THE FLORIDA PEDIATRICIAN

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

Volume XX, Number 3 *August 1997*

THE PRESIDENT'S PAGE

Salutations from Tampa. I hope this finds you all in good health and succeeding in what pediatrics is all about...looking after the welfare and medical and societal needs of the children entrusted to our care.

There are a number of ways to accomplish these ends. For many, our main efforts are directed to the one-on-one and day-to-day care of children in the primary care office setting; I am one of these. Others teach, or do research, or make policy. A few manage to do one or more of these and also find the personal resources to engage in activities and accomplish goals that truly make a difference in their communities (and even state- and nation-wide) over their careers. This year the FPS/FCAAP is instituting a Florida Outstanding Pediatrician Award, with nominations solicited from each Region of the state, to be presented at the Annual Meeting in September. The recipient may or may not be one of the pediatricians who have already received national or international acclaim; the wish is to honor those who have, often quietly and without many kudos, worked to improve the lot of children in their communities. We hope this will be a continuing award. There are a number of worthy candidates in our state.

* * * * *

ELECTION BULLETIN

President: Edward T. Williams III, M.D., Tampa (advanced from Vice President in succession of John Curran)
Vice President: Edward N. Zissman, M.D., Altamonte Springs
Secretary: Richard L. Bucciarelli, M.D., Gainesville
Treasurer: Deborah Mulligan-Smith, M.D., Fort Lauderdale
(The last three were Nominating Committee's slate of candidates and were elected with no additional candidates submitted by membership.)
We welcome the new officers!

* * * * *

Speaking of working for the interests of children, remember that October is Child Health Month. The AAP is promoting a three-year series of programs having to do with substance abuse, beginning this year with tobacco, and the Regional representatives are being provided with materials for media exposure, patient and family education, and samples of goodies (stickers, pamphlets, etc.) available to individual offices to help promote the message.

This is an ideal chance for local physicians (and/or societies) to work with media, schools, businesses, and community organizations for kids' issues. Might even help with marketing (I am probably going to be editorially chastized for such an unworthy thought, but you know what I mean).

Our Legislative Committee has just met, and is already at work at promoting some of our issues which survived the last session but are not yet enacted, such as a 911/Poison Control Center interface, primary enforcement of seat belt usage, and several others...and, of course, appropriate funding for CMS, pediatric AIDS networks, etc. In addition, FMA has several issues worthy of support, such as due process for HMO/physician disputes and tort reform.

Perhaps our primary issue for the Chapter Chairman's Forum of the AAP this year is a resolution for redistricting, in order to provide more equitable representation of the membership from the Southeast U.S. at the national AAP. Ed Zissman and I, along with our neighbors from District IV of the AAP, will be presenting the case, possibly with the help of John Curran, the drafter of the

*(see **President**, page 23 ▸)*

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Dianne S. Elfenbein, M.D.
(Adolescence)
Lance Wyble, M.D.
(Neonatal-Perinatal)

Safety is Number 1

Editorial writers must seem at times to be repetitious. After all, there are really only so many issues to talk about - or is it harangue about? I guess the sign of the good editorial writer is that he is never at a loss to find new words for the expression of old thoughts.

So it is that I must once again try to fill this page with something you will find worth reading - picking and choosing from the issues at hand.

I suppose that, at this time of year, the issue that concerns me most is safety - the well being of our charges, the children. This is true all year long, but particularly in the summer time. School is out, but will be back in session not long after this newsletter is read. There will have been plenty of time for our "kids" to learn bad habits which can continue, along with the warm weather, into the fall months. Thus, "anticipatory guidance" is never wrong, even if stressed and re-stressed all year long.

Let's pick a few safety items.

"...safety in the water..."

"...safety on the water..."

Number 1 is always *safety in the water*. Each year, I wince as I read of (or see on TV) another death of a young chld by drowning. For years, we have been first in the country, a truly dubious honor. Attempts to stem the tide have taken many forms, ranging from parent education regarding safety measures to teaching infants to defend themselves since the parents have failed. Frankly, I do not believe infants really can do this, and I do not believe the technique used really imitates what happens when an infant falls into the water accidentally - head first. I believe some are ready for swimming lessons at two, many not until 3, and the AAP supports this view.

So we get back to the parents. Education to the fact that fences usually protect only the neighbors' children doesn't help enough. Development of "4th side fences", even those which look good, doesn't help enough in this state of relaxed living and pool-side entertainment. The impetus has to stay with us - the pediatricians who are the teachers. The concept of 100% supervision must be taught over and over - not 95%, not "I only left for a moment to answer the phone", but always.

Along with safety in the water, we need also to think and advise about *safety on the water*, our waterways. It is true that not only is there not enough teaching of the mechanics of boating and navigation, but also not of safety of passengers, including the children. No child should ever be on a boat, or even dock-side, without a proper life jacket, worn properly. And the parents need to be instructed in a constant and consistent process of reinforcing this with their children.

And speaking of boats, how many of you have seen young children running ski boats? Why? Do most young children have enough concept of safety (their own and that of others)? I shudder! It is a dangerous toy!

"...bicycles...skates ...skate boards ...school sports..."

Number 2 is *bicycle safety*. Who can fault this time-honored form of transportation? We finally have a helmet law - not perfect but a law. But we also have the motorcycle folks, constantly pushing against helmets for them.. What a great example to set!

Where do we come in? We need to educate that the bicycle is a "stunt machine" for only the very few, while for most it is a method of transportation, with "rules of the road".

(Continued on page 23 ▸)

THE REGIONAL REPRESENTATIVES REPORT

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

Region II reports:

As usual theRegion 2 Area is abuzz with activity.

University of Florida Department of Pediatrics/Jacksonville:

The department of pediatrics graduated 10 pediatric residents; 3 accepted fellowships: adolescent medicine, emergency pediatrics and pediatric GI and the other 7 entered primary care pediatrics.

The resident match was highly successful with all positions matching for the 7th consecutive year. All 10 positions were filled by graduates of American medical schools.

Several new faculty were hired in primary care and neonatology. The neonatologists recently gained the contract to provide services at the BMC-Beaches Hospital and now provide services at 6 Jacksonville area hospitals.

University Medical Center:

UMC continues in negotiations with Columbia to provide management of the hospital; however, Shands Hospital began discussions to acquire Methodist Hospital just across the street from UMC. This may result in Columbia reconsidering its position to provide a partnership with University Medical Center. This issue is quite confusing and fluid at this time. Columbia presently owns

*(See **Region 2**, page 26 ▸)*

[redacted]

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[This directory is updated in each issue. For e-mail addresses of the membership of the Florida Chapter/AAP, please consult the published Directory of Membership.]

Region VI reports:

The pediatricians in Southwest Florida who work with Children's Medical Services are happy with an upcoming geographic move. During the first part of August, CMS Offices, General and Specialty Clinics, Island Coast Primary Care Project will be moving to the Children's Hospital of Southwest Florida at Health Park. This move will bring both the Primary and specialty Care into one facility for their treatment of Health Care for Children.□

J. W. Bartlett, M.D.
Regional Representative, Region VI

[redacted]

Mutual congratulations are exchanged as John Curran hands over presidency to Ed Williams at May Executive Committee Meeting.

[redacted]

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Report of the Committee on Legislation and Government Affairs

Submitted by:
Nancy Moreau, Legislataive Liaison
Tallahassee, FL

(Once again, it is a pleasure to publish Nancy Moreau's report of her major effort during the Legislative Session, along with other members of a very elite group; as was done last year, the report will be published in two parts.)

The 1997 Legislative Session marked a significant turning point for Florida Government with both the House of Representatives and the Senate being controlled by Republican majorities. This shift in power which had been moving forward for several years brought about substantial changes in the way legislative business is conducted.

Unfortunately for many who had been in the process for years the process changes left many veterans dumbfounded with the additional hurdles which had to be negotiated in order to move legislation forward. The Florida Senate was well prepared for the 1997 Session, but the House of Representatives struggled to get its process up and running while having to manage discord within their own party as well as the displaced Democrats who were unaccustomed to being in the minority. All in all things have settled down and as the new process is learned everyone again struggles to have their issues heard.

The Florida Pediatric Society set an ambitious agenda for the 1997 Legislative Session. Thirteen substantive issues were supported by the Society, eight of which passed and are awaiting the Governor's signature. This success would not have been possible without the tireless efforts of many members of the Society, but in particular the attention provided by the Legislative Committee, John Curran, President, Louis St.Petery, Executive Vice President and Gerold L. Schiebler, Child Advocate Member.

Among the issues addressed by the Society was the return of the Child Protection Teams, Sexual Abuse Treatment Program and Child Abuse Prevention Projects (Mills Bill) to Children's Medical Services within the Department of Health.

This issue alone consumed an enormous amount of time as we struggled with the Governor and State agencies to recognize the need for continuing medical direction of these functions. In the end a compromise was reached through the efforts of Senator Doc Myers who held the votes needed to effect this important change. Other important legislation passed included revisions to Florida's Clinical Laboratory Act to remove jurisdiction of the Clinical Laboratory Personnel Board over physician office personnel and removal of health planning assessments; revisions to insurance and HMO statutes to provide uniform benefits for children including a thirty day window to add newborns to policies; revisions to seat belt laws to require children under sixteen to be restrained in both the front and back seats of motor vehicles; and legislation prohibiting discrimination in insurance coverage due to genetic testing.

Listed below is a summary of legislation passed during this session which impacts the health and safety of children or the practice of medicine.

LEGISLATION SUPPORTED BY FPS/FCAAP

HB 1357 (CH. 97-237) - Department of Health

Updates numerous provisions of public health statutes to reflect current practices and procedures which have changed over time. Among the provisions of this bill are the following which are of particular importance to the Pediatric Society:

- Medical direction of the Child Protection Teams and Sexual Abuse Treatment Program is transferred to the Division of Children's Medical Services along with $814,833 to fund the medical directors of these programs.
- The director of the Division of Children's Medical Services is designated as a deputy secretary and the Deputy State Health Officer for Children's Medical Services who reports directly to the Secretary of Health.
- Specifies that interfaciltiy transport of neonates must occur in appropriately licensed and staffed emergency medical services vehicles and provides rule making authority to the Department.
- Creates a children's advisory committee appointed by the Secretary to advise the Department on preventative, pre-hospital, hospital, rehabilitative, and other post-hospital care of children.

Effective Date: July 1, 1997

CS/SB 270 (CH. 97-91) - Clinical Laboratory Act

Revises Florida's Clinical Laboratory Act to exempt physician office labs from the annual local health planning assessment of $150. The act also eliminates the State's facility licensing fee of $100 after July 1, 1998 and eliminates the jurisdiction of the Board of Clinical Laboratory Personnel over physician office personnel and transfers verification of training to the Agency for Health Care Administration. The bill also creates a new section of statute to specify the qualifications of a clinical laboratory director. Effective Date: May 24, 1997.

*(see **Legislation,** page 18 ▸)*

GENERAL PEDIATRIC UPDATE V

September 19-21, 1997
Amelia Island Plantation
Fernandina Beach, FL

SCIENTIFIC SESSIONS

Topics	Speakers
Urinary Tract Infections	George Richard, M.D.
Adolescent Visual Diagnosis	Jonathan Schneider, D.O.
Update on Diabetes Mettitus	Janet Silverstein, M.D.
Hypoglycemia in Newborns	Jay Goldsmith, M.D.
Advances in Genetics	Jaime Frías, M.D.
Breast Feeding and Maternal Infections	Joan Meek, M.D.
EMS for Children	Deborah Mulligan-Smith, M.D.
Pediatricians and the World Wide Web	Lewis Wasserman, M.D.

* * * * *

Annual Business Meeting and Luncheon: Sep 20, 12:00-2:00 PM
Women's Section Breakfast: Sep 20, 7:00-8:00 AM
Saturday Night Reception: Sep 20, 7:30 PM (Free)

For more information call (904) 224-3939

Hotel: Amelia Island Plantation (800-874-6878 or 904-261-6161)

Note:

If you are a Fellow of the American Academy of Pediatrics, you are [redacted] Chapter of the American Academy of Pediatrics, and you automatically receive The Florida Pediatrician. If you have not already done so, **please pay your Florida dues,** billed through the Academy Office.

Healthy Kids Corporation: Another Building Block

Steve Freedman, PhD
Gainesville, FL

When Dr. Pomerance, editor of this newsletter, issued a gracious invitation to have an article on the Healthy Kids Corporation I saw it as an opportunity first, to share the facts relevant to the development of the Healthy Kids model, and then to comment on the meaning Healthy Kids Corporation could have for the future. I am grateful for the opportunity.

