baby is comfortable, when she relaxes, and when she goes to sleep.

This is good practice for later on. To keep in contact with our kids at whatever age they find themselves, we have to learn to use their language, things that they can understand. At this first face to face meeting, it is hard, because the baby can't understand much and can hardly express anything except discomfort. Later on, as their senses mature and they learn to understand words, you can communicate with them more easily. But all through life, communicating with children takes a lot of care and effort. Trying to communicate here at the beginning is a good first step.

While you are still in the hospital, make as much use of the nurses as you can. They are experienced and you can probably learn some things from them about baby care. You don't have to say that there is something wrong with your baby in order to request some company from them while you are feeding, and indulge in a little conversation about babies in general. Make sure, too, that you go to the baby bathing class. Sometimes, of course, you will receive conflicting information from different nurses. That just shows that opinions differ. Once again, rely on yourself, and don't hesitate to ask for our (enlightened) opinions.

Later on at home, the first weeks are very hard. It reminds me of when I was an intern, just out of medical school. Both periods feature sleep deprivation, dealing with new responsibilities, an occasional sense of desperation, and a cloudy knowledge that someday it will be easier. Both experiences also have a sense of an initiation rite; we can look back and say, "I'm different since I went through that."

As someone who has gone through both of these rituals, my advice is to accept it with the knowledge that it is necessary and that it will soon be over. For both mothers and fathers there are ups and there are downs; when you are up, enjoy it, and when you are down, don't pretend that you are not. Sometimes when you are depressed, you will get into little arguments with each other. The mother will be depressed and the father will be anxious about caring for this new baby, and little "helpful suggestions" from the latter will not really help the former. Nor will sarcastic answers from the former help the latter—"If you're so smart, why don't you try changing a diaper for a change?"

Bite your tongues, both of you! And if you can't do that, one of you say, courageously, "I guess we're depressed and anxious, aren't we?" Then maybe get some sleep. It is a hard time, and tempers get frayed. But, take it from me, things do get better!

Having a baby is a big league experience, so don't cheat yourself out of it. Be sure that you don't have a lot of obligations beyond the baby this first month. Don't hesitate to tell family and friends to postpone their visits, because last night was the pits. If they can help, fine, but otherwise.... Actually, some of my patients have told me that having someone around for the first few weeks to share the burden can be terrific, both for you and the helper who get to share the excitement. But if you opt for a companion and helper, make sure that the situation is firmly structured so that you are in control, able to do what you want to when you want to, and the helper doesn't subtly become the boss. It's your baby, so you get to choose what to do, and when.

Giving birth is one of those times in life when all sorts of feelings come to the surface, when the windows of the soul are open. Try to accept that in good grace. Let those feelings bubble up and express them when you can, knowing that five minutes later you might be host to an entirely new feeling. Not all those feelings will be pleasant ones. Sometimes you will be depressed. Very likely, at some point you will experience fear. What if the baby gets sick? What if he or she is stolen away in the night by crib death (SIDS)? These fears might be very real to you—and they are normal fears, however unrealistic they may be. In fact, I have yet to give a lecture to a prenatal class when one of the questions from the audience does not concern rare but serious diseases of the baby. You feel the potential loss because you love so much, and you know you never did anything to deserve such a gift, so why shouldn't it be taken from you? All I can say is, accept your worry as a sign of love, and bring your baby in to see us if that will help.

On the other hand, you have probably heard of Postpartum Depression. This happens when a mother gets severely depressed, which is not only sadness and tearfulness, but a lack of any pleasure and a hopelessness. This is an important condition to be conscious of—it can be treated, and it is important to treat! We will screen for this in the office, but let us know if you think this is something you might have.

Mothers have done most of the child rearing in our society, but that doesn't mean that fathers aren't important, and thank goodness fathers and mothers are becoming more co-equal all the time. Still, possibly because of societal conditioning and practice, most mothers quickly become better at day after day caring for the kids. I know for sure that

they are better at breastfeeding. If this is the case, then it seems clear to me that mothers owe it to fathers to be patient with them, and show them how to do things slowly, carefully, and with good humor. And we men should be patient, too, and accept suggestions and instructions with good grace. Sometimes, of course, the two of you will be equally adept, or equally tired, and sometimes men will have strengths that women won't. So, it is another challenge of male/female interactions to raise the kid in a way that is good for him and good for you. Do it nicely, with good humor, and good luck to us all!

### III. Feeding the Baby

#### A. BREAST VS. BOTTLE

The first decision to make in feeding your baby is whether to use breast or bottle. Whichever you choose, the baby should not get whole cow's milk for at least a year. Both infant formulas and natural breast milk have much less salt and protein content than cow's milk, and the baby can handle it much better this way.

We enthusiastically recommend breastfeeding, if it is possible for you, because of the advantages breastfeeding offers. Certainly, breastfeeding has withstood the test of time. Most often breastfeeding is more convenient than bottle feeding, as long as a mother is around. Breast milk has antibodies in it that come from the mother and protect the baby against intestinal and possibly respiratory diseases for many months. Another possible advantage of breast milk is that it might lead to fewer allergies for the baby. Finally, there is thought to be a psychological advantage in the connection established between mother and child through the breast. In sum, breastfeeding is a good thing, and we recommend it.

While the baby is breastfeeding it is not necessary to give supplementary feeding if the infant is nursing well. If the baby needs supplementation because of jaundice or poor weight gain, use formula and not water, because he or she will need the extra calories and protein. Sterilization is not necessary; just keep the bottles clean with soap and hot water, and make sure that they dry out afterwards.

Once breastfeeding is well established in the first two to three weeks, I think that it is a good idea for the father to give the baby one bottle a day, using either expressed breast milk (preferably) or formula. Here is why: (1) A bottle a day is good for fathers. It can be enjoyable to feed babies, it gives a father a feeling of closeness (father bonding) and a feeling that he is sufficient to serve this child's needs. (2) It is good

for a mother, too, since it gives her a rest from a very arduous job, especially if it is done at night. (3) It is also good for the baby. Adding a bottle at this age is much easier than later on, when it might be refused, and yet it is late enough so that the breast is not rejected.

We have had great success recommending this supplemental bottle; just be sure that the breastfeeding is well established before proceeding with the bottle, because just like real people, babies are lazy, and it is easier to get milk out of a bottle than out of a breast. So when you're "breaking in" the baby let him or her get used to the work of sucking from the breast first, so he or she doesn't get used to the fast flow of the bottle.

Many mothers will be going back to work soon, and they wonder what to do about breastfeeding when they do. I generally recommend that you start out breastfeeding fully, with that one bottle a day supplement. Get used to pumping breast milk and saving it, so that breast-milk-from-a-bottle can be the substitute for breast-milk-from-the-breast when Mom is at work. The best time to pump is in the morning, one hour after the first feeding, which allows the breasts to refill after the morning feeding. When at work, pumping milk every 2-4 hours should keep the supply coming. Most mothers can then breast feed on a regular schedule when at home, and pump when at work. If that doesn't work, formula is an adequate substitute.

Fresh milk can be stored in the refrigerator and used for 3-8 days, in the freezer for 3 months, and in the deep freeze for 6 months. When thawing the milk, use the oldest milk first; you can defrost it by placing the sealed container in warm water for 30 minutes. Don't use hot water or microwave, because those processes might destroy some of the protein in the milk. Thawed, refrigerated milk is safe for 24 hours.  
*Do not refreeze.*

**How long should you breast feed?** Every woman feels differently and there is no "right" answer. The younger the baby the more beneficial the protection, and babies from allergic families might be especially helped. Recent recommendations for duration of breastfeeding have extended from 3-6 months to one year and even two years. But in the end most women have a feeling when they are "done."

Despite all the excitement over breast milk, it isn't the end of the world if you go with formula. There are many excellent formulas produced, including **Similac Advance Earlyshield** or **Similac Organic**. If you decide to use a formula instead of, or in addition to, breastfeeding, we invite you to talk to us so we can advise you.

The formulas come with rather elaborate instructions on sterilization of bottles, boiling of water, etc. Personally, I think that these instructions are vestiges of a bygone era when water supplies were not reliable, and it is good enough nowadays to wash the bottles in hot, soapy water or a dishwasher, making sure that they dry completely between uses. Many people like to prepare the day's formula at the beginning of the day and store it in a refrigerator, warming the bottle to body temperature at the time of feeding. It is a good idea to use the concentrate or the powdered formula, because these are more economical than the ready-to-use versions. For the first six months use fluoride-free water to mix it, and after six months use our East Bay water which has fluoride, which strengthens the teeth. If your water does not have fluoride in it please tell us so that we can prescribe a fluoride supplement at six months.

When you feed the baby his or her bottle, hold him or her close, just as though you were breastfeeding. He or she gets to feel warm and comfortable this way, and so do you. **Do not prop up a bottle for the baby to suck on going to sleep** (or anytime, actually, if you can help it). Milk taken this way is bad, and juice is even worse. The effect is to keep a constant supply of sugar in the mouth, which allows germs to flourish, and as a result the teeth rot. Enough said.

## **B. TECHNIQUE OF BREAST FEEDING**

The technique of breastfeeding is a learned art. Some mothers master it easily; others have to work harder. Every mother and baby pair seems to have a unique experience. We have nurses in our offices who can give you special help, so don't hesitate to ask. They can be of terrific assistance. Don't suffer! Ask for help, because it's there.

In the first few days you will most likely not be producing milk, but colostrum. This thin liquid is good for the baby, for it helps to clean out his or her intestines, and gives him or her some of those good protective antibodies. Be patient while you wait for your milk to come in, because it usually takes a few days. In the meantime, feed the baby regularly to give the colostrum, and to stimulate milk production. Newborns should be nursed whenever they show signs of hunger, such as increased alertness or activity, mouthing, or rooting. Try not to wait for crying, because that is a late indicator of hunger. If he or she does cry, try to calm him or her down before trying to nurse. You don't need to limit the number of times your baby nurses—look at the baby, not at the clock. It's normal for newborns to “cluster feed” in the beginning, feeding several times in a row, even hourly, before sleeping for a longer period. In general, most newborns are fed 8-12 times every 24 hours. If it is less than 8 for you, please call us.

It is ideal to offer both breasts at each feeding, but it is more important that your baby has enough time to finish the first breast before switching sides, usually 15-20 minutes. Going that long ensures that the baby gets the fatty milk with the most calories, which comes as the breast gets near empty. It's OK if the baby only gets a shorter sucking period on the second breast, just start with that one the next time. Using a safety pin on the bra strap can help you to keep track which one was first last time. Try different positions for feeding—sitting, lying down, the “football hold,” and others. See which ones you and your baby like, and also notice if you can tell that different lacteal glands in the breast are emptied with different positions.

To get the baby to take your nipple, gently stroke the baby's bottom lip with your nipple in a downward position several times. Pause to see if he or she will open his or her mouth very wide with the tongue down. The baby has something called the rooting reflex, which causes him or her to turn toward the source of that stimulation. Make sure that the baby's lips are flipped outwards, and that he or she has a good mouthful of breast tissue. Some mothers have a very large areola and it is not necessary, or possible, for their babies to take in the entire areola during breastfeeding. In general, it is more important to try to cover a larger portion of the areola with the lower jaw, since this will prevent the baby from closing the jaw on the sensitive nipple tip. To break the baby's suction use your finger in the corner of his or her mouth. Don't just pull your breast out, because that will hurt.

If the baby is attached on the breast in a good position, you should feel very comfortable—there may be a tugging sensation, but no pinching. Again, let us know if you need some help. It takes some practice, and some coaching can help.

### **C. MILK SUPPLY**

Initially, it is hormones that stimulate your breasts to make milk. To sustain that production the milk has to be continually removed. The more effectively and efficiently the milk is removed, the more milk will be produced. So, if you want to have a lot of milk, just keep feeding the baby fully and frequently. If there is trouble latching on, use a breast pump for 15-20 minutes every 2-3 hours.

### **D. THE MATERNAL DIET**

Occasionally food you eat causes gas in the baby and makes him or her fussy. These foods might be: broccoli, cabbage, cauliflower, chocolate, onion, peanuts, milk or milk products. But mostly they don't cause any distress at all.

Your diet does not have to be anything special, just a normal, well-balanced diet with enough water so you are not thirsty. Since you will be feeding the baby frequently, you might want to eat small, frequent meals yourself. Just because you are feeding the baby milk doesn't mean you have to drink milk yourself. No alcohol is a good rule; it takes about 4 hours to clear alcohol from the blood and from the breast milk supply.

### **E. FEEDING FREQUENCY**

Before your milk comes in, it is normal for the baby to lose up to 7% of birth weight. Then your milk will come in and you will feed him or her every 1½ to 2½ hours, and it will be easier to hear the baby swallowing. As time goes on and the baby's stomach grows, feeding becomes less frequent, for a total of 8-12 feeds per day.

There are two basic theories on when to feed a baby, by demand or by schedule. The demand theory says to feed the baby when he is hungry; the schedule theory says to feed him or her at predetermined times, usually every three or four hours. Do what seems best to you, but most of us now favor demand, expecting an eventual 2-2½ hour schedule.

Babies are very variable in the ease with which they settle into a schedule. Some never really do, alas. But most are more or less successful in feeding rather regularly, for a half hour or so at a time. If he or she goes longer, and you are happy, who am I to break up a happy combination? You might have to burp him frequently to get the gas up—it is more polite as well as more comfortable to get it out the top than out the bottom. And remember, being hungry is not the only cause for crying. Look around for what else might be doing it. If every time the baby has a discomfort and cries, he or she gets a nipple shoved in the mouth, it is possible that he or she will pick up the habit, and every time something goes wrong in life, he or she will reach for something to eat or drink. It is better, both now in the newborn period and later on, to find the specific problem and solve it directly.

One last word on scheduling—if the baby insists on sleeping through the night, let him or her do it. Don't look a gift horse in the mouth. The exceptions to this precept would be in the very first stages of breastfeeding, when you want to empty your breasts on a very regular basis to get the milk flowing properly, or if the baby is not gaining weight properly.

## **F. BREAST FEEDING PROBLEMS**

There are four things to tell you about here:

1. **Flat or inverted nipples**—This is usually just a temporary condition that resolves itself. Try rolling your nipple with your finger to help puff it up. You can also use a breast pump for several minutes to help draw out the nipple. Our lactation consultants tell us not to use a nipple shield unless they recommend it and monitor it.
2. **Sore nipples**—This happens a lot. Don't stop breast feeding because of it; in fact, breast feed more frequently and the soreness will disappear soon. Nurse on the least sore side first, and make sure that the baby is in a correct position and latches on correctly. Use non-plastic lined bras or bra pads, and change them frequently to keep the nipples dry. If your nipples become dry or cracked you can rehydrate them with Pure Lan 100, which is a safe, pure, hypoallergenic USP modified lanolin. Also, if you expose your nipples to air, heat, and even sun between feedings, this can help. (Yes, this can mean going topless.) You can also wear multiple holed breast shells between feedings, which will allow air to circulate and prevent rubbing by your bra. If the soreness doesn't start to disappear after a few days check with us—a good latch is usually the best therapy for sore nipples, and we might be able to help you with this.
3. **Engorgement**—This is most frequent around the third day when the milk supply increases. Five minutes of warm moist compresses just before feeding can help. So can frequent feedings, or expressing or pumping milk. Also, you can gently massage your breast as the baby nurses, which will help the milk flow freely. Then after nursing you can apply cold compresses to reduce the swelling.
4. **Relactation**—Sometimes, because of a premature baby or an infection you (the mother) might have had, breast feeding cannot be started immediately, or once started, it must be interrupted for a while. Don't despair. You can pick up feeding with a little persistence, even if the milk is not coming very well at first. Just keep at it, perhaps supplementing with formula at the beginning, but later on you will be able to handle the whole thing by yourself.

## **G. FEEDING SOLID FOODS**

We generally wait until four to six months of age, to start solids. That is how long it takes a baby's intestinal enzymes to appear fully, and to be able to break down food enough so that large pieces of proteins don't slip through into the blood, and thus produce allergies. Also, new evidence suggests that waiting too long may actually increase the

risk of allergies. So between four and six months is best. This is also about how long it takes the neurological system to mature, so that the baby can coordinate the muscles enough to be able to eat. Eating is complicated, if you think about it: you have to open and close your mouth at the right time, push the food down with your tongue, and open the glottis so that the food doesn't come out your nose. Not so easy! (As a matter of fact, the more I think about it, I'm feeling pretty proud of how well I have learned to eat so well!)

