THE FLORIDA PEDIATRICIAN

The Newsletter of the Florida Pediatric Society/Florida Chapter American Academy of Pediatrics

Volume XVIII, Number 3 *August 1995*

THE PRESIDENT'S PAGE

Several months have passed since my assumption of the presidency and I would like to provide somewhat of a progress report with regard to a number of active issues. An issue brought to me by members emphasizes the need for each of us to be a teacher to medical students, resident physicians, and even our younger colleagues. In fact, the Hippocratic Oath states "*I will import knowledge of the art by precept, by lecture, and by every other mode of instruction to students who are bound by a stipulation and oath, according to the law of medicine, but to none others".* Although each of us has differing contact with students, I would like to emphasize the need in these times for us to partner with our colleagues in academic medicine to develop opportunities for each of us to be a teacher. It is also an opportunity to advocate for the advantages of a career in pediatric medicine.

On the economic and legislative horizon, there are issues that concern all of us regardless of the site of our clinical care. The governor's veto of legislation that provided an increase in Medicaid fees for pediatric specialty physicians was unanticipated. We have worked with the Florida Medical Association through the Board of Governors and the appropriate channels to make it a priority to restore funding to the fee rate approved in October 1988. The FMA Board of Governors endorsed the following statement: "That the FMA take all appropriate legislative actions to return Medicaid provider pediatric specialists' fees to a fee rate approved in October 1988, and to increase emergency physicians providing care to Medicaid recipients to those rates provided to primary care physicians." **This will be a priority of the Society/Chapter**. In addition, we will be working with appropriate leadership in the legislature to deal with exclusive use labs, appropriate primary care funding through Children's Medical Services and explore issues in concert with the FMA that will enhance access to medical services for the children we serve.

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"...return Medicaid provider fees to rate approved in October 1988..."

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Currently, I am in the process of either reaffirming or appointing Chairs of a number of committees as detailed elsewhere in this Newsletter. I would like all members of the Society to consider whether they have the opportunity to participate actively in a committee or to provide expertise and, if so, to contact the relevant Committee chair indicating willingness and desire to participate in the activities of organized medicine. I have also asked the Presidents of each of the related specialty societies to join us in a Council of Pediatric Specialties within our organization so that we can interdigitate our legislative, economic, and practice issues for the greater good of our membership. We look forward to working with all our colleagues in advancing important issues of medical care or children. At the national level, your president has been requested by the Academy leadership to participate in the drafting of model "early discharge" legislation. (I need your input on this issue - some have already written - keep it coming!).A number of items are currently under review in the relations with the Department

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COMMITTEE CHAIRMEN

Adolescence
Dianne S. Elfenbein, M.D.
Tampa, FL
Bioethics
Donald V. Eitzman, M.D.
Gainesville, FL
Careers and Opportunities
TBA

Child Abuse and Neglect
Jay Whitworth, M.D.
Jacksonville, FL
Child Health Financing and Pediatric Practice
Edward N. Zissman, M.D.
Altamonte Springs, FL
Childhood Disabilities
Stanley N. Graven, M.D.
Tampa, FL
Collaborative Research
Lorne Katz, M.D.
Coral Springs, FL
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Herbert H. Pomerance, M.D.
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Fetus and Newborn
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Tampa, FL
Home Health Care
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Tampa, FL
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Gwendolyn B. Scott, M.D.
Miami, FL
Lay Child Advocate Groups and Legal Needs of Children
Audrey L. Schiebler
Gainesville, FL
Legislation and Government Affairs
TBA

Membership
TBA

Multicultural Pediatrics and International Health
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Miami, FL
Nutrition Committee
TBA

Pediatric Critical Care and Emergency Services
Salvatore R. Goodwin, M.D.
Gainesville, FL

School Health/Sports Medicine
David A. Cimino, M.D.
St. Petersburg, FL
Scientific Meetings
Douglas J. Short, M.D.
Orlando, FL
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Robert Threlkel, M.D.
Ken Morse, M.D.
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Council of Pediatric Specialty Societies
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Augustin Ramos, M.D.
(Pediatric Cardiology)
Richard Signer, M.D.
(Pediatric Surgery)
Gaston Zilleruelo, M.D.
(Pediatric Nephrology)
Dianne S. Elfenbein, M.D.
(Adolescence)
Lance Wyble, M.D.
(Neonatal-Perinatal)

THE EDITORIAL PAGE

Where Do We Go From Here?

We ask this question more and more these days. Are we really at a cross-roads? Are we, like Yogi Berra, at a fork in the road and taking it?

Problems for pediatric practice did not just start. If we look back three decades, we realize that the practice of pediatrics in the so-called "private sector" has long been in turmoil. Some of us recall the era of solo practice, its trials, its house calls, its gratifications. The practitioner cared for his "population", and donated time to providing care for the needy - with no compensation. Economic reality eventually provided the stroma for change, aided by the realization that pediatricians' families deserve the same "care" that we prescribe for others. Group practices, began to emerge. The house call, with its very personal relationships, disappeared. Fewer and fewer needy found care in the private office. Medicaid, with its grossly underpaid visits, was a disincentive to care; it was easy to see that each visit was a financial loss to the office. The academic world filled some of the gap, and realized that it too could lose money! Public Health entered the world of primary care, where previously the concern was only with matters of public health.

The escalating cost of seeing and of hospitalizing patients resulted in rising insurance costs, and gave birth to the H.M.O. Early attempts were either very successful or a resounding failure, but quickly proved that this is one way to provide care. The blossoming of Medicaid reimbursement brought some patients back to the private office, but this event only accentuated the plight of the working poor.

"...at a fork in the road and taking it?"

Surprizingly, there was very little overt response to these changes. For the most part, pediatricians did "business as usual", decrying the oceans of paper work and the departure from the image of being "the family's friendly advisor". It was time for the cauldron to boil over - and it did.

Everyone appeared to be totally caught up in the hysteria of change. Every one had an opinion - for or against, and usually quite vocal - about the "Clinton Plan" to reform health care. Cries of "a New World" vied with the voices of doom. The Task Force was either "the best ever" or "the worst ever". Business as usual was replaced by extreme activism for change - or for the *status quo* ("if it ain't broke, don't fix it"). And meanwhile "Managed Care" was born. Strange that a new name created chaos over something already there! Activism now had a cause.

Then the Congress was remodeled. The ground rules seemed to change. The new era seemed doomed - but was it? Pediatricians breathed a sigh of relief, unless they recognized that the new player, Managed Care, was here to stay, and that behind its drive were the powerful insurance companies, trying to reduce costs and essentially doing so by reducing the amount of care.

So, where <u>do</u> we go from here? Do we go back into the wood-work and act as if nothing happened? Can we, with the new "ogres" around? No, indeed we must go forward, becoming more realistic activists.

What are the issues we face? Certainly <u>universal access to care</u> remains a problem, not talked about very much anymore. It should be, including the sub-issues, such as a definition of whether access is availability of care, or utilization of available care? Can we assure universal access?

Another major issue raised by the Administration early, and still around, is <u>payment</u>. Is a single payor better or worse than the current system? Which way is better for <u>patients</u>?