Background

During the late 1980's and early 1990's an increasing number of children dropped out of the ranks of the insured. The retreat by employers from subsidies for family health insurance is thought to have significantly influenced this trend. Approximately twenty-five percent of Florida's 3 million children are not insured for health care. As a consequence, these children are typically treated for urgent or emergent conditions in inappropriate settings and do not share the continuity of care enjoyed by their insured peers.

Florida has one of the nation's largest uninsured populations. Nearly 23 percent of those below the age of 65 are uninsured, representing over 2.5 million residents, about one-third of whom are children. A recent study by the American Hospital Association has projected that the number of Americans without health insurance will increase by 7 million over the next six years. This means that there will be 46 million Americans without health insurance in the year 2002, many of whom will be Florida's children.

The Florida Healthy Kids program currently provides access to comprehensive health insurance through contracts with commercial health plans to 38,000 children in seventeen Florida counties. In Fiscal Year 1998, it is budgeted for coverage of about 60,000 children.

The importance of Healthy Kids and the school enrollment-based model is evident not only in the number of children who now receive health care, but also in the well-deserved recognition that it has received. In December 1996, the Florida Healthy Kids Corporation (Healthy Kids Corporation) received an Innovations in American Government Award from the John F. Kennedy School of Government at Harvard University and the Ford Foundation. Selected from 1,560 applicants, Healthy Kids was honored for its outstanding example of creative problem-solving in the public sector. In addition, the Robert Wood Johnson Foundation has made grant money available to replicate the Healthy Kids Replication Program with award up to $3 million to a maximum of seven states.

Access to health care is crucial to the development of a child. Children who have health insurance are more likely to receive preventive care - the pediatric care that helps keeps a child in good health. Children who do not have affordable access to a physician are less likely to seek treatment for minor illnesses… suffering until the body heals itself or the condition becomes too severe for home remedies. For many of these children, their primary source of health care is the emergency room. The Centers for Disease Control in 1991 reported that, for 13 percent of children ages 15 and under, hospital outpatient departments were their primary contact for health care services. Another study found that uninsured children under the age of 19 are eight times more likely to receive care inappropriately in an emergency room than children with insurance. The severe outcomes of these medical conditions reduce the child's ability to attend school and participate in the activities of a normal childhood. The costs associated with this level of care are not limited to the child, but affect the community as a whole. Emergency room services are expensive, especially when they are used to treat illnesses that could have been prevented by an earlier visit to a physician. Lack of health care coverage is an important factor in the delay of seeking preventive and acute care. Children with health insurance are more likely to be fully immunized, have more preventive care visits, fewer physician office visits for illnesses and fewer emergency room visits. For children with a regular source of care, total health care costs are lowered by an estimated 25%.

According to the 1996 Current Population Survey, one in seven children in America is uninsured. This amounts to an estimated 10.5 million kids. Contrary to common perception, these children are not part of any entitlement

In fact, 87% of the uninsured children live in households headed by working adults. And while the majority of Americans get health insurance through their employers, the number of employers that offer health insurance to dependents is continually decreasing as the cost of health insurance increases. Even for families that have access to health insurance for their children through their employer, the cost can be prohibitively expensive. Because employers typically cover workers rather than families, the chance of being uninsured is about 40 percent higher for a child than for an adult. Despite expansions in Medicaid, the number of uninsured children above the current Medicaid eligibility levels continues to increase. As a result of these two factors, the majority of uninsured children live in households with incomes just above the federal poverty level.

Part of Florida's high uninsurance rate can be attributed to the characteristics of the state's business economy. Larger firms are more likely to offer health insurance as a benefit than small firms. More than 95 percent of Florida's businesses employ fewer than 25 individuals. The structure of current insurance programs has left over 800,000 of Florida's children uninsured. This problem is partly a result of the system of employment-based health insurance.

School Enrollment-Based Health Insurance

The Healthy Kids Corporation uses school districts to create large health insurance risk pools for the purpose of bringing affordable, accessible, quality private sector health care to the population of uninsured children. This innovation was based on the concept presented in the New England Journal of Medicine in 1988 by Steve Freedman , Ph.D., F.A.A.P., a member of the Florida Chapter. Formed in 1990 by the Florida Legislature under section 624.91, Florida Statutes, the Healthy Kids Corporation is a private not for profit corporation with two missions: to organize school children groups for the provision of a comprehensive health insurance product for children, and to facilitate the provision of preventive health care services to the same population. The statute establishes a board of directors which directs the activities of the corporation, determines program eligibility, designs the comprehensive health insurance benefits, and oversees the administrative activities of the program.

Most American children attend school. School systems can be used as a mechanism for creating large groups of people to cover participants the manner large businesses do. This is identical to current employment-based insurance, except that school children become the "employees," qualifying themselves and, potentially, their siblings for coverage.

A group composed of school children is large enough to provide an insurance benefit package and premium prices that are a good fit for middle income families. For example, moving the insurance contract from the employer to the school system enhances the "portability" of coverage for the children, especially for the child that has a pre-existing illness.

School districts volunteer to develop an agreement with Healthy Kids Corporation and parents decide whether to purchase the coverage… a private, voluntary mechanism for insuring large numbers of uninsured.

The Corporation and Insuring Program

The Florida Healthy Kids Corporation, a not for profit corporation, operates directly under the supervision and approval of a 13-member Board of Directors. The Board of Directors annually appoints an Executive Director who has the responsibility for the general and active management of the Corporation and sees that all orders and resolutions of the Board are executed. Financial and compliance audits are conducted each year by a CPA firm to ensure that the Corporation is in compliance with generally accepted accounting procedures and practices. The Corporation is required by Florida Statute to annually submit a report to the Legislature.

- Healthy Kids Corporation has contractual arrangements for the provision of many services:
- The Corporation selects its insurance partners through a competitive

*(See **Healthy Kids**, page 24 ▸)*

Liability and Managed Care

Committee on Medical Liability

ABSTRACT. This statement is intended to inform practitioners of the liability issues arising from managed care arrangements. Although it is not possible for pediatricians to completely insulate themselves from all liability in these areas, this statement offers a number of strategies to decrease the chances of being successfully sued. However, because case law within this realm is constantly evolving in each state, these serve only as guidelines and are subject to both local and emerging developments.

Although managed care has existed since the 1930s, it has only recently affected the majority of pediatricians. With managed care as a way of life for at least 80% of pediatricians, a new set of medicolegal issues is emerging. In addition to this, a pediatrician now has to contend with a new set of financial as well as medical issues. The most common areas that affect pediatricians include utilization review, compensation through financial incentives, termination policies for both the physician and the patient, abandonment, and limitation on referrals and testing. Although pediatric care often involves parental, as opposed to patient, decision-making, for ease of reference in discussing these issues, the term “patient” is used throughout this statement. This term is used with the understanding that it refers to either the minor patient or the guardian(s), as appropriate and as consistent with the Academy's policy.

UTILIZATION REVIEW

In the past,pediatricians made decisions about a patient's treatment based primarily on what the pediatrician perceived were the patient's medical needs and wishes. Due to the public’s increased awareness of tbehigh cost of medical care, its demand to curb those costs, and the fiscal methods used by managed care to meet these demands, the pediatrician can often be placed in a very uncomfortable and legally risky position.

The cornerstone of legal cases dealing with the issue of utilization review is *Wickline v Siate of California*.[2] The court in that case stated that the responsibility for deciding a patient’s medical course belonged to the treating physician, not to the insurance company. It went on to say that those administering utilization review programs could be held liable if the programs were administered in an arbitrary or negligent manner, and that the treating physician could not point to the health care payor as the liability "scapegoat.” A more recent case, *Wilson v Blue Cross of Southern California*[3] upheld portions of *Wickline* but greatly increased a health maintenance organization’s liability in the area of utilization review, although it did not absolve the physician from liability for inappropriate or improper treatinent.

As case law continues to evolve in this area, it is important for pediatricians who are subject to utilization review to consider the following:

Plan Issues

- Reviewers must include at least a registered nurse or physician, preferably a pediatrician.
- Any case in which approval was denied rnust be reviewed by a physician, preferably a pediatrician.
- There must be a reasonable appeals process in place.
- The physician reviewer must be available to discuss any denials over the phone.

If a contract does not contain the above-meritioned provisions, the pediatrician needs to renegotiate the contract with the managed care company.

Pediatrician Issues

- Pediatricians should use the entire appeals process to render the most appropriate care for their patients.

The recommendations in this statement do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

- Pediatricians should document all conversations regarding utilization review issues.
- In the rare case that a pediatrician cannot reach a reasonable agreement with utilization reviewers, the pediatrician should discuss with the patient the option of paying independently for medical care received outside of his or her insurance coverage. It is irnporatant to document this "informed refusal" if the patient chooses to refrain from receiving the noncovered care.

INCENTIVE OR BONUS PROGRAMS

Although it has never been proved that incentive rograms really do change physician behavior and decrease medical costs, they nonetheless continue to be used by managed care organizations. It is very difficult to defend one’s position in cases in which there is directfinancial gailn atached to medical decision making. Pediatricians considering involvement with a program that uses incentive or bonus plans should consider the following:

- In most cases, a broad-based program is easier to defend. These programs are based on the actions or expenditures of a group of physicians instead of one individual physician and on a time frame that considers the actions over a month, quarter, or year instead of each individual episode of care.
- A program that is tied not only to utilization but also to quality of care is far superior to a program that does not consider quality.

TERMINATION

Another area of risk is that of termination of the contract. Any contract that a physician signs should clearly state both the company’s and the physician’s responsibility with regard to termination of the contract. The contract should list what events or actions can lead to termination by either party and the length of time necessary to terminate the contract.

The contract should also discuss issues surrounding termination of the pliysician/patient relationship. These include, but are not limited to, physician notification of patient termination and under what conditions a physician can terminate his or her relationship with a patient. Many managed care organizations have clauses in the contracts that allow termination of the physicicin-pafimt relationship in the event of a patient’s continuous gross noncompliance with the treatment plan or a patient physicaly or verbally abusing the physician. In all cases, the events used to justify termination must be well-docurnented.

When a patient-physician relationship is to be terminated, it is important for appropriate, timely notification to occur so as not to constitute abandonment.

ABANDONMENT

Although it may ultimately be the responsibility of the managed care cornpany to notify patients that their their primary care physician is no longer a provider within their organization, it is prudent for the pediatrician to notify the patient of a change of status within the organization. To best reduce the risk of an accusation of abandonment, at least 30 days before leaving, the physician should notify each patient affected by registered mail. Included in this letter may be a list of providers within the organization who are available to the patient.

Notification alone, however, may not be sufficient to avoid a claim of abandonment. If the care of the patient cannot be transferred expeditiously, the patient may continue to have a right to care despitethe lack of a contract between the physician and the managed care organization. The physician similarly may be bound to provide treatment to a patient even in the event of the

*(See **Managed Care**, page 23 ▸)*

TETANUS: COMPLICATIONS AND MANAGEMENT IN A PEDIATRIC INTENSIVE CARE UNIT

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M. Yousuf Hasan, MD.
Division of Pediatric Critical Care, University of Florida-Jacksonville
Jacksonville, FL

Tetanus disease has been known to man since the 14th century when John of Arderne, an English surgeon, described a case of tetanus following a gardening injury.[1] While the incidence of tetanus has declined dramatically in the United States, case fatality rate is still about 20-30% and increases to 50% for those older than 60 years of age.[2,3]

With the successful control of severe reflex muscle spasms by curarisation and intermittent positive pressure ventilation the major problem in severe tetanus is the management of circulatory disturbances that occur as a consequence of autonomic dysfunction. Various pharmacological agents have been used to control sympathetic overactivity. Labetalol, a drug with alpha and beta- adrenergic blocking properties was used in the management of cardiovascular instability in some cases of severe tetanus. In the literature, only one child with severe tetanus received labetalol by continuous infusion to control sympathetic overactivity. Since tetanus is so rare in the United States, many physicians have little experience with its serious complications and management.

We present a case report of a child with severe tetanus, where a labetalol infusion was successfully used in stabilizing the cardiovascular disturbances. We will review the literature, offer a disease overview, present our experience and discuss tetanus complications with emphasis on the management of autonomic dysfunction in pediatric intensive care unit .

