THE FLORIDA PEDIATRICIAN

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

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THE PRESIDENT'S PAGE

[This month's column is contributed by our Vice President]

Greetings and best wishes to all. I have been directed by our august and estimable President to author this month's Presidential page, I presume as one of his various (and variably successful) strategies to groom me for elevation to his position. While this has probably been a hard pull on his part, I certainly appreciate the effort and plan to do my best to justify the confidence.

For the membership, a couple of requests:

You will soon receive a listing of the resolutions to be considered at the annual Chapter Chairmen's Forum, as an insert in AAP News. There will be a mechanism for communicating to the Chapter leadership your wishes for consent (or otherwise) for each resolution. Please take a moment to do so. If you feel strongly about an issue, please call, fax or e-mail, or write John Curran or me and we will do our best to represent the views of the membership on the floor of the Forum.

This is one of the primary ways to bring your opinions to the National AAP. The Chapter Forum is in early September. Our responses from the membership in the past have often been dismally sparse, so if you care, now is the time to speak up!

Second, remember that October is Child Health Month, for which the theme is once again

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"...a listing of the resolutions [for] the Chapter Chairmen's Forum..."

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Violence Prevention. Press kits and reproducible information sheets are available to you and your patients through the AAP (or your Regional Representative) and brochures are available through the usual ordering channels.

Probably many of you are familiar with the ongoing discussions regarding the possibility of the AAP redistricting. District IV currently has approximately twice the membership of some other districts, which leads to relative underrepresentation in some national AAP functions. This is under discussion (and negotiation) in various fora of the Academy. Comments and opinions are welcome. Be aware that this *is* a current interest of Dr. G. Schiebler, so any negative opinions are tendered at your own risk!

We now have additional (sorely needed and greatly appreciated) administrative assistance in the form of Edie Lovingood, who occupies a virtual office somewhere in the bandwidth (for net aficionados) of Tallahassee, who will answer to fpscaap@medone.org. She will undoubtedly respond if you write to Louis St. Petery.

Various of the appropriate officers and committees of the FPS/FCAAP are in process of trying to sort out or ameliorate concerns of the membership having to do with the more onerous aspects of dealing with managed care, HCFA issues, etc., as they come to light. Some of this is heavy slogging, so keep us informed, and we will do our best.

With warmest regards.

Edward T. Williams III, M.D.
Vice President

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THE EDITORIAL PAGE

Child Health Month is Coming!

Summertime is a time when most people expect to "take it easy". We are like other people, and we too may expect to take it easy - or at least easier. The winter respiratory season is behind us, till next winter. The "polio season" is a thing of the past, fortunately, even though polio is not yet extinct. In many areas, some children are away - at camps or on vacation with their parents. Even we may be away for a while. And there are less meetings to go to during the summer.

So, isn't this the time to do less? Perhaps; but many of us do not have minds that turn off easily; we champ at the bit when there is less to do. So, this becomes a time for reflection, a time for planning, and a time to worry over what else it is we should be doing (that funny feeling all of us have had from time to time). The inevitable question for pediatricians and other health care givers to children comes up at this time: "Are we doing *enough* for *enough* children?"

Recently, I have become aware that children are no longer our "patients". Some years ago, they became our "clients", thanks to insurance companies, and to a degree to social agencies. Now they aren't our "clients" anymore. Now they are our "customers" - part of the new managed care world! All this may not be surprizing to the old-timers, but this denigration of our professionalism is merely on the outside. To most of us, we are still the professional advocates for children that we always have been, still concerned with "doing enough for enough children". And still worried whether the new order will be good for children, or whether we are taking steps in reverse gear.

"patients?"
"clients?"
"customers?"
Or, still patients to us?

So, with Child Health Month fast approaching, we need, both individually and collectively, to answer the question. Our availability to examine, immunize, and advise is not enough, even where appropriate for the changing scientific times. Access must be measured by utilization - by reaching *all* of the children with our knowledge and talents.

This newsletter is one way. Many of the items included bring knowledge and methodology to our almost three thousand readers. The AAP column helps. So does the newer "CATCH Corner". And so does the point-counterpoint column on managed care.

Our scientific page has been successful in bringing new happenings to the members. And our reports from the eight regions not only tell regional members what is going on but also communicates these matters to those in other regions, often of help to them.

These are examples of how your society participates - for you. Add to this the willingness of the Academy spokespersons within the state to be available to the media, and all together this becomes a monumental contribution by FPS/FCAAP. Our legislative agenda is another way. How can we better pay tribute to those who work so hard for children each spring in Tallahassee than to publish herein (see page 6) some of the results of their labors.

"...not just a month but all year..."

All this pales next to what the individual can accomplish, in his own area, by caring well for children, by educating those he knows and those not yet found, by volunteering care for the medically indigent, by media appearances, and in myriad other ways.

So, with Child Health Month soon to come in October, your Society joins you in saying: "Not just a month, but all year!". *-The Editor*

THE "GRASS ROOTS"

THE REGIONAL REPRESENTATIVES REPORT

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

Region II reports:

Northeast Florida is undergoing many changes in regard to pediatric practice these days. Duval County is now in Stage III of managed care (greater than 60% enrollnent, institutions consolidating, private practitioners joining salaried entities). Two years ago there were 13 separate independent hospitals in the district. Now two hospitals have closed and the others have coalesced into four hospital systems with additional attrition still likely. With Stage IV approaching (80% enrolhnent, capitation) it appears that the private practice of pediatrics may soon be ending. These changes are particularly difficult for resident training hospitals as both insurance companies and government are becoming increasingly resistant to financing medical education. Teaching hospitals cannot pass on education costs to service billings and still remain competitive for managed care contracts. These pressures force strange bedfellows, i.e., University Hospital, the urban teaching site of the University of Florida, is simultaneously buying primary care practices, joining with county public health clinics, adding school based clinics and contracting with a for profit management company (Columbia Health Systems).

Fortunately for children, the Children's Health Center, an agreement between the Department of Pediatrics, University of Florida/Jacksonville, Nemours Children's Clinic, Wolfson Children's Hospital and University Medical Center, continues to provide a single system of pediatric indigent and subspecialty care in a cooperative manner. This includes movement of the Children's Heart Program from University Medical Center to Wolfson Children's Hospital, the joining of pediatric Public Health Clinics with the Department of Pediatrics and development of public school based pediatric offices under a Jessie Ball duPont grant as Nemours withdrew from their inner city primary care satellites.

I want to congratulate Dr. Robert Miller, Chief of Pediatric Cardiology, for being the recipient of the first endowed chair in the Department of Pediatrics.

In January we welcomed Dr. Robert Kettrick as the new Medical Director of Nemours Children's Clinic, replacing Dr. Morey Haymond, who is returning to academic medicine at Baylor University. Dr. Kettrick was formerly the Chairman of Pediatric Anesthesia and Critical Care at the Alfred I. duPont Institute in Delaware.

There has been a little mix-up in the District II election for alternate. Dr. Jerry Bridgham was in line for the position as President of the Northeast Florida Pediatric Society (NEFPS) and won the seat in our District II vote. Unfortunately neither Jerry nor the president-elect of the NEFPS feel that they can devote sufficient time to the position so we will have another election before the next FPS executive committee meeting.

Finally, through the outstanding efforts of John Curran, Gerry Schiebler and Paul Wharton, children's issues were supported in the latest legislative session. These pediatric activists, and I'm sure I'm failng to include many others, were able to encourage legislation that (1) brought most children's health services out of HRS and into a physician-directed Department of Health, (2) passed bike helmet legislation, (3) provided for physician directed newbom hospitalization and (4) obtained sufficient fimds for completion of the statewide poison center program. All this was done when the legislative mood was to cut funds, cut programs and reduce government. We should all be proud of The Florida Pediatric Society legislative comniittee.

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

Region VI reports:

The last session of the Florida Legislature has shown the first stages of a backlash against child abuse prevention. Under the guise of "reform" and "parental rights", a nationwide campaign is underway that would allow abuse to be called acceptable discipline and delay the acceptance of reports by the authories until serious damage has already occurred. The American Academy of Pediatrics is aware of this trend and has asked us to be on the lookout for the following ruses:

1. *Elimination of anonymous reports.* However, these reports are no more likely than any other reports to be unproveable and valid reports may not be made due to fear of retribution.
2. *Cutting down on invalid reports.* Nationwide, 30-40% of reports are confirmed as abuse. Not all the rest are "false". In perhaps an equal number abuse is not able to be proven.
3. *Waiting until abuse is certain before it can be reported.* Everyone wants to stop child abuse before it gets so serious that it is obvious to even the most casual observer. Early intervention may allow for effective prevention and counseling services and avoid the need to remove the child from the home.
4. *HRS is so insensitive and aggressive that many children are frivolously removed from their parents.* HRS has enough trouble handling all the serious calls they get to be overly aggressive with minimal cases. All caseworkers know that they will have to prove their case before a judge within 48 hours. If the aim is to improve the performance of caseworkers the more appropriate course is to improve their pay and working conditions to attract suuperior personnel and have them stay in their jobs long enough to get good at it.