These are the two issues that the President seemed to be pushing for. But Managed Care has apparently occupied our thoughts and should continue to, as has

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The President's Page

(continued from page 1)

of Health and Rehabilitative Services. The recruitment of the Medical

Director for Children's Medical Services has been deferred in order to carry out a full recruitment effort and to identify the most qualified candidates. The uncertainty that underlies a special health care session and possible legislation for a separate Department of Health relates to the need to defer this critical decision for the direction of programs for children with special health care needs. In addition, your Chapter has worked actively with the Florida Medical Association, representatives of the hospital associations, and Children's Medical Services, to review the Infant Metabolic Screening Program in Jacksonville, and to look at ways to address the issues of rule making and the "baby tax" imposed upon obstetric facilities. The Infant Screening Advisory Committee will meet in the fall to review the results since the initiation of the congenital adrenal hyperplasia program and may make some refinements to the program. Dr. Weiss, Dr. Cimino, Dr. Smith and I had the opportunity to review some aspects of the Lead Screening Program implemented in Pinellas County. The State Health Office has recently distributed a request for comments with regard to proposed requirements for immunizations at the seventh grade level in the public school system and a means for tracking them beginning in 1997/98. This will be addressed in a separate communication, but the Society has had ample opportunity to comment with the support from the Drs. St. Petery and others. The Tallahassee office is diligently working out some of the issues of varicella vaccine coverage within the periodicity schedule as recognized by the State Health Insurance Office and we will keep you apprised of this matter as it develops, as it has been an area of concern.

Lastly, I would like to express my pride for the leadership shown by Drs. Cimino and Morse in our ability to secure appointment to national Committees of the American Academy of Pediatrics for Dr. Jaime Frías on the Committee on Genetics and Dr. David Cimino on the Committee on School Health.

Thanks again for all your support and I hope that I will provide the leadership and support needed as we enter the new year. I am lookaing forward to our annual retreat in Orlando on September 8, 9, and 10, at which time we will examine the topic of managed care and develop methods for the provision of education and materials in support of our membership. We have secured a distinguished group of participants, including Dr. Len Kutnik from San Diego, who will provide us with the California strategy and perspectives.

John S. Curran, M.D.
President

P.S. For the technologic aficionados my E-mail address is jcurran@com1.med.usf.edu. For the rest, I apologize for telephone tag. keep comments and information coming. We will have an E-mail address in Tallahassee in the next two weeks.

Editorial

(continued from page 2)

capitation, an ugly outgrowth of the managed care system. With both, the uncomfortable feeling exists that the insurance companies are concerned primarily with the "bottom line", and not with the quantity nor the quality of care for children.

Alarming also is the current push to remove Medicaid from the federal budget and replace it with "block grants", with their checkered history. What will happen to children in Florida under such a system? Will care be decreased?

Shall we, with these pressing problems, forget the less political

(continued next column)

problems we have been trying to resolve? Have we lost sight of drug abuse, child abuse, sexual abuse of children, early pregnancy, violence in television, to name a few? And now we see a disturbing tendency (bottom line again?) towards the so-called "drive-through delivery", which promises to set us back 50 years. Unfortunately this is commanding preventive legislation in several states, enathemous to those of us who feel it should not be necessary to legislate good medical care. We will do a great disservice to children if we neglect these problems because of the greater visibility in the political arena.

We must continue, one by one and collectively (especially in this organization), to push forward with all of our concerns - on a community level, in the State legislature, in Congress, and right here in our Newsletter. We will be successful only in proportion to the effort we expend. Every one of us has a role to play. Let's do it!

The Editor

[*The Florida Pediatrician* will publish guest editorials, whenever they are suitable for appearance in this column; the right is reserved to convert to a Letter to the Editor, if this form is more appropriate.]

GENERAL PEDIATRIC UPDATE IV
May 3-5, 1996
SCIENTIFIC SESSION
Speakers will include**:**

Jack Hutto, M.D.
Jack Campbell, M.D.
Bernard Maria, M.D
Joel Andres, M.D.
Ovidio Bermudez, M.D.
Robert Manniello, M.D.

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BUSINESS MEETING

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FRIDAY NIGHT RECEPTION

For more info call: 904-877-9131

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COMMITTEE REPORTS

Report of Committee on Sports Medicine and Fitness

Several key issues have been explored during the past year. Several members of the Society have expressed interest in participating on the Sports Committee for the next year. Doctors in the Miami, Gainesville, and Tampa areas are among those interested. I have spoken with the Sports Medicine liaison person from the State of Georgia, and will continue to share ideas. An attempt was made to contact interested physicians at the recent Annual Meeting of the Florida Pediatric Society. I will attempt to coordinate a committee meeting with one of our Executive Committee meetings in the near future.

The following are key issues for which we must develop recommendations.

1. A standardized pre-participation sports physical and interim physical form needs to be coordinated with the Florida High School Athletic Association. I have talked with Dr. Stephen Lucie (Jacksonville Sports Medicine Program), who is attempting to work with the family practice physicians and the FMA to standardize a form. The format currently being used in Jacksonville has been accepted through-out north Florida. Dr. Lucie would like to be kept informed of our progress.

2. As a member of the Jacksonville Sports Medicine Committee, I was approved to do an informal general sports survey on high school athletes and I am in process of tabulating this data. This is a follow-up to a similar study which I did several years ago.

3. I have tabulated the findings of a research project documenting the use of Ritalin in 150 Attention Deficit youngsters that are followed at the Hope Haven Children's Clinic here in jacksonville. These findings will be reported at the upcoming Ch.A.D.D. meeting. The findings generally support the belief that slightly less than 50% of attention deficit youngsters take psycho-stimulant medication (e.g., Ritalin) before their sports participation. This number was much less than anticipated. It was also found that 141 of the 150 attention deficit youngsters enjoyed participating in some extra-curricular athletics.

4. The American Academy of Pediatrics Committee on Sports is revising their Physical Fitness and the Schools statement. Current data show the tremendous problem of overweight children and adolescents in America, and this needs to be addressed. A strong statement from the Florida Pediatric society recommending mandatory participation in physical education at the middle school and high school level needs to be explored.

5. A statewide tabulaltion of the high school injury registry would be helpful.

6. Pediatricians who participate as sports medicine volunteer physicians in the schools need to be documented. Concerns over possible litigation have apparently affected volunteer physicians throughout many programs in the state.

7. Dissemination of information stopping the use of "smokeless tobacco" and alcohol in youthful athletes needs to be under-taken. A supporting statement needs to be generated and publicized throughout the State of Florida.

8. The use of bicycle helmets and the need for a suitable law need to be shared with our legislature. Status of the current bill needs to be updated and pediatricians need to urge and promote in their practices the use of helmets for biking, skating, and skate-boarding.

I have been in communication with Dr. Greg Landry, who is currently on the Academy's Sports Medicine Committee, as to the possibility of his speaking at an upcoming Florida Pediatric Society meeting. Dr. William Strong, of Augusta, who is a very active member of this committee, has also expressed an interest in speaking.