Case Report

A 12-year old Amish male stepped on a fish bone as he was walking barefoot outside his house. He did not seek medical attention at the time, however, five days later, he developed slight swelling of the left lower leg and started to limp. He had mild back pain and occasional leg spasms. Over the next two days, the patient developed generalized stiffness, back pain, difficulty with swallowing and jaw pain. The patient was taken to a local emergency department where his presumptive diagnosis was tetanus. He received 500 units of tetanus immunoglobulin and was transferred to our institution for admission and treatment.

Although he had not received any childhood immunizations due to religious beliefs, his past medical history was noncontributory. On admission his general physical examination was remarkable for swelling and cellulitis of left foot. His baseline lab values were within acceptable limits except for CPK which was elevated and continued to rise, maximizing at 1,365 IU on his third day of admission. Epinephrine level were high in both blood and urine.

During wound debridement in the operating room, a 6 cm long section of fish bone was removed and bone biopsy showed evidence of necrosis and osteomyelitis. Over the next 24 hours, his condition deteriorated rapidly. He developed tetanic generalized spasms with opisthotones, risus sardonicus and abdominal rigidity. The patient was transferred to the PICU where he was placed on a continuous infusion of midazolam at 0.1 mg/kg/hr. In addition, he was receiving intermittent boluses of lorazepam, diazepam and morphine sulfate. He continued to have spontaneous spasms every 5 minutes that produced apnea, cyanosis and bradycardia requiring mechanical ventilation. While intubated he required an average of 120 mg of midazolam each day by IV constant infusion, as well as diazepam and lorazepam boluses 0.1 mg/kg every 3-4 hours alternatively. He received morphine sulfate up to 60 mcg/kg/hr by infusion. Pancuronium bromide was infused at a rate of 0.1-0.2 mg/kg/hr to control muscle spasms and facilitate mechanical ventilation.

During the second day after intubation, the spasms were controlled but cardiovascular instability continued with sinus tachycardia of 150 bpm and intermittent systolic hypertension up to 160 mm Hg. By day 3, there was increasing cardiovascular instability with systolic blood pressure varying from 120-180 mm Hg and heart rate from 80-120 bpm. These variations were not always in response to stimulation and occurred despite adequate sedation and analgesia and use of lidocaine 0.5 mg/kg via endotracheal tube or intravenously prior to ETT suctioning. Heavy sedation and analgesia failed to provide control of sympathetic overactivity or elevated catechol levels in blood and urine.

On day 4, intermittent infusions of labetalol were started. The dose was 0.25 mg/kg to be repeated and doubled every 10 minutes, as needed to a maximum of 2 mg/kg/hr. Initially, labetalol boluses produced an immediate fall in systolic blood pressure from 160 to 110 mm Hg and a decrease in the pulse from 125 to 90 bpm. This improvement was sustained only for 1-2 hours.

The following day, labetalol dosing was switched from intermittent to continuous infusion at 2 mg/hr resulting in sustained control of hypertension. It was possible to reduce sedation and discontinue lorazepam boluses. After 24 hours the labetalol infusion was reduced to 1 mg/hr and systolic blood pressure was maintained in the range of 100-140 mm Hg. Attempts to wean labetalol further were unsuccessful until the sixth day when the labetolol infusion was slowly discontinued.

After one week of intubation, tracheotomy was performed. Interventions were limited to reduce he risk of iatrogenic complications. During the first week of hospitalization, the patient lost 3 kg, despite enteral tube feeding at 1500 kcal/day. It was necessary to increase caloric intake to 2500 kcal/day to maintain positive nitrogen balance and regain weight.

The patient received four weeks of claforan and penicillin. Physical therapy was provided during hospitalization. After three weeks of heavy sedation, neuromuscular paralysis and mechanical assistance, he was weaned from mechanical ventilation. Muscle spasms resolved, however profound weakness continued. He was unable to recall anything of his ICU stay, did not complain of pain and kept good p.o. nutrition as the enteral diazepam was slowly weaned over 7-10 days.

Discussion

Tetanus is an exotoxin-mediated disease. It is caused by Clostridium tetani, an anaerobic, gram positive, spore forming rod. The organism produces two exotoxins; hemolysin, and tetanospasmin; the latter is a neurotoxin that is responsible for the clinical manifestation of tetanus disease. [4,5] Tetanospasmin spreads to the central nervous system and binds to gangliosides.[6] Here it blocks the release of neurotransmitter from the presynaptic inhibitory neuron.[7] The loss of inhibitory impulses results in cardinal clinical manifestations: reflex irritability and autonomic hyperactivity.[4] The most common presenting complaints are those of generalized tetanus. After an incubation period of 3 days to 3 weeks, patients complain of stiffness in the jaw, abdomen, or back and dysphagia. As the disease progresses, rigidity and trismus occur. Generalized rigidity of facial muscles causes the characteristic expression of risus sardonicus. Reflex spasms develop within 1 to 4 days of the first symptoms. Spasms may be precipitated by minimal stimuli such as noise, light or touch and last from seconds to minutes. They can be painful or dangerous, causing apnea, fractures or rhabdomyolysis.[8]

Ideally, tetanus is treated in an ICU. Managing patients with tetanus in the Intensive Care Unit has significantly reduced the rate of mortality from this disease.[9] The most important early aspect of treatment after airway protection is passive immunotherapy with human tetanus immunoglobulin, to eliminate as much of the toxin burden as possible. The source of toxin should be eradicated by debridement. Although the disease is caused by the toxin, not active infection, the use of antibiotics may be of help, particularly when there is osteomyelitis. Penicillins are the most frequently used antibiotics although metronidazole may be useful.[10]

*(see **Tetanus**, page 21 ▸)*

CHILDREN'S HEALTH PROGRAMS IN FLORIDA

Gerold L. Schiebler, M.D.
Gainesville, FL
Child Advocate Member

(This article appeared in The Florida Pediatrician in March 1982 and is reprinted here because of its continued timeliness. It first appeared in the December 1979 Florida Bar Journal.)

The formation in 1973 of the Children's Medical Services (CMS) organization within the Department of Health and Rehabilitative Services was the keystone that allowed the development and funding of a panorama of children's programs in the State of Florida. Children's Medical Services was the platform from which efforts could be catapulted relating to enhanced health for children with special problems - particularly those that have long-term chronic disease. CMS provided the status in state government to allow an administrative unit to speak solely for infants, children and adolescents. CMS was an outgrowth of the original Crippled Children's Organization in Florida which had been established in 1929.

Thus today, on its 50th anniversary - simultaneous with the International Year of the Child - CMS is the highest level organizational unit representing children in any state government. This vantage point more easily allows the coalescence of forces and advocates of children and their special needs.

Equally essential to the success of the CMS programs was the decision of the Florida Pediatric Society (FPS) to hire a lobbyist who would represent the organization and and its legislative goals. These goals were closely related to those of CMS. The presence of such a lobbyist in Tallahassee throughout the year developed further the image of the Florida Pediatric Society and its special relation to CMS.

This lobbyist could represent children's causes and needs throughout the year. Such a presence is becoming increasingly necessary, particularly since with each advancing year legislative committees are meeting throughout the year, prior to the annual formal spring session.

It also gave the Florida Pediatric Society the opportunity to monitor the irnplementation of new legislation and associated rules and regulations. This is just as essential as securing the passage of a law through the legislature. Many advocacy groups have been successful in passing pro-children's legislation, only to fail when they lacked the resources to carefully watch the implementation of the law.

The lobbyist taught the pediatricians and their allies the workings of the legislature. Such special knowledge is of the essence if one is to achieve success in that cauldron of legislative activity - Tallahassee. It included: (1) knowing the power structure of the House and Senate and the differences in their rules and philosophy; (2) getting acquainted with the key members of the legislature - ones who have the capacity of making decisions; (3) ascertaining which pediatricians knew such legislators best; (4) understanding the committee and subcommittee system; (5) knowing the process of getting a bill on the agenda of a committee or on the floor of either chamber; (6) timing the maximal impact on the involved legislators at the appropriate time in the process; (7) learning how to present the key facts in a concise and clear fashion.; and, (8) being able to achieve maximal coalescence of efforts with involved legislators without causing a counter-reaction of irritation and even anger. All these, and many more, techniques must be mastered by any individual who expects to compete successfully for the attention and support of legislators, both for conceptual ideas encompassed in legislative bills and the associated funding so necessary to the implementation of such legislation.

Pediatricians alone often cannot muster the full support of all the involved legislators. Fortunately, the Florida Pediatric Society (and indirectly, CMS) on many key issues was able to get the support of the Florida Medical Association, members of the Florida Voluntary Health Association, and the coalition of over 30 child advocacy organizations, meeting under the leadership of Florida's Center for Children and Youth. The latter is an organization committed to addressing all the challenges of infants, children and adolescents - not only health and nutrition.

This alliance of forces over the years, in concert with many committed legislators, has been instrumental in the passage of much pro-child legislation. Some of this legislation has become the model for other states and even the federal government. Such legislation would include: (1) the law relating to the enhancement of the role and scope of Children's Medical Services; (2) allowing the funding of individuals with chronic illnesses past the age of 21 years, if they had been sponsored by CMS prior to that time; (3) the Neonatal/Perinatal law establishing Florida's program for premature babies and newborns with special problems, along with the much needed funding for this program; (4) the neonatal insurance law making it mandatory that in all family insurance polices, coverage for the infant would begin from the moment of birth, without any exclusion clauses up to a certain age; (5) the revision of the adoption statute to allow families at all income levels to adopt children with long-term chronic and very expensive diseases - and to have CMS fund the costs of such health care (this rapidly increased the number of children adopted into families and allowed such children to have a more normal environment without the involved family having to absorb the fiscal impact of the child's illness; (6) funding for child abuse programs under CMS, as child abuse in today's society remains one of the greatest maimers of children; (7) passage of a neonatal screening law to set up a statewide program to check for those diseases and biochemical entities which needed to be identified and treated early to prevent or ameliorate developmental disabilities or retardation; and, (8) a law to ensure that every child at the ap propriate age would be examined for scoliosis (curvature of the spine) to prevent serious deformity of the spinal column.

For maximal effectiveness in the legislative forum, such issues should be carefully thought through; a position paper should be established listing the advantages of such legislation; the objections and impediments to such legislation should be anticipated and overcome; early in the legislative process, the sponsorship and profiling of such bills should be obtained from committed and powerful legislators; identical bills should be introduced in both the House and Senate, often after review by the staff directors of the appropriate committees of the Senate and House, and the legislative liaison staff of the Secretary of the Department of HRS; the proposed legislation should be reviewed with the Governor's staff to make sure that there are no philosophical objections to such a bill which could result in a veto; and support from the natural allies of pro-children's projects should be garnered. All of these are important! They do not guarantee success, but they are vital if any success is to be achieved at all.

The children of Florida have been most fortunate to have had during this time committed "pro-child" Governors and a superior legislature with skillful staff. Their support for children's programs, both conceptually and fiscally, has been a model for other states to emulate.

Continued progress can be made if the legislature continues to see that such programs produce results; prevent duplication of costly medical facilities; prevent disability, disease, and retardation in children; become the health models from which other states learn; produce a favorable image for the involved legislators who have committed themselves to children's projects; and result in programs, upon close scrutiny and auditing, which have a favorable benefit in relationshiip to the cost. Much remains to be done, particularly coordinatirig all

*(see **Emphasis**, page 26 ▸)*

SPECIAL ARTICLE

THE CRISIS OF THE KIDS

Reed Bell, Sr., M.D.
Physicians Advisory Council
Florida Family Policy Council

Today one baby in three has no legal (responsible) father! Teenagers once accounted for 50% of illegitimate births. However, in 1992, teens produced less than a third (30%) while women ages 20-24 had 36%, and ages 25-44 years had 35% of babies born out of wedlock. The generational momentum of these non-marital rates is predicted to produce illegitimacy rates up to 40-50% of all births.

The number of children in one-parent families dramatically increases when the results of no-fault divorce and unwed births are combined. The significance? Continued family fragmentation into the next generation!

Demographers attribute the dramatic changes to a decline in social disapproval, i.e., the stigma once attached to unwed motherhood is fading fast. Compounding the problem is the rise in the number of women who become sexually active at earlier and earlier ages, co-habit more and marry less; and have children later in life. Unwed mothers are still overwhelmingly young, poorly educated and have low incomes - a poor prognosis for the child and the welfare society.

The children of unmarried or divorced single parents are:

- 6 times as likely to be in poverty
- 2-3 times as likely to have emotional problems and to drop out of school
- they have 5 times the risk of delinquency and violent crime
- they are 3-4 times more likely to give birth illegitimately
- they are 2 times as likely to divorce and be a single parent in poverty
- they are 3 times more likely to use drugs and commit suicide

Children of single parents are also at risk for increased child and spouse abuse and far more likely to lack competence, character and a work ethic.