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

Kudos

...to John S. Curran, M.D., President of the Florida Chapter AAP/Florida Pediatric Society, upon his appointment as Executive Associate Dean for Academic Affairs at the College of Medicine, University of South Florida. We wish him well in his new position. Fortunately, this appointment will not affect his presidency of our organization.. *Our congratulations!*

EDITORIAL OFFICE

Editor:

Herbert H. Pomerance, M.D.
Department of Pediatrics
[redacted]
Tampa, FL 33612
(Ph)813/272-2710
(Fax)813/272-2749
e-mail: hpomeran@com1.med.usf.edu

(Please address all correspondence, including *Letters to the Editor*, to this address)

Report of the Committee on School Health and Sports Medicine

David A. Cimino, M.D.
Chairman
St. Petersburg, FL

This past year Dr. John Curran, president of the Florida Chapter, combined the Committees on School Health and Sports Medicine to form one Committee to address issues affecting both of these areas. At the present time this seems to be an appropriate recommendation. Since I serve on the Committee on School Health of the American Academy of Pediatrics, he requested that I chair this committee. One of my main goals in writing this brief column is to solicit interest in committee membership and ideas regarding committee agenda.

I currently have three issues that I will be addressing:

1) To encourage and facilitate involvement by members of the Florida chapter in School Health/Sports Medicine issues in their local school districts. Each school district has a mandated school health advisory committee and we should encourage physician membership on these committees.

Goal: To have a member of FPS involved in every school district throughout out the state.

2) To develop uniformity and utility in the athletic pre-participation evaluations. This from district to district, is often superficial, and represents missed opportunity for appropriate interaction.

Goal: To have each school district adopt the AAP protocol and forms.

3) To seek clarification and uniformity in the timing of the pre-participation physical exam, and the signing of the certification for participation. Since this is governed by the Florida High School Athletic Association, but interpreted by local school districts, I plan to work with FHSAA to achieve agreement on appropriate timing.

Goal: To expand the time during which the pre-Participation physical can be done and clarify the purpose and timing of certification.

If we are able to accomplish these goals we will significantly and appropriately involve the Florida Pediatric Society in partnership with education and other health agencies in our state. Other issues will manifest themselves and we will have the framework for interaction.

I request that any member having a desire to participate please contact me and let me know in what capacity you want to be involved. Also let me know of any specific issues of concern. My Fax number is (813)892-8804; e-mail address is ciminod@allkids.org.

Kudos

...to Edward J. Salzman, M.D., who is the recipient of the Clifford E. Grulee Award for 1996. Dr. Salzman is honored for his many years of contribution to the American Academy of Pediatrics, particularly in the area of education of pediatricians on practice management methods. *Our congratulations!*

Report of the Committee on Ennvironmental Health, Drugs and Toxicology

Charles F. Weiss, M.D.
Chairman
Siesta Key, Florida

There has been considerable publicity and notoriety in the press concerning the danger from lead in mini-blinds. However, in a four-hour search via America on Line and Physicians on Line, I found the only references on AOL. Apparently, there is considerable danger, and all pediatricians need to be aware of this.

June 27th, New York Times, with byline Patricia Leigh Brown:

"Imported Blinds Pose Lead Risk to Children"

June 30, New York Times, with byline Susan Gilbert

"Blinds: Get the lead Out"

Both articles are rather straightforward and should not cause hysteria. Important phrases and quotes are documented below:

June 27 article:

...Consumer Products Safety Commission determined that imported vinyl miniblinds 'can' present a lead-poisoning hazard to young children...

After two months of testing, the Government agency reported that non-glossy vinyl mini-blinds, imported from China, Taiwan, Mexico and Indonesia, and bought for $5 to $10 a window, would eventually deteriorate forming lead dust that poses a health hazard to children 6 and younger...estimates that 25 million such blinds were sold in the U.S. in the past year.

...problem came ...to light...in Arizona and North Carolina, ...when isolated by health officials (blinds) as a cause of lead poisoning to children iln mobile homes where no lead-base paint was present.

Following are quotes from a CPSC spokesperson:

...blinds manufactured in the U.S. have not used lead as a stabilizer...

...the vinyl in some mini-blinds deteriorated from exposure to sunlight and heat, causing lead dust to form on their slatted surfaces... When they come out of the box, they aren't harmful...but...there are other types of stabilizers...The stabilizers are used to bond molecules of plastic.

Landrigan calls the commission's action "prudent and reasonable" ..."This seems like an unnecessary use of lead"

..."the government hasn't asked for a recall"...

Sunday, June 30 article:

...non-glossy blinds deteriorate in sunlight or heat within a couple of years [a point to note in Florida]. This lead acts as a binding agent...Young children, whose fingers are often in their mouths can easily ingest dust and suffer lead poisoning within a month's time! [Do not have substantiating data for time element (cfw)].... the risk is not nearly as great as that posed by lead in imported crayons...

American vinyl and aluminum blinds contain no lead. Some foreign manufacturers are voluntarily making lead-free vinyl blinds, which will be labelled when they appear in stores...

..."It is reasonable for parents who are concerned about their children's exposure to lead in mini-blinds to have them tested", said Jerry M. Hershovitz, Acting Chief of Lead Poisoning Prevention at the CDC. "But the threat posed by mini-blinds and other potential sources is not enough to justify universal testing", he said..."I think we need to put this into perspective", Mr. Hershovitz said. "The imported vinyl mini-blinds are an unnecessary and avoidable addition to lead in households. But we can remove the blinds."

[Thanks once more to Chuck Weiss, for a timely and important report on a potential source of problem for all of us. After the first volley, there appears to have been no follow-up, but this does not negate the threat. -Ed.]

REPORT FROM THE 1996 REGULAR LEGISLATIVE SESSION

The 1996 Regular Legislative Session concluded on schedule with mixed results for the priorities of the Florida Pediatric Society. The Society was unsuccessful in stopping medical malpractice legislation which expands the statute of repose for children and the child abuse legislation which redefines abuse for purposes of investigation. However, the Society counts among its successes the passage of legislation involving time limits for newborn hospital stays, a separate Department of Health to include Children's Medical Services programs, teenage driving restrictions, requirements for bicycle helmets for children under 16, HMO coverage of diabetes education and supplies, direction within the State budget for the development of pediatric facility and services standards, and direction for the development of comprehensive emergency medical services for children. Within the State budget the Society's efforts on behalf of children were rewarded with increases in funding for the Poison Control System, the establishment of two new pediatric AIDS networks, expansion of the pediatric liver transplant program and legislative direction to maintain currently operating CMS primary care programs.

Unfortunately CS/HB 1853 which would have given patients better standing to sue HMOs for denying needed treatment and would have prohibited "gag" clauses in such contracts was vetoed by the Governor after a hard fought campaign by the HMO industry and business interests.

The Society can be proud of its many accomplishments this session. Members will continue to work very closely with the various agencies of state government to implement legislative directives for the development of pediatric standards and programs for children.

Following is some legislation which passed this session and was among the Society's priorities (both supported and opposed), as well as legislation affecting the practice of medicine or of general interest for its effect on children and adolescents. Other items will be presented later on.

CS/CS/SB 886 MEDICAID MANAGED CARE (CH. 96-199)

This legislation addresses numerous regulatory areas of the Medicaid program as it relates to the managed care environment. Of note is the directive to the Agency for Health Care Administration (AHCA) to seek federal waivers to allow an alternative service network to be created through Children's Medical Services to serve children with special health care needs. Standards for the selection of providers and operation of the network are to be developed jointly by CMS and the Medicaid program.

Also addressed are requirements for HMO subscriber access to and reimbursement for emergency services; marketing and enrollment practices of Medicaid HMOs; establishment of quality assurance requirements for both Medipass and HMO providers; limitations on the active patient load for Medicaid managed care plan physicians and various insolvency protections administered by the Department of Insurance.

Effective Date: July 1, 1996

CS/HB 555 - WILLIAM G. "DOC" MYERS PUBLIC HEALTH ACT OF 1996 (CH. 96-403)

A Department of Health is created composed of present public health and CMS programs. The department is to be headed by a physician with advanced training or extensive experience in public health administration. Effective July 1, 1997, the various health professional boards will also be moved to this department. The Department of Health and Rehabilitative Services will be renamed the Department of Children and Family Services and will be responsible for the Child Protection Teams and sexual abuse treatment programs for children.

Effective July 1, 1996, the Governor is to appoint a six member transition advisory committee to prepare for the implementation of the Department of Health and the reorganization of the Department of HRS. The Governor is also directed to appoint the Secretary of Health by October 31, 1996. There is created a 15 member task force to study the organization and structure of state health programs. Membership is specified, as well as topics of study. The task force report is to be submitted to the Governor and Legislature by December 31, 1996.

Effective Date: January 1, 1997, except as otherwise provided.