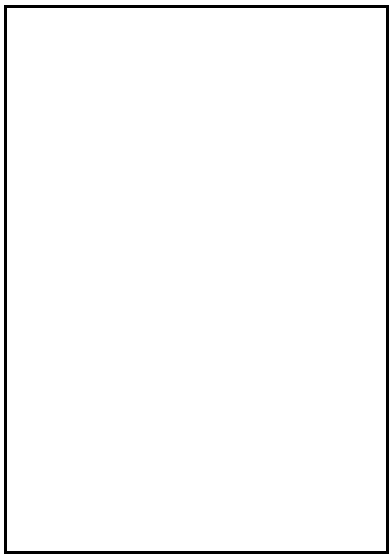
This has been a very active year, and we look forward to the upcoming monograph revision of the Pre-Participation Physical Evaluation that will be prepared by the Committee on Sports Medicine and Fitness at the national level.

Joseph A. Pesek, M.D.
Jacksonville, FL
Chairman

Kudos again!

We are delighted to note that **Lewis A Barness** will receive the **1995 American Academy of Pediatrics Medical Education Lifetime Achievement Award** at the Annual Meeting of the Academy in San Francisco, on October 17th.

Our congratulations to Dr. Barness for winning still another award for his outstanding service to Pediatrics!



Patricia Simmons, M.D. addresses the Annual Meeting in May

HAS YOUR ADDRESS CHANGED IN THE LAST YEAR?

Please send an update to the Executive office to assure receiving mailings. Thanks!

THE REGIONAL REPRESENTATIVES REPORT

(Each month we will provide reports from two of our eight regions)

Region II reports:

Major news continues to concern the reorganization of medical care as a result of managed care initiatives.

Columbia Health Systems has already purchased two area hospitals (Memorial and Orange Park), with no immediate positive or negative effects. They are close to signing a management contract with University Medical Center, which should substantially improve this hospital's financial situation. They were unable to purchase Methodist Medical Center since the charter at Methodist demands its continuance as a not-for profit institution.

Baptist Medical Center and St. Vincent's Medical Center (the two largest in Jacksonville) have combined. This move should produce considerable savings and realign some services. St. Vincent's will probably eliminate pediatrics entirely, as Baptist has the new Wolfson Children's Hospital and has recently been granted Level III neonatal beds. Negotiations to move pediatric cardiology to Wolfson are still progressing.

Mayo Clinic - St. Luke's Medical Center is planning on opening an obstetrical service. It is unclear at present whether they will require a neonatal service.

Military base realignment has closed some facilities in Jacksonville, but expanded others, and the net result is an increase in military personnel at a time when military dependent care was being privatized. It is unclear what the next step will be.

The agreement between the Division of Primary Care at University of Florida/Jacksonville and the Department of Public Health continues to mature. This has resulted in the opening of an additional primary care office at an inner city public school. It is said that other inner city schools are also interested.

The private pediatricians are continuing to feel the pressure from managed care on the one hand and joining IPAs on the other. IPAs apparently lend some security and negotiating power, but sacrifice some autonomy. Many are concerned about long-term contracts.

Despite broad cutbacks in funding during the last legislative session, the Florida Poison Center Network was awarded additional funding for computer networks and data collection. The Jacksonville center is formulating the data collection system.

Lucian K. DeNicola, M.D.
Regional Representative
Region II

Region VI reports:

Children's Advisory Boards: The Sarasota County Commission has just established a 22-member Children and Youth Services Advisory Council to advise the County Commission on funding for children's programs. The council will include one physician. Permanent funding of at least $1.6 million per year was established. This is an increase over current funding. Members of the Sarasota community have been working toward this goal for many years, since a ballot referendum to create an independent board to oversee children's programs which would be funded by a taxing authority was defeated by Sarasota County voters.

(Continued next column)

Manatee County has had just such a tax supported children's services board for several years now. By all accounts it seems to be working well. Its aim is to attempt to provide funding for new programs and initiatives. The Manatee County Commission, however, has gone back on its commitment to use the children's tax money as an addition to previously allocated monies for children's services. They have eliminated funding for some children's programs, saying that if the Children's Services Board thinks that these programs are so worth-while, they should fund them out of their own funds.

Breast-Feeding Week: Many projects have been organized throughout the state in honor of Breast-Feeding Week in early August. Breast-feeding Advocates of Sarasota County, a group consisting of lactation consultants, representatives of the LaLeche League, health department nurses, hospital nurses, community members, and a pediatrician, is attempting to increase breast-feeding rates. Awards were given out to a pediatrician and a business that were felt to be the most ooutstanding in promoting breast-feeding. A community event to promote and publicize breast-feeding was held. Katie Powers, a lactation consultant and nurse at Manatee Memorial Hospital was honored by being named Co-Grand Marshall (along with Governor Chiles) of the Healthy Babies Parade in Tallahassee.

Jerome H. Isaac, M.D.
Regional Representative
Region VI

A Note to Interested Members:

A letter has been received from the Perm Region Children's Hospital in Russia, with 1000 pediatricians, soliciting cooperation with us on solutions to some of their problems, including professional skill enhancement, public health program development, and "social protection". An exchange of information is desired. If any of our members are interested in this type of outreach, please contact directly:

Koriukina I.P.
Perm Region Children's Doctors Association
13 Lenin str.
Perm 61400 Russia
Tel:(3422)32-46-74 Fax:(3422)48-23-18

James Stockman III, M.D. addresses the Annual Meeting in May.

THE ANNUAL MEETING - 1995

May has become an excellent time for pediatricians in

Florida to update their knowledge of general pediatrics and to renew old friend-ships.

The Disney Contemporary was again the site of the Scientific Session of the Florida Pediatric Society/Florida Chapter of AAP. Pediatricians, family practitioners and nurse practitioners were hosted to an excellent array of talks ranging from childhood AIDS to sports injuries.

Victor Strasburger, M.D., University of New Mexico, began our program with a fascinating discussion of the effects of television violence on our youth. Film clips from today's TV shows highlighted his most entertaining and enlightening talk. His plea for responsible TV programming was extremely well presented and deserves our support. [See report on TV legislation on page 14].

One of the goals of our meeting is to bring up to the minute information to our attendees. Dr. Michael Muszynski of Arnold Palmer Hospital for Children & Women, Orlando, accomplished that goal in his discussions of AIDS and New Developments with Old Pediatric Pathogens. How does the general pediatrician participate in the care of a child with HIV infection? How does pneumococcal resistance affect everyday pediatric practice? Why has Group A beta hemolytic Strep become a major cause of severe illness? These and many other questions were answered during these superb talks.

On Friday evening, the Florida Pediatric Society hosted a family social gathering to renew old friendships and meet the faculty. Combining work and play is certainly the way to hold a meeting.

On the second day, Dr. James Stockman of North Carolina, President of the American Board of Pediatrics, discussed office evaluation of anemia and current controversies in ITP management. His talks were filled with pearls to be used in our practices.

Dr. Lawrence Schachner of the University of Miami discussed the differential diagnosis of vesicular-pustular rashes in the newborn, and the steps to take in the workup of such a rash. He also reminded us that there is no such thing as a healthy suntan and of the continuous need for sun protection for all of our patients.

On Sunday morning, Dr. Lyle Micheli presented an overview of pediatric orthopedic trauma and sports medicine for the pediatrician. The importance of thorough training of our children's coaches and trainers became evident through Dr. Micheli's discussions.