The significance is staggering because of its impact on children and our society as a whole. For example, the median yearly income in 1993 for a two-parent family was $43,578; for the single parent (divorced) it was $17,014; and for the single parent (unwed) $9,272.

Surprising and ominous is a huge jump in the non-marital birthrate reported by the National Center for Health Statistics. For the year 1992 unmarried births totaled 1,224,876 or 30% of all births. This represents a 54% increase since 1980 when unwed births were only 18%. In 1940 unwed births were 4%; in 1955, 8%; in 1970, 16%; in 1980, 18%; in 1990, 27%; and in 1992, 30%. What will it be in the year 2000?

The family is tremendously relevant. America is in crisis and has no alternative more valid than restoring fatherhood. We must rebuild a Marriage Culture based on enduring marriage relationships. We can manage the medical needs of our youth, but we are "dumbing down" our kids and losing them to life-style "choices", i.e., our moral decline.

The signs and symptoms warrant the diagnosis: "Fatherless America". The root of our social problems is family dissolution and the absence of husbands as fathers.□

Child Health Month

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.

October is Child Health Month. The Governor has been asked to declare this for the State of Florida, as he usually does.

The Child Health Month theme for 1997-1999 is substance abuse prevention. This year, the Americal Academy of Pediatrics will focus on tobacco use, specifically smoking, environmental tobacco smoke and smokeless or chewing tobacco - and the health risks they pose for children.

The FPS/FCAAP encourages you to acquire the related AAP brochures to display and distribute in your office. The following are available:

"Smoking: Straight Talk for Teens"

"The Risks of Tobacco use: A message to Parents and Teens"

"Environmental Tobacco Smoke: A Danger to Children"

"Smokeless Tobacco: Guidelines for Teens"

The price for each brochure is $29.95 per 100 copies. The AAP member price is $24.95 per 100 copies. To order one or more of these brochures from the AAP, call (800)433-9016, and ask for "Publications".

We hope you will participate in Child Health Month by obtaining one or more of these brochures and displaying/distributing them in your office.

All of us need to contribute as much as possible to Child Health Month, in order to raise awareness of the problems still confronting the children of our country.

Look also for press releases as October approaches: you may be called upon by your local media outlets!□

Note: *Visit our society's permanent website at:* **www.flmed.net/fps** *for all you want to know about our society, including a summary of The Florida Pediatrician.*

Note:

Another summary of The Florida Pediatrician is on the website for the [redacted] ***Chapters.***

FROM THE AMERICAN ACADEMY OF PEDIATRICS

1997 NATIONAL ACADEMY ELECTION

The National Academy election was held this past spring, and the results were as follows:

Vice President Elect	**Joel J. Alpert, M.D.**
District I:	
Alternate Chairperson	Eileen Ouellette, MD
National Nominating Committee	Suzanne Boulter, MD
District III:	
Chairperson	Susan Aronson, MD
District IV:	
Alternate Chairperson	**Charles Linder, MD**
National Nominating Committee	**Francis Rushton, MD**
District VI:	
Chairperson	Ordean Torstenson, MD
Alternate Chairperson	Kathryn Nichol, MD
District VII:	
Alternate Chairperson	Gary Peck, MD
National Nominating Committee	Larry Patton, MD
District IX:	
Chairperson	Lucy Crain, MD

Of the 32,476 voting members, approximately 37% returned ballots. 37% returned ballots.

For Dictrict IV, the statistics are slightly less than average: Of 5743 voting fellows, 35% returned ballots.

For Florida, statistics are even worse:
Of 1137 members, only 350 voted, or 31%.
There are also 879 members in District IV who are classified as Chapter 00 (to wit, not identified with any chapter). 226 voted, or 26%. Most of these are in Florida. Thus, if we add the entire group to the 1137 identified, there would be 2016 members, with only 576 voting, or 28.5%.

[Not a good showing! We are one of the largest chapters, but we do not use our power in proper democratic fashion: by voting. -Ed.]□

SCHEDULE OF MEETINGS OF THE AAP

Annual Meeting:
New Orleans, Louisiana
November 1-5, 1997

Spring Session:
Atlanta, Georgia
April 4-7, 1998

The Seniors among us will be interested in the program prepared for the Senior Section, which will meet on Monday, November 3rd, from 2:00 to 5:00 PM during the Annual Meeting of the Academy:
Moderator: Doris A. Howell, M.D., Program Chairperson

2:00 PM - Senior Section Chairman Welcome - Herbert L. Winograd, M.D.
2:05 PM - Introduction to Program - Doris A. Howell, M.D.
2:15 PM - Pediatric Education II - Jimmy L. Simon, M.D., Committee Chairman
2:30 PM - Double Nickel Club - How to Afford to Travel - James L. Reynolds
2:50 PM - Panel - Challenges Abroad for Alert Pediatricians (keep your cutting edge honed) - members of International Pediatric Society
Jane G. Schaller, M.D.
Karen N. Olness, M.D.
Robert J. Haggerty, M.D.

3:30 PM - Coffee Break
4:00 PM - Travel for Enlightenment and Enjoyment - Daniel J. Shapiro, M.D.
AAP Travel Office/Consultants
Agency Representatives
Elderhostel, AARP, American Express Seniors Programs, etc.
4:45 PM - BUSINESS MEETING - Chairman, Herbert L. Winograd, M.D.

5:00 PM - RECEPTION

All Seniors attending the AAP Annual Meeting are urged to join the group for an informative and friendly afternoon.□

Kudos

...to Arnold L. (Bud) Tanis, who was honored by the City of Hollywood, Florida on January 15, 1997. Bud was recognized for over 40 years of caring for the children of Hollywood. The Mayor and the Board of Commissioners presented him with a proclamation, making January 16, 1997 "Dr. Arnold Tanis Day". A reception was held in his honor. Bud was cited, in part, for his efforts toward passage of the Florida Child Restraint Bill, and for his role in passage of the legislation which provided insurance coverage for routine pediatric care. Bud started practice in 1957.

Congratulations, Bud!□

PEDIATRIC TB SKIN TEST ISSUES

William Hite
TBC Program Manager
Landis Crockett, M.D., M.P.H.
Division Director for Disease Control
Florida Department of Health

Discussions of pediatric skin testing for tuberculosis in Florida have historically focused upon school age children. In 1994, at the time of the Tuberculosis in School Children Legislative Report, forty counties had some school screening program in place. However, any discussion of pediatric skin testing that is limited to this age set is incomplete at best. Approximately two thirds of pediatric TB cases occur under the age of five. Children infected between five and fourteen years of age usually develop disease in adult life rather than childhood.[8] Thus, school testing programs will fail to prevent most TB disease among children, and require focused interpetation if used to identify candidates for preventative therapy. Both the Florida Bureau of TB Control and Prevention and the U.S. Public Health Service Centers for Disease Control and Prevention (CDC) concur that school children as a group are not a risk group for TB infection or disease, and suggest targeted screening in place of less focused, broader based testing policies.[9]

Prevalence of TB infection as measured by skin tests must be interpeted with reference to the test's sensitivity and specificity. Sensitivity can be impacted by errors in the testing procedure, and by a variety of host factors, including severe TB disease, HIV infection, other immunosupressive diseases, some viral infections (measles, mumps, varicella), live virus vaccination, malnutrition, and renal failure.[2] Test specificity is most influenced by the prevalence of infection, and by variable cut-off points chosen for interpetation of the TB skin test. The following table, taken from Bass[2], illustrates the effect of these variables upon the predictive value of positive TB skin tests.

	Test Specificity	
Prevalence of Infection (%)	0.95	0.99
50	0.95	0.99
25	0.86	0.97
10	0.67	0.91
5	0.5	0.83
1	0.16	0.49

Infection rates for high risk groups, such as contacts to TB cases, immigrants from countries with high case rates, and others, is estimated to lie between 25% and 50%. The background infection rate for the United States is considered to be somewhere between 5% and 10%. Finally, school testing in some Florida counties has elicited reaction rates of only 2% to 3%.

As can be seen above, routine skin testing of children for TB will in most cases be a low yield and misleading activity. For the testing to adequately serve its purpose, it is necessary to identify children belonging to high-risk groups or possessing medical risk factors for TB infection. Hakim and Grossman10,7 identify the following children as being at high risk for tuberculosis:

- Children who are socio-economically deprived
- Those who have medical risk factors for TB reactivation
- Those living with one or more persons with TB disease
- Inhabitants of neighborhoods with high TB case rates
- Children from high risk areas (Asia, Africa, Middle East, Latin America, the Caribbean)
- Ethnic minorities (Blacks, Hispanics, Asians, and Native Americans)
- Incarcerated children
- HIV-infected children
- Those children frequently exposed to adults at high risk for TB (shelter and nursing home residents, migrants, drug users, the homeless, HIV-infected)

The tuberculin skin test should be read as positive at 5mm for children who are close contacts to a case of tuberculosis, who are suspected to have TB disease, or who are immunosuppressed. The test should be considered positive at 10mm for children under four years of age, children with medical risk factors for progression from infection to disease, and children with increased environmental exposure, from high risk adult contacts at home or abroad. Children four or older with no risk factors should be read as positive at 15mm.[7] A history of BCG vaccination is not a contraindication to skin testing, and a positive reaction usually indicates infection with TB, especially if the child is a contact to a case or has a connection to high-prevalence areas. Larger than minimum positive reaction sizes, and the number of years passed since vaccination also proportionately affect the likelihood of the test representing TB infection.[5]

Much of the information needed to assign patients into a risk category can be elicited from the patient or relatives when taking the initial history. Dr. J. Starke[1], while associate professor of clinical pediatrics at the Baylor College of Medicine in Houston, and director of the Children's Tuberculosis Clinic of Harris County, Texas, developed a five question test for this purpose in 1994. A negative answer to all five questions is interpreted as representing low risk for TB infection.

1. Was the child or his parents born in a country with high TB rates?
2. Is there a family history of TB over at least two generations?
3. Does the family have significant contact with anyone who is HIV positive?
4. Has any family member been in jail or prison during the past five years?
5. Does the child live in a community with a high rate of TB?

The difficulty with questionnaires of this type, and with the criteria listed earlier, is that the required information for some replies may be unknown both to the client and to the physician. The Florida Bureau of TB Control and Prevention, working through the County Health Departments is the resource able to provide local epidemiological information regarding areal risk groups and neighborhoods, as well as new information on state and national epidemiology relevant to the subject. There are currently fourteen TB Control Managers, and a similar number of TB Surveillance Coordinators, available to assist the clinician in these endeavors. Most are located in the County Health Departments, and all are reachable through the local Health Departments' Tuberculosis Control Programs. Besides possessing information regarding local at-risk populations and areas, these positions can access similar data from the statewide or national perspective,

*(see **Skin Test** on page 26 ▸)*

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

Meetings, Meetings, and More Meetings

Patricia J. Blanco, M.D.
Florida CATCH Facilitator

This year has been a very busy organizational year for CATCH. From a national perspective, the AAP Department of Community Pediatrics hosted its second National CATCH meeting in San Diego, California on May 8th thru 10th. This two day meeting was jam-packed with pediatricians from across the nation who have made a difference in the lives of the children in their communities. These physicians recognized an unmet need in their community, became pro- active, collaborated with others who shared their concerns, and found solutions to the problems locally. It can be done. The meeting was not only inspirational, but practical as well. State facilitators were trained in needs assessment, program evaluation, collaboration and motivation.

While at this national meeting, I was fortunate enough to hear the AAP keynote speaker, Judge Charles Gil. As I listened to Judge Gil's sobering dissertation, I became filled with a sense of outrage. For too long we have allowed our nation's leaders to give lip service to the needs of children. We must demand that local, state and national leaders be accountable for their actions. We must insist that they prioritize children's issues not only in speech but in deed. Pediatricians also must take stock. We cannot afford to simply be good quality physicians and put our heads in the sand. If we truly believe that children are our future and if we truly care about children, we must become passionate advocates for kids and we must dedicate our own personal resources whether it is time, money or expertise toward efforts to improve the health and welfare of our children.

State facilitators from District IV also met together in Charleston, South Carolina February 7-9 with Dr. Marion Burton our regional CATCH facilitator. This meeting allowed us to work in small task forces to devise CATCH action plans for our individual states. It was a great work session. We were able to share much information.