SB 1860 NEWBORN HOSPITAL DISCHARGE (CH. 96-195)

Individual and group health insurance policies and HMO contracts covering maternity services may not limit coverage for the length of a maternity or newborn stay in a hospital or for follow up care outside the hospital. The attending obstetric or pediatric provider (physician) is to determine the medical necessity for hospital care pursuant to the prevailing standard of medical care consistent with proposed guidelines for perinatal care of the American Academy of Pediatrics or the American College of Obstetricians and Gynecologists. Additionally, insurers and HMOs must provide coverage for post delivery care for mother and newborn infant to include physical assessment and performance of any medically necessary clinical tests and immunizations in keeping with prevailing medical standards. Follow up care may be provided at the hospital, the attending physician's office, an outpatient maternity center, or in the home by a qualified licensed health care professional trained in mother and baby care.

Insurers are required to communicate active case questions and concerns regarding post delivery care directly to the treating physician or hospital in writing and are also required to have written protocols for utilization review and quality assurance. A study is to be conducted by the Agency for Health Care Administration to evaluate the clinical effects of shorter stays in the hospital. The report is due by January 1, 1998.

Effective Date: October 1, 1996.

CS/SB 474 - HIV/AIDS REPORTING (CH. 96-179)

This legislation requires HIV counseling to include information about availability of partner-notification services, the benefits of such services as well as the confidentiality protections available as part of such services. County public health department are required to maintain a list of anonymous testing sites and must disseminate such list to all physicians.

Reporting of HIV infection and AIDS must be conducted using the HIV/AIDS Reporting System (HARS) developed by the Centers for Disease Control and Prevention. Newly determined cases of HIV infection may be required to be reported by physicians and laboratories. Protocols for pretest counseling shall require disclosure to the patient of HIV reporting requirements and the availability of anonymous testing sites.

When venous blood is drawn from pregnant women for sexually transmissible disease testing, HIV testing shall be offered. Counseling for HIV testing of pregnant women is established as the prevailing professional standard of care, which must include a discussion of the availability of treatment if the pregnant woman tests HIV positive. If such testing is refused reasonable steps must be taken to obtain a written statement of such objection signed by the patient which must be placed in the patient's medical record. Immunity is provided to physicians and other attendants when a pregnant woman refuses HIV testing and her child contracts HIV or AIDS from the mother.

Effective Date: October 1, 1996

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IN A CHANGING HEALTH CARE ENVIRONMENT- SOME THOUGHTS ON WHERE THE AMERICAN ACADEMY OF PEDIATRICS SHOULD BE HEADING

Leonard A. Kutnik, M.D.
District Chairman, District IX A.A.P.
San Diego, California

[Dr. Kutnik was a guest speaker at our Annual Meeting, in May 1996. His comments were well received and I asked him to contribute a column for us.-Ed.]

For those of us who practice medicine today, we live in tumultuous times. Our health care world is undergoing a dramatic transformation as it moves from a healing art, with care delivered by a cottage based industry to an efficient integrated system operating under the rules of a financial marketplace. This involves a major shift in power as medical decision making shifts from physicians to payers and purchasers who appear all too eager to base their determinations solely upon price.

In all likelihood, managed care will continue to grow and capture an ever expanding share of the health care market. HMOs already have grown to 52 million enrollees and continue to grow by 35% a year. As the recognized low cost options, they will dominate the industry. (HMOs are projected by most experts to be the payers of health care for over 80 million people by the year 2000.) The inevitable corollary of this rapid growth of larger and larger HealthCare companies is the need for physicians to reorganize themselves into larger and larger physician groups and into integrated delivery systems (combinations of physicians, hospitals and management administrative companies). This means the demise of not only most solo physician but also single specialty small practice groups (e.g., three-five pediatricians working together). The landscape of American medicine will be changed forever and the predominance of the membership of the AAP will be converted from independent practitioners into employed, often salaried physicians.

ROLE OF NATIONAL AAP

As California's elected representative on the Board of Directors I have given considerable thought to how the AAP can evolve most effectively to assist this shifting membership base in dealing with the myriad changes in the health care environment that will occur over the next five to ten years. I perceive five major domains in which the AAP will need to intensify and/or develop its efforts in order to help children and to assist its membership in adjusting to these changes so that we may concentrate on the care of our patients, rather than on the stresses associated with medicine's conversion from healing art to business.

ADVOCACY

The AAP's role as an advocate for children will become even more relevant and necessary in the new environment. For-profit managed care companies driven by "bottom line considerations"(which translates into the need for income for their stockholders) will not be championing the needs of politically powerless groups with little financial clout, such as children. One of the strengths of the AAP, which helps define it as a professional organization instead of a trade organization, is its mission to enhance the well-being of children. Our advocacy efforts need to be further intensified both at a Federal and State level. AAP fellows take great pride in belonging to an organization that is a champion for children. After all, we all became pediatricians in order to help children stay healthier and we take great pride in our ability to enable the children we care for to have a better life.

DEFINE THE VALUE OF PEDIATRICIANS

Today primary care pediatricians and the pediatric specialist brethren face a potential threat to their future ability to function as caregivers for children. The average primary care physician in the U.S. today takes care of 1250 patients. Most HMOs operate with ratios of 1 primary care provider for every 1700 to 2000 enrollees. If all of health care were transformed into an HMO environment in the year 2005, one-third of all the primary care doctors presently in practice would need to retire or find another line of work. The statistics are of even greater concern for specialists.

To a large degree, this future threat of physician oversupply accounts for the increasing pressure from family physicians and pediatric nurse practitioners to expand their role in the care of children. Their claims that they can provide primary care for children at a lower cost and just as effectively as pediatricians are already finding a receptive audience by some HMOs operating in the more financially competitive markets.

The AAP will need to define the value that pediatricians bring to the health care market in their role as primary caretakers for children and pediatric subspecialists who provide cost effective care for the more complex problems. The term "value" in today's health care world is defined by the equation VALUE = QUALITY/ COST. The AAP will need to demonstrate to employers and managed care companies that pediatricians are as cost effective as family physicians or nurse practitioners. More importantly, the AAP must make the case that pediatricians add value to the care of children by increasing quality through their expertise, training, parental education and preventive approach to medical care.

QUALITY IMPROVEMENT

The decisions made in health care today are based almost solely on price and cost. The payers of health care (employees and government) will continue to pressure the health care industry by reducing their premium payment per employee until they are convinced that all the "excess" has been wrung out of the system. In California we have seen reductions of premiums of 5% per year for the last few years by larger business groups like CALPERS and Pacific Business Group On Health. The employers will continue their pressure on price until they see an end to the excessive profits being made by the HMO industry. Eventually, perhaps as soon as five or six years, the decisions on who will be allowed to provide care for patients will truly shift from cost to quality. To prepare for that day, in fact to hasten its arrival, and to protect children in the interim, the AAP will need to markedly enlarge its role in the quality arena.

In my opinion, development of health care quality standards and outcome measures is the crucial pathway for physician organizations to reclaim some control over the way that health care is delivered. I am aware that some thoughtful pediatricians are concerned that parameters will be used by managed care companies as prescriptions for care, to be followed as a cookbook, rather than for their intended purpose as educational tools to improve quality. While this danger exists, a realistic view of the environment shows that clinical guidelines will be developed by some organizations. None are likely to be better for children or pediatricians than AAP evidence-based practice parameters (guidelines), appropriate process measures and functional outcome determinations.

(continued on page 17)

Studies in Tourette's Syndrome

Archie A. Silver, M.D.
Professor and Director
Child and Adolescent Psychiatry
University of South Florida

R. Douglas Shytle, Ph.D.
Clinical Instructor
Child and Adolescent Psychiatry
University of South Florida

In the past 5 years, the Tourette's Syndrome (TS) clinic in the Department of Psychiatry at USF College of Medicine has initiated a series of studies to understand the biology of TS and at the same time discover more effective and less toxic ways of treating children and adult TS. The studies have been directed into 4 major areas:

1. Treatment of tic symptoms with transdermal nicotine patch.
2. The discovery of a peptide in the blood of patients with Tourette's syndrome but not in patients who do not have Tourette's syndrome. Will this prove to be a biologic marker?
3. The determination of the type of learning problems found in children with Tourette's syndrome and a classification of their visual-motor defects.
4. Studies into the molecular genetics of Tourette's syndrome.

1. The transdermal nicotine patch: We are in the third year of a National Institute of Health-supported and FDA-approved, double-blind, placebo-contolled study of the effects of transdermal nicotine patch on the symptoms of Tourette's syndrome. In addition, we have also utilized the patch on a clinical basis with patients who are not in the experimental study or who have completed the study. Our general finding is that, in many cases transdermal nicotine can significantly reduce the severity and frequency of motor and vocal tics, decrease anxiety, diminish the intensity of premonitory urges and improve visual-motor function. We have also found that in many cases the effect of one transdermal nicotine patch may last for several days. We have reported these results in the scientific literature. However, the true extent of any benefits of transdermal nicotine in TS will come with the completion of our NIH-supported study in May of 1997. We would appreciate referral of patients 8-18 years of age for this study.

2. The biological marker: In collaboration with Dr. Tom Thomas and his laboratory assistant Chris McClenahan, we started to look at molecules found in the blood and saliva of TS patients. Results so far have found an unknown molecule - a peptide - in the blood of patients with TS which does not generally appear in patient who do not have TS. This is a promising lead which we are currently following.