Following numerous requests from last year's attendees, Dr. Patricia Simmons of the Mayo Clinic returned. We were treated to two excellent discussions of pediatric and adolescent gynecology. Who of us has not been faced with the young child with premature thelarche or the sexually active teenager with multiple problems?

With such an excellent array of topics and speakers, what will we do next year? More of the same! Our speakers will be Dr. Jack Hutto (Pediatric Infectious Diseases), Dr. Jack Campbell (Pediatric Radiology), Dr. Bernard Maria (Pediatric Neurology), Dr. Joel Andres (Pediatric Gastroenterology), Dr. Ovidio Bermudez (Pediatric Adolescent Medicine) and Dr. Robert Manniello (General Pediatrics).

What can you expect? More great topics, more pearls for practitioners, lots of friends, and a new part of Disney - the Yacht Club. So, make plans to join us on May 3, 4, and 5, 1996, for General Pediatric Update IV.

Douglas J. Short, M.D.
Chairman, Committee on Scientific Meetings

LEGISLATIVE LISTENINGS

Nancy Moreau, Legislative Liaison, filed this report.

I was asked an interesting question during the Annual Meeting, when the legislative report was given. It had to do with the attitude of the legislative bodies, the Senate and the House of Representatives. What has changed to make our priorities so hard to achieve? There is no easy answer except to say that a convergence of several factors has made the Florida legislature and executive branch more difficult than ever to influence.

The FPS has lost its connection to powerful leaders who have in the past championed our causes and made them a priority. Through retirements and other ill fortunes, legislators who once forced consideration of children's issues are now gone. The remaining few face a difficult task of trying to overcome slimmer voting margins.

A shift in political power has given the Republican Party a very strong voice by controlling the Senate, and in the House of Representatives they are within six seats of attaining control there too. I mention this because most newly-elected Republicans have brought with them a "laissez faire" attitude towards government. This has been especially evident in promoting child safety issues such as the use of bicycle helmets, prohibitions on children riding in the back of pick-up trucks and mandatory seat belt usage. Many newly elected members simply do not want any governmental interference in their lives, no matter what the ultimate effect.

There was very evident this past session a contest between the Senate (Republicans) and the Governor (Democrats) over who has the political power to dictate State policy in health care, education and public safety (i.e., prisons). This contest has thwarted efforts to move forward in health care to insure standards, as managed care companies rush in to capture as much business as possible. Even with a speaker who has focused his priorities on children, a road block remains in the Senate, where sympathies run deep for the business community.

Everyone's efforts will be needed more than ever over the next several years to insure that children are not forgotten as govern-ments rush to economize in health care and cut government programs.

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Workers' Compensation Certification

Many members have been confused by the Health Care Praovider Certification Rule, effective March 14, 1995, which established the process whereby health care providers become certified pursuant to section 440.13(3)(a), Florida Statutes, in order to receive payment for treating work-injured employees.

The rule occupies many pages, but the important facts for pediatricians are contained in the exceptions: **physicians who treat less than twelve injured workers in a calendar year**, physicians providing emergency treatment, and certain specialists such as radiologists, pathologists and anesthesiologists. The occasional provider is required to comply with all other rules of the division when rendering treatment. **An application must be completed**, but the course work is not required. Create your exception: obtain an application from the Division of Worker's Compensation of the Department of Labor (904)488-3431, or your local medical society.

GLEANINGS FROM HERE AND THERE

(Items of interest to the membership, heard or seen around the State, the Nation, or the World)

Varicella Vaccine:

[Some of this report is repeated from the May Issue:]

Recommendation of the American Academy of Pediatrics:

"The Academy recommends varicella vaccine for routine use in children over 12 months of age who do not have a history of varicella. **A single dose should routinely be given between 12 and 18 months of age. Older children may be immunized at the earliest convenient opportunity, also with a single dose. Healthy adolescents past their 13th birthday who have not been immunized previously and have no history of varicella infection should be immunized against varicella by administration of two doses of vaccine 4-8 weeks apart."** [About 90% of all cases occur between ages 12 months and 14 years of age, 50 % between 5 and 9, justifying the schedule]

The need is real, again from the AAP:

"Of the 3.9 million estimated cases of varicella annually, about 90 fatalities are reported in the United States...Social and economic costs (estimated $399 million annually) are significant and include an average of 8.7 days lost from school and 0.5 to 1.8 days of adult caretaker time lost from work...**A cost-benefit analysis estimates a $384 million annual savings from routine, universal use...**"

In the last issue, our President, John Curran, offered cautions:

Varicella may not be an automatically covered benefit. Many managed care organizations have stipulated vaccinations in accordance with AAP schedules. This can be used to advantage with commercial insurance plans. Capitation contracts should be reviewed with regard to policies involving new vaccines and their potential fiscal responsibility. Some organizations have carved vaccines out from capitation, others have included them.

There appear to be many questions being asked by parents about the varicella vaccine. These are being asked of pediatricians, and of the manufacturer. Here are some, with ideas for answers.

1. **Why should I vaccinate my child against a rel-atively benign disease?**

Chicken pox is not a benign disease. Although most children seem to escape its ravages, the 90 deaths per year are prevent-able, and there are severe complications, including Staph or Strep skin infections (common), encephalitis (1.7/100,000 cases in children between 1 and 14 years of age), acute cerebellar ataxia (1/4,000 cases in children under 15 years of age), pneumonia (7.8/100 cases hospitalized), and of course Reye's Syndrome, now not very common. There is also some evidence that varicella during the first trimester of pregnancy may result in congenital varicella syndrome, including limb hypoplasia, chorioretinitis, cortical atrophy, and other abnormalities, as well as precipitating premature labor and delivery in the mother.

2. **How long will the vaccine protect my child from chicken pox?**

Evidence exists that there is significant protection (95%) against severe infection. There is no evidence so far of loss of immunity during 6-10 years of follow-up of healthy children. Until vaccine use becomes widespread, exposures to varicella will continue to provide "booster" effect; the need for booster doses will not be known until after this time period.

3. **Can the vaccine increase the risk of developing shingles later in life?**

It does not presently appear that there is increased risk. Rates of occurrence are about the same for those who have had varicella and those vaccinated. However, experience in this country is not yet of long enough duration to allow reassurances.

4. **Can the vaccine virus be transmitted from vaccinees to varicella-susceptible children or adults?**

Data are incomplete. There is reason to believe that virus particles are shed and may be able to produce disease in some groups, and close association with these high-risk individuals (newborns, pregnant women, the immune-incompetent should be avoided). Care should be exercised in utilizing the vaccine in such individuals or in families with such individuals.

[If you come upon other questions asked, send them in. We will reserve some space in the November issue to respond.

5. **May varicella vaccine be given with other vaccines?**

Varicella vaccine may be given concomitantly with MMR vaccine, using a separate syringe and a separate site. [I hear there is work in progress on combining the two vaccines.]

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Dr. Zissman has filed with the insurance commissioner a request for an advisory that varicella vaccine is one of the vaccines recommended by the American Academy of Pediatrics and should be covered under our CHIRP legislation.

Dr. Zissman advises that Blue Cross will be discontinuing conseling services by January 1, 1996.