Please join me at our first statewide CATCH meeting which will be held on Saturday, September 20, 1997 in conjunction with the Florida Chapter meeting at the Amelia Island Plantation Hotel on Amelia Island. Come and learn how you might make a difference in the lives of children in your community.□

Florida CATCH Meeting

September 20, 1997

2:00-2:20	1. Introduction "CATCH" A Historical Perspective -Thomas Tonniges, M.D., F.A.A.P.
2:20-2:40	2. Public Private Partnerships as a Platform for CATCH activities - O. Marion Burton, M.D., F.A.A.P.
2:40-3:00	3. CATCH Video - "Making a Difference for America's Children
3:00-3:15	Break The Florida Experience
3:15-3:35	4. The Tallahassee Primary Care Program -Louis St. Petery, M.D., F.A.A.P.
3:35-3:55	5. A Collaborative Community Endeavor-The School Based Clinic of Northeast High School -David Cimino, M.D.
3:55-4:15	Reach Out and Read in Tampa -Sharon Dabrow, M.D.
4:15-4:45	Bridging Public Health-The Community and the Pediatrician -Claude Dharamraj, M.D.
4:45-5:00	Questions□

Visiting Professorships/CATCH Planning Grants

The time has come for pediatric academic institutions to begin formulating plans for applications for the visiting professorship program. Be sure to give both Florida Chapter President, Dr. Edward Williams, and me sufficient time to write letters of endorsement for your proposals. Wyeth-Lederle CATCH planning funds should be available for the next grant cycle in the fall. Please begin working on these projects now. Also, remember that these funds are not to be utilized for implementation purposes. For more information about these funds, please contact:

Patricia J. Blanco, M.D.
Florida CATCH Facilitator
3675 W. Waters Avenue
Tampa, FL 33614□

See: "Current C.A.T.C.H. Programs in the State of Florida", page 27

Reach Out and Read

Dr. Sharon Dabrow, at the University of South Florida, has been successful in obtaining a small seed grant to initiate the Reach Out and Read Program of Tampa. This program is housed at the 17 Davis Residency Clinic in Tampa, and has been embraced enthusiastically by the pediatric residents. For further information, please contact:

Sharon Dabrow, M.D.
USF Department of Pediatrics
General Pediatrics
17 Davis Boulevard, Suite 308
Tampa FL 33606-3475
(813)272-2268□

F.Y.I

[The following is excerpted from a letter to Edward Zissman, M.D., Chairman of the Child Health Financing Committee of the Florida Chapter, AAP, written by Bob Sharpe, Chief, Medicaid Program Development, in Tallahassee.]

This letter is in response to your interest in Florida Medicaid policy concerning spacer devices for asthma inhalers and peak flow meters for management purposes. A Durable Medical Equipment (DME) procedure code has been discovered for use in billing spacers. The code is A4627, which:

- does not require an attached medical report,
- may be billed electronically, and
- Medicaid recipients through age 20 may be eligible for this service based on medical necessity.

Please disregard the previous information that you received from Medicaid in July regarding how to bill a "By Report" claim for spacers.

Peak flow meters (code W9764) may be reimbursed for recipients ages 5 through 20. To be eligible for a peak flow meter, the diagnosis must show moderate to severe asthma, and the item must be part of a continuing asthma treatment plan.

Electronic billing may be utilized without an attached report from the physician prescribing the device; however, the DME provider must always retain the required medical documentation in the recipient's files for audit purposes.□

EXPANDING THE FIELD

Deborah Mulligan-Smith, M.D.
North Broward Hospital District

The National Commission on the Role of the School and the Community in Improving Adolescent Health issued a ***Code Blue*** alert.

> For the first time in the history of this country young people are *less* healthy and *less* prepared to take their places in society than were their parents and this is happening at a time when our society is more complex, more challenging, and more competitive than ever before. (AMA and NASBE, 1989)

The continued downward trend in health suggests that existing efforts to promote health and prevention of disease or injury are unsuccessful. Add to this sad state of affairs a societal shift where neither the family nor the community assumes responsibility for care of the child. The American Academy of Pediatrics Division of Child Health Research surveyed "Participation and Interest in School Health Programs."[1] About one in five pediatricians (22%) participates in a professional capacity in local school health programs, usually without pay: most of these pediatricians teach a class, consult on school health services/curriculum, or treat children with special needs referred by the school. Older pediatricians, those in general pediatrics, in rural or suburban practices and in solo or group practices are more likely to participate in local school health programs. The reason for not participating or limiting participation in school health given by most pediatricians is lack of time (74% so reporting). In order to begin or increase their involvement in school health programs about two-thirds of pediatricians say they need information on how they can make a meaningful contribution with the limited amount of time they have available, as well as information on how to get started in local school health.

Many communities strive to address school health and safety concerns by creating partnerships for education, coalitions, mass media campaigns, community health councils and the like. The state of Florida is mired in 48th place for health and education. School nurses tending to our children's bruised knees and feelings have gone by the way of the dinosaur. There exists a complex distribution of our limited number of school nurses. Some of Florida's 67 counties are lush with staff, others have one school nurse covering more than one county.

The major causes of mortality among youth who attend primary and secondary schools continue to include accidents, homicide and suicide; major morbidities include drug abuse, violence, nonfatal accidents and lack of safety precautions (e.g. failure to use safety belts or helmets), sexually transmitted diseases and unintended pregnancy, and mental health problems (depression, anxiety, somatic complaints) [2]. The leading cause of a child's visit to an emergency department is injury. To injury, add a smattering of asthma, diarrhea, rash, lice and tinea and you have just described a typical case load in the average day of the emergency physician. For that matter, it could describe a typical day for the school nurse. *As pediatricians we are the link between the community, the school and the emergency medical system.*

Collaboration and integration of services by pediatricians and the EMS community could improve outcome for patients and families with multiple health needs. The EMS system is rich in resources that could be channeled into the school health system.

- It is the EMS provider who has direct access to well children in classroom education. What child can resist a uniformed EMS provider complete with fire truck/ambulance discussing safety measures?
- It is the role of the EMS Medical Director to prepare the EMS providers for clinical care rendered when the school accesses 9-1-1.
- It is the emergency medicine physician who has his/her finger on the pulse of trends in community health. There clearly exists a synergistic relationship between the community health and that of the school.

Florida's Comprehensive School Health Program encompasses eight identified components consistent with the Institute of Medicine report on Schools and Health. (1997)

- Health Services
- Health Education
- Physical Education
- Nutrition
- Counseling and
- Psychological Services
- Health School Environment
- Faculty and Staff Wellness
- Family and Community Involvement

The inspiration to write this solicitation of your assistance came from attending the 1997 Florida Conference on School Health. Two physician speakers attended this 600 registrant conference. The registrants were a warm, receptive audience hungry for knowledge in how we can further enhance our relationship between the physician and the school. A rewarding first step into this process could be to make your services available to your neighborhood school and EMS providers.

References:
1. American Academy of Pediatrics Division of Child Health Research Periodic Survey of Fellows #26. *Participation and interest in School Health Programs*.
2. National Academy of Science and Medicine. Institute of Medicine Report on Schools and Health. 1997.

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.

Legislation

(◂continued from page 5)

HB 1785 (CH. 97-166) - Insurance and HMO Benefits for Children

This legislation creates parity between indemnity and HMO benefits for children by requiring both types of health insurance to provide the same coverage. This legislation revises Florida's Child Health Assurance Act to require plans to meet current standards contained in the American Academy of Pediatrics schedule for Preventative Pediatric Health Care. The bill also revised the newborn statute to eliminate the preenrollment requirement allowed for HMO's and gives HMO subscribers a minimum of 30 days to enroll newborns with coverage extending to the time of birth. HMO's will also be required to cover the children of subscribers beyond the policy's limiting age if the child is mentally or physically handicapped and chiefly dependent on the subscriber.

Effective Date: July 1, 1997

HB 297 (CH. 97-159) - Managed Care Organizations

This legislation provides a number of changes in the regulation of managed care organizations. Among the new provisions is a prohibition on any contract term that inhibits health care provider communication with patients regarding their treatment options, usually referred to as "gag clauses". This bill further requires the development of recommendations for preventive pediatric health care consistent with Medicaid's EPSDT standards (these are based on the AAP's schedule of care) and the establishment of goals to achieve specified benchmarks by specified dates for enrolled pediatric populations. Modifications are made to the subscriber grievance process; regulation is established for fiscal intermediary services organizations that develop, manage or administer the business affairs of health care professional providers; HMO's are required to employ Florida licensed medical directors; policies are to be developed to determine when exceptional referrals to out-of-network specially qualified providers should be available; policies are to be developed and maintained for the provision of standing referrals for subscribers with chronic and disabling conditions which require ongoing specialty care; requirements are established for continuing care by a terminated provider for a subscriber who is in the third trimester of pregnancy, until completion of postpartum care; and requirements are established for information requested by subscribers or potential subscribers.

Effective Date: July 1, 1997

CS/SB 1682 (CH. 97-179) - Health Insurance

This bill is the State's implementing legislation for the Federal (Kennedy/Kassenbaum) Health Insurance Portability and Accountability Act of 1996. Changes to Florida's insurance laws include the requirement that group policies must allow new dependents to enroll within 30 days of marriage, birth or adoption and prohibits the application of preexisting condition exclusions to pregnancy or to newborns or adopted children who are enrolled within 30 days of birth of adoption placement. Group policies are prohibited from discriminating due to a person's health status, medical claims experience, receipt of health care, medical history, genetic information or evidence of insurability. The standards of care for a newborn's hospital stay have been modified to allow for the use of the most current standards in keeping with prevailing medical standards. Other preexisting condition exclusions are modified for group plans and individual and group policies are required to be guaranteed renewable.

Effective Date: May 30, 1997

HB's 37 & 127 (CH. 97-182) - Insurance / Genetic Testing

Health insurers are prohibited from requiring or soliciting genetic information, using genetic test results, or considering a person's decisions or actions relating to genetic testing in any manner for any insurance purpose. This bill provides that in the absence of a diagnosis or a condition relating to genetic information, no health insurer may cancel, limit, or deny coverage or establish differentials in premium rates, based on genetic information.

Effective Date: January 1, 1998

CS/SB 1002 (CH. 97-) - Highway Safety and Motor Vehicles

This legislation makes numerous changes to the statutes administered by the Department of Highway Safety and Motor Vehicles. Regarding children, adolescents and teenagers the bill requires motor vehicle passengers who are 6 through 15 years of age to be restrained by a seat belt, regardless of their location within the vehicle. The bill also modifies the bicycle helmet law to make it a pedestrian violation, punishable by a $15 fine for a person under the age of 16 who rides a bicycle without a helmet. Driver's license requirements were changed to allow persons with a learner's license to operate a vehicle only during daylight hours for the first 3 months and between the hours of 7 p.m. and 10 p.m. 3 months after the issuance of the learner's license and allows without penalty drivers less than 18 years old to drive "directly" to or from work if they are driving while the night-time driving restrictions are in effect. Effective Date: October 1, 1997

PROFESSIONAL REGULATION

CS/SB 948 (CH. 97-273) - Physician Profiles

This legislation requires physicians and others to submit specified information which will be compiled into practitioner profiles to be made available to the public beginning July 1, 1999. Information required to be submitted includes: graduate medical education; hospitals where privileges are granted; specialty certification; year the physician began practice; description of any criminal offense committed; description of any final disciplinary action within the last 10 years; professional liability closed claims exceeding $5,000 reported to the Department of Insurance within the last ten years; professional awards and publications; languages, other than English, used by the physician to communicate with patients; and, participation in the Medicaid Program. Prior to public release, physicians will be given an opportunity to correct any factual errors in the information contained in the profile. Penalties are provided for failure to submit and update the information required by the profile. Initial licensees will be required to submit fingerprints for a national criminal history check and beginning in the year 2000 renewal of licenses will require a one-time submittal of fingerprints for a criminal history check.

This legislation also provides for an emergency suspension of physicians who are uninsured and who fail to satisfy malpractice claims, file notice of appeal or provide a court order staying execution of the final judgment pending an appeal. Upon request, the public may access information the Department of Health maintains on bankruptcy proceedings filed by any physician as well as medical malpractice closed claim reports.

A toll-free hotline for consumer disciplinary complaints is established, and, the Agency for Health Care Administration's investigation and recommendation of findings on disciplinary complaints are to be made within 6 months of the filing of the complaint. Effective Date: October 1, 1997, or as otherwise provided in the bill.