3. Learning: Together with Dr. Deborah Harris, of our School of Education, we have found that children with TS are most often normal in reading and comprehension. However, it is in writing that they most often have trouble. These results have been published in the educational literature. We are currently analyzing visual-motor function (which we feel is the basis for the writing problems) in TS. The importance of this is to emphasize the specific learning deficits of the child with TS and to train teachers on methods of recognizing and treating those problems.

4. Molecular genetics: We are fortunate in having a molecular genetics laboratory in our department (Dr.Michael Mullan). Although his initial work centered on Alzheimer's disease, Dr. Mullan has become more interested in Tourette's syndrome. Accordingly, he is prepared to analyze the DNA spectrum of patients with TS as well as their family members. This study is just in its beginnng stages.

For more information regarding these studies please contact Dr. Silver at 813-972-7062 or Dr. Shytle at 813-972-7070.

October is Child Health Month!

Help Them Thrive, Birth to Five

Jane Boles
Project Manager
Department of Community and Family Health
U.S.F. College of Public Health

Professionals working with families, mothers and children are always looking for new methods of communication. The **Help Them Thrive, Birth To Five** social marketing campaign is providing high quality, fully tested tools that can be utilized by all health care professionals as they continue to encourage healthy behaviors.

Background

Since 1990, Florida's efforts in prenatal care are estimated to have saved more than $200 million in health care costs. Infant deaths have dropped 10 percent so that our infant mortality rate is now in line with the national average and is ahead of all other Southeastern states. But the work is not over.

According to the *Kids Count Data Book, 1996,* Florida ranks 46th of the 50 states in the status of children, using 20 indicators of well-being. The state ranks 33rd in the percent of low birthweight babies. The teen birth rate and the numbers of children living in poverty is climbing,

Campaign History

To better grasp the scope of infant and childhood problems in the state of Florida, the Florida Developmental Disabilities Council undertook a prevention and early intervention social marketing study. Four areas were determined to contribute to healthy birth outcomes: family planning or baby spacing; prenatal care; immunization and preventive pediatrics; and parenting and early intervention.

Examination of these four areas identified attitudes, values, beliefs and other factors that influence consumer behavior. The analysis also looked at the types of motivational strategies, conununication channels, products and service delivery practices that are most effective in reaching at-risk populations. Awareness of the problem is important from all points of view, but especially from that of the one person who must ultimately take action: the at-risk mother; the pregnant teen; the parent who must take time to immunize his or her baby.

Through individual surveys, focus groups and literature reviews the study learned more about why babies are born unhealthy; why pregnant women are not seeking care; why young children have not been immunized; why special-needs children are not receiving necessary services.

All four areas focus on different aspects of care but there are similarities in the findings. It was consistently confirmed that women of all ethnic and economic backgrounds have a common goal: to be the best mother possible. All parents have high aspirations for their children and place high value on health care at all stages of development. If the study was able to identify common, positive goals held by parents, why then do we not have more success stories?

The analysis also identified barriers to success that continue to be numerous. They include financial constraints; crowded conditions in clinics; impersonal service; transportation problems; difficulty getting off work for appointments; fear or lack of understanding of the issues; and where to turn for help. Parents are ready to accept help to access care if it is offered in the right way.

(continued on page 19)

CYSTIC FIBROSIS - RECENT ADVANCES

James M. Sherman, M.D.
Associate Professor of Pediatrics
Mary H. Wagner, M.D.
Assistant Professor of Pediatrics
University of Florida

Cystic fibrosis (CF) is the most common lethal genetic disorder among Caucasions, affecting one in two thousand. There have been remarkable discoveries in CF in the last two decades. We will review a few of the recent advances.

CYSTIC FIBROSIS GENE

The gene for cystic fibrosis was discovered in 1989,and there has been remarkable progress since in understanding the cellular defect and in developing therapeutic approaches. The gene codes for the cystic fibrosis transmembrane regulator (CFTR), a protein 1480 amino acids in length acting as a channel to regulate movement of chloride ions across the epithelial surface. More than 550 mutations of CFTR have been discovered to date, with several classifications of genetic defects resulting from different mutations: (1) absent production of CFTR, (2) abnormal processing of CFTR preventing normal movement to the cellular membrane, (3) CFTR with normal membrane placement but abnormal activation characteristics, (4) CFTR with normal membrane placement but abnormal chloride ion conduction. The most common defect is deletion of the 508th amino acid (phenylalanine), known as ΔF508, accounting for 70% of the CF mutations, and defective transport of the CFTR from the Golgi to the cell membrane.

The large variety of mutations accounts, in part, for the different phenotypes seen in CF. Investigators have been examining the relationship of genotype to phenotype. It appears that there is a relationship between genotype and the severity of pancreatic disease, with pancreatic insufficiency occurring when two "severe" alleles are inherited. Pancreatic sufficiency has been associated with mild mutation of one or both chromosomes. The majority of genotypes discovered thus far, including ΔF508, are "severe" in terms of pancreatic function.

An association between genotype and severity of pulmonary disease is postulated, but the correlation is not clear. Patients with pancreatic insufficiency tend to have more severe pulmonary disease, but wide variability of pulmonary function has been shown in each genotypic group. Some with pancreatic sufficiency have been shown to have severe pulmonary manifestations, while some with pancreatic insufficiency have normal pulmonary function. For pulmonary disease, the phenotype is probably strongly influenced by modifying factors such as environment, intercurrent viral illness, and perhaps other genetic factors.

GENE THERAPY

Discovery of the CF gene opened up the possibility of gene therapy as a therapeutic tool, stimulating scientists throughout the world. The lung has been targeted because it is responsible for most of the mortality and morbidity in CF. Some researchers have studied delivery of the corrected CF gene to the nasal passages, since the nose is accessible and has epithelium similar to that of the lung. In this way, the results of gene transfer and cellular gene correction can be measured directly. The disadvantage of the nasal model is that observations there may not be directly applicable to lung.

Current issues include:

- How best to get genes into respiratory tract cells.
- How many respiratory cells need corrected genes to reverse the abnormalities that lead to CF lung disease.
- How often the corrected genes will need to be reapplied.

Initial trials have been designed to demonstrate that the normal CF gene can be delivered effectively and safely into the airways of CF patients, with a change in cellular function.

Several modes of delivering the gene into cells have been studied, including two viruses (adenovirus and adeno-associated virus) and liposomes. Liposomes are specializsed fat capsules which fuse with the cell membrane and deliver the gene into the respiratory cell. Initial trials have had varied results. Some researchers have shown that the corrected gene is delivered to the target cellss but abnormal function is not reversed. Others have shown both effective delivery of the corrected gene and transient correction of abnormal cellular function.

Several trials have used adenovirus as the vector for CFTR delivery with variable results. Studies thus far have demonstrated expression of CFTR in respiratory cells. However, adenovirus has generated a host response in several subjects, with one patient developing constitutional symptoms and an inflammatory response after delivery to the lung. Adeno-associated virus (AAV) is another vector under investigation, with some advantages over adenovirus for gene therapy. AAV is tropic to respiratory epithelium as is adenovirus; however, AAV does not express viral proteins, thus decreasing the potential for immune response. AAV requires co-infection with adenovirus in order to cause infection itself in target cells. Problems identified with viral vectors include the potential for immunologic clearance of the virus and cells expressing viral proteins. This immunologic "experience" with the virus could generate antibodies making repeated use of the viral vector problematic. There are several centers around the world which continue to work on all aspects of gene therapy. Specific areas of research include demonstrating the most efficient mode of delivery with minimal toxicity to patient and developing practical delivery methods such as aerosols.

FIBROSING COLONOPATHY

In 1994, the first colonic strictures were reported in patients with CF. Several patients presented with bowel obstruction and required surgical intervention. The development of strictures was temporally related to the introducction of high strength pancreatic enzyme supplements. These reports prompted the voluntary removal of these high dose supplements from the market by their manufacturers.

Subsequently, the Cystic Fibrosis Foundation (CFF) and the FDA have completed a case control study, from 1990 to 1994, of 31 CF patients with colonic stictures matched to controls. The colonic strictures were validated histologically to be fibrosing colonopathy. Of the 31 cases, two thirds were male and ages ranged from 1.5 to 12.1 years. There was a strong relationship to total lipase doses in the ½ to 2 years prior to surgery. Affected patients took twice the dose of controls (mean doses: 12,916 units of lipase/kg/meal in cases versus 4799 units of lipase/kg/meal in controls. The lowest dose in a case was 3227 units of lipase/kg/meal. The risk of fibrosing colonopathy was unrelated to the enzyme product. Earlier reports suggested that an additional risk factor for developing fibrosing colonopathy was a history of meconium ileus. No new cases have been reported since September 1995, 18 months after the high strength product was removed from the market.

Precise mechanisms underlying development of fibrosing colonopathy are not clear. There are probably several factors involved, including:

(1) Protease delivery to the large intestine
(2) Involvement of the enteric coating of enzymes.
(3) Additional toxins in the enzymes.