In starting solids, *remember two principles*. The first is this: introduce each food slowly, and only one new food at a time. You want to find out how the baby reacts to the food, and it takes a while to find out. Does he or she like it? Does he or she get a rash (the most common symptom of food allergy in a baby), or diarrhea? Does he or she throw up? If you have changed only one food, you have a good idea what caused the upset. To be sure, stop giving it to him or her for a few days and let the symptoms subside, then give the food again. If the same symptoms reappear, you know for sure what caused it.

The second principle is this: don't mix a whole bunch of foods together. Instead, feed the baby pure tastes. If you give him or her pure carrots, he or she will learn to eat for taste, and to appreciate it. If it is carrots mixed with chicken and rice and rhubarb, the taste will be confusing. He or she will get the idea that all there is to eating is stuffing your face, and who wants him or her to think that?

Don't worry if you feed your baby only a few different foods. He or she doesn't need the variety that we do. And they don't have to be particularly tasty—what is “blah” to us is often what is delicious to them. *Also, remember:* while we all want our babies to progress as fast as our friends' babies, is our six month old really “behind” our neighbor's kid if ours doesn't yet eat pepperoni pizza?

Parents wonder how much food a baby “should” get. The baby knows and will tell you, or rather he or she will show you by indicating his or her interest in food. If there is hunger, it is appropriate to feed, it is as simple as that. The only way to overfeed babies is to force them to eat when they are full, and they will show you they are full by turning their heads away. Just respect that show of disinterest, and you are home free.

#### IV. OLDER SIBLINGS AND THE NEW BABY

*There is no way to prevent sibling rivalry—it is natural and understandable. And don't worry, it will naturally go away in 40 or 50 years!*

Imagine this, ladies: your husband comes home one day and says, “Honey, guess what? I'm so excited! Tomorrow, I'm bringing home a new wife! You'll love her! She's very cute. Now, I know that it will take a little getting used to, but in time, I know that you'll adjust. She'll be a great friend to you in time, you'll go shopping together, and everything. Now, some nights I'll sleep with her, and some nights I'll sleep with you, but I'll love you just as much as I always have!” He might not get away with it.

But, to a certain extent, that is what we are asking an older child to accept when we bring home a younger one. Luckily, they are more adaptable than we are, and they *will* get used to it. But at first, let's expect some backsliding on the older child's part, what is called “regression.” This is just a natural way of reacting to the trauma of losing one's exclusive place in the family.

It is best to understand this process and to let it go on; it is no time to insist that the older one “be a little man” about it. If the older one sees you breast feeding the little one and wants to horn in, let him! It will last about five seconds. If the older one was toilet trained before and now has some accidents, it is no time for a reprimand. Just be supportive, and in time a good adjustment will be made. If the older one expresses negative feelings about the new addition, agree with him or her! Validate his or her right to have those feelings, and let them come out (but don't forget to protect the baby! Don't leave the little one alone with the big one!) If you allow the “bad” feelings to be expressed, the “good” ones can come out, too, pure and unadulterated.

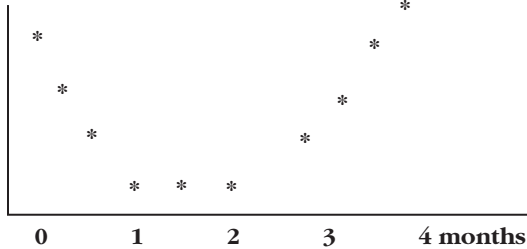
It seems rather natural for the father and the older child to pair up, and let the mother and little one be together more. Some of this is inevitable, but the older one will miss his or her mommy, and the mother will miss the closeness with the older one, too. So, one thing that you can do is for the father to take care of the younger one some of the time, and let the mother and older child re-experience their former exclusive closeness. When a mother takes the older one out for a little trip “just the way it used to be,” it can be a very moving and rejuvenating experience. All of a sudden, “misbehavior” can just disappear.

**There are other things to be done as well:**

- Make a fuss over the older child when you bring the baby home from the hospital.

- Ask your friends and relatives to make a fuss over the older child when they come to visit, and maybe bring a present.
- Let the older one help care for the new one as much as possible.
- Reserve a special time for the mother to play with the older child each day.
- Sometimes, when you are with the older one and the younger one cries and wants attention, delay for a while to show the older one that the younger one does not really matter more.

## V. Sleeping, Crying and Parent Satisfaction



This, sports fans, is the parent satisfaction curve. At birth, your pleasure is very high (the “\*” shows pleasure); you are high. Then, sleep deprivation takes its toll. By six weeks you are wondering if you have done the right thing, after all. The baby’s crying is increasing, of all things. There is some regularity, with the awake periods and the asleep periods each longer, and you love your baby, but isn’t he or she a little, er, I hate to say it, but a little vegetable-like?

When you feel that, it is generally the low. What do you get then? Pretty soon, the first smile, and all is forgiven. Then comes a laugh, and even a reaching out, and you are happier than you have ever been.

I point this out not to depress you, but to give you some hope, when you are near the low, that there is light at the end of the tunnel!

Now, more about sleeping. Some babies love to sleep and sleep through the night at two weeks of age (this is rare!), while others seem to fight sleep and are still waking up at night for months and months. There are no clear rules in this area, but there are two major pitfalls. The first is The Reversal. This occurs when the baby is up at night and so are you, so when he sleeps during the day, so do you. You have then been reversed. To beat this one, keep him or her up during the day as best you can, until he or she finally collapses at night—an acceptable time to collapse.

The second pitfall comes some months later, after a night sleeping pattern has been established, and he or she suddenly starts to wake up at night again. Maybe it is a tooth. You are concerned, so you go to check him or her and maybe give a feeding, and after a few nights of this he or she is in the habit and won't quit. If this happens, you have to make up your mind to quit. Try **The Ten Minute Rule**. When he or she gets up, wait ten minutes by the clock (with a child crying, 10 minutes not by the clock is about two or three minutes), then go in and comfort him or her. Don't feed, just comfort, then leave. Then the real howling can begin. Wait 10 minutes, by the clock. Then go in and comfort again, and leave. Do it once or twice more like this. After a few nights of this, he or she will be sleeping through the night, and so will you.

If you are too soft hearted to do this, try thinking that he or she needs to learn how to comfort him or herself, and that this is a developmental task to accomplish—it's good for them.

If you still can't do it, don't worry about it. Just get used to getting up once or twice a night, and in the end, no harm will be done. It is certainly nothing to feel guilty about if he or she still gets up at night.

Whether your baby is a difficult sleeper or not, it is a good idea to establish a regular routine of going to sleep. Do it the same way every night, and you will feel more security yourself, and the baby will be guided by this routine into a proper sleep frame of mind. (It usually worked on me better than the kids, actually.)

## VI. Specifics of Child Care

### **A. SOME NORMAL THINGS THAT BABIES DO**

It is perfectly normal for babies to hiccup, sneeze, pass gas, and to startle. These wonderful characteristics, that only get better with time, are nothing to worry about. Some babies also look cross-eyed for a while, and most often this corrects itself in three months. Spitting up is also not uncommon, but unless it becomes excessive we usually don't have to worry about this too much, unless the baby's weight gain is affected.

### **B. SIGNS OF ILLNESS**

It is not normal and may be dangerous if a baby runs a fever of over 100 degrees during the first two months. If this happens, you should contact us right away.

A more common newborn condition is jaundice, which means that the baby's skin turns yellow, and the whites of the eyes become the yellow

of the eyes. Usually jaundice comes simply because the baby's blood is thicker than ours, the cells break down more quickly, and the released hemoglobin is a little too much for the baby's immature liver to handle. If this happens, call us and we will evaluate it, and fix it if necessary.

Other things to be concerned about in the first month would be persistent irritability, listlessness, or decreased appetite.

#### **C. CONSTIPATION AND BOWEL MOVEMENTS**

The patterns of baby's bowel movements are quite varied, but generally are not anything to be concerned about. Some babies move their bowels after every feeding, especially if they are breast fed. Sometimes a baby will go a day or even two or three or more without having a bowel movement. Especially if the bowels are hard, he or she might strain, cry, and get a red face trying to pass it. Don't worry, because the baby isn't going to get sick over this problem, but it might help to place a thermometer gently up the rectum to help to stimulate a movement, or to use an infant glycerin suppository, which is available at a pharmacy. Sometimes the bowels can be loosened a bit by feeding prune juice or apricot nectar but sometimes this doesn't work. In any event, while constipation might trouble your baby a little bit, it is not a dangerous condition. Don't worry, but make sure to bring this to our attention so we can help.

#### **D. CARE OF THE NAVEL**

The stump of the umbilical cord will dry up and fall off within a week or two. Until it does, don't give the baby a tub bath. Keep the navel dry and clean, by just sponge-bathing using water. We used to recommend alcohol wipes, but now we think it isn't necessary. After the umbilical stump falls off, there might be some watery, red oozing for a day or two, but that's normal. If it is very red, tender, and swollen, it might be infected, and it is important to let us see it right away.

#### **E. CIRCUMCISION**

Is it good or bad to have your baby boy circumcised? There are arguments both ways on this question, and we can go either way. Circumcision is certainly not medically necessary, but it does make cleanliness easier, and there is less infection and irritation with a circumcised penis. On the other hand, there are sometimes accidents with circumcision, where the foreskin is cut a bit unevenly, or when there is bleeding that has to be stopped with a stitch or two. By the way, if your family has a history of abnormally heavy bleeding please tell us before you ask us to circumcise your baby.

When we circumcise a baby, we use local anesthesia beforehand, and the procedure is so brief and easily forgotten, you probably don't have to worry about the baby's discomfort too much when trying to decide yea or nay.

Deciding whether or not to have your baby circumcised can seem like one of life's biggest decisions, but it really is not. It's just one of life's first decisions. There is no right decision here, but there is a right way to come to the decision—that is by making it together, with collegial give and take. Make this a good example for the future decisions you will have to make!

If you decide not to have a circumcision, just use normal hygiene with the penis, and it will most likely be fine. If you have a circumcision by the Plastibell method, there will be a little plastic ring around the end of the penis for a week or so, until it drops off by itself. If it is done by another method, the skin will be raw for a few days; just keep it clean, and put on a little Vaseline for a few days so that it doesn't stick to the diaper.

#### **F. EYES, EARS, NOSE, AND MOUTH**

Mostly, if you leave these organs alone, they will be okay. Specifically, do not use Q-tips for the ears. If you push a Q-tip into the ear you usually don't get wax out, but you do push it in, and that doesn't help anyone.

Lots of times a baby's nose gets congested. It is generally nothing to worry about, and you can sometimes clear it up by sucking out the mucus with a bulb syringe. If that doesn't work, sometimes salt water nose drops can be useful. Just take four ounces of water and a quarter teaspoon of salt, mix it, and put a drop of this solution in each nostril every few hours as needed.

#### **G. BREATHING**

Babies don't breathe with the same rhythm that we do. They breathe periodically. First they will breathe fast, then slow so that you wonder when and if it will start again, then fast again. This is normal, and is caused by the immaturity of their neurological system. After a few months it gets to be like ours.

#### **H. BREAST AND VAGINA**

When a baby is not yet born, it gets its nourishment from the mother's blood. Along with this nourishment comes some of mother's hormones. The same hormones that make the mother's breasts grow can also make the baby's breasts grow, no matter which sex the baby is. You

can feel this breast tissue, and if you squeeze it, it will sometimes produce milk, called “witch’s milk.” This is normal and will go away in a few weeks as the baby is no longer exposed to the mother’s hormones.

A girl baby will sometimes pass a little blood through her vagina, just like a period. This results from being exposed to mother’s hormones and then being withdrawn from them, and is normal. Don’t worry, her next period will probably be at least a decade later! Little girls will also accumulate a white, lubricating substance just within the lips of the vagina, and this is normal.

### **I. SKIN**

Babies often get rashes of several different sorts. Most of these will simply go away of their own accord. The white dots on the nose, for instance, are called milia, and go away in a few weeks. “Stork bites” are red patches on the back of the scalp, usually near the neck; and “Angel’s kiss” is the same on the face, usually around the eyelids and forehead. They take a bit longer to disappear, sometimes as long as a year. Also, many babies develop newborn acne, from about age 3 weeks to 3 months, a result of hormone changes after birth. There are other rashes as well; we can name them in the office, just for fun.

It is tempting to use oils on a baby’s skin at first to make it super smooth, but these can clog the pores and produce rashes of their own. It is generally best just to leave the skin alone. In particular, stay away from lotions that have peanut oil in them, because they may lead to peanut allergy.

### **J. ROOM TEMPERATURE**

Babies are usually most comfortable at temperatures that we ourselves like. The most common mistake is to get too concerned about a baby’s catching cold, and keeping the room too warm as a consequence. One light blanket over a baby is generally enough. On the other hand, the year that you have a new baby in the house is not a good year to pursue extra special savings in the heating bill. This year, pay PG&E a little extra, and keep the house comfortable.

### **K. SLEEPING POSITION AND PLACE**

We used to advise parents to let babies sleep on their bellies, but recent evidence indicates that on rare occasions this can be dangerous. This is probably because they might re-breathe air they just exhaled, and gradually suffocate. That is why we now say: BACK TO SLEEP. That is, try to get your baby to sleep on his or her back. Most can do this, but if they can’t, try the side. Remember, however, that infants can

suffocate if they get trapped between a mattress and the frame or wall, or if they get wedged against an adult and a mattress, or if they sink into a waterbed mattress while on their stomach. They should sleep in a crib with a firm mattress for safety.

#### **L. TAKING A BABY OUTDOORS AND IN CROWDS**

If the weather is good the baby can be taken outdoors after the first week. Just keep him or her out of the direct sun, because the newborn skin is very tender and babies can't sweat very much, so they can become overheated easily. By the same token, don't overdress the baby.

I think that it is a good idea to keep the baby away from crowds. Most infections are passed by touch, and in a crowd everyone will want to touch the baby, and it is hard to stop them, even when you know that they could be transmitting germs. Just stay away for a few months.

#### **M. TRAVELING BY CAR AND AIRPLANE**

The early months are often the easiest ones to drive with a baby in the car. Just make sure that you get a car seat, and use it faithfully. Those facing backwards give the best protection. Babies should be rear-facing until at least 12 months of age, or until they weigh at least 20 pounds, whichever comes later. It is important to use the car seat. Even if the baby feels secure in your arms, if there is an accident and the car stops short, the baby will become a miniature projectile before you can react, and tragedy can easily result. Just get the car seat, and use it. The back seat is generally the best place for him or her, and while they are in car seats, don't put them in a seat with an air bag.

You can take a baby on an airplane at a very young age. Just remember to feed the baby on the way down. The act of swallowing should open up the Eustachian tube in the ear and equalize the pressure, thus keeping the baby comfortable. Remember, on the way *down*. On the way up, the ears do fine by themselves.

#### **N. THERMOMETERS**

If you don't know how to read and use a thermometer, have a nurse teach you in the hospital. It is important to have one at home, and to know how to use it, because if you are afraid your baby is sick, you have to know his temperature, it's as simple as that. You can take a baby's temperature under the armpit, or in the rectum, but don't use the forehead strips. They are not consistent enough to be useful.

#### **O. COLDS AND FEVERS**

Babies catch colds just like the rest of us, especially after the first four months or so, when the protective antibodies that they got from the

mother's blood have disappeared. Then they are on their own and will have to build up immunity the hard way, by getting sick and resisting it.

**There are a few simple things to do for a cold:**

1. Give clear liquids. For example, **Pedialyte**<sup>®</sup>, an electrolyte solution for babies and children; 7-UP<sup>®</sup> that has been allowed to go flat, or, for older children, Gatorade<sup>®</sup>, if they won't take Pedialyte.
2. To open up a congested nose, especially before eating, use salt water nose drops (made by mixing four ounces of water and a half teaspoon of salt).
3. Give acetaminophen drops (see dosage in next section) if that seems to make the baby feel better.
4. Take his or her temperature a couple of times a day.

**When babies get sick, they often get fevers. Here are some things to remember about fevers:**

1. A fever does not hurt a baby, even if it goes very high. Fevers do not "cook the brain," or anything like that. A fever might even be helpful in getting rid of the germ that is causing the infection. A fever is simply the body's reaction to an infection.
2. If the baby gets a fever over 100° in the first two or three months, call us. After that, fevers are common and not usually a sign of danger, even to 104°. It *is* worrisome, however, if the baby has unusually severe symptoms, such as marked irritability, lethargy, a stiff neck, or a bulging soft spot on the scalp (the fontanelle). For these symptoms, call us at once.
3. To reduce a fever and make the baby more comfortable, you may give acetaminophen drops every four hours. The dosage is: 0.4 ml for 6-8 pounds; 0.6 ml for 9-11 pounds; 0.8 ml for 12-17 pounds; 1.2 ml for 18-23 pounds; or 1.6 ml for 24-35 pounds. (See complete dosing charts under "Fever Phobia" later in this book.) Sometimes a lukewarm bath can be helpful, too.
4. Try not to panic. On the other hand, we get upset about our children when they are sick, too, so we will understand your distress.