HB 1925 (CH. 97-261) - Health Care Practitioners / Regulation

Effective July 1, 1997 the regulation of health care professions are transferred from the Agency for Health Care Administration to the Department of Health including consumer complaint, investigative, and prosecutorial services, however the Department is allowed to contract with the Agency to provide services. The bill also allows records owners to charge the actual costs for copying records. The Department of Health is required to appoint a task force of representatives from various health care associations to develop procedures for validating professional credentials of health care practitioners. The Department is further required to issue an emergency order suspending the license of any person who pleads guilty, is convicted or found guilty, or pleas nolo contendere to a felony relating to the Medicaid or Medicare Programs or relating to controlled substances. An alternative licensure path for foreign licensed physicians is created by providing an exception to residency requirements for foreign-trained physicians. Such applicants must meet specified requirements which include the completion of two years of supervised practice under a Florida-licensed physician approved by the Board of Medicine and successful passage of the USMLE. A revision is made to the malpractice financial responsibility requirements imposed on medical physicians who are retire or who maintain a part-time practice to allow such physicians to qualify for an exemption to the financial responsibility requirements by changing the indemnity limits from $10,000 to $25,000 for any claims incurred within the previous five years.

Effective Date: July 1, 1997, unless otherwise provided

HB 2013 (CH. 97-264) - Health Care Professions / Regulation

This legislation contains many of the same provisions relating to physicians which have been detailed in HB 1925 above. However, this bill also contains changes for other health professions, as well as the following applicable to physicians: provides a definition for the active practice of medicine and clarifies that resident physicians are subject to grounds for discipline applicable to all physicians; allows hospital residents to prescribe controlled substances; allows dentists to prescribe certain schedule II controlled substances; allows pharmacies to dispense controlled substances based on the receipt of a facsimile of a prescription; and, requires the Boards of Medicine and Osteopathic Medicine to establish practice guidelines for physicians to prescribe weight-loss drugs.

Effective Date: July 1, 1997□

HB 53 (CH. 97-3) - Physicians / Limited Licensure

This act deletes a requirement that a medical physician must be retired or show intent to retire in order to obtain a limited license to practice medicine. This revision provides that if a physician is not fully retired in all jurisdictions, he or she can only use the limited license for non-compensated practice.

Effective Date: October 1, 1997

SB 1784 (CH. 97-295) - Medical Practice

This legislation allows full-time medical residents who are in training programs in Florida to sit for the medical licensing examination without applying for medical licensure to practice in this state.

Effective Date: July 1, 1997

[To be continued in next issue]□

Tetanus

(◂continued from page 9)

Wounds should be debrided to remove foreign bodies and devitalized tissue. Administration of antispasticity agents is the major element of treatment to compensate for the failure of central nervous system inhibition. Finally, supportive care until recovery occurs by the formation of new synapses is essential to minimize the risk of precipitating spasms. The patient's room should be as quiet and dark as possible. Active immunization should be initiated prior to hospital discharge.

Complications and Intensive Care Management

In severe cases of tetanus, life-threatening respiratory and cardiovascular complications can follow with troubling rapidity following the initial diagnosis and admission to the hospital. One half of mortality associated with tetanus can be attributed to the respiratory complication of the disease.[11-14]

Respiratory failure may occur as a result of muscle rigidity and reflex muscle spasm that characterizes the disease or may be secondary to hypoxia following atelectasis and pneumonia.[1,8] The optimal approach to a tetanic patient with respiratory compromise lies in early intervention with airway control and spasm control. Intubation of the trachea should be carried out when maintenance of the airway is in doubt. As the presence of the endotracheal tube is in itself a strong stimulus for spasms, some authors recommend that a tracheotomy be performed immediately.[2,15] The use of mechanical ventilatory support and neuromuscular blocking agents is often required for these patients with impaired ventilatory gas exchange. These patients should be well sedated while paralyzed.[1,2,8,15]

Control of tetanic spasms should be carried out simultaneously as measures are being taken for airway control. The benzodiazepines are the most widely used agents currently available for the control of tetanic spasms and rigidity. These drugs are GABA-A agonists, thereby functioning as indirect antagonists of the effect of the toxin on inhibitory systems.[16-18] Diazepam is used most commonly in managing tetanus in children.[18] Lorazepam may be preferable because of its longer duration of action.[1]

A continuous infusion of midazolam in large doses could also be employed.[20] In our patient, we used a continuous infusion of midazolam for two weeks then replaced it with diazepam via enteral feeding tube. We used diazepam up to 35 mg(1 mg/kg/dose) every 3 hours (280 mg/day). Sedation and amnesia are other properties of benzodiazepines and provide a great value in patients with tetanus.

Propofol has been used as a sedative agent in ICU.[21,22] Limited experience with propofol as a suitable drug for maintaining sedation and muscle relaxation in patients with tetanus is reported.[20,23,24]

Dantrolene, is a direct muscle relaxant which acts at the level of the sarcoplasmic reticulum. This agent may be of value in selected cases.[26,27] When GABA-A agonists are unable to control the muscle spasms, adding a neuromuscular blockade (NMB) to the therapy becomes necessary.[8,20,23] In our patient, we initially used vecuronium at 3.5 mg/hr (0.1 mg/kg/hr) and later switched to pancuronium for cost effectiveness.We had to increase the dose up to 6mg/hr. Interestingly, we were able to wean the patient off neuro muscular blocking agents after we had optimized his diazepam at 35 mg every three hours.

Baclofen is a structural analogue of GABA; when administered intrathecally, baclofen diffuses through the capillaries of the spinal cord, binds to the GABA-B receptors in the substance gelatinosa of the dorsal horn, and inhibits monosynaptic extensor and polysynaptic flexor transmission.[28] Muller, et al[29] were able to abolish tetanus-induced rigidity and spasms totally by infusion of intrathecal baclofen. Further clinical studies are needed to prove its effectiveness.

The cardiovascular complications are the most serious complications of tetanus once the airway has been secured.[1] The prevention of death from respiratory causes disclosed the cardiovascular manifestations of tetanus.[30] The pathogenesis of cardiovascular disturbances is postulated to be result of tetanus exotoxin effect on; (a) brain stem damage resulting in fatal cardiac and respiratory failure,[30]; (b) myocardial depression (toxic myocarditis),[8,30] this postulation now believed to be more likely due to excessively high levels of circulating catecholamines;[31,32] (c) inhibiting synapses in the CNS resulting in widespread disinhibition of autonomic nervous system (31,32) which may lead to the syndrome of sympathetic nervous hyperactivity[5,23,26] and/or parasympathetic overactivity.[31,32]

In 1968, Kerr, et al [33] described the syndrome of sympathetic nervous hyperactivity: "sustained but labile hypertension and tachycardia, irregularities of cardiac rhythm, peripheral vascular constriction, profuse sweating, pyrexia, increased carbon dioxide output, increased catecholamine excretion, and in some cases, the late development of hypotension." These signs and symptoms, if they occur, usually develop toward the end of the first week. They may occur spontaneously or in response to every minor stimulus, as in the case with tetanus spasms. It cannot be alleviated through pain control or sedation. Most such patients manifest elevated plasma catecholamine levels.[34] Prolonged sympathetic overactivity may end with profound and preterminal hypotension and bradycardia; it often indicates imminent death.[32,35,36] Parasympathetic overactivity may lead to preterminal bradycardia and sinus arrest, salivation and increased bronchial secretions. Direct damage to the vagal nucleus has been implicated,[37] as well as local damage to the sinus node, and to reflex excessive vagal tone.[38]

Prompt recognition and treatment of autonomic dysfunction are important in reducing the mortality in this disease. Clinicians agree that reduction of stimulation of the patients if possible and providing additional pain relief with narcotic agents should be the first step. A trial of morphine therapy may be advantageous.[39] Morphine induces a peripheral venous and arteriolar dilation in man mediated by a reflex reduction in sympathetic alpha adrenergic tone.[40] Morphine therapy was used successfully in several cases of generalized tetanus to control autonomic hyperactivity. It has been given at 1-2 mg/kg every 12h for 22 days in one case report and at 5-30 mg IV infusion over 30 minutes every 2-8 hours.[40,41] Our patient received morphine sulfate as continuous infusion 60 mcg/kg/hr (for 12 hour period) without noticeable effect on hypertension. Only if all this is unsuccessful at controlling the episodes of hypertension should an attempt be made to treat it with other drugs.

Labetalol is both an alpha and beta adrenergic blocking agent.[42] It also inhibits the uptake of norepinephrine into nerve terminals. It was used successfully in our patient in controlling the labial hypertension when the combination of heavy sedation, narcotic analgesia and muscle paralysis failed. Our patient received labetalol initially as intermittent IV boluses 0.25-1.0 mg/kg then placed on continuous infusion of 2 mg/kg/hr. The infusion was weaned over four days with no further episodes of hypertension. Similar results were obtained in other cases.[43-45] However, the group from King Edward VIII Hospital, South Africa have reported a conflicting result.[46] In addition to its favorable side effect profile[47] enough experience in the continuous administration of intravenous labetalol for prolonged period of time has accumulated in children.[48,49] In spite of success of propranolol alone in controlling tachyarrhythmias and hypertension, fatalities associated with its use preclude its use alone for treating this disease.[50,51] The combination of propranolol and alpha blocking agents such phentolamine and guanethidine type drugs has increased the efficacy with which propranolol lowers blood pressure.[8,31,52] Two recent reports described the successful use of continuous magnesium sulfate infusions to control the autonomic dysfunction of severe tetanus and concluded that this technique is a useful adjunct to sedation, paralysis and ventilation.[53,54] In other reports, the magnesium sulfate did not give adequate control of blood pressure despite consistent plasma magnesium level in the recommended range (2.5-4.0 mmol/L). [53-55] In this case adding clonidine in combination with magnesium, sedation and paralysis provided better control.[55] The narrow margin between therapeutic toxic blood level of magnesium as well as the need for frequent monitoring of magnesium level may limit its use for this purpose.

Dolar[56] described the use of atropine to control parasympathetic overactivity. Atropine has been employed as a continuous infusion in the treatment of four severe tetanus cases as a supplement to routine therapy. With this treatment his patients maintained complete cardiovascular stability. Further studies are needed to prove its effectiveness in treating severe tetanus patients.

The association between sympathetic overactivity and protein catabolism which subsequently resulting in inevitable loss of lean body mass in patients severely affected by tetanus was described recently.[57,58] O'Keefe[57] advocates the use of aggressive forms of nutritional support (e.g., total parenteral nutrition including sufficient insulin to maintain normal glycemia) but attempts to provide large number of calories by using a more dense formulation may be complicated by uncontrollable hyperglycemia and osmotic diarrhea. Linton[59] advocates measuring the actual metabolic rate in individual patients to ensure that an appropriate nutritional regimen is designed. Our patient lost four kilograms during the first week of hospital stay despite receiving 2,000 kcal/day formula via nasogastric tubes which was increased to 2,500 kcal/day without any problem in serum blood glucose or diarrhea. Measurements of metabolic rates

(Continued next page▸)

using an indirect calorimeter device is a reasonable approach, so accurate metabolic requirements of the patient could be measured. Using readily available high calorie liquid nutrition via enteral feeding tube represent the most appropriate method of meeting the patient metabolic requirements.

Other secondary complications that have been reported included stress ulcer, thromboembolism skin breakdown and orthopedic complications include dislocation of the temporo-mandibular and shoulder joints, myosistis ossificans and vertebral fractures.[8] Rhabdomyolysis, which may produce acute renal failure, is a common complication of generalized tetanus.[1] Pneumonia and sepsis are real threats in today's ICU environment and if not prevented, recognized and treated aggressively, could prove to be fatal.[60] It should resolve with the usual attention to fluid and electrolyte management.

Conclusion

A significant portion of population in the United States and worldwide is non- or under-immunized, hence they are at risk for contracting

tetanus. Familiarity with tetanus disease, its clinical features, pathogenesis, complications and principles of management is an important task for every clinician. Any patient, regardless of age or severity of tetanus, has a chance of a full recovery if optimally managed. Our recent experience with use of high dose of benzodiazapines for muscle spasm control and sedation, and use of continuous infusion of labetalol for sympathetic hyperactivity control in a child with severe tetanus was successful . We hope it will add a current perspectives for the pathogenesis and management of severe tetanus.

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Managed care

(◂continued from page 7)

plan's financial insolvency.

LIMITS ON TESTING AND REFERRALS

There are a variety of methods that managed care organizations use to limit referrals and testing. One method commonly used is the physician "'report card." The company keeps track of the number and cost of testing and referrals ordered by each physician The physician is then compared with his or her peers. These numbers can be very misleading depending on a variety of factors, such as patient age and severity of illness within the physicians practice. The pressure that might be associated with this type of oversight may cause an individual

pliysician to withhold necessary testing and/or referrals inappropriately.