An Alert

There is a proposed amendment to Rule 10D-3.088, F.A.C., to incorporate the recent recommendation of the Immunization Practices Advisory Committee (A.C.I.P.). A later issue will advise whether this amendment has become effective. The proposed amendment will:

1. Effective with the 1998/99 school year, require completion of the hepatitis B vaccine series for kindergarten entry and attendance.

2. Effective with the 1997/98 school year, require completion of the hepatitis B vaccine series, a second dose of measles vaccine (preferably MMR), and a tetanus-diphtheria booster for seventh grade entry and attendance. [Note that the last of these is at variance with the currently accepted time for dT. booster.]

READERS:

Do you have ideas you would like to share with your colleagues, tips on practice, short-cuts to better care for children, other thoughts? *The Florida Pediatrician* would like to receive guest columns, which will be published as space permits. Columns will be accepted on the basis of suitability for the Newsletter, and may need to be edited with approval of the writer for space and readability. Why not try your hand?

FROM THE LOCAL PEDIATRIC SOCIETIES

(Each month we will provide news from one of the local societies)

THE PEDIATRIC SOCIETY OF PINELLAS COUNTY

The Pediatric Society of Pinellas County held three meetings during the past year.

At our May 5th meeting of 1994, Dr. Heinz Eichenwald from Texas spoke on the subject of "New Antibiotics for the Treatment of Otitis Media".

Also at this meeting a recommendation was made to dedicate the new Emeergency Room at All Children's Hospital to the late Dr. Cordes, who passed away in June, 1994. Dr. Cordes was a long-time supporter of All Children's Hospital. Later in the year, the ER was named for Dr. Cordes at an assembly attended by many medical and civic leaders of St. Petersburg.

On December 8, 1994, we welcomed the distinguished Dr. Charles Bluestone, ENT physician from Pittsburgh. Dr. Bluestone included in his visit making rounds with All Children's Hospital ENT physicians and residents. The topic he chose to speak on at the December meeting was "Airway Obstruction in Children: A Problem Solving Approach to Diagnosis". The meeting was well attended.

At our meeting on January 12, 1995, Dr. John Barnes from All Children's Hospital in St. Petersburg spoke on "X-ray Puzzlers in Pediatrics". The meeting was held at the Stouffer Vinoy Resort.

Our Society continues to have an interest in supporting resident research projects at All Children's Hospital. This interest was conveyed to appropriate individuals at ACH.

Ways to increase attendance at meetings was discussed.

Stephen G. Nelson, M.D.
President

MEMBERSHIP ALERT!

Do you know any pediatricians, Fellows of the Academy or not, who appear to have been overlooked by the Society, and are therefore not members? **Contact the Executive Vice President.** There are several kinds of membership in the Society:

Fellow: A Fellow in good standing in the American Academy of Pediatrics - automatic membership on request.

Member: A resident of Florida who restricts his/her practice to pediatrics.

Associate Member: A physician with special interest in the care of children.

Military Associate Member: An active duty member of the Armed Forces stationed in Florida and limiting practice to pediatrics.

Inactive Fellow or Member: Absenting self from Florida for one year or longer.

Emeritus Fellow or Member: Having reached age 70 and having applied for such status.

Affiliate Member: A physician limiting practice to pediatrics and in the Caribbean Basin.

Allied Member: A non-physician professional involved with child health care may apply for allied membership.

Honorary Member: A physician of eminence in pediatrics, or any person who has mede distinguished contributions or rendered distinguished service to medicine.

Resident Member: A resident in an approved program of residency.

Medical Student: A student with an interest in chld health advocacy.

FROM THE SUBSPECIALTIES

THE FLORIDA SOCIETY OF PEDIATRIC NEPHROLOGY

The Florida Society of Pediatric Nephrology is a recogized specialty group of the Florida Medical Association. Florida physicians or Ph.D.s with major, continuing interest in pediatric nephrology are eligible for active membership. Curremtly there are twenty-seven active members. The last meeting was in June at the Sheraton Bal Harbour, in conjunction with the Florida Society of Nephrology. A joint scientific program was held, with discussions of dialysis efficiency, treatment of nephrotic syndrome, HIV nephropathy, and Hepatitis C and renal disease. Meetings are held in the Fall and in the Spring, the latter at the same time and location as the Florida Pediatric Society spring meeting. Current research projects and interesting cases are presented in addition to discussions of political issues affecting children with renal disease.

Over the past year, the FSPN has worked on practice guidelines for several common pediatric renal problems. Led by the immediate past president, Dr. Gaston Zilleruelo, we have embarked upon establishing a consensus for the evaluation of asymptomatic microscopic hematuria, urinary tract infections in children, and renal tubular acidosis. Sub-committees of three members for each topic have met to discuss the various approaches to these clinical problems and is in process of finalizing algorithms and suggested protocols of value to the practicing pediatrician in the initial evaluation and informed referral of children with these diseases. It is hoped that this work will be published in the FMA Journal, so that an appropriate, efficient, cost-effective evaluation for these problems can be available to pediatricians throughout the state.

The next meeting of the FSPN will be on October 14 at the Hilton at Walt Disney World Village in Orlando. Further discussions of the evaluation of common pediatric renal problems will be held, as well as presentation of interesting cases. Pediatricians interested in attending this meeting should contact the undersigned, at 1633 Physicians Drive, Tallahassee, FL 32308, Ph. (904)877-1162.

Frank C. Walker, Jr., M.D.
President

NOTICE

The Agency for Health Care Administration, Council of Licensed Midwifery seeks a certified pediatrician for membership on the Council, which meets three times a year. Members receive no pay but are reimbursed for travel and receive per diem. Call William H. Buckhalt, Executive Director, at (904)488-6015.

The Scientific Page

Molecular Genetics and the Astute Clinician

Jaime L. Frías, M.D.
Lewis A. Barness Professor and Chairman
Department of Pediatrics
University of South Florida College of Medicine

The last decade has witnessed notable advances in medical genetics. A true avalanche of new knowledge in molecular genetics and developmental biology is rapidly being transferred from the laboratory and is becoming part and parcel of clinical medicine. The Human Genome Project, created as an effort to construct genetic maps and elucidate the DNA sequence of the human genome and the genome of other organisms, has been a major contributing force to this progress.

New laboratory techniques and approaches that facilitate the study of human disease have been developed and clinicians are eager to apply them to the investigation of specific disorders. Indeed, it is rare today to read a scientific journal without running across reports on new findings that either enhance our understanding of diseases with complex and multifactorial etiologies, such as cancer, diabetes, and autoimmune disorders, or expand our knowledge of the molecular basis of monogenic diseases or syndromes. Take, for example, the skeletal dysplasias, a group that comprises more than 200 inherited disorders of the skeleton and which, albeit individually rare, collectively constitute an important segment of congenital malformations. Major advances in the understanding of the molecular genetics of these disorders have been reported in the last two years.