## **P. SMOKING**

Babies should not smoke, and if you smoke around them, they get your second hand smoke, and they get sick more often than they have to. Smoking is a terrible addiction, and if you can't quit, that is understandable. But at least try to smoke outdoors for the baby's sake. If you wind up smoking less as a result, that would not be a tragedy, either. If you want to stop smoking—this is what we recommend—ask us. We can help.

## **Q. VITAMINS**

Vitamins go in and out of fashion. Currently, vitamins A, C, and D are recommended for breast fed babies, because they don't get much vitamin D from breast milk and actually can get rickets. Less controversially, we know that fluoride is good for a baby's developing teeth, and this element does not get into breast milk. For that reason we recommend that you give the baby vitamin A, C, and D drops starting in the first month, and fluoride drops starting at age six months until the baby is taking a significant amount of East Bay water (which is fluoridated). Please check with us for advice on vitamins—we want to give you individualized advice.

## **R. PACIFIER**

Babies have a need to suck that is apart from hunger and their need for nourishment. So how do you allow them to suck without overfeeding them? The pacifier. I don't think that pacifiers lead to thumb sucking. On the contrary, one theory says that if babies get all the sucking they need as an infant, they will "get it out of their systems" and not go on to thumb sucking. In any case, we do want our babies to have their needs met, and there is no evidence that using a pacifier does any harm. Even dentists agree.

## **S. HEARING AND VISION**

Babies can see right at birth, but they seem to focus at things about two feet in front of them. This means that when you are feeding them, they can see your face clearly. We don't know who they think you are, but if you are feeding them, they probably think that you are friendly.

Babies can also hear at birth, and recognize their mother's voice specifically within the first week. Presumably, they can do the same for a closely involved father as well.

Parents often detect if there is something wrong with the vision or hearing before we do. If you suspect something is amiss, let us know. Sophisticated tests are available to check a baby's hearing and vision, and while we don't routinely do these, if there is a serious question of abnormality, we will certainly get them done. Babies are now having their hearing checked at the hospital prior to discharge, which helps eliminate that worry for us.

## **T. EAR PIERCING**

If you want to have your little girl's ears pierced (there, I made a distinction between girl babies and boy babies!), let us know. You can have it done at a jewelry store, or we can do it in the office. Stud ear-

rings are better for children than hoops, because they won't catch on anything and tear the earlobe. If you wait a few months before doing it, we will have a larger object to aim at.

#### **U. PETS**

Let me tell you a story. I had a dog. I loved this dog so much, it was obscene. As I look back, I'm sure that I was waiting for a child to love, but at the time, I really wondered if I could ever love the new child as much as I loved that old dog. I really did.

So when my son was born, I made sure that the dog didn't feel displaced. I let the dog lick my son all over, and encouraged them to be together.

Then it turned out that my son was very allergic. What did he turn out to be especially allergic to? Dogs, of course. I thought that this was because we let the dog have so much access to the baby. But, amazingly, recent evidence says that my conclusion wasn't right. Instead, recent evidence indicates that early contact is actually protective for the development of allergies. Go figure.

On the other hand, we are seeing more and more asthma in our patients, and there is a theory that this is due to better hygiene! The theory is that if kids are exposed to antigens (things to be allergic to, generally proteins) early in life they become accustomed to them and don't become allergic!

I used to say, keep the pets away for at least six months, but now I'm not so sure. Go figure. But at least I wouldn't let a pet alone with the baby unsupervised, unless your pet is a fish.

#### **V. FINGERNAILS**

The easiest time to cut your baby's nails is when he or she is asleep, or when feeding, when the hands are relaxed. The easiest way to do it is by filing them down with an emery board, coming over the top of the nail, gently. Or by using a blunt-ended baby scissors, which also works well.

#### **W. WASHING**

Babies don't need to be bathed all that often; unless you or the baby likes it a lot, you don't need to bathe him or her every day, because a sponge bath will do just as well. Mild soaps like Neutrogena® and Dove® seem to do best with the skin of a baby.

## VII. Some Advice for Later Months

### A. IMMUNIZATIONS

In modern times we still get sick sometimes, but we don't get nearly so seriously ill as people used to. We just take for granted nowadays that our children will grow up healthy. Sometimes they don't, but for the most part they do.

This is not at all the way it used to be. Parents used to count themselves lucky if half their children survived to adulthood. Nowadays, if a family experiences even one death of a child, we sympathize and wonder why they had to be singled out for grief.

An important reason for our modern success is immunizations. What is an immunization? Usually, the body becomes immune to a germ after it is infected by that germ for the first time. At that first meeting, the body fights the germ with its immune system—antibodies and white blood cells. The next time the body is infected with that same germ, the body recognizes that germ right way, and calls out ammunition it had stored from the last battle, so the germ cannot make any progress at all the second time.

An immunization gives the body a sample of that germ, enough for the body to make the antibodies against the germ without actually catching the disease. When the germ actually does try to infect the body some-time later, the body acts as though it has already had the disease, calls out the ammunition, and you never even know you were exposed.

We have to think, then, that we not only have a responsibility to our own children for them to be immunized, but we have a social responsibility as well.

In addition, when everybody gets immunized, we have something called *herd immunity*. Look at it this way: if there is a herd of 100 cows, and 99 of them get immunized, the 100th is protected also, because where is she going to catch the disease from, if everyone else is immune? We have the same situation with our own herd of people. If everybody gets immunized against polio, those few who cannot tolerate the vaccine are protected by the actions of others.

What is the downside of vaccines? There has been some public controversy over the safety of these immunizations. Notice I say "public," because within the profession of pediatrics there is almost no controversy at all. There are some scientists and physicians who have different, alarmist views, but I do not take them very seriously. The proof of

the pudding: all our Bayside practitioners give their own children all of the recommended immunizations.

With some of the vaccines, notably chickenpox, it is possible that the vaccine is not quite so protective as it would be if you had actually gotten the wild disease and achieved your immunity that way. We also are not quite sure if the protection will last for a whole lifetime. Still, the odds are that even if a child does get the disease later on, it will be in a much weakened form, and the illness will hardly be noticed.

Our modern vaccines have very few side effects. There is always the chance of a local reaction, with pain, warmth, and swelling at the site of the injection. Applying ice and giving some acetaminophen or ibuprofen usually takes care of these small reactions promptly. Some of the vaccines can actually cause a short-lived fever. The measles vaccine can cause a fever for a couple days (about 15% of the time) and a mild, measles-like rash (5%). This reaction is usually very mild.

There used to be more controversy associated with possible hazards of pertussis (whooping cough) vaccine. This is the “P” part of the DTP vaccine. Since 1991, however, we have used a new vaccine called DTaP in which the pertussis vaccine is an “acellular” vaccine. This gives far fewer reactions than the old vaccine, and is at least as effective as the older one. So we really do not worry about this one anymore.

My advice to you on immunizations is this: read about them from the literature we have in the office, consider your options, but in the end, we all give our own kids the immunizations, and we would hope that you would, too. Not only do we protect our own children by doing this, but we also contribute to the herd immunity, and thus help others as well.

Here is our current schedule of immunizations:

1. **DTaP** (diphtheria, tetanus, acellular pertussis [whooping cough]): 3 shots, 2 months apart, starting at 2 months of age; 1 booster at 18 months of age; 1 booster at 4-6 years of age; then a Tdap (same components, but with lower strength diphtheria and pertussis) at age 11. Then a Td every 10 years, or between 5 and 10 years if a deep cut occurs during that time.
2. **Polio injectable vaccine (IPV)**: 2 shots, 2 months apart, starting at 2 months of age; 1 booster at 6-18 months of age; and 1 booster at 4-6 years of age.
3. **Rotavirus**: 3 oral Rotavirus vaccines at 2, 4, and 6 months.
4. **HIB** (Haemophilus Influenzae type B vaccine – prevents meningitis): 3 shots 2 months apart, starting at 2 months of age; and 1 booster at 15 months of age.

5. **Hepatitis B:** 1 shot at the first newborn visit, 1 shot one month later, and 1 shot about 5 months later.
6. **Varicella** (chicken pox): 1 shot at one year of age, another before going to kindergarten.
7. **MMR** (measles, mumps, and rubella [German measles]): 1 shot at 15 months of age, another before going to kindergarten.
8. **Prevnar** (Pneumococcal vaccine—prevents meningitis): 3 shots 2 months apart, starting at 2 months of age; and 1 booster at 12-15 months of age.
9. **Hepatitis A:** 1 shot sometime after age 1, a booster 6-12 months after the first one.
10. **Menactra** (Meningococcal—prevents meningitis): 1 shot at age eleven.
11. **Gardasil/HVP** (human papilloma virus vaccine—prevents cervical cancer and warts): 3 shots, starting at age 11, then one 2 months later, and one 4 months after that.
12. **Influenza:** Every year after 6 months of age—2 shots the first year, and one shot each year thereafter. It can be an injection, or after age 2, it can be a mist into the nose.

## **B. OTHER TESTS**

We like to check a child's blood count periodically to check for anemia, which is usually a result of iron deficiency. Currently, we are testing once at 9-12 months, once at 18-24 months, and then at your and our discretion.

Tuberculosis has been on the rise nationwide, and we first test for exposure to TB with a skin test at one year, and yearly TB risk surveys. Depending on the risk, and local requirements, we may repeat the test each year or two. If the test is positive—as indicated by a marked eruption and swelling on the arm two to three days after the test—that doesn't mean that the child has TB, it simply means that he or she has been exposed. We would follow a positive test with a chest X-ray, and possibly with medicine to be on the safe side.

## **C. TEETHING**

The first signs of teething come at about three months of age, when the baby starts drooling and biting on things. It will still be several more months, however, until the first eruptions of teeth appear. Sometimes it is even much longer—the current record in our practice is 14 months for the first tooth!

With teething most often comes discomfort. Sometimes the baby will even start rubbing an ear, probably because the nerves that go to the jaw and the ear are near each other. Giving acetaminophen for the discomfort seems to work well. Alternatively or additionally, you can rub soothing solutions on the gums, for instance, clove oil, Orajel®, Anbesol®, or Numzit®.

Teething is not supposed to cause fever by itself, but it is possible that teething lowers the baby's resistance and fever comes from a resultant cold, or infection.

The time and order of the appearance of teeth is variable (and hereditary), but here is a rough schedule:

- central incisors: 6-12 months
- lateral incisors: 9-14 months
- canines: 16-22 months
- first molars: 13-17 months
- and second molars: 24-30 months

#### **D. GROWTH AND DEVELOPMENT**

One of the most important things that we do at your well-child visits is to monitor your child's growth and development.

The growth part is relatively easy; we measure height, weight, and head circumference, and plot it on our standard charts. We are more interested to see that your child is growing consistently, rather than exactly what percentile of growth he or she is at. Some kids are going to be big and others small, that's life; we just want to make sure that nothing is wrong with his or her health, and as long as the growth is consistent, we can be pretty sure that everything is all right.

Development is harder to assess, and it is one of the things that pediatricians are supposed to do well, even though it is hard. For you as parents, of course, development is the most fun thing about the baby—seeing whether he or she says “mommy” or “daddy” first, taking the first step, etc.

There are several books available that detail what to look for in development, and if these are fun for you, and they help you to appreciate your child, read them. But what they are not good for is to figure out if your child is “normal.” Leave that hard job for us: if you are worried, tell us, and we will take it from there. Development is very variable, and it goes forward in fits and starts, and on different fronts at different rates. If the books just make you worry, stop reading them. I always worry that the books will get between you and the direct appreciation and enjoyment of your child, anyway.

If you want a general guide to the first six months of motor development, here it is: at first, babies move all their extremities about, but none of it is voluntary movement, it is just reflexes strung together. When they do start to attain voluntary control, they develop from the head down. First they move their eyes voluntarily; then the neck, and they can lift their heads; then the shoulders and the arms, and they can reach out and grab; then the trunk, and they can roll over (this is the most variable of all the signs of development); and finally at around six months, they have control of their hips and spinal muscles, and they can sit up.

For a guide on communications development, look for a baby to develop about 10 different ways to contact you—from smile, to frown, to cooing, to funny face—by the first four months.

### **E. STANDING UP**

Parents worry that if you hold an infant up to help him or her to stand, or if we put them in a Johnny-Jump-Up or in a walker, that it will make them bowlegged. There is no need to worry. Bones are not made of dead wood, but of living bone tissue. If it were dead wood, it certainly would bend, but since it is living, it reshapes itself constantly according to the pressures on it. Actually, then, the pressures of standing erect actually help the leg bones to straighten!

### **F. SHOES**

The point of getting shoes is so that he or she won't hurt his or her feet on something on the ground. The point is not to give support to the ankles. The people with the best feet in the world are those who usually don't wear shoes. Inexpensive shoes generally do the job, so long as they are rather soft and conform to the contours of the foot.

### **G. WORKING MOTHERS**

To work or not to work, that is the question. My advice is, wait as long as you can to answer it. Before the baby comes, it is very hard to predict how you will feel. Even those most devoted to their careers can be so tied to the baby and the home that they will do anything to avoid leaving. On the other hand, some mothers need a break, and part-time work, if available, is a welcome relief. Quite often, of course, economics dictates the answer, which is that work is necessary, like it or not.

Remember this: you will suffer more than your baby. As long as you find good day care (and most people find this more easily than they expect), the baby will be happy, even if you are not. The unhappy fact is, you will miss more than you will be missed.

Get used to having kids....

## VIII. Books We Recommend

Personally, I have difficulties with many books about child care. Some are just outright misleading. Others are so complex that they leave you with a feeling a great inadequacy, like, “How am I ever going to be an adequate parent? I can’t understand or remember all this, and it’s the most important thing in my life!” Other books talk down to you as though you were an idiot, and others are so sweetsie-poo I want to vomit.

There are, however, some that we like and that are helpful. Here is our best current list:

*A Mothers’ Circle*, by Jean Kunhardt, M.A., and Lisa Spiegel, M.A., and Sandra K. Basile. I recommend this book to all my mothers as the first book they should read.

*Taking Care of Your Child*, by Pantell, Fries, and Vickery, Addison Wesley. This is a great book for the parent of a sick child. It starts you off with your child’s symptoms, then leads you down to what to do.

*Baby and Child Care*, by Benjamin Spock. The original guide, still going strong, even longer than the Energizer.

*Your Child’s Health*, by Barton Schmitt, Bantam. Action-oriented short essays on common childhood problems.

*The Difficult Child*, by Stanley Turecki, Bantam. A great book for all parents, not just those who think that their child is “difficult”. It explains the temperaments of children, and how they differ. Also, an excellent guide to discipline. Well written!

*How to Get Your Kid to Eat...But Not Too Much*, and *Child of Mine*, both by Ellyn Satter, Bull Publishing. The author is a nutritionist and a family therapist. Her advice on nutrition and feeding is superb.

*The Birth of a Father*, by Martin Greenberg, Avon. How to be a father to a newborn, and allow your feelings to come through. A real help! (The author was an intern with me at UCSF)

*The Good Enough Parent*, by Bruno Bettelheim, Vintage. Interesting for psychologically inclined intellectuals—but good!

*Infants and Mothers*, by T. Berry Brazelton. All the books by Brazelton are really good. He helps you to understand children very well.

*The Magic Years*, by Selma Fraiberg, Scribner’s. Another nice book about understanding the behavior and development of children in early childhood.

*Help Me Say It: A Parent's Guide to Speech Problems*, by Carol Barach, Plume. An excellent guide to understanding how a child learns to talk and communicate.

*Caring for Your Baby and Young Child: Birth to Age 5*, by Steven Shelov, Bantam. The official American Academy of Pediatrics guide book. Better than I expected, but at 660 pages, not one to curl up with.

## SECTION 2: A FEW ESSAYS ON RELEVANT TOPICS

### Positive Parenting

When a child is about 15 or 18 months old, many of us get up in the morning and just start saying “no,” because we know that that’s what we are going to be saying all day long. We’re trying to protect our kids and to help them learn, and to protect our stuff, too.