Another way in which a managed care company may involve itself in the referral process is by limiting those specialists to whom a primary care provider can refer. It is important that a pediatrician be able to make referrals to pediatric medical subspecialists and pediatric surgeons. There is legal precedent for physician liability based on making referrals to **a** subspecialist that the pediatrician knew or should have known was inappropriate or incompetent. If a plan denies a referral to a pediatric medical subspecialist or pediatric surgeon, the pediatrician shoud notify the patient of the option of paying out-of-pocket for the consultation and, if necessary, obtain a written "informed refusal."

HOLD HARMLESS CLAUSES

"Hold harmless" clauses are often found within managed care contracts. These clauses place the physician at total risk in the event of a medical rnalpractice suit and relieve the managed care organization of any liability. A pediatrician must attempt to ne gotiate with the managed care company to have such a clause deleted. If unsuccessful in removing the "hold harmless"' clause, the pediatrician must check with his or her malpractice carricr to ensure that this clause does not negate the malpractice coverage, Noncoverage by a carrier in this situation may render the clause nonnegotiable because the pediatrician would be shouldering an unacceptable risk.

Another nonnegotiable clause is one that censors physician-patient communication. Termed "gag clauses," these provisions prohibit physicians from fully discussing treatment options with their patients and thereby compromise a physician's ethical and legal duty to the patient. Pediatricians must not sign contracts that contain such provisions.

EMFLOYEE RETIREMENT INCOME ACT OF 1974 (ERISA)

Presently, ERISA laws, which protect self-funded employee benefit plans, prevent many patients from successfully suing their health care entity for negligence. In *Corcoran v United Healthcare,*[4] the court stated that the health care plan did make medical decisions but only "in the context of making a determination about the availability of benefits under the ERISA plan." Under certain conditions ERISA may limit not only the ability of a patient to claim malpractice but also the monetary amounts available from a lawsuit. Recently, however, the ERISA preemption provisions have come under attack and their scope may become limited.

RESPONSIBILITY OF PEDIATRICIAN IN MANAGED CARE

As managed care continues to expand, so will the legal pitfalls that an individual pediatrician may en,counter. It is the responsibility of each pediatrician to keep up with this ever-evolving area of medical care and thereby continue to offer the best medical care possible at tlieleast possible risk to both patients and providers.

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PEDIATRICS (ISSN 0031 4005).

In Memoriam

Duffy Moore, Past President of the Florida Pediatric Society (1984-1986), died on June 4th, in his home in Ft. Myers.

Dr. Moore was a unique pediatrician and a real children's advocate. He will be remembered for his work in developing pediatrics in Ft. Myers over 33 years and bringing neonatology to the community.

His humor, casual attire, and commitment will be irreplaceable. He was often called "The Chastity Belt of the FPS" for his insistence on accountability during a much less complex time.

[redacted] Hamlet", 1444 Larkspur, in Ft. Myers.□

[redacted]

President

(◂continued from page 1)

Resolution. Remember that the Forum is one of the primary ways for the grassroot membership to have issues heard and debated by the AAP Board of Directors. It's not quick, but it works.

Please remember the Annual Meeting this September. There is always a first-rate group of presenters (and this year is no exception), the atmosphere is congenial, the surroundings relaxing, AND, at no added price, you have the chance to meet and chat with your Society/Chapter representatives about issues which concern you.

Hope to see you at Amelia Island!

Respectfully,

Edward T. Williams III, M. D.□

[redacted]

Editorial

(◂continued from page 2)

Number 3 is *skates*, another time-honored way of life. The new in-line skates look as easy and as graceful as do ice skates, but they do have their danger, and again are a "stunt machine" for only a very few.

Number 4 is the *skate board*. On a purely personal basis, I can find no "socially redeeming value" in these. They seem dangerous for all, including the unwitting bystander (e.g., in the malls.)

Finally, I must comment on *sports in the school.* This should be the safest of all, with people trained in proper physiology in supervisory positions. BUT, as advocates for children, we need to be more involved, not only as team physicians, but to assure that the leaders are really appropriately trained, that the younger children are not being pushed into contact sports for which they are too young, and the every child who is to participate in sports has been properly evaluated in advance by his pediatrician.

Yes, we are the advocates for children. We have our work cut out for us. But, as we continue to spend less and less time treating our patients for infections, we must spend more and more time educating them (and their parents) in safe living.

-The Editor□

Healthy Kids

(•continued from page)

bid process and enters into an individual contract with each.

•An independent Third Party Administrator is responsible for records management; eligibility determination; and billing and collecting.

•The Institute for Child Health Policy provides evaluation services, including satisfaction, utilization and cost studies of Healthy Kids.

•Medimetrix Group provides consulting services for actuarial review of health care providers, network evaluation and general consulting services.

•Innovation in Healthcare Quality conducts medical record review and quality evaluation of care provided for Healthy Kids enrollees at each site.

•The School District in each site has a contract with Healthy Kids Corporation outlining responsibilities of the school district and the Corporation.

•An agreement is entered into each year with the State of Florida Agency for Health Care Administration to facilitate release of State funds to the Corporation.

•Shands Hospital in Gainesville, Florida serves as a tertiary care facility for Healthy Kids enrollees at Medicaid reimbursement rates.

•In each program site, a local steering committee provides program input. The working document between the Corporation and the Local Steering Committee is an Operational Protocol.

Benefits

Program benefits are designed specifically for children and include immunization and well child checks, office visits to participating primary and specialty physicians, pharmacy, mental health, home health, vision/ hearing screening, outpatient procedures, emergency services, and inpatient services including transplants. There is a $1,000,000 life time max benefits, some limitations apply and small co-payments are required for certain services. There are no exclusions for pre-existing medical conditions and no waiting periods.

Eligibility

Standard program eligibility begins at kindergarten and extends through grade twelve. Under the minimum standard, children must be age five to nineteen and enrolled in school. They must not have comparable insurance at the time of enrollment and must not be enrolled in Medicaid, Medicare or other comparable governmental sponsored health benefits programs. However, local sites have the option to extend the age eligibility to younger children who are enrolled in pre-school or who have a school-age sibling. Of the seventeen program sites, fourteen have extended eligibility to younger children. However, because school enrollment is a requirement, at this time there are no children younger than three years of age in the program.

Subsidy Eligibility

Certain eligible children receive a subsidy based on their eligibility for the National School Lunch Program. A sliding scale has been established to coincide with the lunch program guidelines. Children with family incomes up to 185 percent of poverty are eligible for a reduced premium. Families with income exceeding 185% FPL (Federal Poverty Level) may participate in the program, but those families are responsible for the full cost of the monthly premium and administrative services (about $51 per child). Using the National School Lunch Program for determining eligibility reduces the administrative costs of determining and verifying family income and utilizes an existing program with which families with school-aged children are already familiar.

Quality Assurance

The Florida Healthy Kids Corporation contracts with an independent quality auditor to evaluate and monitor the quality of care provided by the insurance providers and physicians in the Healthy Kids program. National Committee on Quality Assurance and American Academy of Pediatrics standards are used. The Corporation also contracts with the Institute for Child Health Policy to evaluate the program, including family satisfaction, health service utilization and cost effectiveness. In addition, there is a standards committee of board including Pediatricians. This committee sets contracting standards and reviews exceptions to those standards of , credentialing, referral patterns, etc.

While the children enrolled in Healthy Kids represent a variety of backgrounds and characteristics, there are some qualities that are common among them. The average child enrolled in Healthy Kids is 10 years old and lives in a household with at least one working parent. The average family is headed by a married couple and has some college education. The most common illnesses diagnosed among the children are asthma and other respiratory infections. Through the program, these children are able to get the health care they need to stay active and healthy, improving their school performance and decreasing the utilization of emergency rooms.

Families' Contribution

Families contribute to the cost of the premium based on a sliding scale which parallels with the lunch program. Family contributions provide an average of 30% of the total funding for the program.

Local Community Contribution

Each Program Site has its own local steering committee responsible for designing the local program, including any enhancements to the basic eligibility and benefits which are required by Healthy Kids Corporation. The steering committee is responsible for securing the funds for the local match on premium subsidies.

Local funds are be deposited with the state program in order for a Florida Healthy Kids program to be implemented in any district. Local communities with a Healthy Kids Corporation agreement contribute to the cost of the monthly premium for children subsidized subsidies in their area. In the first year, the financial commitment is set at 5% of the cost of the insurance premiums and third party administrative services. A fully developed site (5 to 8 years of participation) provides about 40% of the total funding for the program.

State Contribution

State general revenue provides the balance of funding in each location. The current level of general revenue approved by the Florida Legislature is $16 million. The combination of family and local funding provides a total budget of $38 million for the 1997-98 fiscal year and will provide coverage to 60,000 children. These funds currently provide about 30% of the total funding for the program.

This voluntary combination of community plan design and governance; local, state and family financial participation; and private sector business orientation has demonstrated significant success in assuring greater access to health care for children.

Commentary

The following are my observations, opinions and projections as a professional who has been involved in the development of both Healthy Kids Corporation and Children's Medical Services.

Healthy Kids Corporation

Healthy Kids Corporation is designed to serve children in school linked programs and their siblings. While 14 sites offer coverage to siblings 3 years or older, no site has chosen to serve siblings from birth. It is true that Medicaid serves a large proportion of newborns and infants from low income families. Indeed, Medicaid covers all infants who would be eligible for subsidy under the Healthy Kids program. Consequently, I believe that Healthy Kids Corporation should encourage a local site to request a separate "infants and toddler" premium for families who can afford it. While this is a local decision, it would be important to see what impact a sizable, presumably healthy, infant and toddler group would have on the cost of coverage for that age group.

Children's Medical Services

For years it has been acknowledged that the Children's Medical Services network of specialty Pediatrics and specialized institutions represents the benchmark for quality medical care for children with special health care needs. However, access to that network is largely limited to low income families. Medicaid has developed a relationship with Children's Medical Services, Florida's state employee health insurance program has not; nor has Healthy Kids Corporation; nor has any of the major private purchasers of health care. Children with special health care needs insured under any insurer should have access to the Children's Medical Services network. This could be accomplished if the Children's Medical Services network was organized as a private, risk bearing, provider service network that could offer itself as a re-insurer to the rest of the insuring community.

Financing Integrated Systems of Child Health Care

Florida finances the health care for more than thirty percent of its children, rich and poor alike. Medicaid, Children's Medical Services, Healthy Kids Corporation, and the state employee health plan are all major tax funded purchasers of child health care, each with different administrative structures, eligibility requirements, benefit structures, and contracted networks. However, ultimately the practitioners and institutions that take care of the children are the same regardless of the insuring mechanism. If the financing of child health care that is supported by state funds were to be consolidated, such a "primary payer" would have enough market strength to stimulate integrated systems of care for all Florida children from primary through quartenary care.□

Publication

August 1997

The American Academy of Pediatrics (AAP) is pleased to announce the publication of ***The Classification of Child and Adolescent Mental Diagnoses in Primary Care: Diagnostic and Statistical Manual for Primary Care (DSM-PC) Child and Adolescent Version.***

This system of classification gives a method to achieve accurate diagnosis and coding of mental health and other beliavioral disorders, and was not designed to promote unbundling of codes to provide for higher reimbursement. Rather, it is a system to increase early awareness of mental and behavioral conditions for referral to appropriate health services.

The AAP considers the ***DSM-PC Child and Adolescent Version*** ground-breaking as the first manual to provide a system to describe mental conditions not only at the disorder level but also at the problem and normal variation level. We feel strongly that it is important for health care providers to diagnose symptoms that present at these subsyndromal levels to facilitate opportunities to provide early intervention and mental health care prevention strategies, as well as provide a cost savings to families and insurers through early diagnosis.

Because of the frequency of well-child health visits, pediatricians are in a unique position to recognize psychosocial issues at early stages and to establish an initial diagnosis. Again, the purpose for such a diagnosis is to prevent subsyndromal conditions from becoming more serious and to facilitate the identification of disorders that should be referred for intervention.

Currently, the AAP has disseminated over 2,000 copies of this manual to pediatricians and other primary care health providers. In addition, several *DSM-PC Child and Adolescent Training Sessions* have been conducted. The AAP believes this manual should be incorporated into primary care pediatrics to facilitate the identification of mental and behavioral health conditions in children and adolescents. The consistent use of the manual will ensure that all children and adolescents have appropriate access to care as well as improved health outcomes.