In early 1994, achondroplasia, the most common form of dwarfism and the prototype of this group of disorders, was found to be linked to the area in the short arm of chromosome 4 distal to an anonymous marker, *D4S43*. This region, thoroughly studied in the immediate past, because of its closeness with the locus for the Huntington disease gene, was known to contain the gene coding for fibroblast growth factor receptor 3 (*FGFR3*). By virtue of its known function - expression in cartilage and brain and mediation of the effect of fibroblast factors in chondrocytes in a mouse model - *FGFR3* became a strong candidate for the achondroplasia gene. Later in the year, two groups of investigators independently identified mutations of this gene in patients with achondroplasia. The specific mutation, reported in more than 200 cases thus far is a guanine to adenine transition in nucleotide 1138, resulting in the coding for glycine instead of arginine at position 380 in the mature protein. Only one patient studied had a different mutation, a guanine to cytosine substitution at the same position.

Other distinct mutations of the *FGFR3* gene have been identified in a significant proportion of patients with hypochondroplasia, a condition similar to but less severe than achondroplasia, and in patients with thanatophoric dysplasia, which constitutes the most common form of perinatally lethal skeletal dysplasias.

Mutations in two of the other fibroblast growth factor receptor genes, the *FGFR1* and the *FGFR2* genes, have been described in some of the acrocephalosyndactilies - i.e., Apert, Pfeiffer, Jackson-Weiss, and Crouzon syndromes - a group of skeletal dysplasias characterized by varying degrees of craniofacial and limb abnormalities. In addition, a recent report has identified mutations in a region of the cartilage oligomeric matrix protein (*COMP*) gene that encodes a Ca binding motif in patients with pseudoachondroplasia and with multiple epiphyseal dysplasia, demonstrating that both conditions are allelic.

In other skeletal dysplasias, while the gene has not yet been sequenced, linkage studies have identified their loci and candidate genes are under close investigation. Such is the case with pycnodysostosis, the disease that probably affected the famous French painter, Henri de Toulouse-Lautrec. Different investigators have described linkage of this disorder to the long arm of chromosome 1, specifically *1q21*. Two strong candidate genes exist in this region - the interleukin-6 receptor gene (*IL6R*) and the myeloid cell leukemia-1 gene (*MCL1*) - both involved in the differentiation of monocyte/macrophages into osteoclasts, which is the most likely site of the primary defect in this condition.

This progress, that affects many different areas of medicine, is the result of combined efforts of basic researchers and clinicians. It is important to emphasize that the elegant laboratory work leading to these discoveries would not have been as successful, or perhaps even possible, without the contributions of clinicians who meticulously study and identify the disorders under investigation. The thorough and careful delineation of phenotypes has proven to be not just an enjoyable academic exercise but the heuristic base leading to the defin-ition of the molecular genetics of many of these syndromes. The astute clinician who recognizes minor and/or major departures from the morphologic norm in his/her newborn patient is, in a sense, initiating the chain of discovery. The specialist may help define additional aspects of the disorder, but it is the primary care physician who is in the best position to document and define the characteristics and the natural history of the disease. Splitting or lumping becomes then a logical corollary of these observatins. While clinical heterogeneity usually heralds causal heterogeneity, disorders that appear phenotypically different may be the result of the same mutation and simply represent different shades in the spectrum of gene expression. On the other hand, disorders that appear clilnically similar may have different modes of inheritance, different prognoses, and be the result of different genetic defects. Throughout the ages, astute clinicians have recognized these issues and the fact that, in most cases, the genetic specificity of a phenotype is merely an inference. A close collaboration between the practicing physician and the molecular geneticist will help generate additional knowledge that, in turn, will help us better understand phenotype-generated correlations. The benefits that our patients and their families can derive from this are immeasurable.

References:

1. Bellus GA, McIntosh I, Smith EA, et al (1995): A recurrent mutationn in the tyrosine-kinase domain of fibroblast growth factor receptor 3 causes hypochondroplasia. Nature Genet 10:357-359
2. Francomano CA (1995): The genetic basis of dwarfism. N Engl J Med 332:58-59
3. Gelb BD, Edelson JG, Desnick RJ (1995): Linkage of pycnodysostosis to chromosome 1q21 by homozygosity mapping. Nature Genet 10:235-237
4. Muenke M, Schell U, Hehr A, et al (1995): A common mutation in the fibroblast growth factor receptor 1 gene in Pfeiffer syndrome. Nature Genet 8:269-274
5. Mulvihill JJ (1995): Craniofacial syndromes: no such thing as a single gene disease. Nature Genet 9:101-103
6. Schell U, Hehr A, Feldman GJ (1995): Mutations in *FGFR1* and *FGFR2* cause familial and sporadic Pfeiffer syndrome. Hum Molec Genet 4:323-326

EMPHASIS ON ADOLESCENCE

Emphasis on adolescence continues with this third in a series of four articles for 1995.

THE PELVIC EXAMINATION

As the American Academy of Pediatrics has encouraged comprehensive health care for patients up to age 21 years, more pediatricians are retaining adolescent females in their practices. Knowledge of maturational changes,

gynecologic problems, and sexuality concerns are therefore important. Few components of the complete physical examination, however, evoke as much anxiety for doctor and patient as does the pelvic exam. Yet, a sensitive and caring approach, plus familiarity and skill with the technique, will ease the exam and hopefully sensitize the patient positively for future encounters. The pediatrician who has made the genital exam a routine part of total health care has already demystified this component within a health care setting.

Reviews of normal anatomy, sexual maturity ratings (Tanner stages), menstrual physiology, history-taking styles, and consent/confidentiality principles may be found in standard textbooks, AAP's Adolescent Health Update series, or in gynecologic literature. These are worth-while topics for other adolescent patient encounters as well. While parental involvement is ideal and should be encouraged, many adolescents will require confidential attention.

The accompanying table lists equipment and supplies needed for the pelvic examination. They do not require any special storage techniques, and all are easily obtainable. It may be helpful to have an examination room designated for this purpose. Office staff should be familiar with scheduling appropriate time for the exam, handling specimens and laboratory forms, and billing procedures. A female chaperone is recommended to assist the examiner, help to alleviate any patient anxiety, and to address medicolegal concerns.

An initial pelvic examination for health screening is recommended by the American College of Obstetricians and Gynecologists for all females at 16-18 years of age. It should be performed earlier if the adolescent is sexually active, has gynecologic symptoms, or requests the exam. Ideally, it should be performed prior to sexual activity so that abstinence, contraception and sexually-transmitted diseasese can be discussed. Common gynecologic complaints prompting pelvic examination include vaginal discharge, menstrual disorders, unexplained abdominal or pelvic pain, severe dysmenorrhea, delayed menarche, and suspected pregnancy. For sexual assault evaluation, referral should be made to forensic experts. It is a good idea to have a working relationship with a local gynecologist who interacts well with teenagers, for referral of problem cases and pregnancies.

Prior to the actual pelvic examination, it is necessary to take a detailed gynecologic and sexual history. Seeing the patient alone, assuring confidentiality, and giving rationale for questions all help to establish rapport. This is done ideally while the female is still clothed. If this is her first examination, a step-by-step description of what is to follow should be given. Specific information regarding pubertal changes and sexual maturation should be obtained. Age of menarche, menstruation characteristics (interval between, duration of periods, amount of flow, associated symptoms), and date of last menstrual period are important.