(continued on page 18)

Emphasis on violence against children continues with this issue and through the year 1996

DEATH DUE TO ABUSE AND NEGLECT

J.M. Whitworth, M.D.
Jacksonville, FL

How many children die as a result of child abuse and neglect in Florida each year?

No one knows!

There is data on how many children known to HRS die each year but well over half of deaths due to abuse and neglect occur in children not known to protective services authorities at the time of their deaths. Many of these children are known to other agencies or individuals who failed to see or accurately interpret the risks to the child. There is data in various registries, but it has been estimated that 85% of childhood deaths from abuse and neglect are systematically misidentified as accident related, disease related or due to other causes. There are widespread flaws in the way deaths are recorded on death certificates, in crime reports, and by the child protection system.[1] Best estimates suggest that about 2000 children die each year from abuse or neglect. In the years since Kempe described the Battered Child Syndrome, there have been more fatalities from abuse than from gang wars, AIDS, polio, or measles. Contrast the public attention given to the latter causes with the widespread belief that abuse related deaths are extremely rare.[2]

Recent studies challenge closely held beliefs in abuse death cases. The "triggers" related to death cases seem to be similar to those which precipitate physical abuse in general. These include inconsolable crying, feeding difficulties, failed toilet training, and unrealistic expectations for "obedience" by parents. We also see a profile of the most likely characteristics shared by child killers. They tend to be in their mid 20's, live at or below the poverty level, often have not finished high school, are depressed and unable to cope with stress, and have experienced abuse first hand. Most child killers are fathers and other male caretakers who injure infants or toddlers by hitting them in the head, by shaking them violently, by intentionally suffocating them, or by immersing them in hot water.

Parents who kill their children are more likely to live in a two adult home rather than as a single parent. In contrast, most people believe that children are more likely to be killed by teen mothers who function as single parents.

Two recent studies shed some light on the issue of intent. Kantor and Williams' studies show that many attacks are so violent that parents must be conscious of the damage they are inflicting.[3] Alexander argues in his 1993 testimony that the extreme force needed to inflict such damage should deter any reasonable parent from such behavior.[4] Similarly, recent studies on the shaking/impact syndrome would lead to the conclusion that accidental death from shaking is almost impossible.

In 1988, legislation was proposed in Florida which would have developed Multidisciplinary Child Death Review Teams. Currently 45 states have local and/or statewide death review while Florida only reviews cases known to HRS. Enabling legislation varies from state to state but all carry out some review of all suspicious or unexpected deaths of young children. Since the majority of deaths due to abuse occur in children less than four, most review protocols provide a cut-off age of six or seven, but some review all cases. Florida has made remarkable strides in providing improved and innovative services to children who are victims of accidents and abuse. Multidisciplinary case planning and review have been shown to be beneficial in many types of cases as evidenced by our Child Protection Team system and anecdotal experience in a few communities. It is felt that a state-wide system for multidisciplinary review of selected child deaths would provide assistance in developing an accurate data base, but more importantly, would provide an opportunity for multidisciplinary assessment
of those cases for which no review process currently exists and might have
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significant effects on prosecution and prevention planning.

The experience in other states with mandatory review teams has been enlightening. In Missouri, there has been a two fold increase in recognized homicides against children and a three fold increase in the prosecution of perpetrators.[5] The initial study showed only 48% of proven cases were ICD-9 coded properly and only 38.8% were recognized as homicides by the FBI's UCR database. Teams can also have salutory effects on a variety of other medical issues. In Sacramento, California, the team was able to identify a cadre of cases which led to changes in pool fencing regulations and resulted in a significant reduction in accidental drownings. In Los Angeles, a rash of poisonings led to recommendations to the Food and Drug Administration to change the coloring and packaging of prenatal vitamins in response to twelve deaths of children who mistook them for candy.

Review committees in Florida could be organized easily. With our cadre of professional medical examiners and the large concentration of pediatric pathologists in the state, review should not pose any threat. Membership on the review committee should include the medical examiner, law enforcement, HRS investigator, Child Protection Team Pediatrician, a psychologist, a prosecutor, and others as desired. The deliberations of the review committee should be confidential unless they become part of an investigation. Catchment areas would vary based on population density and the population to be reviewed could be tailored to available resources as long as the most likely victims were included (children under five). The existence of medically-based multidisciplinary child protection teams would seem to provide a nucleus around which a program could be built.

It would seem that Florida is in the unusual position of needing to catch up with the rest of the country in this most important area of research and practical benefits for the protection of our kids.

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Kudos

...to Arnold L. Tanis, M.D., for his productive service on the Committee on Development of the American Academy of Pediatrics. He has represented our state well, as a leader in pediatrics. *Our congratulations!*

"Who's for Kids and Who's Just Kidding?"

Grab a hammer, or a bumper sticker, the election season is upon us! Now is the time to press political candidates to answer the important question of "Who's for Kids and Who's Just Kidding?" The AAP is helping lead the Coalition for America's Children (CAC) in this task. The CAC is a nonpartisan group comprised of 350 local, state and national organizations dedicated to the health, education, safety and economic security of America's children. The Academy helped found the CAC six years ago to put children's issues on the nation's political agenda.

A public forum is the first step to holding candidates and elected officials accountable for their words and actions. The heart of this year's campaign is building a children's platform from which candidates can present their views on children's issues.

To guide AAP members, a new line of products is available and designed for local tagging. If your chapter or your office has an address stamp, put it on all CAC products you distribute. These include:

- Questions for Candidates Card
- "What is a Children's Platform?" Brochure
- How to Build and Maintain Your Children's Platform Handbook (includes actual architects' drawings).
- The Children's Advocate Campaign Strategy Book
- Candidate Postcards, Bumper Stickers, Coalition Buttons

What can you do?

- Build an actual children's platform or designate an existing child-friendly site, such as a podium at a local children's museum or a gazebo in a city park, as the children's platform.
- Invite all candidates to speak about children's issues.
- Wear a CAC button on all occasions.
- Send a CAC brochure/bumper sticker to all area candidates.
- Distribute fact sheets or issue briefs on children's needs to all candidates. The AAP Washington office has these..
- Attend candidate rallies and ask child-specific questions.
- Submit an op/ed to your local newspaper. The AAP Washington office can provide a model.
- For more information and suggestions, dial up the CAC's web site at **http://www.kidscampaigns.org/cachome.html.**

How do you get started?

- Don't do it alone! Contact your local children's hospital, Junior League or PTA or other CAC members in your area to discuss possible joint activities.
- Purchase materials from the AAP Washington office. The new campaign materials contain everything you need to get started.
- Ask AAP staff for help! Public Affairs in the AAP Washington office can help write op/eds, offer guidance on organizing events and working with the media. Just call 800/336-5475.

The entire campaign is designed to encourage and guide participation at all levels. Whether you hand out campaign buttons in your office or organize a candidate's forum in your community, the goal is to put children's issues at the top of the 1996 political agenda.

For product information, activity suggestions, draft op/eds or other assistance, contact Marjorie Tharp or Leigh Ann Bluestein at the AAP Washington office, 800/336-5475.

Silent March

Let Your Shoes Do the Talking: Gun Violence Protest. Just a reminder to let members know about a national grassroots protest against gun violence that AAP is endorsing. Clinicians, parents and the general public are being asked to send a pair of shoes with a signed note saying how gun violence has affected them.

The "Silent March Against Gun Violence" is once again collecting 40,000 pairs of shoes for a somber protest in Washington, DC on September 30, 1996. The shoes represent the number of Americans - 39,595 people, enough to populate an entire town - who died from guns in 1993 (the most recent statistics). Slightly more gun-related deaths are suicides than homicides; very few are accidents, according to federal statistics. The US has a far higher gun death rate than in any other Western nation.

Florida has a State Silent March Coordinator. Call D. Baca, at (813)554-8175, and find out how to participate. The coordinator may need speakers and medical authority in her public education campaign.

The non-profit Silent March is run by unpaid citizen volunteers. It does not support specific legislation, but promotes violence prevention through regulation of the manufacture, sale, and distribution of guns.

One Year Anniversary of FDA Proposed Rule to Limit Tobacco Access and Appeal

Saturday, August 10th marked the one-year anniversary of the AAP-backed Food and Drug Administration's (FDA) proposed rule to limit tobacco's access and appeal to children and adolescents. The Academy is working with the National Center for Tobacco-Free Kids to raise awareness of the anniversary through the media, which might in turn put pressure on the Administration to release the final guidelines. Although there is no firm date, rumors abound in Washington that the final FDA regulations could possibly be released sometime in August or September. A national press conference is planned, as well as some regional activities to mark the anniversary.

Sample letters-to-the-editor are available from Leigh Ann Bluestein in the Washington office, 1-800-336-5475, as well as advice on where to send such letters. Sample op-eds are also available. If you are successful in getting either published, be sure to send copies tothe Washington office, and please let your Editor know as well.

This effort will be successful in proportion to the effort all members make in its behalf.

Letters to the Editor are welcomed at any time, and will be published in timely fashion. The Editor reserves the right to edit for space available, without change in content or context. Please send contributions to the Editorial Office.