Some of this is inevitable, but not all of it. There is a pitfall here. If all we say is “No, no, no!” all day long, even with the best of intentions, we are creating an atmosphere of negativity in the house. All the kid will think of us is, we are the ones who say “no.” And the worst thing that can happen is that he or she can grow up completely inhibited, not daring to do new things, always looking around to see who is there to say “no,”—or, even worse, always doing the “no” thing, daring you to catch him.

So what to do? Here’s what I suggest:

1. **Boundaries:** widen them. Make sure that when you say “no,” you absolutely mean it, and have to do it. For instance, you know for sure that the street is off-limits. But, how bad is it to touch your new, clean table? If there are things around that she shouldn’t get into, put them away. If the TV is there on the ground or table and she can touch it, she will. So, either put it up out of reach, or let her play with it. Otherwise, you’ll just be playing the “no game” all night.
2. **Balance “no” with “yes.”** Try to figure that for every time you say “no,” you owe him 10 “yeses.” That will have two effects. First, you will try to find some times to say “that’s good” that you missed before. For instance, if he is sitting and playing quietly, you might be tempted to leave him alone and not distract him—but, you could also think of it as a time to get a “yes” in the bank, to balance out a time when you might have to say “no” later on.

A second effect might be to avoid saying “no.” For instance, if she is pulling on an electric cord, instead of making a big deal of it and say-

ing, “No! Cords are dangerous!” and owing her 10 “good’s,” you might just skip the “no” and simply distract her. You don’t have to make it a moral issue for her to learn; in her behavior later on, she will mostly imitate you anyway, no matter what you try to teach her!

## The Horticultural Theory of Child Rearing

Children are like plants, except that they cost more and are more trouble.

Our job as parents is to try to understand what makes each one thrive best, and then to provide him or her with that environment. Leave the motivation to themselves—of course, they all need encouragement and positive reinforcement, but each one has an inborn desire to master things and to grow. We just have to find the proper conditions for each one.

But they are like plants in this way: they will grow and thrive if we find the proper environment for them. Like plants, each one is different. They need different kinds of soil, some do better in full sunshine (extroverts) while some grow best in the shade (introverts). Some need to be near other plants, and do best in large groups; others do best by themselves.

Take, for example, the question of what kind of toys to provide a child with. You can find out what toys work well by following your child around, and seeing what is attractive to him or her. Does he like to bang pots around? Get him some more pots! Does she like to fiddle around with little things that go inside other things? You can find things like that. The important thing to remember is this: *we don’t teach kids, they learn by themselves from their environment*. And they learn what they want to learn.

Do we have to motivate our kids to walk, or to teach them how? Of course not, they just want to do it themselves. They also learn to talk all by themselves, by watching us and imitating. We help them and give them encouragement, but their little brains are programmed to do it all, on their own time schedule.

Do we have to break a child of the pacifier habit? Not really. The pacifier serves a purpose; it gives a child security. When she is ready to stop, she will sense her own readiness, and give it up.

What about bottles? Same thing. One patient of ours kept his bottle for the longest time, and it was hard for his parents to keep off his case. But one day he walked over to a wastebasket, threw the bottle in and said, “Goodbye, bottle!” In the future, he won’t be looking around

for someone else to tell him how to mature; he will listen to his own sense of internal maturation, and he will do it himself.

The later steps of maturation work the same way, including toilet training, including even reading. Our job is not to push them, but to recognize *what* they are trying to do, *when* they are ready to do it, and then *responding* to them and their desires.

## Child-Proofing Your Home

Around the age of six months is a good time to think very seriously about protecting our children from the world around them, before they become mobile explorers. Later on they are going to have to develop enough sense to protect themselves, but in the beginning we have to do the thinking for them. In a way, it is an opportunity for us. Look at it this way: one of our worst fears, even if it is only in the back of our minds, is that our child will get a serious illness. Thank goodness, the odds are that at this age no such illnesses will arise. On the other hand, it is not uncommon for a child to have an accident or to ingest a poison or medicine. So, isn't it lucky that the most likely dangers can be protected against? Of course, we will never know if you saved your child's life by some simple steps you take now, but the odds are that somebody who reads this will—we'll just never know who you are.

One way to protect your child around the house is to live in a padded cell. Most people, however, choose not to do that. The next best way is to think in terms of **multiple barriers**. The first barrier between a child and any danger is generally you, always watching out of the corner of your eye. But that doesn't always work, especially when you are upset about something, or fighting with your spouse. It is at times like these that accidents happen, or when kids swallow pills. It is probably because your attention is diverted, and maybe also because the kids pick up the mood and act it out. Unfortunately, we cannot prevent these times of upset from occurring, but we can think of having more barriers to accidents than just your watchfulness.

For instance: a second barrier is to keep the door to a dangerous room closed at all times, and maybe locked. But sometimes that might be left open. So, a third barrier is to keep the dangerous stuff high in a cabinet. But sometimes an older child will be visiting and might climb up there and offer that forbidden substance to your child. So, a fourth barrier is to keep it locked.

Kiddie locks are good and effective, and I recommend them for most things, but for the really dangerous stuff, such as Drano® and gasoline products and medicines, I think that you had better be safer. Here is

one idea: get a hinge-type lock with a key. Then you can hang the key right beside the lock on a cup hook, so that it isn't inconvenient for you at all, but your toddler can't open it, and neither can most visiting older kids. This arrangement is convenient, yet safe.

Most protective measures you will be able to figure out for yourselves, depending on what your home is like, but here are a few tips. Beware of where you put what you are drinking. Coffee cups should go in the middle of the table, not on the edge. Pots on the stove should have their handles turned inward. If you have a party, don't leave your drinks around afterwards—I once had to hospitalize a drunk two year old in coma. (He did well after sleeping it off and scaring his parents half to death.) Keep children in walkers away from stairs (again, think of multiple barriers) and sharp edges as much as you can. Sharp objects, especially little ones such as toothpicks, are dangerous. (I would probably not keep toothpicks in the house at all—if a child swallows one, it can perforate the intestine.) Electrical outlet covers are good. Never leave a child unattended in a bath, even for a minute. All children should learn to swim by the age of five to seven, but I don't think that learning at the ages of one or two years is an effective safety measure—it might be fun, but it just doesn't offer protection. Turn down your water heater, if you can, to a maximum temperature of 120 to 130 degrees. At these temperatures accidental water burns will be much less severe.

Notice, by the way, that I haven't said a word about teaching your child to understand the word "no," nor about slapping his hand to help him learn. I don't think that these procedures work. Kids at this age just haven't connected up the restraining part of their brains very well. They are much more likely to learn how to play the "no game." That's where they reach out to something, and you say "no," and they look at you and smile, and reach out again, and you dutifully say "no," and so on. I think that you get better trained than they do. My advice is to leave the moral education until later when they will be better learners. In the meantime, use multiple barriers.

Say that you walk in on your two year old and find that he has apparently eaten about half a bottle of pills. What should you do? The first thing to do is to call Poison Control at **1-800-222-1222**, or **1-800-523-2222**. This is the best and quickest way to immediately find out what to do, which will depend upon what was ingested.

Well, this is a lot to think about. And yet, with all these necessary precautions, we still have to strike a balance and let the kids find out some things for themselves. One of the best places to do this, I think, is in a controlled

area, such as the little kids area in the park. The best general policy might be this—make sure an area is childproof, then turn 'em loose!

## Fever-Phobia!

Most parents get very afraid when their children get fevers. As a matter of fact, the majority of calls that we get when we are on call at night are about fevers. Is this fear justified? Or are we too afraid of fevers? Do we suffer from FEVERPHOBIA?

Actually, it's true: many of us are too afraid of fevers. In most cases, fever is simply the body's way of responding to an infection. Fever makes a child uncomfortable, but it usually is not dangerous at all. Fever itself does not cause brain damage. Usually a fever goes up and then just stops at a certain level; even a fever as high as 106 is not harmful to the body or brain! Fever might even be helpful. Some physicians believe that a high fever "cooks" the germs that cause the illness and gets rid of them faster.

Why then do we pay attention to fevers? Because even while fevers are not in themselves dangerous, we do worry about what is causing the fever. Most times it is an infection, sometimes with a virus, which we don't treat with antibiotics, and sometimes with bacteria (like "strep"), which we do treat with antibiotics. Our job as practitioners is to figure out which kind of infection it is and to do the right thing. But most of the time, even if there is an infection that we want to treat with antibiotics, there is no great urgency.

So most of the time you DO NOT have to panic about a fever. Do you have to "break the fever?" No. Do you worry if you give acetaminophen and the fever is not very responsive? Not necessarily. Why do we give feverish children acetaminophen or ibuprofen? There is one main reason—to make them more comfortable. Just getting a fever down doesn't cure anything.

Now, when do you worry about a fever and call us immediately? If your child is 2 months old or younger, we worry more about a fever than with older children. If your young infant has a fever of 100.5 degrees or more, we want you to call us immediately. For older ages, we certainly want to hear at once if your child has a fever of 104.5 degrees or more. Other warning signs are extreme irritability or lethargy, a stiff neck, or little spots of blood under the skin (what we call "petechiae"). Moreover, if your child just seems very sick, you should definitely call us.

Sometimes young children who have a rapid rise of temperature get febrile (or fever) convulsions.

These cause no permanent harm in the great majority of cases, but they are very frightening for parents. If your child has had a febrile convulsion in the past, you will want to treat the fever more aggressively than with most children. And if your child should have a febrile convulsion, remember, you should call us, but in the great majority of cases it will cause no lasting harm.

Now a word about how to treat fevers. Never use aspirin! (Aspirin has been connected with a severe disease of the brain and liver called Reye's Syndrome.) Instead, use acetaminophen (Tempra<sup>®</sup>, Tylenol<sup>®</sup>, etc.) or Ibuprofen (Advil<sup>®</sup>, Motrin<sup>®</sup>, etc.) You can also soak a child in a lukewarm bath (not cold, just lukewarm), but sponging down with alcohol can be dangerous. Finally, a child with a fever should be lightly dressed. Do not dress a child warmly to help him or her "sweat it out."

Here are the proper doses of acetaminophen and ibuprofen:

### Acetaminophen (Tylenol) Dosing Chart

*Give every 4-6 hours as needed, no more than 5 times in 24 hours.*

Weight	Milligram Dosage	Tylenol Infant Drops 80mg/0.8ml 1 dropper=0.8ml	Tylenol Children's Liquid 160mg/5ml	Tylenol Chewable Tablets 80mg	Tylenol Junior Strength 160mg	Tylenol Adult Tablets 325mg
6-11 lbs	40 mg	1/2 dropper (0.4 ml)	1/4 tsp (1.25 ml)			
12-17 lbs	80 mg	1 dropper (0.8 ml)	1/2 tsp (2.5 ml)			
18-23 lbs	120 mg	1 1/2 dropper (1.2 ml)	3/4 tsp (3.75 ml)			
24-29 lbs	160 mg	2 droppers (1.6 ml)	1 tsp (5 ml)	2 tablets	1 tablet	
30-35 lbs	200 mg	2 1/2 droppers (2 ml)	1 1/4 tsp (6.25 ml)	2 1/2 tablets	1 tablet	
36-41 lbs	240 mg	3 droppers (2.4 ml)	1 1/2 tsp (7.5 ml)	3 tablets	1 1/2 tablets	
42-47 lbs	280 mg	3 1/2 droppers (2.8 ml)	1 3/4 tsp (8.75 ml)	3 1/2 tablets	1 1/2 tablets	
48-59 lbs	320 mg	4 droppers (3.2 ml)	2 tsp (10 ml)	4 tablets	2 tablets	1 tablet
60-71 lbs	400 mg	Use liquid or tablets	2 1/2 tsp (12.5 ml)	5 tablets	2 1/2 tablets	1 tablet
72-83 lbs	480 mg		3 tsp (15 ml)	6 tablets	3 tablets	1 1/2 tabs
84-95 lbs	560 mg		3 1/2 tsp (17.5 ml)	7 tablets	3 1/2 tablets	1 1/2 tabs
> 95	640 mg		4 tsp (20 ml)	8 tablets	4 tablets	2 tablets

## Ibuprofen (Motrin, Advil) Dosing Chart

*Give every 6-8 hours, as needed, no more than 4 times in 24 hours*

Weight	Milligram Dosage	Ibuprofen Advil/Motrin Drops 50mg/1.25ml	Ibuprofen Children's Liquid 100mg/5ml	Ibuprofen Chewable Tablets 50mg	Ibuprofen Junior Strength 100mg	Ibuprofen Adult Tablets 200mg
9-12 lbs >3 mo.	25 mg	0.625 ml				
12-17 lbs	50 mg	1.25 ml	½ tsp (2.5 ml)			
18-23 lbs	75 mg	1.875 ml	¾ tsp (3.75 ml)			
24-29 lbs	100 mg	1.875 + 0.625 ml	1 tsp (5 ml)	2 tablets	1 tablet	
30-35 lbs	125 mg	1.875 + 1.25 ml	1 ¼ tsp	2 ½ tablets	1 tablet	
36-41 lbs	150 mg	1.875 + 1.875 ml	1 ½ tsp	3 tablets	1 ½ tablets	
42-47 lbs	175 mg	1.875 + 1.875 + 0.625 ml	1 ¾ tsp	3 ½ tablets	1 ½ tablets	
48-59 lbs	200 mg	1.875 + 1.875 + 1.25 ml	2 tsp	4 tablets	2 tablets	1 tablet
60-71 lbs	250 mg	Use liquid or tablets	2 ½ tsp	5 tablets	2 ½ tablets	1 tablet
72-83 lbs	300 mg		3 tsp	6 tablets	3 tablets	1 ½ tabs
84-95 lbs	350 mg		3 ½ tsp	7 tablets	3 ½ tablets	1 ½ tabs
> 95	400 mg		4 tsp	8 tablets	4 tablets	2 tablets

### **Important Notes:**

1. Ask your health care provider or pharmacist which formulation is best for your child.
2. Give dose based on your child's weight. Do not give more medication than recommended.
3. If you have questions about dosing or any other concern, call your health care provider.
4. Always use a proper measuring device. For example:
  - a. When giving infant drops, use only the dosing device (dropper or syringe) enclosed in the package.
  - b. When giving children's suspension or liquid, use the dosage cup enclosed in the package (kitchen spoons are not accurate measures)

## **YOUR CHILD'S TEETH: MAKING THAT SMILE SPECTACULAR**

Cavities are the most common disease in children. More than 40% have tooth decay by age 5. Tooth decay can cause pain, and affect your child's growth. But you can prevent cavities!

**Birth-1 year:** It is a good idea for the whole family to take very good care of their teeth during this time. Amazingly, if parents brush, floss, and use a dental rinse, they can change the type of bacteria in their own mouths from bad to good. Inevitably, these same bacteria get transferred from parents to baby, and help prevent cavities. Still, to

limit the transfer of bacteria from your mouth to your baby's it is best not to suck on the pacifier to clean it.

As at any age, it is important to avoid sugar. This includes juice. Babies do not need juice, but if you do give it, be sure to dilute it with water and give no more than 1 cup per day. Avoid honey in the first year, and do not add sugary flavorings to baby's milk (like chocolate or strawberry powders). You could add fresh fruit to milk for a special treat.

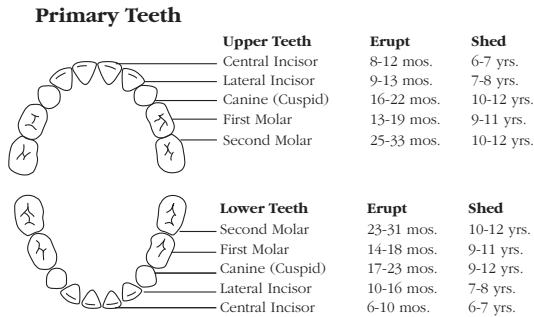
**Some other tips:** give 1 cup of fluoridated water per day when the first teeth erupt. Most of the tap water around here contains fluoride (except for Livermore and Tracy), and Brita-type filter will not remove the fluoride. But if you live in an area without fluoridated tap water, or if you choose to use bottled water that does not contain fluoride, we can give you a prescription for fluoride supplement. Don't let babies sleep with the bottle in the mouth. Brush daily (after milk/before bed) when the first teeth appear using a soft cloth or toothbrush. You can use water or a children's toothpaste without fluoride (swallowing too much fluoride is bad for the teeth). Once the teeth are brushed, avoid milk and juice until morning (if possible).

**1-2 years:** Dentists recommend brushing twice a day. It helps to try to make this a fun time, singing, being funny, etc. Or, you can try to take turns brushing your own teeth and then the baby's. Consider a first dental check this year.