Specific sexual activities, use of contraceptives, history of past pregnancies or sexually transmitted infections, and knowledge of such topics will likely steer the conversation. Education and counseling about sexuality principles often occur during this encounter. From the history, diagnostic possibilities may be entertained even before the actual pelvic examination is done.

Several basic steps are included in a full pelvic examination. The patient should have an empty bladder, be draped as necessary for modesty, and be positioned on her back in a frog-leg fashion with feet in stirrups (lithotomy position). Explanation of what to expect is helpful, as are videotapes, booklets, and pelvis models for demonstration. Continuous dialogue may help to reduce anxiety. The examiner should wear gloves, have good lighting, and not rush.

Inspection of the external genitalia should proceed, noting the Tanner stage, any vulvar lestions, any abnormalities of the clitoris, and the appearance of the hymen. Inguinal lymph nodes should be palpated.

To inspect the internal genitalia, it is necessary to use a speculum of appropriate size. It should be passed into the vagina through spread labia while blades are closed. Aim caudally, being careful to avoid contact with the sensitive urethra. Upon opening the blades of the speculum, the vaginal walls and exocervix may be inspected for discharge, lesions, and inflammation. Touching the vaginal wall with pH paper should be done. Cytologic and infection tests are done next. The Pap smear should be done first before cervical cells are disturbed. use the method recommended by the laboratory to whom samples will be sent for interpretation. An Ayre spatula, cytobrush, cotton swab, or DNA probe may be used. Fix the sample immediately on a glass slide. Samples for gonococcal culture and chlamydia test should be taken next according to directions on the kits used. Vaginal pool sampling may be done for the wet-mount preparation to detect yeast, trichomonas organisms, or white blood cells. Close the blades before removing the speculum from the vagina. Although an intact hymen will dilate to allow passage of a speculum, this is rarely indicated.

Bimanual palpation of pellvic structures is done next, with lubricated gloved fingers internally and the opposite hand palpating the abdomen externally. Pressing on the cervix and uterus will allow assessment of any tenderness or enlargement. Palpating each of the adnexa also will allow assessment of any tenderness, mass, or enlargement. A rectovaginal exam is done, if indicated, for evaluation of posterior pelvic contents or rectal complaints. A rectoabdominal bemanual exam is sometimes helpful in a female whose hymen is intact.

After the examination, allow the patient to dress in private. Then thoroughly explain any abnormalities or treatments. Allow time to answer questions and counsel or educate as necessary. Brochures and other teaching handouts may help to reinforce the information. Asking the young female to recite back what is her interpretation of your explanation will allow for assessment of proper understanding. Any misinformation can then be corrected. Be sure to arrange follow-up plans for subsequent appointment and communication of any pending laboratory tests. Remember to maintain confidentiality as necessary.

The pelvic examination is an important component of health care. It represents a milestone in the female adolescent's maturation toward adulthood, allowing for self-responsibility and independent thought. With special attention to the unique needs of this age group, pediatricians may help to make this examination a positive experience.

Equipment and Supplies for Pelvic Examination

Exam room with running water
Adult-size exam table with stirrups
Good light source (gooseneck or similar)
Gowns, drapes
Disposable gloves
Water soluble lubricant, tissue, pads
Disposable specula (virginal, medium Pederson)
Pap smear materials (Ayer spatula, cytobrush, glass slide, fixative)
Infection test materials (gonorrhea culture, chlamydia test, pH paper)
Wet-mount materials (10% KOH solution, normal saline, glass slide, microscope)

Suggested references

Emans EJ, Goldstein DP. *Pediatric and Adolescent Gynecology*, 3rd Ed. Boston, Little Brown and Co., 1990

Strasburger VD (ed.) *Basic Adolescent Gynecology: An Office Guide.* Baltimore, Urban and Schwarzenberg, 1990

Beach RK. Female Genitalia: Examination and Findings, in *Comprehensive Adolescent Health Care*, Friedman SB et al (eds.). St. Louis, Quality Medical Publishing, Inc., 1992, pp956-962

The Medicaid Problem

This year, Congress is expected to act on proposals to restructure Medicaid in order to control federal spending and increase state flexibility in the use of federal funds. The AAP reaffirms its commitment to the objectives of its "Children First" proposal, calling for the replacement of Medicaid with a one-tier, private insurance system of universal access to health care for all children through age 21 and all pregnant women. Until such or similar health care reform is implemented, we must protect the national safety net that Medicaid provides. **The AAP therefore recommends:**

- Maintain the entitlement status of Medicaid;
- Oppose Congressional efforts to legislate unrestricted Medicaid block grants for the states;
- If Medicaid block grants are enacted, the following protections must be included to assure children's access to care:
- A state maintenance of effort clause requiring both the use of the same eligibility criteria in place on January 1, 1995 and the same level of state funding budgeted on that date. Future state Medicaid funding levels must be increased through a formula which takes into account increases in the cost of medical care.
- States should have access to a federally funded "rainy day fund" or a similar mechanism to prevent states from having to reduce the Medicaid program during periods of increased eligibility in the population due to a number of factors (e.g., economic downturns) when it is most needed.
- Accountability for and entitlement to the preventive care and expanded services mandated under the EPSDT component must remain, and
- Children and adolescents must retain access to appropriately trained and certified providers of pediatric care.
- If Medicaid spending is capped at the federal level with eligibility standards and a basic benefit package maintained as an alternative to or in conjunction with state block grants, a reasonable cap must be employed which allows for a pre-determined level of growth based on reasonable expectations of future cost of health care for vulnerable populations.
- Federal and state governments must require adoption and monitoring of performance standards and measures to assure receipt of services by eligible children, especially where managed care is involved. Performance standards must be readily measurable and outcome based.

There is an **Opposing Point of View**:

- Because of federal bureaucratic micromanagement, incremental reform won't work; what is needed is "sweeping reform" - i.e., converting the program into a block grant to the states, who will "get the job done" because they are "laboratories of innovation" and "closer to the people".
- Central to the block grant concept is broad "flexibility" to all the states to "innovate". Some governors define "flexibility" as meaning no individual entitlement or other "set asides" for specific populations and no requirement that states match federal funds or maintain any level of effort.

(continued next column)

- We're not cutting Medicaid, just limiting increase in the rate of growth in federal spending to bring the program back to a "sustainable" budgetary path.

As members of the Academy, there are **questions we need to consider:**

- How will the Medicaid "reductions in growth" affect your state [of Florida]?
- If no federal protections are built into a block grant, how many children will be taken off the Medicaid roles?
- Where will they go?
- Will the benefits currently provided by Medicaid be cut back?
- What about reimbursement?
- What does a block grant mean in terms of funding, eligibility, and benefits for your state [of Florida]?

* * * * *

Children's Television

The Academy recently circulated the following:

The Children's Television Act of 1990 (H.R. 1677) establishes rules in two major areas, advertising and programming, and directs the Federal Communications Commission (FCC) to consider the extent to which stations have complied with the rules in its review of broadcast license renewal applications.