SENIOR SECTION UPDATE

The Section on Seniors of the Academy of Pediatrics continues to grow. New recruitment efforts have increased the membership to over 1000. The original goals set forth in my article for *The Florida Pediatrician* in February 1995 continue to guide us.

To develop and present educational programs for the Section meedings at the time of the Annual Meetings, to advocate for the needs of children nationally and locally, to help senior pediatricians prepare for career changes or retirement after the age of 55, to promote more attention to a healthy life style as we age, and to support the Department of Development in raising money for Academy programs, all of these influence our activities as a Section.

Have we been successful? Moderately so. Our well received program in San Francisco in October 1995 concerned matters of health. There were discussions on a healthy life style as we pass the sixties. Information on osteoporosis and prostate cancer was aimed at both women and men in the audience. Latest advances in the increasing problem of Alzheimer's Syndrome and support systems for the condition at UCSD were reported. This fall, in Boston, our program will focus on financial planning. A representative from the Social Security Office will explain the latest changes in Social Security and Medicare, Estate planning, presented by Alexander A. Bove, Jr., a practicing trust and estate attorney in Boston and author of many books on the subject, will highlight the meeting. There will also be a presentation by Gerold Aronson on the use of and fun with computers in the golden years. All attendees and their families at the Annual Meeting, whether memberes of the Section or not, are invited. The Seniors will meet on Monday, October 28, at 2 PM. Look for the location in the final program.

Advocacy continues at all levels. The Seniors have liaison with the Council on Government Affairs and the Committee on State Government Affairs, through Don Schiff, past President of the AAP, who will also be on the newly formed Task Force on Health Reform. The most important role for each and every one of us is to question every candidate for National and State election this year on how he or she stands for kids: "Are you for kids or are you just kidding?" Look to future copies of the AAP News for important issues to be discussed regardless of which political persuation you may hold.

And lastly, look for increased activity in Florida to form a group of Seniors for any of the above listed goals or to join together for purely social reasons. Look for mail from Sorrell Wolfson of Palm Beach Gardens as he tries to organize a group of Seniors. And, please, drop me a line as to your comments on the National and Chapter activities for Seniors.

Robert Grayson, M.D.
Chairman, Section on Senior Members
American Academy of Pediatrics.

F.Y.I.

More Hassles with Medicaid

Our President advises us of some new issues with Medicaid, which will influence - and perturb - us as Medicaid providers. These new provisions are being implemented under "fraud and abuse" statutes of the last session.

First, all Medicaid providers must reenroll within a thirty day (since extended to 40 day) period. Reenrollment will start in Dade County on July 17th. Each provider will be required to submit a request for Florida Department of Law Enforcement background check at a cost of $15, and submit this with an application. This is an attempt to find all MD/DOs with criminal convictions/fraud issues, in theory. The Agency can only handle 8,000 reapplications per month and there are 38,000 current providers.

Many physicians may simply choose not to provide Medicaid access and not submit to an FDLE background check. I suspect that the provider file will decrease. (No consideration for poor children or the practitioner).

Unfortunately, the fraud and abuse problem has gotten out of hand in some areas of the state.

IMMUNIZATION ALERT

Hepatitis B Vaccine and Others

Rule 10D-3.088, FS 232.032, adds **Hepatitis B Vaccine** to the immunizations required in public and private schools:

Effective with the 1998-1999 school year, children shall complete the **hepatitis B vaccine** series prior to entry, attendance or transfer to **kindergarten** in Florida schools. Each subsequent year thereafter the next highest grade will be included in the requirement, so that students transferring into Florida schools are added to the immunized cohort.

Effective with the 1997-1998 school year, children entering, attending or transferring to **seventh grade** in Florida schools will be required to complete vaccination against **hepatitis B**, a second dose of measles vaccine (preferably **MMR**), and a **tetanus-diphtheria** booster prior to admittance or attendance. Each subsequent year thereafter, the next higher grade will be included in the requirement, so that stuldents transferring into Florida schools are added to the immunized cohort.

It is believed that most private insurance, and the Vaccines for Children program, will cover these changes.

MEDICAL PRACTICE GUIDELINES

The Agency for Health Care Administration (ACHA), in consultation with the Committee on Maternal and Newborn Hospital Discharge Guidelines, has released Medical Practice Guideline 1, subject: Perinatal Care: Postpartum Care of Mothers and Their Infants.

It is noted that unlike "Standards","Guidelines" are meant to be flexible, although they should be followed in most cases. Guidelines can be tailored for individual needs; deviations can be justified by individual circumstances. Options are intended to be neutral.

Copies may be obtained from:
Agency for Health Care Administration
Dennis Halfhill, Coordinator Medical Guidelines Clearinghouse
2727 E. Mahan Drive, Bldg. 3
Tallahassee, FL 32308
(904)488-1295, Fax (904)488-1261

(more on page 19)

From the Legislature

(continued from page 6)

SB 454 - STATUTE OF LIMITATIONS / MINORS (CH. 96-167)

Under this legislation the statute of repose is extended until a child's 8th birthday. For practical purposes this legislation lengthens the amount of time (presently four to seven years) children under the age of four have to file a claim for medical malpractice; however, it will not apply to those who have been or are eligible to be compensated under NICA, and does not affect causes of action which occurred prior to the law's effective date.

Effective Date: July, 1, 1996.

SB 2370 - BICYCLE HELMETS (CH. 96-185)

Beginning January 1, 1997, children under the age of sixteen must wear a properly fitted helmet that meets designated standards when they ride or are a passenger on a bicycle. This law also requires children under the age of 4 years, or those who weigh less than 40 pounds, who are passengers on a bicycle to be carried in a seat or carrier designed for such purpose which secures and protects the child from the moving parts of the bicycle. Children are prohibited from remaining in such seats when the rider is not in immediate control of the bicycle.

Bicycles may not be rented or leased to persons under the age of 16 years unless they possess a helmet or the lessor provides a helmet for the child to wear.

Law enforcement officers and school crossing guards are allowed to issue bicycle safety brochures and a verbal warning to riders and passengers who violate this law. After January 1, 1998 citations may be issued with a fine, community service or safety course attendance required. First time offenses are to be dismissed if proof of purchase of a helmet is shown.

Counties may opt out of this law prior to January 1, 1998 with the passage of an ordinance pursuant to a public hearing which has been noticed and testimony taken. Further the law exempts private property unless it is open to the use of the public for purposes of vehicular traffic.

Effective Date: January 1, 1997.

HEALTH INSURANCE HEALTH MAINTENANCE ORGANIZATIONS MEDICAID

CS/SB 910 HEALTH INSURANCE / HMOs ANTITRUST (CH. 96-223)

This legislation creates numerous new statutory requirements relating to health insurance and HMOs. Regarding health insurance, new provisions include: a limitation on exclusions for preexisting conditions of no longer than 24 months with credit being given for similar coverage held by the insured within 62 days of the new policy; individual health insurance policies must be renewed at the option of the insured except in cases of nonpayment of premiums, fraud, non-compliance with plan provisions and situations determined to impair a carrier's ability to meet its obligations; denial of claims as medically unnecessary will require an opportunity for an appeal to the insurer's licensed physician who is responsible for medical necessity reviews under the plan; a response is required within 15 business days.

HMOs will be required to provide payment for emergency services and care which are defined. The determination of whether a patient requires emergency services is to be made by the physician examining the patient. If a determination is made that an emergency medical condition does not exist, payment for services rendered is to be governed by the HMO contract. HMOs are prohibited from requiring prior authorization for the receipt of emergency transport, nor may they deny payment based on the subscriber's failure to notify the HMO in advance of seeking treatment or within a certain period of time after care is given. HMOs must comply with statutes governing prehospital and hospital-based trauma services and emergency services and care. Notification requirements are provided for hospitals regarding emergency care provided to HMO subscribers; however failure to provide such notification does not negate an HMO's obligation for payment. Payment options are provided for non-contract providers and language is added to require compliance with emergency care provisions for Medicaid and Medipass patients.

Additional requirements for HMOs include: after October 1, 1996, cancellation of contracts with providers, without cause, will require a 60 day advance written notice to the provider and the Department of Insurance; knowingly misleading potential enrollees as to the availability of providers is added as an unfair method of competition and unfair or deceptive act or practice; HMOs and exclusive

provider organizations are required to provide prospective enrollees with written information about the terms and conditions of the plan, however specific information about providers or services must be requested.

This legislation also creates the "Florida Health Care Community Antitrust Guidance Act" which allows physicians and others to seek antitrust guidance from Florida's Attorney General. Based upon information provided, the Attorney General is authorized to provide a no-action letter for the business activity described by the person seeking guidance. Such letters estop the Attorney General from bringing any action pursuant to antitrust laws provided all information upon which the letter is based is accurate and remains unchanged.

Section 16 of the Joint Venture law which set fees for certain designated services is repealed with retroactive application prohibiting the Board of Medicine from imposing or collecting any administrative fines pursuant to this section.

Effective Date: October 1, 1996.