**2 years and up:** Dentists recommend brushing twice a day. Start using fluoride toothpaste as soon as they can spit it out (but just a small, pea-sized amount). Begin flossing when the teeth are touching. Schedule a dental visit every 6 months. Medi-Cal and Healthy Families patients can call **1-800-322-6384** to find a dentist. If you have another insurance type, feel free to ask us for recommendations.

**Teething:** Most babies do well with teething, but symptoms may include: biting, drooling, sucking, loose stools, gum rubbing, facial rash, mild decrease in appetite, fussiness, ear rubbing, and mild fever (99°-100°). Sometimes teething causes a baby who was sleeping through the night to start waking up. Cold wet towels, or teething rings will help. Try rubbing the gums with your finger for a minute or so. Most babies will require little or no medication, but if you are having a bad night you may try acetaminophen (Tylenol®), Ibuprofen (Motrin®, or Advil®), or a small amount of teething gel (like Oragel®). Avoid frozen items that may burn the lips. Call if the symptoms are more severe or not improving.

**When will those teeth come in?** Genetics plays a big role. The diagram below provides only a rough guide. We have seen many babies with no teeth until after the first birthday, and some lucky babies get the canines (I-teeth, or vampire teeth) first!



### SECTION 3: THE BAYSIDE PEDIATRIC CLINICIANS

We thought that you might like to know something about us, so we have cast modesty aside and prepared these mini-biographies.

#### **BUDD N. SHENKIN, MD, MAPA**

Like so many Californians, I hail originally from the East. I grew up in Philadelphia, graduated from Harvard College with a major in history, and then followed my father and my grandfather into the medical profession, graduating from Harvard Medical School in 1967. Then I moved to California for the first time, completing a pediatric internship at the University of California at San Francisco. I then served in the United States Public Health service for six years. During that time I headed the Migrant Health Program for the United States, and later wrote a book about that subject. I also got a Master's degree from the University of California at Berkeley School of Public Policy (my second move to the Bay Area), did research on health politics at the Stockholm School of Economics in Sweden, and studied at Yale University.

I then returned to the Bay Area for the third and final time, serving a pediatric residency at UCSF. For three years there I was a Robert Wood Johnson Clinical Scholar, doing research, teaching, and writing papers. I then taught for a year in the Health and Medical Sciences Program at UC Berkely.

Finally, I decided I preferred patient care to teaching (and an office to a University), so I went into practice as a solo practitioner in 1979, and I'm glad I did. That original practice in Oakland has now expanded

into Bayside Medical Group. This group practice has proved to be the greatest source of professional pride and satisfaction in my life. I am proud of my fellow clinicians in the group and our staff, proud of the job we do, and I love our patients. At least, that's the way I feel most of the time!

I am Board Certified in two specialties, pediatrics and preventive medicine. I have occupied several positions of leadership in our East Bay pediatric community. I was Chief of Pediatrics at three hospitals: Alameda Hospital, Providence Hospital, and Summit Hospital. I served on the Board of Directors of Summit Medical Group, Muir Medical Group, and Children First Medical Group. I am on the medical staffs of most of the hospitals in the East Bay, including Alta Bates, John Muir, San Ramon, ValleyCare, and Children's Hospital of Oakland, and I am a Clinical Instructor at UC San Francisco. (That sounds like enough, doesn't it?) I am also affiliated with most of our local medical groups, including Hill Physicians Medical Group, Alta Bates Medical Group, Childrens First Medical Group, and John Muir Physicians Network.

I should also mention that many pediatricians have special fields of interest within pediatrics. Mine falls in the field loosely defined as psychosocial pediatrics. I have had special training both as an individual and family therapist, and I find that these skills are very useful in day to day practice.

### **RICHARD D. ASH, MD**

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Like many of my colleagues here at Bayside, I came to the Bay area from the East. I grew up in Pittsburgh, Pennsylvania, went to the University of Michigan in Ann Arbor for my undergraduate education, then the University of Pennsylvania in Philadelphia for medical school.

In medical school, I found pediatrics to be the most exciting field. For me, it was both challenging and rewarding. I liked the spectrum of medical care, from mild problems to diagnostic dilemmas and serious illnesses, as well as following a child's growth and development. I really enjoyed working with new parents, helping them do what is best for their children. My interest in pediatrics probably has a lot to do with my background—I was second in a family of six children, so there were always babies around. My father's business was Babyland, a furniture store for infants and children in Pittsburgh, which is still in the family.

After medical school, I got a taste of the west coast (which is why I came back). Like some of the other physicians here at Bayside, I did my pediatrics residency at Children's Hospital Los Angeles, where I

learned the basics of treating both complex and “routine” medical problems in infants, children and adolescents, as well as providing well-child care.

After my three years of pediatrics training in Los Angeles, my wife and I had our first child and moved back to Pittsburgh, where I joined a three-physician primary care pediatrics group. Over the years, my practice grew to ten pediatricians, and under my direction also merged with other area practices to form Children’s Community Pediatrics, a subsidiary of Children’s Hospital of Pittsburgh, now with over 100 pediatricians. We participated in pediatric resident education as well as clinical research, including childhood immunization studies and behavioral health research. I became active in the leadership of my organization, including serving on its board of directors. I also served on the board of directors of a major Pennsylvania health insurance company, UPMC Health Plan. Through my administrative service, I learned a lot about health care management, and appreciate the opportunity to apply that experience at Bayside—both as a pediatrician and medical director. I am board-certified in pediatrics, and a Fellow of the American Academy of Pediatrics.

My wife, Gale Gettinger, is a professional photographer, specializing in portraiture of children and families. She loved living in California during my residency, and has always been ready to come back—so this move was exciting for her too! Our children both live in the Bay area, so we are happy to be closer to them. My hobbies include music, travel, and digital art. I have always liked new technology and have developed an interest in digital photographic art—for the past few years I’ve been helping my wife with artwork and photographic paintings.

I am very pleased to be a part of Bayside Medical Group and to work closely with the other physicians and staff, helping to provide you with the highest-quality health care for your children. I’m looking forward to meeting you.

**PAULA BRINKLEY, MD, MPH, MA**

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I grew up on the beautiful, multicultural Pacific island of Guam, although my parents were originally from the mainland U.S. Somehow I had the idea from a very young age that I wanted to be a pediatrician. At age 15, I left the humid, laid-back tropics for the rigors of boarding school in snowy New England—while this transition was quite challenging, all subsequent transitions have seemed relatively easy by comparison. I went on to undergraduate studies at Johns Hopkins University in Baltimore, followed by medical and public health school at Tulane Univer-

sity in New Orleans. I was part of the inaugural class of international health pediatric residents at Rainbow Babies' and Children's Hospital in Cleveland, where I combined pediatric residency with obtaining a masters' degree in cultural medical anthropology at Case Western Reserve University.

I always wanted to educate myself as broadly as possible, in public health and medical anthropology, to be able to care for a wide range of patients, both here and abroad. So I studied tropical medicine and Spanish, and during my training spent several months working in less developed areas, such as Bolivia, the Caribbean, Kenya, and Kosovo.

After residency I became Board Certified and returned to Guam to work as a general pediatrician for two years. Then I was the field coordinator for a small nonprofit U.S. health organization in Laos helping to create Laos' first pediatric training program. Going back yet again to Guam I was for seven years the medical director of the Guam Department of Public Health, practicing pediatrics and overseeing two community health centers.

I might still be in Guam, but for a man. My husband Steven is a Berkeley kind of guy, and I have learned to love California, too, so here we are, the two of us and our two great kids, Eli and Sarita. I spent some time at home with them, which probably helps me to empathize more than ever with parents and patients! I consider it a great privilege to be a pediatrician, partnering with parents to take optimal care of their kids, and feel very fortunate to join a practice as congenial, diverse, and patient-focused as Bayside Pediatrics. I look forward to meeting you and to helping you understand and take care of your children.

## **LORI CAESAR, MD**

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I feel it is a great privilege to be someone's doctor. I wanted to be a pediatrician since elementary school, but it has been a long road getting there. After graduating high school in St. Louis, Missouri, I went to Grinnell College in Grinnell, Iowa, where I majored in chemistry, which I loved from high school. Then I did a fellowship at the National Institutes of Health, which I liked, but I found myself disappointed that my laboratory work would not be used for actual patients.

So I was very pleased to be accepted at the University of Rochester School of Medicine in 1999. I loved medical school. However, I continued to have some glitches in the road. My mother was diagnosed with breast cancer my second semester of medical school, and she died a year later. I ended up coming home to Maryland to be with and help take care of her while she died in hospice, a time at home I will never forget nor regret.

After my second year of medical school, I transferred to George Washington University School of Medicine so I could live with my husband. We have been together since we were both 16 years old! At the end of medical school I had my first child, Isabelle Ivy. My children mean the world to me, as I am sure yours do, too! I was fortunate enough to be able to stay home with Isabelle for the whole first year of her life. I then did my pediatrics residency, concentrating in primary care, at Children's National Medical Center in Washington, DC, finishing in 2008. I loved the primary-care office where I did a lot of my training and cried at the end of my last session working there!

My second daughter, Violet, was born during my last year of residency. The way my life has worked, I have had the experience at different times of being both a mother who works more than full-time and a completely stay-at-home mother, both of which come with their challenges and rewards. One of my favorite activities to do with my daughters has always been to read books; this was something I could keep up as a pediatric resident, too.

I am a strong proponent of breastfeeding and have done research into the benefits of breastfeeding, the components of human milk, and the social factors that make for successful breastfeeding.

My husband, daughters and I relocated to the Bay Area in the fall of 2008 so that my husband could work in the area; he had wanted to come this way for many years. We enjoy the nature and weather of the area and plan on staying in California for a long, long time. I am thrilled to have finally reached my goal of being a pediatrician. Now that I am here, I look forward to meeting you and helping you keep your children healthy and strong.

## **JAMES E. EICHEL, MD**

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My first physician role model, my scrappy female New York-trained pediatrician, inspired me back in my early teens to want to become a family physician, so it is fitting that I have come full circle in joining Bayside's pediatricians as part of the family practice division. Since joining Bayside in 1997, I have found that combining family practice and pediatrics in one large practice benefits our patients all along the age spectrum, and certainly enriches my own experience, since about a quarter of my patients fall into the pediatric age group.

Born and raised in the San Fernando Valley, I spent the first 26 years of my life living in Southern California, except for the two months I worked in Belgium and the ten weeks I spent doing medical research

in Nairobi, Kenya. I have a B.A. degree from Pomona College, where I graduated Magna Cum Laude and was elected to Phi Beta Kappa. From there, I proceeded south to UC San Diego School of Medicine, and then northeast to the Maine Dartmouth Family Practice Residency. I enjoyed three long East Coast winters, but I had wanted to live in the East Bay ever since my annual spring break visits to my brother at UC Berkeley in the early 80's, so I came back in the fall of 1992 to start my family practice here.

In a time when the managed care environment has forced many physicians to change their practices in ways that oppose their dedication to taking good care of their patients, I have been very fortunate in that I have been able to build the practice I wanted and to deliver the level of care I wanted to deliver. I offer the full range of family practice services including (but not limited to) health maintenance for all age groups, internal medicine, geriatrics, pediatrics, travel medicine, gynecology, and obstetrics. I speak Spanish and French (and a little Swahili); this and our travel medicine services have resulted in a practice that includes people embodying all of the ethnic, social, and philosophical diversity that make the East Bay such a fascinating place to live and work. This variety has allowed my practice to grow despite the constraints of managed care.

Bayside's philosophy stresses the importance of family and community involvement in the care of patients, and as a family physician I strongly support this philosophy. I love the challenge of taking care of entire families, particularly in today's world where families can take so many different forms. I'm grateful that despite the powerful forces in our society who obstruct our efforts to deliver health care, I remain able to do what I've always wanted: practice the full range of family medicine.

I am also fortunate to have a wonderful family. My wife teaches elementary school here in Alameda, and together we have three daughters who keep us very busy. I play soccer and tennis, and am a devoted Oakland A's fan.

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**LISA ERBURU, MD**

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I have to admit that, although I am a fifth generation Californian, I have waited until 2006 to become a Bay Area resident. I was born and raised in Los Angeles. As a child I grew up coping with juvenile rheumatoid arthritis myself, and this led me to want to be in the medical field. I attended Harvard College where I rowed crew for four years, and where I met my husband. I moved back to Los Angeles for medical school at UCLA, and then took my pediatric residency, also at UCLA.

My husband Mark, a pediatric cardiologist, was stationed in San Diego at the naval hospital, so I followed him there. San Diego lasted 17 years for me, where I practiced pediatrics full time in a group practice, and where I raised my two great kids. Following my own pattern, both attended college on the East Coast, but have returned to California.

In 2005 my husband decided to move again, accepting a position as clinical professor of pediatric cardiology at UCSF. We bought a house in the East Bay and we just love it. I am thrilled that I have been able to find a place for myself at Bayside. It is just what I had hoped I could find. As a Board Certified pediatrician I particularly enjoy taking care of children with special needs, or more complex medical problems. I find taking care of all children, of all ages, sizes, and shapes, just a wonderful privilege. I also now have a great deal of experience as a working mother. I hope that I can share all this with my patients at Bayside.

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**BEVERLY ANNE ESTES, MD**

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Unlike my bicoastal colleagues, I grew up in the heart of the country, living in Oklahoma and spending my summers in the Colorado Rockies. I went to Oklahoma State University majoring in pre-med and microbiology. Then I moved to Budd Shenkin's home town, Philadelphia, and graduated from the Medical College of Pennsylvania, class of '69.

I knew that pediatrics was for me from my first medical school rotation, and I was lucky enough to do my internship at Denver Children's Hospital, and then finished my pediatrics training at Children's Hospital in Oakland.

I was most interested in the growth and development of children, so I opened a private practice of general pediatrics in the Montclair-Glenview area of Oakland, became Board Certified in Pediatrics, and was there for twenty years.

I have remained closely involved with Children's Hospital, both as an attending and teaching physician, and as an official of the medical staff, including a six year stint as Chairman of the Department of Medicine. It has taken a great deal of my time, but the rewards have been commensurate, as I have seen our standards at Children's climb steadily higher.

I joined Bayside Pediatrics in January, 1992, and have greatly enjoyed the group practice experience. I have been privileged to care for children from many diverse backgrounds and have loved seeing them blossom into healthy, young adults. My families have taught me so much over the years, as we have worked together through many of

life's challenges, joys and, yes, sorrows. It has been gratifying for me to have my former patients return to Bayside and entrust me with the care of their children.

Music has been a major part of my life—playing classical piano, singing and dancing through my high school years. I enjoy the Bay Area for the rich offerings of theatre, museums and cuisine. I also love to travel and experience new cultures. I am currently very involved in my church serving as a Deacon. My heart, though, is in the Rocky Mountains where I have a summer home. I spend my summers hiking and photographing the natural beauty of this region with my friends and relatives.

Welcome to our Bayside Family. We work as a team and hope you will get to know each of us as we care for your children.

### **APRIL FREDIAN, MD**

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I was born and raised in the Northeast, with a wonderful family who instilled in me the belief that anything is possible. Because of them, I believed in myself, and tried things I otherwise would not have tried. I joined an all-boys soccer team because there wasn't one for girls, I ate liver and onions for dinner, I joined the volleyball team despite my short stature, I applied to top-tier colleges and wound up obtaining a BS in biology from the Massachusetts Institute of Technology.

After college, I had trouble finding work in the field of biology, and took a job working the cash register at a fine wine and gourmet food store for several months. It was fun at first, but soon grew tiresome, and the itch for adventure overtook me. At the time, Amtrak had a deal: for a set fee, I could travel anywhere in the country for 30 days. I took them up on their generous offer, and, pillow and backpack in tow, hopped on the train. I visited friends in Washington DC, Winston-Salem North Carolina (where, by the way, you could still smoke in the grocery stores!), Arizona, Southern California, and lastly, San Francisco. It wasn't until I reached the Bay Area that I felt at home. I lived here for nearly 6 years, working at Genentech, playing in a competitive pool league, making lifelong friends, and falling in love with the area.

Towards the end of my 6 years, though life was grand, I felt that career-wise I had stagnated. Life in the laboratory did not bring me enough of the human-interaction that I needed. It was at this time that a postcard from St. George's University School of Medicine graced my doorstep. It showed a beautiful school atop a magnificent cliff overlooking turquoise water, and, needless to say, I took it as a sign. I spent the first two years of medical school on the islands of Grenada

and St. Vincent, where I learned a great deal of patience, living on ‘island time’. My two clinical years were then spent at The Brooklyn Hospital alongside Cornell students, after which I graduated from medical school summa cum laude.