Rationale for the law:

- "...it has been clearly demonstrated that television can assist children to learn important skills, values, and behavior, while entertaining them and exciting their curiosity to learn about the world around them"
- "...special safeguards are appropriate to protect children from overcommercialization on television"
- "...television station operators and licensees should follow practices in connection with children's television programming and advertising that take into consideration the characteristics
  of the child audience"

Limits on children's ads:

- "...each commercial television broadcast licensee shall limit the duration of advertising in children's television programming to not more than 10.5 minutes per hour on weekends and not more than 12 minutes per hour on weekdays"

Program requirement:

- "...[serve] the educational and informational needs of children through the licensee's overall programming, including programming specifically designed to serve such needs"

Outreach considerations:

- "...any special non-broadcast efforts by the licensee which enhance the educational and informational value of such programming"
- "...any special effort by the licensee to produce or support programming broadcast by another station in the licensee's marketplace which is specifically designed to serve the educational and informational needs of children"

Establishment of National Endowment for Children's Educational Television:

- "...to enhance the education of children through the creation and production of television programming specifically directed toward the development of fundamental intellectual skills"

[Ed.: Do your stations comply? Let each of us be the watchdog!]

Letters to the Editor

(Please send letters to the Editorial Office. Letters may be edited for length to conform to space constraints, or to improve readability.)

To the Editor:

I recently read an article in the *Florida Ophthalmologist*, which is the newsletter for members of the Florida Society of Ophthalmology, describing primary eyecare and giving a definition of a good general ophthalmologist.

By the writer's definition, a good general ophthalmologist is able to treat simple strabismus and refractive errors in children. This is definitely a misnomer, because there is no simple strabismus and it is very difficult to refract a child below three.

Let me give you an example of a referral that I saw just this week. The patient is a 2½ year old with an onset of esotropia at 1 year of age. The referring ophthalmologist is a good general ophthalmologist, who normally performs cataract surgery. Glasses were tried before surgery but the patient refused to wear them, and in May 1995 an operation was performed. The referral was made to me because the good general ophthalmologist had done all of the surgery that he could do and the eyes were still crossed. Fortunately, there is no evidence of amblyopia, as there is an alternating esotropia with good fixation in both eyes. The patient has 30 diopters of esotropia and a refractive error of +5.50 in each eye. The patient is a Medicaid patient.

This is a classic case of accommodative esotropia, and glasses should be tried before surgery is attempted. If there is a significant esotropia with the glasses on, then that amount should be operated on and not the full amount of crossing. This is a very difficult case to handle, because the patient is a typical 2 year old and refuses to wear the glasses. I, as a pediatric ophthalmologist, know ways of trying to get the patient to wear the glasses, such as arm restraints and atropine eyedrops. I would never operate on a patient like this without taking into consideration the accomodative effect of the +5.50 refractive error.

Good general ophthalmologists are not pediatric ophthalmologists, and you should be aware of this. As managed care reduces the access to patients, it behooves pediatricians to know who takes care of pediatric eye cases and to stand up for their patients and make the proper referral for the good health of the patient.

Stanley I. Hand, Jr., M.D.
Orlando, Florida

I read [Dr. Borrell's] excellently written and expressed Letter to the Editor with interest. If you refer to the third paragraph of my letter to Dr. Bjornstad, printed in the November [1994] issue of *The Florida Pediatrician*, you will see a major concern that I have. It is a moot point when we speak of managed competition or managed heaalthcare. They are intimately intertwined. And they will not successfully control healthcare costs or enhance healthcare delivery.

To answer the question "Do you feel that this bureaucracy would have a bigger heart and more understanding than the insurance companies?", I do feel that we may have a better chance of effecting change, securing freedom of choice, negotiating fees, and saving dollars in a properly designed single payor system. It is a matter of with which entity we can best deal, not a matter of "heart".

Please read Dr. Edward Williams' comments in the May 1995 issue of *The Florida Pediatrician* regarding capitation. This is the managed care/managed competition method of decreasing their risk and controlling cost at the expense of patients and physicians. Capitation is coming down the pike like a hugh steamroller. Just look at California.

We simply must, very thoroughly, evaluate a single payor system. Single payor means just that - one entity pays the bill. Administrative savings can be major. Will it be perfect? No. Will it return us to the "good old days? No.

What has happened in the financing and delivery of healthcare may have been inevitable. However, the public because of apathy and poor health habits, the medical profession because of abuse and apathy, the business community and government because of failure to address tort reform, and the advancement of technology have all hastened the progress of these changes. We must now seek the best remedy.

David A. Cimino, M.D.
St. Petersburg, FL
Past President

[Edited from Dr. Cimino's response to Dr. Borrell]

To the Editor:

UPCOMING CONTINUING MEDICAL EDUCATION EVENTS

THE FLORIDA PEDIATRICIAN will publish *Upcoming Continuing Education* events planned. Please send notices to the Editor as early as possible, in order to accomodate press times in February, May, August, and November.

Program: Space Coast Pediatric Conference
Dates: September 29-30, 1995
Place: Cocoa Beach Hilton Hotel, Cocoa Beach, FL
Credit: 10 hours Category I for AMA Physicians Recognition Award.
Sponsor: University of South Florida College of Medicine, Department of Pediatrics
Inquiries: Mrs. Rebecca Scott, (813)272-2744

Program: Managed Care in Your Child Health Practice
Dates: October 6-7, 1995
Place: University of Iowa Hospitals and Clinics, Iowa City, Iowa
Credit: 9.5 hours Category I for AMA Physician Recognition Award
Sponsor: U. Iowa College of Medicine and AAP District VI
Inquiries: Ms. JoAnn Mandelscheid, (319)356-3462

Program: 13th Annual Care of the Sick Child Conference
Dates: November 7-10, 1995
Place: Hilton at Walt Disney World Village, Lake Buena Vista, FL
Credit: 21 hours Category I for AMA Physician Recognition Award
Sponsor: Orlando Regional Healthcare System
Inquiries: Patti L. Devlin, (800)648-0450

Program: Advances in Respiratory Care of the Newborn
Dates: November 9-11, 1995
Place: Sonesta Beach Resort, Key Biscayne, FL
Credit: 20 hours Category I for AMA Physician Recognition Award
Sponsor: U. Miami Dept.of Pediatrics, Div. of Neonatology
Inquiries: Charles R. Bauer, M.D., (305)243-5808

Credit: Credit has been applied for, but notice not received by time of publication
Sponsor: Florida Association of Pediatric Tumor Programs
Inquiries: Ms. Susan Easter, (813)632-1309

Program: 5th Annual Masters of Pediatrics: Leadership Conference Exploring Contemporary and Future Pediatrics
Dates: January 25-29. 1996
Place: Fontainebleu Hilton, Miami Beach, FL
Credit: 22.5 hours Category I for AMA Physician Recognition Award
Sponsor: Department of Pediatrics, University of Miami School of Medicine
Inquiries: Fran Fabrikant, (305)243-3994, FAX (305)243-4050

Program: 31st Annual Pediatric Postgraduate Course
Dates: January 28-February 1, 1996
Place: Sheraton Bal Harbour Resort, Miami Beach FL
Credit: 24 hours Category I for AMA Physician Recognition Award
Sponsor: Miami Children's Hospital
Inquiries: Donald H. Altman, M.D., (305)666-6511, ext. 4366

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Program: Advances in Pediatric Hematology/Oncology
Dates: November 16-18, 1995
Place: Sheraton Plaza Hotel, Orlando, FL