PROFESSIONAL LICENSING

CS/HB 1363 - CONTINUING MEDICAL EDUCATION / FOREIGN TRAINED (CH. 96-309) PHYSICIANS / MEDICAL FACULTY CERTIFICATES

Continuing medical education requirements for licensed physicians are revised so that the Board of Medicine may require as a condition of licensure the completion every 2 years of 1 hour, instead of 5, in risk management or cost containment and up to 2 hours in other topics related to the physician's medical specialty. This bill revises requirements for the board to approve criteria for, and content of, continuing education courses.

An alternate licensing pathway for certain foreign trained physicians is created. Foreign trained physicians who have practiced medicine for at least five years will be allowed to sit for the United States Medical Licensing Examination (USMLE) or an examination developed by the Agency for Health Care Administration (AHCA) to qualify for a restricted license to practice medicine. To qualify candidates must have successfully passed the requirements of the update course authorized by the Board of Medicine and the University of Miami School of Medicine offered in November 1990 or November 1992. They must also possess a certificate of completion of the course; document at least 5 years of active medical practice in another jurisdiction; and not have been disciplined or under investigation for any violation of medical practice. Exceptions are provided for applicants who previously have taken parts of the national medical licensing exam which is no longer available. Five attempts are allowed to pass the examination. The Board of Medicine is authorized to impose restrictions on the applicant's practice and may establish supervision requirements for holders of a restricted medical license. After 2 years full licensure will be awarded if the restricted license holder is not under discipline.

Effective Date: May 30, 1995

CS/SB 112 - OSTEOPATHIC PHYSICIANS (CH. 96-147)

This law declares a state policy that licensed osteopathic physicians and licensed medical physicians be accorded equal professional status and privileges. Health facilities and entities that contract with physicians to provide managed care or risk-based care are prohibited from discriminating against licensed osteopathic physicians.

Effective Date: October 1, 1996.

[Our congratulations to all those who were part of the tremendous effort which had to be made to effect this much change in one session. Our congratulations also to Mrs. Moreau for her monumental effort in putting this report together for us. This is only a fraction of the total report which Mrs. Moreau prepared. The remainder of the material is of sufficient important to all that it is planned to include it in the November issue -Ed.]

THE FLORIDA C.A.T.C.H. CORNER

C.A.T.C.H. (Community Access to Child Health) is important to all of us. We will try to include an article or comments about C.A.T.C.H. in each issue.

Community Access to Child Health

CATCH Limited Edition Print promotes the well-being of children. There is a new Academy exclusive: a unique print created for the Community Access to Child Health (CATCH) program. There is a flyer detailing the significance of the print and explaining the CATCH program. Supplies are limited. For more information, call the

Welcome, New Members

We welcome the following individuals, who have become Fellows of the American Academy of Pediatrics and the Florida Chapter/AAP:

Amy Zaron Aqua, M.D.	West Palm Beach, Florida
Ali Ashmead, M.D.	Okeechobee, Florida
Douglas Barlow, M.D.	Boca Raton, Florida
Scott A. Baron, M.D.	Ft. Myers, Florida
Roxanne L. Edwards-Barbee, M.D.	Tavares, Florida
Eric S. Cameron, M.D.	Hollywood, Florida
Stacey A. Clark, M.D.	Wellington, Florida
Rani Simon Gereige, M.D.	Clearwater, Florida
Teena L. Hughes, M.D.	Tampa, Florida
Jay H. Klein, M.D.	Palm Harbor, Florida
Lucyna Lagod, M.D.	Orlando, Florida
Susan Foster Massengill, M.D.	Gainesville, Florida
Jose A. Perez, M.D.	Apopka, Florida
Leon Julio Reinstein, M.D.	St. Petersburg, Florida
Emad K. Salman, M.D.	West Palm Beach, Florida
Caron F. Sanua, M.D.	West Palm Beach, Florida
Galdino Silva-Neto, M.D.	Miami, Florida

HAS YOUR ADDRESS CHANGED IN THE LAST YEAR?

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

We salute...

...Gwendolyn B. Scott, M.D., on her appointment to a two-year term on the AAP Committee on Pediatric AIDS.

...John Curran, M.D., on his reappointment to the Council on Child Health Finances.

Congratulations...

...to Rene Montero, M.D., for a long and distinguished career in pediatrics. An octogenarian still active in clinic work in the Miami area, he recently received an award from the North Dade Health Center, in recognition of his dedication and service. North Dade Health Center is affiliated with Jackson Memorial Hospital.

Managed Care

(continued from page 7)

At present the AAP has developed its Ambulatory Care Quality Program (ACQIP) and is continuing its process for creating practice parameters and functional outcome disease specific measures. The AAP can build upon this excellent beginning by undertaking a significantly expanded role iln determining what characterizes quality care for childrenduring the present window of opportunity. To accomplish this it will need to create relationships with national quality monitoring organizations, such as the National Committee on Quality Assurance (NCQA) which has produced the present quality standard, the HEDIS report cards for HMOs. Additionally, the AAP will need to develop partnerships with large group practice associations and large national HMOs to develop guidelines and outcome measures for children.

EDUCATION

Postgraduate education has been the core activity through which the AAP has provided assistance to its membership. I foresee the educational role of AAP expanding to provide training in the variety of new skills that tomorrow's pediatrician will require. The AAP will need to develop and teach a program on dealing with organizations and management. The focus of this course will be to provide skills to pediatricians that will enable them to concentrate on their care of children, while minimizing the external interruptions created by their changing work environment. This curriculum may include:

- Strategies for pediatricians to navigate through complex business organizations;
- Techniques to assist parents in working within systems to obtain the best care for their children (especially for the child with special needs);
- Development of advocacy skills to enable pediatricians to promote the needs of children within their complex organizations;
- Development of leadership skills for pediatricians to successfully advocate for their own needs within large health care systems;
- Education on how to network with other organizations interested in the needs of children;
- Development of skills in quality management;
- Time management skills to enable pediatricians to cope with the volume of patients they will be required to see each day in order to be economically efficient.

RESEARCH

The AAP has a unique network of pediatric practices, geographically distributed throughout the United States, which are involved in clinical research: the PROS network. This is a unique resource and offers tremendous potential to perform large, rapid, practical clinical research protocols on office based pediatric care, examining how it is being delivered. PROS also offers a way to measure the impact of quality improvement programs developed by the AAP quality initiative. This network will need to be further enhanced, and provided with the resources required to become a major factor in health care research on children.

Times of change, while stressful, often offer opportunities. I am confident that the AAP will be able to evolve and adjust while staying true to its core mission of enhancing the well-being of children. In fact, there are likely to be many other important initiatives that the AAP of the future will need to undertake in addition to the five domains I have identified. The AAP will innovate and grow as a professional organization in order to guide its pediatrician membership through the difficult period of adjustment they must undergo as the changing health care environment unfolds.

The Scientific Page

(continued from page 10)

(4) Additional exposures such as laxatives and gastrograffin.

The CFF Conssensus Conference has suggested keeping enzyme

doses less than 2500 units of lipase/kg/meal and evaluation of thsoe patients who appear to require higher doses. Fibrosing colonopathy must be considered a potential diagnosis CF patients with evidence of obstruction, bloody diarrhea, chylous ascites, persistent abdominal pain, diarrhea, and poor growth. Risk factors include: age < 12 years, enzyme dose > 6000 units lipase/kg/meal for six months, history of meconium ileus or distal intestinal obstruction syndrome, and a history of abdominal surgery. The definitive diagnosis is made by histologic review of surgical specimens. Evaluation for fibrosing colonopathy includes a barium enema (shortening and narrowing of the colon), endoscopy with biopsy, and ultrasound to measure bowel wall thickness. Treatment includes decreasing the enzyme dose, nutritional support and surgery in those with obstruction dor persistent symptoms.

ADDITIONAL THERAPIES

A wide variety of different modes of therapy has become available or placed under investigation in the past several years, including pulmozyme (DNase) and ibuprofen. Pulmozyme or dornase alpha, a recombinent form of human DNase, has become widely used in the past three years in CF patients. A large multicenter trial reported improved lung function, improved "well-being" and decreased hospitalization rates in those treated with pulmozyme, on a dally basis. Pulmozyme is delivered by the nebulized route and works by "cutting up" the excessive DNA found in the sputum of CF patients. This excessive DNA comes from the influx of inflammatory cells which fight lower respiratory tract infection by bacteeria such as Staph and Pseudomonas. Side effects from this therapy include dysphonia and facial irritation. This therapy must be used an a daily and costs approximately $10,000 per year. Some centers give a short term trial of this medication over several months and monitor patient response before committing to long term therapy. Recent research has shown that CF patients demonstrate evidence of an exaggerated inflammatory response in infancy, even without evidence of a lower respiratory tract bacterial infection. This has led to trials of anti-inflammatory agents as a therapy to delay or decrease lung damage in persons with CF. Results of a trial with high dose ibuprofen were reported in 1995. This study showed better lung function and better maintenance of weight for height in those receiving high-dose ibuprofen compared to a placebo. The most dramatic effects were shown in thse starting the ibuprofen when younger (ages 5-13 years). However the trial included a small number of patients, too small to allow adequate collection of information about the side effects of ibuprofen which include gasttrointestinal bleeding, abdominal pain, and renal damage. The authors also had information suggesting low-dose ibuprofen caused an increasse in inflammation. This therapy, if used, needs to be monitored with blood levels to allow appropriate dose adjustment as well as vigilance for for ibuprofen side effects. A similar benefit was clained for alternate day prednisone until a larger multi-center trial showed excessive side effects. Therefore, many centers have not begun high-dose ibuprofen pending such larger trials.