I then went to Brown University in Rhode Island for my residency in Family Medicine. As the first doctor in my family, I wasn’t sure what I was in for, but I’ve found that Family Medicine really is the perfect career for me. It allows me to listen to people’s stories, care for newborns and 101 year-olds, teach people about themselves, and help them take better control of their lives by helping them also to believe that truly, anything is possible.

I look forward to meeting you and your family, and hope to know you for years to come.

### **KATYA GERWEIN, MD**

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I was born in Berkeley (at Alta Bates, in case you were curious). I grew up here, with the exception of a few years of toddlerhood in Gilroy where I came to love eating garlic and hearing Spanish, which I now speak as well. After graduating from Berkeley High, I moved back east where I majored in social anthropology at Harvard. After college, I worked at the Institute for Health Policy Studies at UCSF learning how tobacco companies and pharmaceutical companies insidiously try to influence medical literature and medical policy. I then headed back east again for the next eight years, to do my training at Harvard Medical School, Children’s Hospital of Boston and Boston Medical Center.

Pediatrics has always been the field that I loved—from the ongoing relationships with parents and children to the complex scientific issues of the growing body. It was the fulfillment of one of my life goals when I became a Board Certified pediatrician. While I learned a tremendous amount in residency about children—their health and diseases—I felt as if I had a second residency when I had my son Ezekiel immediately after residency. Not only was sleep deprivation included, but I learned a tremendous amount about breastfeeding, development, and sleep that no one had taught me in the hospital or clinics. My second child, Jesse, added new dimensions to my learning.

After residency, I worked in the Children’s Hospital Boston Emergency Department, but I missed primary care pediatrics. I wanted to know what happened after my patients left the ER—to make sure the constipation was treated and resolved, to follow the treatment of the child newly diagnosed with leukemia, to counsel and meet again with the parents driven to distraction with colic. I also missed the Bay Area,

being near family and friends. When we moved back to Berkeley and I joined Bayside in 2002, I felt like I was really where I belonged. We very much enjoy the amazing hikes practically in our backyard, the year-round gardening, and being close to family and friends. My other passion outside of medicine is wheel thrown pottery, which I've been doing for more than 18 years.

I'm looking forward to developing a relationship with you and your children at Bayside.

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**CAROL L. GILL, MD**

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I grew up in a mining camp in Nevada and went to Stanford University for my B.S. Degree. I attended the University of Arizona for Medical School and San Francisco Children's Hospital for my pediatric training. I have been practicing pediatrics since: first in Gilroy and now in Livermore.

In my college years I had the opportunity to live in Germany and Iran. I count myself very lucky to have seen Afghanistan before the Russian invasion and Iran before the revolution. I have a special fondness for travelers and immigrants and am very interested in your stories. The science of medicine: detecting disease and promoting health is my intellectual passion; but the fun of medicine lies in getting to know you and your children.

I have been happily married and sadly widowed. I have three kids currently in college. We have had most of the small animals available as pets so I have some suggestions if you are considering getting a pet. I also like to talk to your child about what he is reading and may suggest books my kids enjoyed. I particularly like trying to figure out practical solutions for the "what I'm doing isn't working" questions in parenting.

I look forward to meeting you and getting to know your child.

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**TINA HONG, MD**

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I am unusual among the Bayside clinicians, because I actually grew up in the Bay Area—in San Francisco. My family spoke Cantonese, so that was my first language, and English was "officially" my second language. But as I have gone on through school, English has become my dominant language, although I am still quite fluent in Chinese.

The first time I ventured away from home was to travel across the Bay to UC Berkeley for my undergraduate education. That was a baby step compared to my next stop which was (almost mandatory for a Baysider) Philadelphia, where I attended medical school at Hahnemann

Medical College. After my second very COLD stormy winter, as well as my first hot and HUMID summer in Philly, I realized how I had taken for granted the temperature climate of California all these years. I yearned to return to the friendlier California shores. I was very lucky to obtain a residency in pediatrics at Children’s Hospital Los Angeles.

Children’s L.A. was a great place to learn to take care of very sick children, and I found that helping them to get better and watching them heal was very rewarding. But I was even happier when I had the opportunity to help young families with their babies by providing anticipatory guidance, and helping them get through what young families have to get through. In training I imagined these little babies maturing into young adults and looking forward to their first prom, or going off to college. That is what I look forward to in practice everyday. Since joining Bayside in 1999, my joy in taking care of patients has remained unblemished, and as my “babies” become teenagers it only gets better!

### **MICHELLE JONES, MD**

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I was born in Cleveland, Ohio, and moved to sunny California at less than 2 years of age. Thus, Northern California is my home. I love living here and have spent most of my life here.

I left my hometown of San Francisco to attend University of California, Davis, and majored in biology. Initially, I wanted to be a civil rights attorney and follow in my paternal grandfather’s footsteps. While working as an intern at the San Francisco NAACP, I realized that while I enjoyed helping others, I couldn’t eradicate racism all alone. I went back to college after finishing that internship, looking to help others, and decided to try my hand at animals.

I milked cows, I watched horses get “put to sleep”, and I fed eagles and other raptors. But I found that, as much as I loved helping the animals, none of them talked to me. So then I began working at a free clinic in Sacramento, helping indigent families who had no other choice in their healthcare. I loved it! So by the beginning of my junior year in college, I was set. A biology major in the works, a love of helping others, and a strong desire to see patients be well—voilà! I was off to medical school shortly thereafter.

I traveled to Philadelphia to medical school at Hahnemann (now Drexel). I enjoyed being away from home but also missed it a lot. In medical school I loved my pediatrics rotation, seeing the resilience of children and their attitude towards life. They are so full of energy. I enjoyed educating parents, and most of all, I felt I was making a difference in someone’s life.

After medical school I came back home for my pediatrics residency at Children’s Hospital Oakland. I loved Children’s, and as a result of my training I’m very comfortable taking care of children at all levels, from routine physicals to more complicated needs, such as sickle cell disease or cancer. I had my first daughter during residency and understand how hard it is to work 80 hours a week and breastfeed a baby in the middle of the night! For all mothers, I am with you as you balance work and children—whether you are a full-time, stay-at-home mom or a working outside-the-home mom. It is no easy task!

After residency I worked in a private pediatric practice in the East Bay for 2 years, and then started my own private practice in 2007. In addition, I continue to work part-time as a pediatric hospitalist, taking care of children who are hospitalized. I really enjoy taking care of children—both in the hospital and in the office setting.

My husband and I have been blessed with three beautiful children—two daughters and a son. Our youngest child was recently diagnosed with a very rare medical condition, so now I am both a “patient” and a doctor. I can see both sides of the coin and understand the side of medicine where one is on the receiving end. As a result, I am grateful to be joining Bayside Pediatrics, so that I too can be a part of a bigger group of doctors, with all the advantages of a high-quality group practice and still provide personalized, patient-centered care in a small office setting. I look forward to caring for you and your family and look forward to meeting you. I consider it a true honor if you choose me to be your child’s doctor.

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**ANNA REBECCA KERR, MD**

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I graduated with a bachelor’s degree from Princeton University and then received my medical undergraduate education at the University of Pennsylvania School of Medicine. Since I had a military scholarship in medical school, I then moved to the Naval Hospital in San Diego for internship and residency training in pediatrics. I spent one of my four years in San Diego on a submarine tender, taking care of the active duty men and women on board. In 1985 I moved for three years to Great Lakes Naval Training Center in northern Illinois to practice pediatrics for real; then, in 1988 I moved to the Oak Knoll Naval Hospital in Oakland, where I was a member of the teaching staff. After all those years of training, I had finally reached the Bay Area, and I will never leave!

In 1991 I left the Navy after ten years of active duty and worked for Kaiser in Hayward for 2 years before coming to Bayside. I left the Navy so I could stay in one place (the Bay Area) and do one thing

(take care of kids); I left Kaiser because I wanted to practice medicine in a more personal and less institutional setting. I'd much rather be an integral part of a small organization than a disposable part of a large one.

I am Board Certified in Pediatrics. One of my favorite aspects of pediatrics is following a child's growth and development over time. I also enjoy helping parents to take care of the usual pediatric problems of runny noses, fevers, coughs, and stomach upsets. Since I have raised a child of my own successfully to adulthood, I can tell you the latest of what works and what doesn't from my personal experience!

I am hoping that in my years with Bayside I can develop lasting relationships with our patients, watch the kids grow up, and watch them have children of their own. Along the way, I am hoping to share your hopes and joys, and whatever troubles your family might experience, right along with you.

### **MICHAEL B. LINN, MD**

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I was born in the windy city, Chicago. I majored in biology at the University of Michigan in Ann Arbor, but returned to Chicago for medical school, where I graduated from the University of Chicago-Pritzker School of Medicine in 1995. Although I loved Chicago blues and pizza, I had shoveled enough snow. I came out west for my specialty training in pediatrics at Children's Hospital Los Angeles (the very same program that trained my brilliant associates: Dr. Hong, Dr. Quan, and Dr. Ash). Upon completion of my training I was asked to stay on as Chief Resident. The extra year granted me the opportunity to do a lot of teaching, and even more learning.

I met my wife Karen in medical school. She completed her training in Obstetrics and Gynecology at the USC/Los Angeles County Women's and Children's Hospital in 1999. She also obtained a Master's degree in Public Health from Berkeley, and she now works at UCSF. We have 2 wonderful girls. Kira was born in 2003 and Sada in 2006. They taught us a bunch that they don't teach in medical school! We spend our free time singing, dancing, hiking, swimming, traveling and camping whenever possible.

One of the things I love about Bayside is the tremendous patient diversity. I speak Spanish pretty well, having traveled in Mexico and Central America, as well as the wilds of LA County Hospital. During medical school, I volunteered in Chimaltenango, Guatemala, at the Behrhorst Clinic. I also have studied traditional Chinese medicine briefly. I am fascinated by the vast scope of medical science, and the ways in which

people view health and disease. I plan to continue my studies in Spanish and alternative medicine in hopes of communicating better with my patients and providing all the options that modern medicine has to offer.

I look forward to meeting you and your children. I know that together we can keep them healthy and happy!

### **J.D. MAYNARD, MD**

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I grew up in Huntington, a small town in the southwestern corner of West Virginia. No jokes about West Virginia, please, but I did come from a large family: my father was one of fourteen children, and my mother was one of six. I myself am the oldest of only three children, but I figure I have about 40 cousins—no one is quite sure how many! Being raised in that atmosphere, surrounded by children and, since I was one of the older children, caring for many of them early and often, I came to see the world through their eyes. As I continued in college and then medical school, both right there in Huntington, I think it was that vision, seeing the world through the eyes of children, that led to my becoming a pediatrician.

West Virginia was great, but when it came time to do my residency in pediatrics, I headed west to UC Davis. I still feel nostalgic for West Virginia, but I knew a good thing when I found it, and after residency I moved immediately to Tracy, and then to Livermore in 1994. For six years I practiced happily in Tracy, but after a while the commute got to me, and I was thrilled to be able to transfer my practice location to the Tri-Valley area at Bayside.

I really love pediatrics. I knew it was right for me when I started my residency, and although I wavered slightly and tried radiology for a while, that experience only convinced me more that pediatrics is the best career in the world (most of the time). I feel very fulfilled to have a continuous relationship with the children and families I take care of. It think that it is important to figure out illnesses as they come up and to treat them properly—I try hard to be at the forefront of practice knowledge and techniques. I also take pride in trying to guide children and their families in healthy ways of living. And, perhaps an inheritance from my father who was a teacher when I was young, I particularly enjoy teaching patients about chronic illnesses such as asthma and diabetes. I hope that my conviction about the importance of pediatrics comes to benefit you and your family.

I also love to travel, I have fun with personal computers, and I like to read science fiction. If you share one of these interests, let me know.

Interests like these are always the most fun when you talk about them with fellow enthusiasts!

**BRITA MOILANEN, MD**

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Hello! I grew up near Seattle, where I spent lots of time with my family camping, hiking, fishing and sailing around the Pacific Northwest. My dad used to consider the beginning of fishing season a reason to take us out of school for a week. When it came time for college, I was lucky enough to be accepted to Stanford University, and as soon as I got here I fell in love with the Bay Area. I planned on a career in biology research, but as I was working on my undergraduate thesis, spending long hours in the lab, I realized that while I love the science of biology I really am happiest working directly with people. I decided to combine these two things by studying medicine.

I then traveled further south to the University of California at Irvine for medical school. In medical school I considered many possible specialties, but choosing pediatrics turned out to be a very easy decision. As soon as I started working with pediatric patients I suddenly felt very much at home. I liked the pediatric physicians, I liked the science and problems of pediatric medicine, and I loved the patients. I had never really believed in epiphanies, but as I was driving home down the LA freeways one day it just occurred to me that I was going to be a pediatrician. There was no question. It was the easiest decision I had ever made.

For my residency training I went all the way across the country to Washington, DC where I worked at Children's National Medical Center, a large pediatric hospital. I had the opportunity there to work with brilliant specialists and take care of children with rare and complicated problems, but the place I was happiest was the clinics. Meeting the families and working with them to get through illnesses and help their children deal with chronic problems was very rewarding. That is why I chose to pursue a career in general pediatrics.

Although I very much enjoyed living on the East Coast for a while, after residency I was eager to move back to the West Coast. I was very happy to find a practice like Bayside, where I work with a large group of excellent pediatric doctors. I am looking forward to meeting you and working with you to help your children grow up happy and healthy.

When I am not busy at Bayside, you will find me playing in the great outdoors. My significant other and I are avid cyclists, both on the pavement and on the trails. When we're not pedaling, we're hiking or running along the trail with our dog. Did I mention that I'm happy to back in the Bay Area?

## **STEPHANIE MOSES, MD**

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My husband and I were both raised in the suburbs of New York City. We were married when we were very young and we both graduated from Cornell University. I worked while my husband was in graduate school and then he supported me while I was in medical school at UCLA. I had been a math major in college but I chose medicine because I wanted more interaction with people. My father was a Freudian psychoanalyst and my mom was a nurse so I was quite familiar with the medical field.

Throughout medical school I enjoyed many different types of medicine but there was nothing else that matched my feeling in pediatrics. I therefore did my residency at Oakland Children's Hospital and have worked in private practice in the Tri-Valley area for more than 25 years. I love working with parents and children, watching the family evolve and the children grow.

We have three daughters of our own who are our joy and our challenge.

## **JANET PERLMAN, MD, MPH**

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I am also originally from the East, New Jersey, to be exact. I graduated with honors from Rutgers University with a major in, believe it or not, Fine Arts. Then I heard the siren call of California, and came to UC Berkeley for a Masters in Fine Arts in Sculpture.

While art was wonderful, I had to get back to people, so I then worked with adolescent boys in a psychological rehabilitation center, and got my teaching credential at UCB the next year. My first teaching was at the Lakeside School for 7th and 8th grade children who just were not making it in the public schools.

I had by then discovered that I loved taking care of children, but something was missing for me in the experience of teaching, so I turned to health. I was a community health worker at the Berkeley Women's Health Collective for the next four years, while I went back to college yet again, and gathered up my premed required courses. I applied to medical school and they told me I was too old.

I fell back and regrouped, and since I had always been into food, I managed the bakery for a year at Fat Apple's, and learned how to engineer large scale production. I was regrouping, but I also found a part of myself that I hadn't known was there: I loved running a small operation, and always "keeping the ovens full. Finally, I thought that I would give medical school one last try, and they took me!

I went to the UCB-UCSF joint medical program got my MPH from UCB and a masters in Health and Medical Sciences in 1982 and then the MD from UCSF in 1984. I wrote papers on health policy issues, especially on the disabled and on prenatal care for low-income women, went to Kaiser Oakland for my three years of pediatric residency, and subsequently became Board Certified in pediatrics.

The highlight of my professional career so far has been joining Bayside Pediatrics. I still keep my ties to academia by teaching physical diagnosis and medical interviewing to UCSF medical and nurse practitioner students. I am a Clinical Professor at UCSF. I often have students with me and totally enjoy this aspect of my work, mentoring students as they start on their career path. I also lead workshops on physician wellness and enjoy exploring the meaning of our work with other physicians. But my heart is here at Bayside, where I can control much of my professional activity and don't have to be constrained by a bureaucracy the way a Kaiser doctor has to—I can “keep the ovens full” all by myself. This way, I feel a lot closer to my patients, and that's the way I like it.