The AAP and its members are committed to working with managed care organizations to strengthen the organization, delivery, and financing of health services to children. Please contact the AAP Publications Department (847-228-5005) to order a copy of the ***DSM-PC Child and Adolescent Version***. For specific questions or to learn more about this important manual, contact Jill Mallin at 847-981-7941.

Thank youfor your time and interest.

Sincerely,

Joe M. Sanders, M.D.
Executive Director□

HAS YOUR ADDRESS CHANGED IN THE LAST YEAR?
Please send an update to the Executive office to assure receiving mailings. Thanks!

Career Brochure Available

The AAP Division of Public Education has a resource for AAP members who will be talking to school children about what it is like to be a pediatrician. Available in reproducible flyer format, "Pediatrics: A Rewarding Career Choice" starts with a basic definition of pediatrics and further describes the many roles a pediatrician plays. Children can also learn about the range of career opportunities in pediatrics and how best to prepare for a medical career throughout school.

To receive a copy of the reproducible flyer, please contact Debbie Carney in the Division of Public Education at 800/433-9016, ext. 6771.□

Helping parents raise children with healthy bodies and minds is the goal of Born to Read: How to Nurture a Baby's Love of learning. The program seeks to build partnerships betwen health care providers and librarians to reach out to new and expectant "at-risk" parents and help them raise chldren who are "born to read".

In a three year demonstration project administered by the American library Association (ALA), and funded by a grant from the Prudential Foundation, five projects were begun at sites throughout the United States. Projects included literacy training for parents, encouraging early interaction with fathers, reading and health promotion programs for parents and infants, mulilingual programs, development of a "mobile classroom" to take materials and programs to neighborhoods, creation of cable television programming, and other innovative activities. In each case, the goals are to break the intergenerational cycle of illiteracy, to impress upon parents the importance of reading to their children, and to promote greater public awareness of health and parenting resources available in the community.

Based upon the success of these programs, other health care provider/library teams have worked together to raise local funds and implement Born to Read programs in their communities. For information on how to organize a Born to Read program, contact the Born to Read Project/Association for Library Service to Children, 50 E. Huron St., Chicago, IL 60611 (800)545-2433 or Susan Marshall, Director, Division of Information and Archival Services at the AAP (800)-433-9016, ext. 4722. You can also visit the Born to Read web site at www.ala.org/alsc.born.html.

Susan Marshall
Division of Information and Archival Services□

Did You Know?

Pediatrics now has *Pediatrics electronic pages*, available through the Internet. Each month, there are 6 - 10 new peer-reviewed articles. Abstracts will be included on green pages in the regular issue of *Pediatrics*. However, the complete articles will be available only on the electronic pages. *Pediatrics electronic pages* may be accessed via an internet connection and a World Wide Web Browser. The site is located at **http://www.pediatrics.org.**□

Emphasis

(◂ continued from page 11)

screening and health programs for children under the aegis of both the Departments of Health and Rehabilitative Services and Education. This will prevent costly duplication of effort and ensure that each child receives the appropriate medical care at the least possible cost.

Health professionals must always be cognizant that they should rely on their professonal knowledge and other sources to give each legislator and staff member the best possible information. Never be too proud to say that one doesn't know! Then expeditiously seek an answer and promptly relay such information. Courteous, informed, consistent and persistent exposition of one's position often pays great dividends in the legislative arena. Finally, for the present and future generations of infants, children and adolescents, may their supporters and advocates alwavs have the committment, eloquence and energy to represent them well. Future legislative efforts will include the introduction of bills that: (a) ensure that all transportation costs are covered in the neonatal insurance act, so that the payment of an infant's transportation costs to a perinatal center would be an intrinsic part of the policy; (b) a law that should increase the immunization rate of children, by exempting the involved health professional from civil suit when that health professional gives a state-rnandated immunization to a child and follows all the standard protocols for giving such an immunization; and (c) legislation to set the temperature of home hot water heaters at 125"F to prevent many of the serious scalds and burns of children (besides, it would save energy).□

Region 2

(◂continued from page 3)

two hospitals in the Jacksonville area.

Wolfson Children's Hospital:

Most pediatric inpatient services are now consolidated at the Children's Hospital. The pediatric partnership known as the "Children's Health Center" is made up of Wolfson Children's Hospital, University of Florida, University Hospital (with its ties to public health) and Nemours Children's (with its ties to Mayo Clinic). This cooperative agreement directs children to whatever facility provides specific care i.e.: primary care, trauma, medical subspecialties, etc. and provides an academic environment for pediatric residents' and medical students' education for University of Florida and Mayo trainees.

Nemours Children's Clinic:

This year the Clinic and the Children's Hospital built an elevated connector over I-95 linking the two institutions. Nemours also celebrated the acquisition of the subspecialty pediatric faculties at Arnold Palmer Children's Hospital in Orlando and the Sacred Heart Hospital in Pensacola. Dr. Paul Pitel became the chairman of the Department of Pediatric Medicine at Nemours/Jacksonville, replacing Dr. Ian Nathanson who assumed the Medical Director's position at Arnold Palmer Children's Hospital in Orlando.

Private Pediatric Community:

Managed care continues to be the driving force in the pediatric community. Some practices have been bought entirely by organizations, all have contracts and many have expanded to satellite offices in new growth areas. At least 2 organizations are developing nurse call services that pediatricians can utilize instead of taking their own calls. Several practices have added associates as capitated managed care contacts have encouraged more primary care visits.□

Lucian K. DeNicola, M.D.
Regional Representative

(◂ continued from page 15)

to aid in the assessment of children new to a given area. The Florida Department of Health welcomes the opportunity to provide the medical community with resources in this or any other aspect of TB control or treatment.

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F.Y.I

[The following, provided for us by Ed. Zissman, is from a letter sent to Judy Cooper of the FMA by Tracy A. Ippolito, Medicaid Program Development. It answers a question often asked by practitioners.]

"As we discussed on the phone, the situation you described - where a patient (who is a Medicaid recipient) refuses to pay their private insurance copayment - is not actually a Medicaid issue. A patient cannot refuse to pay the copayment associated with their private insurance plan under the guidelines set forth in federal regulation prohibiting enforcement of Medicaid copayments.

"A physician always has the option of choosing not to accept Medicaid as the method of payment, which, in this case would clearly leave the issue one between the private insurer, the patient, and the doctor. And, in that case, the physician would look to the private insurer's policy regarding enforcement of copayments - not Medicaid's copayment policy."□

Add a 'pearl'...from Chuck Weiss

Always on the move, Chuck wants us to know more about his concern with acetaminophen poisoning.

The Florida Poison Information Network reports for us on acetaminophen "exposures" (i.e., reports to the network) for 1996:

Acetaminophen	4,553
Ametaminophen in combination with other drugs	2,286

That's enough to worry us! Thanks, Chuck!

Current C.A.T.C.H. Programs in the State of Florida

Status	Name	Start Date	Contact	Enrol l	Annual Budget	Source of Funds	Description of Services	Target Population	Barriers Encountered
Active	CATCH of Brevard	Spring 1992	Donald Arnold, MD Sharon B. Rosman,RN 1260 S. US1 Suite202 Rockledge, FL32955 407-631-8035	2348	$475,000	State & Fed. Funds 3rd Party Providers Medicaid	24 hour access to a primary care physician. Professional services rendered in physicians' offices or in hospital emergency rooms	CMS clients and their siblings Foster and shelter care childlren Developmental services children and their siblings Other HRS children and their siblings	Ability to attract participating physicians in all areas
Active	Child Health Assistant Project, Inc.	May 1988	G. Neal Wiggins, M.D. 809 N. Stone Street Deland, FL 32720 904-738-1742	1600	State: $378,900 3rd Party: $194,333	Medicaid or 3rd Party provider, HRS budget	a)General pediatric care in office setting b) Telephone consultations c) Special assistance for medication, orthopedic shoes, eyeglasses, humidifiers d) Psychological counseling	Indigent population of Volusia County, all children involved with any HRS program	Inconsistent state funding
Active	Children for a Better Tomorrow	Oct 1996	Marie F. Weston, M.D. 427 Coconut Circle Ft. Lauderdale, FL 33326 954-389-7951	100 in 1st yr, 1000 +/yr by 4th yr.	$127,000	Fed. and local grants, partnerships, in kind services	Youth Nonviolence workshops twice weekly for 11 week periods, integrated into core public school curriculum for at risk youth	At risk youth within the public school population	Funding delays
Active	Pinellas County School-based Clinic Program	August 1991	David Cimino, M.D. All Children's Hospital University Teaching Serv 801 6th Avenue South St. Petersburg, FL 33701	8210/ yr	$286,821	J.W.B. - grant Pinellas County PHD ACH, Medicaid	Health physicals, referral services, immunizations, llab tests, care of acute and chronic problems, nutrition counseling, mental health counseling, prevention info	Underserved adolescents of Pinellas County	Poor results to Medicaid billing
Inactive	Ambassadors of Healthy Eating - a nutrition program	-----	Martha Valiant,M.D. Public Health Unit Dir. P.O. Box 70 Labelle, FL 33935	-----	-----	-----	-----	-----	-----
Active	Tallahassee Primary Care Program	July 1984	Louis St. Petery, Jr, MD 1132 Lee Avenue Tallahassee, FL 32303	12000 /yr	$2,188,856	45% state general revenue; 55% Medicaid and other 3rd party reimburse.	Provision of all primary care services for indigent children in private practice offices	Indigent children living in Tallahassee, Quincy, Panama City	No role models to follow; no appropriate data base; in-adequate funding

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: Symposium by the Sea: The Annual Meeting of the Florida College of Emergency Physicians
Dates: August 15-17, 1997
Place: Marriott Marco Island, Marco Island, FL
Credit:
Sponsor: Florida Emergency Medicine Foundation and the Florida College Emergency Physicians
Inquiries: Registrar, (800)766-6335/(407)281-7396 Fax (407)281-4407)

Program: Practical Pediatrics
Dates: August 29-31, 1997
Place: Hilton Head island, SC
Credit: Hour by hour for Category 1 for AMA Physicians Recognition Award
Sponsor: American Academy of Pediatrics
Inquiries: AAP, call 1-800-433-9016, ext 7657 or 6796

Program: Pediatric Certification/Recertification Specialty Review Program
Dates: September 9-13, 1997; September 17-21, 1997
Place: Costa Mesa, CA; Totowa, NJ
Credit: 42 Hours in category 1 of AMA Physicians Recognition Award
Sponsor: National Medical School Review
Inquiries: Call 1-800-533-8850, 4500 Campus Drive, Suite 201, Newport Beach CA 92660

Program: Practical Pediatrics
Dates: September 18-21, 1997
Place: San Francisco, CA
Credit: Hour by Hour for Category 1 for AMA Physicians Recognition Award
Sponsor: American Academy of Pediatrics
Inquiries: AAP, call 1-800-433-9016, ext 7657 or 6796

Program: Practical Pediatrics
Dates: October 17-19, 1997
Place: Phoenix, Arizone
Credit: Hour by Hour for Category 1 for AMA Physicians Recognition Award
Sponsor: American Academy of Pediatrics
Inquiries: AAP, call 1-800-433-9016, ext 7657 or 6796

Program: Space Coast Pediatric Conference
Dates: Octobe 31-November 1, 1997 **(note change of date)**
Place: Melbourne Beach, FL
Credit: 10 hours for Category 1 for AMA Physicians Recognition Award
Sponsor: University of South Florida and Holmes Regional Medical Center
Inquiries: Ms. Rebecca Scott (813)272-2744 or FAX (813)272-2749 *Place:*

Program: APLS: The Pediatric Emergency Medicine Course
Dates: November 1-3, 1997
Place: New Orleans, LA
Credit: Hour by hour for Category 1 for AMA Physicians Recognition Award
Sponsor: American Academy of Pediatrics
Inquiries: AAP, call 1-800-433-9016, ext 7657 or 6796

Program: Advances in Pediatric Hematology/Oncology
Dates: November 20-22, 2997
Place: Royal Plaza Hotel, Orlando, FL
Credit: To be determined
Sponsor: Florida Association of Pediatric Tumor Programs
Inquiries: Susan Easter, PO Box 17757, Tampa, FL 33682 (813)632-1309

Program: Practical Pediatrics
Dates: December 12-14, 1997
Place: San Antonio, TX
Credit: Hour by Hour for Category 1 for AMA Physicians Recognition Award
Sponsor: American Academy of Pediatrics
Inquiries: AAP, call 1-800-433-9016, ext 7657 or 6796

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