In the last 15 years life expectancy for patients with CF has increased from a mean of 22 years in 1991 to 30 years in 1996. Gene therapy, lung transplantation, improved nutrition and anti-inflammatory therapy will be the tools for sustaining this improvement in the next decade.

Kudos

...to Joseph R. Zanga, M.D., who has been elected Vice-President (President-Elect) of the American Academy of Pediatrics.. *Our congratulations!*

E. Stephen Edwards, M.D., District Chairman, addresses Annual Meeting in May 1996

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.

Our thanks to Jim Hillman, M.D., for his effort in producing the major contribution reproduced here.

Table 1.-Symptoms and Management of Marine Stings

Animal	Symptoms	Treatment
Jellyfish	Stinging, burning, redness	Vinegar, isopropyl alcohol, papain, talcum, physical removal of the tentacle, topical steroids
Fire coral	Stinging, burning, redness	Cleansing of area, gentle scrubbing with soft brush, topical steroids, topical antibiotics
Portuguese man-o-war	Stinging, burning, redness, blisters, anaphylaxis, shock	Prevention of drowning, vinegar, isopropyl alcohol, papain, talcum, physical removal of tentacles, topical steroids, treatment of open wounds, topical antibiotics, systemic antibiotics, ACLS, treatment of shock
Sea anemones	Stinging, burning, redness	Cleansing of area, gentle scrubbing with soft brush, topical steroids, topical antibiotics
Stingray	Intense pain, possibly of the entire extremity, discoloration, redness, cyanosis, possible tissue necrosis, foreign body, wound infection, tetanus	Immersion in hot water of 110 to 120 degrees F, foreign body removal, wound irrigation and care, analgesics, antibiotics, tetanus prophylaxis, careful monitoring for infection
Sea urchins	Pain, redness, swelling, foreign body, wound infection, tetanus	Immersion in hot water of 110 to 120 degrees F, x-ray, foreign body removal, wound irrigation and care, analgesics, antibiotics, tetanus prophylaxis, careful monitoring for infection
Bony fish sting Scorpionfish Lionfish Stonefish	Pain, redness, swelling, foreign body, local vasoconstriction, tissue necrosis, wound infection, tetanus, muscle weakness, myocardial conduction blocks, shock, cardiopulmonary arrest	Prevention of drowning, immersion in hot water, wound care management as above, ACLS, critical care, antivenom
Catfish	Pain, redness, discoloration, possible tissue necrosis, foreign body, woound infection, tetanus	With some species immersion in hot water, x-ray, foreign body removal if present, copious irrigation and cleansing, wound care, antibiotics, analgesics, tetanus prophylaxis
Coral cuts	Late onset burning, rredness, pain, secondary infection	Cleansing of area, gentle scrubbing with soft brush, topical steroids, topical antibiotics, observation for infection

Reproduced with permission from Hillman JV. Marine Animal Exposures in Florida. J. Florida M.A. 1996; 83:187

Help Them Thrive

(continued from page 9)

The Challenge

The challenge is to make that happen. And meeting that challenge is the **Help Them Thrive, Birth To Five** social marketing campaign. It is seizing upon the opportunities to break down those barriers by making tools available to providers who are willing to take the initiative. This ground-breaking, innovative approach to the issues surrounding newborns and infants will soon reach every corner of the state and will be easily accessed by every person in Florida. The campaign materials include public service announcements for radio and television, posters, brochures, reminder systems, post cards, bill boards and bus signs.

Research shows that something as simple as patient reminders can dramatically increase the utilization of services. But research also shows that available services will be used more if less concrete things are stressed. By expanding hours in which services are available and by making patient waiting areas more comfortable and friendly, there will be higher utilization rates. Staff taking time to answer questions, showing respect for the patient's and family's input and concerns, offering emotional support, all help encourage the use of needed services. That, coupled with the campaign materials to generate a greater awareness and utilization of intervention services, makes up this integrated, multifaceted coordinated effort.

A coordinated state-wide distribution of public advertising materials is planned so you will soon see billboards and PSAs on television as the state is blanketed with positive messages that will encourage healthy birth outcomes. But because each city, town or community in Florida is different, much of the campaign will be implemented locally by local providers and citizens concerned with maternal and child health. **Help Them Thrive, Birth To Five** in your community, while utilizing the same research, training, materials and products as other communities across Florida, may realize its goal differently from a neighboring community. It is through the involvement of groups active and concerned in each community that the statewide success of the program will be achieved.

Help Them Thrive, Birth To Five is one of the first comprehensive social marketing campaigns to be implemented in the United States. It is the beginning of many possibilities that will make an enormous difference to the children and families of Florida.

[For more information about the **Help Them Thrive, Birth To Five** campaign and its materials, call (813) 673-9377.]

More FYI

(continued from page 14)

Revision of official State List of Notifiable Diseases

A *reminder*: Chapter 10D-3, Florida Administrative Code, requires all licensed health practitioners to report all cases of notifiable diseases and conditions to the county public health unit in the county of residence of the case. It is of note that such reports are also required of schools, child care facilities, restaurants, camps, food outlets, storage or processing establishment, jails and detention centers, nursing homes, clinics and hospitals. The following has been received as changes by addition to the state list of notifiable disseases:

- Cyclosporosis - characterized by watery, often prolonged diarrhea, abdominal cramping, anorexia, fatigue, weight loss; more common in the summer months; recently recognized in the U.S., associated with contaminated water and contact with soil.
- Drug-Resistant Streptococcus Pneumoniae Invasive Disease (DRSP) - most frequent cause of bacterial pneumonia at all ages, common cause of bacteremia and otitis media in children, and a leading cause of meningitis in the U.S. Reports of DRSP increasing.
- Enteric Diseases Due to E. Coli O157:H7 and other Pathogenic E. Coli - Discovered in 1982, now 3rd or 4th most common enteric bacterial pathogen; bloody diarrhea, no specific treatment; commonly foodborne, usually bovine origin. Reportable since 1994.
- Hantavirus Infection - Hantavirus pulmonary syndrome (HPS), a recently recognized viral zoonosis, with febrile prodrome, rapidly progressive respiratory insufficiency, and high mortality; has been seen in Florida.
- Human Ehrlichiosis - Two potentially fatal diseases caused by bacteria in the genus Ehrlichia: one species causes human monocytic ehrlichiosis (HME), another causes human

granulocytic ehrlichiosis (HGE); both similar, with leukopenia, thrombocytopenia, elevated lliver function tests; difficult to diagnose; most cases in adults, some in Florida.

UPCOMING CONTINUING MEDICAL EDUCATION EVENTS

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

Program: Pediatric Trends
Dates: August 30-September 1, 1996
Place: Hyatt Regency, Hilton Head Island, SC
Credit: ≥15 hours Category I for AMA Physicians Recognition Award.
Sponsor: American Academy of Pediatrics
Inquiries: CME Registration, AAP, (800)433-9016, ext 7657 or 6796.

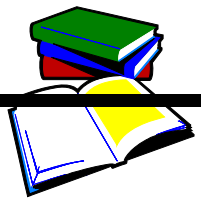
Program: Space Coast Pediatric Conference
Dates: September 27-28, 1996
Place: Melbourne Beach Hilton Hotel, Melbourne Beach FL
Credit: 10 hours Category I for AMA Physician Recognition Award
Sponsor: Department of Pediatrics, University of South Florida
Inquiries: Ms. Rebecca Scott (813)272-2744

Program: State-of-the-Art Pediatrics
Dates: October 11-13, 1996
Place: Hotel del Coronado, San Diego, CA
Credit: ≥15 hours Category I for AMA Physician Recognition Award
Sponsor: American Academy of Pediatrics
Inquiries: CME Registration, AAP, (800)433-9016, ext 7657 or 6796.

Program: The "Fetal" Neonate
Dates: November 14-16, 1996
Place: Sonesta Beach Hotel, Key Biscayne, FL
Credit: 20 hours Category I for AMA Physicians Recognition Award.
Sponsor: Division of Neonatology, Department of Pediatrics, U. Miami
Inquiries: Elisabeth Ravelo, Coordinator (305)243-5808/6660

Program: Pediatrics in Progress
Dates: November 15-17, 1996
Place: Westin Rio Mar Beach Resort, San Juan, PR
Credit: ≥15 hours Category I for AMA Physician Recognition Award
Sponsor: American Academy of Pediatrics
Inquiries: CME Registration, AAP, (800)433-9016, ext 7657 or 6796

Program: Advances in Pediatric Hematology/Oncology
Dates: November 21-23, 1996
Place: Wyndham Harbour Island Hotel, Tampa, FL
Credit: undetermined
Sponsor: Florida Association of Pediatric Tumor Programs, Inc.
Inquiries: [illegible] (813)632-1309.



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