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**CYNTHIA A. QUAN, MD**

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I am originally from Edison, N.J., the town that had the first electrically lit street in the world, since it is right near the famous inventor's laboratory. Like him I was always fascinated by technology, but for me, it was the technology of the body—the way our eyes transform images to our brains, the way our bodies digest food, and the way our muscles and brains coordinate our every move. So when I left Edison to go to Johns Hopkins University, I intended to study biomedical engineering, and I hoped to invent the first artificial heart.

Perhaps not like Edison, however, I found that I really didn't want to be an engineer, because I wanted to work with people, so I chose a career in medicine. I was lucky enough to be admitted to Johns Hopkins Medical School. Then I found that I delighted in being with children. I spent hours just watching them or playing with them as a Sunday school teacher. Even after working a 16-hour shift as a nurse' aide, I did not want to part with the newborns or children in the ward, these precious little people with their own unique personalities. I just had to become a pediatrician.

My brother was the first family member in California, and I visited him frequently in Silicon Valley. I loved California, and I was lucky enough to be chosen for a wonderful pediatric training program at Children's Hospital Los Angeles. After three years there I moved to the Bay Area to be closer to my family. Just before joining Bayside, I spent two years practicing pediatrics in Sunnyvale, Monterey, and here in the Tri-Valley area.

I love snowboarding, golfing, traveling, and teaching and playing with children at Sunday school. I am very active with my church and have volunteered at clinics in Uganda, Nigeria, and Mexico. Through these experiences I have come to understand the terrible needs of the Third World, and I have learned a great deal about African and Mexican culture. As a deeply religious person, I have also increased my faith in God through these experiences. It was such a fulfilling experience for me to serve others, especially since so little of my time seemed to mean so much to them. I hope that I will have the chance to practice medicine overseas again in the future.

Despite the excitement of serving abroad, my main work and devotion will remain here at home. As a Board Certified pediatrician, I look forward to sharing your excitement in the birth of your children, the first teeth, the first steps, the wins in sports, and college decision. Stressful, sleeping-deprived times will come when your child is sick, and I want to help you through these difficult times, to reassure you, to guide you, and to answer your questions. It will be an honor for me to be part of your child's growth and development, and for me to be your child's pediatrician.

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**ASHA RAMCHANDRAN, MD**

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I was born in Madras, India, and grew up in the setting of an extended family—uncles, cousins etc., all in the same house. I think that this experience may be why I think families are so wonderful and so important. In this setting, I remember fondly learning to play Indian classical music on the violin, and spending summer vacations reading and staging plays with friends.

My fascination with life science began in high school when I was introduced to the evolution of all our worldly species from a single cell. I decided to become a doctor. In time, I graduated from Kilpauk Medical College, Madras University, with honors. My best subjects were physiology, which explains how the body functions, and pathology, which is physiology gone wrong. I almost became a pathologist, but when I considered life beyond the microscope without people to interact with, I just could not do it. Then, as I rotated through the pediatrics ward in the final year of medical school, I realized the enormous impact even simple preventive measures had on the lives of children. I had found my calling—I always loved children, medicine gave me the opportunity to think scientifically, so I would be a pediatrician.

I did my pediatric residency at the Child's Trust Hospital in Madras, a premier children's hospital in India. Here I was exposed to a wide variety of illnesses in newborns and older children. After my residency I

worked for two years in the department of neonatology, watching tiny babies surviving despite great odds against them. I also did research at this time, publishing seven scientific papers, and volunteered my services at free clinics for poor families.

During this time my future husband was working at Silicon Valley. When I moved to California, in order to qualify for a medical license, I took another full pediatric residency at White Memorial Hospital in Los Angeles, and then became Board Certified in pediatrics. Through my experience at White Memorial, I can now speak passable Spanish. I also speak German, Hindi and many other Indian languages.

I joined Bayside Medical Group in October, 1998. I have immensely enjoyed working with my colleagues here, and especially doing well baby care. I see myself as being in a partnership with parents in caring for their children.

I enjoy reading, listening to music, and spending time with my family.

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**NEENA SHAH, MD**

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I was raised and educated in Bombay (Mumbai), India. I completed my medical school and residency, with honors and distinctions, in one of the major academic hospitals in Bombay. During my medical school, I met my future husband, who is also a pediatrician. After completing residency in Bombay, we decided to move to New York in pursuit of higher studies. We finished our Pediatric residency at Children's Medical center and SUNY (State University of New York), Brooklyn. I am a Board Certified pediatrician.

After New York, we moved to Stephenville, Texas, where my husband and I practiced with a medical group for over 10 years. Here I gathered a vast amount of experience and confidence in dealing with comprehensive childhood care. I developed a special interest in newborn care, asthma and preventive medicine.

While our professional lives were very fulfilling in Texas, we decided to move to the Bay Area, where we have family, and where living is such a wonderful experience. So here I am at Bayside! I am very excited to join the physicians at Bayside Medical Group. I share their philosophy in giving the highest quality care to patients. I will strive hard to meet the expectations of our patients and their families.

As a pediatrician, I feel I have the unique opportunity to be a health advocate for children, to help them make safe and healthy choices, and prevent potentially harmful diseases as adults. I take up this responsibility very seriously and look forward to tackling different challenges

involving your child's health. Being a parent myself, I fully comprehend the daily challenges of parenthood and tremendous sense of responsibility in raising our children as happy healthy and self-reliant individuals.

I speak passable medical Spanish and am fluent in several Indian languages. I am particularly sensitive to the vast cultural diversity in the Bay Area. Our two children are a constant source of inspiration and parenting challenges. My interests include classical dance, reading, cooking and outdoor activities.

I look forward to meeting you and it will be my privilege and joy to be your child's health care provider.

**STEVEN SONG, MD—Pediatric Allergist/Immunologist and Pediatric Rheumatologist**

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Ever since I saw an electron micrograph of an immune cell reaching out and grabbing a bacterium with its pseudopod in an issue of National Geographic, I've been fascinated with the immune system. I'm a self-professed geek when it comes to all things immunology, and it was a natural fit for me to pursue a career in a related medical subspecialty.

I grew up in the suburbs of New York City, in New Jersey, the son of two immigrants from South Korea who moved the United States for a brighter future for their children. Unfortunately, my mastery of the Korean language only applies to matters of cuisine, but my parents' passion for education was passed on to me. I was lucky enough to work my way up the Ivy League corridor for my schooling; I earned my B.S. in Molecular Biophysics and Biochemistry at Yale University, stayed in New Haven for medical school, and completed my general pediatric internship and residency at Brown University in Providence, RI.

After finally admitting to myself that California offered so many of the things I love to do, I moved to Stanford University for my dual fellowship in Allergy/Immunology and Pediatric Rheumatology. During my fellowship I was able to realize my dream of learning about the entire spectrum of immunologic disease, from severe combined immunodeficiency, through allergy and atopic disease, and rheumatologic and autoinflammatory diseases.

In my spare time, I enjoy cooking with my wife, who happens to be an allergist as well. I have taken great pleasure from learning about things like the Maillard reaction, and I am extremely grateful that my wife is a willing participant in such culinary experiments. I also love travel, looking at tropical fish from their perspective, hiking, and doing my best to avoid automobile traffic on Skyline Boulevard on my bi-

cycle. Hurling down a snowy mountain on my snowboard is my newest hobby—always with a helmet, of course—and I am slowly learning how to avoid careening off of cliffs.

After fellowship, while working in urgent care at Childrens Hospital of Oakland, I came upon an opportunity to join Bayside Medical Group as a subspecialist in both Allergy/ Immunology and Pediatric Rheumatology. I jumped at the chance to work with the physicians, nurses, and staff at this wonderful practice, and to bring my knowledge and passion for immunologic disease to my patients. I sincerely look forward to meeting you.

### **MONIKA STEVENS, MD**

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Born in Fort Collins, Colorado, to two graduate students, I moved at the age of one with my parents to Covina, a smallish city in Southern California, where I grew up. I was the neighborhood babysitter, both popular and available, perhaps foreshadowing my later emergence as a pediatrician. I left Covina for college at UCLA, which started me as a traveling person, as were my parents before me.

At UCLA I tutored others in chemistry and biology and became supervisor of UCLA College Tutorials. I graduated Summa Cum Laude with a degree in Physiology. Before entering medical school, I worked as a substitute public school teacher and was a medical college admissions test instructor. I used my earnings to fund a backpacking trip through Europe, several camping trips around the U.S., and to buy my first car and computer to take with me to Nashville, Tennessee, where I attended Vanderbilt School of Medicine.

I enjoyed studying medicine at Vanderbilt, as well as running, biking, listening to Nashville's live music, and continuing to teach medical college admissions classes. It was there that I realized that I could meld my love for children, science, and teaching into one fulfilling career as a pediatrician. I also did medical rotations in the middle of the dense Costa Rican jungle and in breathtakingly beautiful Sydney, Australia. Josh, now my husband, visited me often in Nashville and together we took trips to many areas of the world.

I did my pediatric residency at Los Angeles County Hospital and University of Southern California Medical Center. I enjoyed living in sunny Santa Monica with its pedestrian and biker friendly neighborhoods. More importantly, I loved my residency that provided me with fantastic teachers and mentors, an outstanding training, the opportunity to learn medical Spanish, and a profound appreciation for the inequalities that exist in our health care system.

Now, I am happy to have moved to the Bay Area, a region for which I have long held a deep appreciation. Since moving here my husband and I have welcomed our daughter into our family and we feel like we have found our permanent home. I am so pleased to have joined Bayside Medical Group, a practice that serves a true cross section of the East Bay. I am looking forward to dedicating many years of service to my new patients and to my new community.

### **MARIANNE TOSICK, MD**

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I was born on the East Coast, in Massachusetts, and grew up in the Midwest, in Indianapolis, Indiana. As the daughter of a radiologist and a registered nurse, medical conversations were a familiar part of my life. As kids, my sister and I were intrigued by medical illustrations of childhood diseases that we found in one of my father's medical books. I am amazed to think that we now have vaccines to prevent many of these diseases!

I attended the University of Denver and Purdue University where I studied drama and sociology. Then I got married and moved to Houston with my husband. I wasn't satisfied with my previous studies, so I switched back to science and completed a degree in biology at the University of Houston. I then continued my studies at the graduate level in nutrition, intending to pursue a career in medicine. Finally, I got my medical degree and completed a pediatric residency at the University of Texas Medical School at Houston. I chose pediatrics because I liked working with children and was impressed by their ability to recover from serious illnesses quickly. I felt honored to be selected to remain at the university on the faculty for four years, where I supervised and taught residents in a nursery taking care of premature babies. The babies were cute, but I really missed the older children and working in an office, so I left the university and joined a group practice associated with Texas Children's Hospital, where I stayed for six years.

I came to the Bay Area in 1999, because, once again, I followed my husband, who accepted a position as a dermatologist in Union City. It has been wonderful to explore the beautiful areas around the Bay, and I don't miss the hot and humid summers in Texas one bit! After I came here I worked with several groups before I was able to come full time to Bayside. I am very happy to be joining Bayside, which is well known for its excellent patient care.

I am Board Certified in pediatrics. My greatest joy in pediatrics is to meet babies, toddlers, school children, and teenagers, and their families, and watch them all grow up and mature. I look forward to meeting all of you.

## **JODY ULLOM, MD**

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I was born and raised in Minnesota. I traveled to Oregon for my undergraduate training in Chemistry. Toward the end of my studies I realized I had a passion for science but really enjoyed working with people. So it was a natural extension for me to pursue medical training.

After finishing medical school at Oregon Health Sciences University, I began my pediatric residency at Stanford. My husband and I always spent our free weekends hiking on Mt. Tam near Mill Valley. So on one of these hiking trips, we went through open houses and ended up buying our current house in Mill Valley in 1994.

After completing pediatric residency, I was a substitute doctor for a variety of practices. It was a wonderful learning experience. I came to the Pleasanton office as a temp in 1996. There was just something about the people and the situation that was just right for me. So when I was offered a permanent part-time job, I accepted. At that time I was also working at CPMC attending high risk deliveries and working in the Neonatal Intensive Care Unit.

While I enjoyed the challenges of this work for five years, it all came to a halt when my son, Kaveh, was born in 2000. I quickly realized that coming back to work two days a week in an outpatient setting would be ideal for a working mom. When my daughter, Kimia, was born in 2003, I knew my family was complete. I have always enjoyed parenting issues and I get a lot of on-the-job training with my children. I understand why knowing what the right thing to do with your children and doing it are not always easy. Thus far my job as a parent has been both my most challenging and my most rewarding.

My passions in pediatrics are promoting breastfeeding, nutrition and prevention of obesity, examining the negative effects of electronic media on children, and optimizing preventive care in asthma.

When I am not at work, I love going to the library with my kids, reading, gardening, cooking with my son, bike riding and hiking.

It is truly my pleasure to be a partner in the care of your children

## **TING WAI WANG, MD**

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So many of my colleagues think they come from the East—but I really come from the East, in my case, China! I am part of the Baby Boomer generation—I wonder if that could be why I am a baby doctor.

I grew up in Hong Kong and received my higher education in Taiwan. Then I moved to the United States and completed my pediatric residency

in 1975 at Brooklyn-Cumberland Medical Center in New York, and Jersey City Medical Center in New Jersey. I then became a Board Certified Pediatrician. I also completed a mini-Fellowship in Allergy and Immunology at the University of Wisconsin in 1983. First, I practiced pediatrics in Wilmington, Ohio, and then for 10 years in Bloomington, Illinois. Finally, I moved west to California, practicing in Oakland and San Leandro for five years, and later in Tri-Valley. In 1997 I joined Bayside Medical Group. I was especially attracted to Bayside for two reasons. First, Bayside has a good number of excellent pediatricians who enrich each other's experience daily. Second, I am very pleased that Bayside emphasizes high quality care for patients. Overall, as I have moved from place to place, I feel that I am journeying and pressing on toward the heavenly goal.

My wife and I have two wonderful daughters. Joyce is a Speech-Language Pathologist at Children's Hospital Oakland's Pleasanton Satellite Clinic. Justina just graduated from UC Davis and is looking for a career in the medical field. Joyce plays violin and Justina the viola. They both perform and serve in their church orchestra with several performances throughout the year. My wife and I feel very blessed that our daughters have the wonderful opportunity of this free and prosperous country that we ourselves did not have in our youth. Knowing where we came from and where we have arrived makes us very grateful to value and enjoy our home sweet home.

Since I am from China, I speak Cantonese and Mandarin. So, I may speak English with an accent. If you have trouble understanding me, don't hesitate to ask me to repeat what I said! Helping you is very important to me. I am very proud to be a practicing pediatrician, and to be able to contribute to the health of our children. "Train up a child in the way he should go, and when he is old he will not depart from it." This thought from Proverbs is what motivates me most as a pediatrician.

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### **DEBRA WEISS-ISHAI, MD**

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When I was in elementary school I first told my family that when I grew up I wanted to be a doctor. That idea faded for a while and other career paths seemed more interesting, like being an astronaut or a U.S. Senator. But when I took my first class in Anatomy & Physiology in high school, I was hooked and steered my life toward becoming a doctor.

I attended UC Davis as an undergrad, majoring in biological sciences and political science (just in case I still wanted to pursue that Senator dream). After graduation, prior to medical school, I worked as an elementary school teacher, a job I found to be very challenging and demanding. It gave me a newfound respect for all of our wonderful

teachers out there. Then I attended Sackler School of Medicine and went on to do my pediatric specialty training at the University of Maryland Hospital for Children. Despite the hard work, I loved my residency—I was part of a group of people who provided such a high level of academic and collaborative medicine. I loved learning about disease processes and ways to heal children or prevent illness in the first place. After residency, I returned to California to be near my family. I became Board Certified as a pediatrician, and worked as a hospitalist, taking care of children who were hospitalized. I then joined Bayside and found that I truly enjoyed taking care of families on a continuous basis. I feel that I have become an important member of the families that I treat and find it so rewarding watching these children grow and develop.

I feel that taking care of your children is a great and profound responsibility. I have three children of my own and they are infinitely precious to me, as yours are to you. As parents, you must entrust your child's health to your pediatrician. I understand that and work hard to provide my patients the highest level of care and attention. They deserve no less.

#### **CHARLES D. WOODARD, MD**

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Unlike my fellow pediatricians and friends, I actually come from this place. I was born in San Francisco and raised in the East Bay, and did my undergraduate work at UC Berkeley, majoring in biological sciences. In my junior year I attended the World Campus Afloat, studying on a ship and sailing around the world. I acquired a taste for seeing the world, so I did graduate work in zoology and marine biology at St. Andrews in Scotland. Since I liked it over there, I continued on to medical school at the University of Manchester in England.

After that, I started my clinical training at Bolton, England, with six months of medicine and six months of surgery general training, and then started on the surgical specialty road for a year, but, to tell the truth, I got sick of patients behaving like children. I figured if that is what patients are like, I might as well get the real thing, and I switched to pediatrics, and that felt right.

I took three years of basic pediatrics residency at Rush Medical College and Presbyterian-St. Luke's Hospital in Chicago. I was very happy making my way through the ranks and becoming Chief Resident, and I especially loved the smallest of the small, so I thought I would become a neonatologist. After finishing a two year neonatology fellowship where I was also an instructor at Rush Medical College, however, I found that I was missing a continuing relationship with the families that I met and became friends with in the nursery.

After all that training and travel, my wife moved back to the Bay Area and I followed her lead. I came home in two senses: home to the Bay Area, and home to primary care pediatrics. I worked briefly for Maxicare, and then joined Bayside Pediatrics, where I feel right at home.

I am Board Certified in pediatrics. Following families and their normal evolution through the years is exactly what I want to do. I am still very interested in preemies and newborns, and I seem to be the one in the group who gravitates to the complex and bizarre illnesses that sometimes appear. Solving these puzzles is one of my real pleasures.

### **STEVEN T. YEDLIN, MD—Pediatric Surgery**

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I was born and raised just outside of Detroit, in an area that started out being fairly rural but as I grew up, became suburban. I stayed local for college, graduating from Oakland University in 1971 with a BS in chemistry. I was a swimmer in college and was honored by being named as a NCAA All American—my best stroke was freestyle.

I always loved science, but I wanted to serve people with science directly, so medical school was a natural choice. I was lucky enough to be admitted to a leading medical school, Washington University in St. Louis, which was my father's hometown. I chose surgery, since I like the direct approach to the patient and coming from a family of engineers, I have always been good with my hands. I completed a general surgery residency and then a research fellowship there at Barnes Hospital.

During my surgical training I was inspired by Jesse Ternberg, MD, the first female surgical trainee at Washington University, and its first pediatric surgeon. I was so impressed with her dedication to specialized surgical care for kids that I chose the same field. To pursue this career I moved back to Detroit for a two year Pediatric Surgery Fellowship at the Children's Hospital of Michigan, staying there for another three years as Director of Surgical Education. While there I passed my Boards in Pediatric Surgery, which I have since done two more times.

In 1987 I broke away from the Midwest and moved to California with my wife to be, Patte Bishop MD, also a pediatric surgeon and a longtime California resident. We both joined the pediatric surgery group at Children's Hospital Oakland, headed by Ed Free MD, a pioneering pediatric surgeon and another admirable mentor. I have been here in the East Bay every since, practicing general pediatric surgery for 20 years. At Children's I was honored to be elected to the Medical Staff Presidency, and Chairman of the Department of Surgery.

I also have been part of Children First Medical Group since its founding in 1995, serving on the Board and also intermittently as Medical

Director and Acting CEO. I am currently Chief Medical Officer and work there half time.

My wife and I left the surgical group at Children's in July 2007. I devoted myself to CFMG as interim CEO, and look forward to our hiring a full time CEO so I can go back to being Medical Director. In March 2008, I joined Bayside Medical Group as its first pediatric specialist. Because of my multiple commitments, I have chosen to limit my surgical practice primarily to consultations and outpatient procedures. While I enjoy the challenge of administration, taking care of patients is something I hope never to give up.

Patte and I have a son who is entering college in the Fall of 2008. We enjoy gardening, eating out, and I still take the occasional swim. I have been very lucky in my life, I think, with my choice of being a pediatric surgeon, marrying my wife, having our son, and living in the East Bay.

### **ALBERT YU, MD**

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Some would say I had a unique childhood! I spent my early years in San Francisco's Chinatown living above a fortune cookie factory. Then my father decided to accept an engineering job overseas. We moved to the island of Sumatra, Indonesia, and lived in the middle of a jungle for several years. Afterwards, we made another big move to Nigeria, Africa, and lived there for several more years. I was already in my teens by the time we returned to California. Looking back, I am so grateful for those experiences because they helped to develop my appreciation for ethnic and cultural diversity.

Maybe that's why I attended UC Berkeley, arguably one of the most diverse colleges around. It was an incredible experience going to school there. I was attracted to biology during my studies and did research on plants and animals. During that time I also volunteered at the local Alta Bates Hospital and at the "Suitcase Clinic" for the homeless. Those experiences sparked a passion for the health sciences and for community outreach.

A few years later, I was blessed with the opportunity to learn medicine at UCLA. While training in the art of healing, I found myself drawn to children. I discovered that I enjoyed forming relationships with parents and following kids as they grew. I did extra rotations in pediatrics, volunteered at community clinics, and helped lead our school's Pediatric Interest Group. Nothing gave me greater pleasure than taking care of children so I knew I had found my calling.

I completed my pediatric residency at UC Irvine and loved it. There, I took care of a good mix of simple and complicated patients and learned Spanish on the job. While training, I became interested in the lungs. I was drawn to the physiology and challenge of pulmonary patients so I pursued a fellowship at Childrens Hospital Los Angeles. Fellowship was exciting and the consultations I did for children with lung disease kept things interesting. Yet midway through, I realized that I missed general pediatrics and its focus on nurturing the growth and development of children. So after finishing two years I decided to return to general pediatrics. I still have a special interest in the lungs. Now my focus is to enhance the care I can give as a general pediatrician with my knowledge and skills from pulmonary medicine.

My wife, Yvonne, is also a general pediatrician who I met during residency. In our spare time we like to jog, hike, snowboard, and read. We love to spend time in the great outdoors and at the beach. Lastly we have a heart for community outreach and medical missions, volunteering whenever we can. I am extremely happy to be a part of the Bayside family! I look forward to meeting you and providing the best care for your children!

### **MICHAEL ZWERDLING, MD**

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There is a tree growing in Brooklyn to commemorate my birthplace, but I've been a Bay Area resident since high school in Piedmont. I went to UC Berkeley School of Public Health and received a bachelor's degree in biostatistics. Then I went on to UCSF for my medical degree. I spent two years at the Massachusetts General Hospital in Boston, then returned to San Francisco to complete my pediatric training. I was a research physician on a study of the association of events occurring during pregnancy with outcomes in children, but after two years of that I decided that I enjoyed clinical pediatrics more than research. So ever since then I have practiced primary care pediatrics in west Contra Costa County. I am Board Certified in pediatrics.

I live in Lafayette (where my wife was born), with three dogs, three cats, and two birds. I have three daughters, all of whom live in the East Bay. My wife is a registered nurse and a lactation consultant, and as a result I have developed an increasing interest in breast feeding in recent years. I try to incorporate this into my practice on a regular basis.

Downhill skiing and Cal football are consuming interests—GO BEARS!

## **SABRA DALY, BS, RRT, PA-C**

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I was born and raised in Oakland as a third generation Bay Area native. I was always interested in medicine, even as a small child, when I played at nursing dolls and baby kittens back to life. It was only natural for me to major in cell and molecular biology at San Francisco State, from which I graduated Summa Cum Laude.

My next step in the medical field was to become a respiratory therapist, working in all areas of the hospital: ICU, ER, pediatric ICU and neonatal ICU. I took care of patients with asthma and lung disease, postsurgical patients, and preemies on ventilators. While that was often thrilling work, I wanted to expand, so I returned to school at UC Davis, where I received my Physician Assistant degree from that excellent program. Then in 2001 I joined Bayside, where I have felt right at home every since.

The variety of family practice is very appealing to me. On any day I will see patients of all ages with all sorts of problems. I enjoy managing chronic conditions, diagnosing and treating medical problems, doing histories and physicals, doing well-woman examinations, injecting joints, doing in-office biopsies and minor surgeries— all of it! In addition, I also enjoy practicing travel medicine, which is another service of Bayside's family practice division.

On the personal side, I live in Alameda and enjoy spending time with my husband, Peter Heelan, and my two children, Nora and Niall. I play Irish music on the concertina and accordion, and I am often seen playing local gigs at Irish functions. (Yes, that's my heritage, all right!)

## **MICHAEL DE ROSA, MPH, PhD, PA-C**

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My journey to clinical medicine has been a bit circuitous and perhaps longer than most, though I have never strayed far from biomedical science. When I left Occidental College in 1989 with a baccalaureate degree in Psychobiology I faced a choice between medical school and a doctoral program. A number of factors led me away from medical training at that time. I had developed a deep and abiding interest in the human brain and its functioning, and my ultimate career goal was to teach. Consequently, I made the choice to pursue a Ph.D. in Neuroscience at UCLA.

In 1994, with a degree in neuroscience, I left California for the first time in my life with my wife and we travelled to New Jersey. For 30 months I worked in a neuroimmunology laboratory as a post-doctoral fellow. This was a good learning experience but I ultimately came to realize I had

begun to lose sight of my career aspirations. I was getting further and further away from the classroom. So I took a second post-doctoral fellowship at Berlex Biosciences in Richmond, California and moved back to my home state and to a region in which I had always hoped to live.

While at Berlex, I began teaching part-time throughout the Bay Area. Ultimately, I was hired to teach basic sciences in a new program at Samuel Merritt University, the first Master's degree-granting Physician Assistant Program in California. Quickly, I was given an opportunity to become a full-time faculty member and I had achieved my goal of teaching at the graduate level, and in a medical curriculum. After several years as a member of the faculty I was given the opportunity to become a physician assistant myself.

I was introduced to Bayside by one of my Samuel Merritt graduates, Heidi Heal, a PA in the practice who suggested I do my own Family Medicine rotation under Dr. Eichel's supervision. I was overwhelmed by my experience and the opportunity to finally do medicine, something I had thought about since deciding to go into the Neuroscience program out of college. When I completed my PA training and a Master's in Public Health for good measure, I was fortunate enough to be invited to return to Bayside Medical Group to work as a PA on the family practice team. I could not ask for a better group of colleagues, from Dr. Eichel, to the other PAs, to the office staff, my experience here has been truly amazing. I now enjoy the best of both worlds; leading the PA Program at Samuel Merritt College and working as a clinician two sessions per week affords me the opportunity to truly blend two profound interests into a busy and exciting work week. I am extremely grateful for the opportunity and look forward to working with you.

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### **HEIDI I. HEAL, PA-C**

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My mom always said, "Someone in this family has to go into medicine, with a name like Heal!" She got her wish—I knew I wanted to be in the medical field from a young age. I was (and still am) repeatedly awed by the complex systems that come together to sustain life. I grew up in rural Chico, California with a family that spent every possible moment in nature. I was able to feed my biological curiosity by spending countless hours sitting in trees watching insects, studying frogs and worms in the backyard, and taking apart flowers piece by piece to wonder what each part's natural purpose might be.

I chose University of California, San Diego for my undergraduate degree mostly because of the school's great reputation in the science

fields. I worked my way through school doing odd jobs like driving buses and transporting patients for the MRI department at Children's Hospital. I graduated with a B.S. in Physiology and Neuroscience. Shortly after graduation I entered PA school for my Masters in Physician Assistant studies at Samuel Merritt College in Oakland. Once I was a PA, I took two months off to study Spanish in Guatemala. I currently live in Alameda with my husband and children. I work in both the Berkeley and Alameda offices for Bayside

It's such a pleasure working here—a continuous challenge and a pleasant patient population, as well as great colleagues. Our supervising physician for the family practice division of Bayside, Dr. James Eichel, is a wonderful mentor. I look forward to serving your medical needs as part of the Bayside team for many years to come.

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**SARA S. KOENIG, CPNP**

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I am a Bay Area lifer. I was born in San Francisco and raised in Mill Valley, spending my childhood in the shadow of Mount Tam. I didn't go far for undergrad, moving down the coast to UC Santa Cruz, earning a degree in Sociology, and graduating with honors.

During college, I spent a semester abroad studying in Hungary, igniting my life-long passion for travel and experiencing different cultures. After graduation, I set off for a five-month adventure throughout Southeast Asia.

Once I returned to the states, and quickly learned that a corporate desk job was not for me, I took off again—this time to spend a year in Osaka, Japan, teaching English to junior high school students. That year was transformative for me, in that I learned working with children would always be an integral part of my work life.

Upon returning to San Francisco, I realized that I wanted to work with children in health care. I lost a dear friend to cancer when she was only 23 and it led me to seek a job in pediatric oncology. I was hired at UCSF in the Pediatric Oncology department as a clinical trials coordinator and worked in this capacity for almost four years. It was there that I met two wonderful pediatric nurse practitioners, who, in my eyes, had mastered the art of blending medical knowledge with a compassionate human touch. They became my mentors, and I started going to night school to complete my prerequisites to apply to nursing school. During these years, I also volunteered every week in the Child Life department, helping chronically ill children forget about their illnesses through play therapy.

After three long years of working and going to night school, I left the Bay Area for the exotic town of New Haven, CT, and embarked on earning my RN and MSN from Yale. As if the program wasn't difficult enough, I got pregnant after the first year of the program, gave birth two days after final exams of my second year, and had an infant for the remainder of my education. The challenges of breastfeeding, the lack of sleep, and the illnesses and hospitalizations I encountered that first year with my son made me a better clinician.

After graduating, I returned to the Bay Area as my husband and I longed for those incredible sunny 70 degree February days. The strong pull of our friends and family also enticed us back. I currently live in San Rafael, CA, with my husband and two young sons. I enjoy spending time with family and friends, hiking and exploring the beautiful surroundings, and doing yoga when life allows me to do so.

I really enjoy practicing preventive medicine. Working with families, educating and empowering them to make positive, healthy choices for themselves and their children, is my goal. I look forward to meeting you!

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**SAMANTHA RILEY, CPNP**

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I cannot remember a time when I didn't think I would be working with children someday. I believe I proclaimed my future a nurse for babies at the age of 8 in my Girl Scout troop. By 12, I was the local babysitter in our town, Pandora, Ohio, population 1,100. Pandora featured Friday night high school football, Saturday Ohio State football, and Sunday Cleveland Browns football.

Although I loved growing up in a small town with family everywhere in sight, I was happy to be an undergraduate at John Carroll University in Cleveland, where I graduated with a BA in biology. Then I entered a Nurse Practitioner program at Case Western Reserve University, where I received my RN and Masters Degree in Pediatrics, and became board certified. I had a dual major in Family Practice, which enables me to be especially attuned to teenagers.

After working at Rainbow Babies and Children's Hospital in Cleveland, I moved to San Francisco, where I have found a real home, even though I am still a Midwestern girl at heart. After working at Lucille Salter Packard Children's Hospital at Stanford with children with many different illnesses, I transferred to University of California at San Francisco, again as an RN, working on a pediatric cardiology transitional care unit. I have continued to work part time at this job after taking a position at Bayside, and it reminds me constantly of the resilience of children when faced with challenges beyond everyday life.

I live in San Francisco with my husband, who travels frequently, and who sometimes takes me with him, to places such as the United Kingdom, Ireland, Amsterdam, Western Australia, Mexico, and many cities in the US. Though I love exotic places, I still enjoy the trips back to Ohio, and seeing my younger sister in Chicago. I also enjoy San Francisco cuisine, reading, hiking, camping, biking, kayaking, and everything that gets me outside into adventure!

### **LINDA STEPHAN, CPNP**

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Growing up in Southern California I enjoyed warm weather and learned to appreciate outdoor activities—I enjoy doing just about any sport that gets me outside. I stayed on the West Coast for college, attending UC Santa Barbara, and was able to be outdoors by competing on the sailing team. In college I realized that I enjoyed studying science because I like understanding how things work and how we develop. I earned a Bachelor's degree in Cell and Developmental Biology. I particularly liked understanding how the human body works, and taught an undergraduate physiology class at UC Santa Barbara for a year. Although I enjoyed science I knew I also really liked to work with children. Through much of high school and college I was able to save money by babysitting.

I combined my desire to understand the science behind how we work and my enjoyment of working with children, and decided to study to become a Pediatric Nurse Practitioner. I left California for Philadelphia, to study at the University of Pennsylvania. I received a second Bachelor's degree in nursing and then continued to study further at Penn, and graduated Summa Cum Laude with a master's degree in nursing, becoming a Certified Pediatric Nurse Practitioner.

Before moving to the Bay Area I spent some time working as a Pediatric Nurse Practitioner in Boston. However, after experiencing a very cold Boston winter, I knew it was time for me to return to the West Coast and to warmer weather, and joined Bayside in 2004. I am glad to be back on the West Coast where I can enjoy being outside year round.

I look forward to developing relationships with you and your family, and addressing any concerns you may have about your child's health as your children grow and develop.



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