

THE FLORIDA PEDIATRICIAN

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

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THE PRESIDENT'S PAGE

Greetings from Tampa. I hope this finds you well and thriving in the ever more exciting realm of managed care. Since our last communication, several things of at least middling interest have transpired. We have been graced by a visit from our new AAP President, Joe Zanga, and his lovely wife Christine. The Zangas were in the area as Joe presented a Grand Rounds at All Children's Hospital, followed by attendance at an Emergency Medicine conference in Naples. In the midst of all this, they joined a number of the FPS/FCAAP leadership for a rainy but very collegial dinner out. Joe has some ideas about the importance of the family unit in child health which will be forthcoming in AAP activities as his tenure progresses.

* * * * *

“..ideas about the importance of the family unit in child health care which will be forthcoming..”

* * * * *

The aforementioned Naples conference was preceded by a meeting of the AAP Committee on Pediatric Emergency Medicine (COPEM, for the acronymically inclined), to which your president was invited as a courtesy by the AAP. I found this to be a most stimulating experience, not having had much involvement with national Academy committee activities in the past. For one thing, I would encourage the membership that you definitely get your money's worth ... this was a working meeting, with very few breathers in the course of a long agenda. Some items of interest were 1) a new version of the COPEM Handbook in the works; 2) several joint ventures with the Academy of Emergency Physicians, such as an EMS-C coordinating committee and joint sponsorship of a National EMS Week in 1998; and several joint policy statements. I was educated and happy to see that COPEM appears to be in good hands.

Work continues on the FPS/FCAAP hopes for new state legislation to accommodate the Title XXI/SCHIP funding in Florida. John Curran outlined the "Phase 2" ideas in the last Florida Pediatrician, with further details to follow. I have received some feedback from members who are concerned that long-standing goals of the Society such as promotion of a medical home and the concept of the pediatrician (and pediatric specialist) as the proper provider for the

(see *President*, page 22 ▶)

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(Adolescence)

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THE EDITORIAL PAGE

“Of HMOs and Substance Abuse”

No, this is not an attempt to link the two items together! Nonetheless, the two subjects seem to be most on our minds right now.

Is there such a thing as “battle lines to be drawn”, or “a line in the sand”, concerning HMOs? If so, then this has occurred. Strangely, the voices we are hearing are not our own, albeit there is certainly a gulf separating those of us who favor managed care via HMOs and those who just as fervently hate them. The voices of dissent, however, have come from such diverse sources as patients complaining about choice of physician, TV movies, news magazines, and even financial magazines. The only positive voice is that of one of our own members, who consistently supports the concept and the execution.

“...battle lines to be drawn...”

Where will this lead? I don’t believe anyone has the answer to this just yet. Certainly there are aspects which are unpalatable, some even the subjects of legislation across the nation (free choice of physicians and the right to sue HMOs are two such). Will the perceived “quest for the bottom line” ultimately be the undoing of managed care as we know it today? Suppose it is. What will replace it? Will the replacement be more palatable (or more favorable) to pediatricians in general? Will it be the “single payor” concept previously touted? Who knows?

One thing is certain, though. Through this time, we must maintain our dignity and our excellence of care for children, adolescents, and young adults, advocated so well by AAP President Joe Zanga later in this issue.

“...emphasis on tobacco use...”

Meanwhile, the AAP has embarked on a new three-year incentive, designed to increase the awareness of the pediatric and patient communities to the problem of substance abuse, and its prevention. This year, the emphasis will be on tobacco use in the young. We too will look at tobacco, in our own “Emphasis on...” section, during this year 1998. We hope this will contribute well to the overall effort, and will spur members to create their own “war” on the problem. The first of the series can be found in this issue.

So there is the challenge for the new year: two issues, diverse in their nature, but both problems to the pediatricians of Florida and both dominating their efforts, in Florida and across the nation.

-The Editor □

THE "GRASS ROOTS"

THE REGIONAL REPRESENTATIVES REPORT

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

Region IV reports:

In November of 1997, Region IV of the Florida Pediatric Society/FCAAP honored Senator Toni Jennings for her contributions to the children's health in the State of Florida. Senator Jennings gave a speech to the Central Florida Pediatric Society regarding the future of children's health care issues in the State. The meeting was well attended and very informative. The next Central Florida Pediatric Society meeting is on February 5th, and Russell Steele, M.D. will speak about "the changing immunization schedule" and Barbara Watson, M.D. will address the society regarding varicella. The meeting will be at the Orlando Museum of Art.

"The Care of the Sick Child" conference was held in November and it was well attended in Orlando.

The Nemours Children's Clinic has moved into its new home across from Arnold Palmer Hospital for Children and Women, and is up and running. Florida Hospital, Columbia Park Hospital and Orlando

(See **Region IV**, page 23 ▶)

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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 VIII reports:

Region VIII encompasses Dade and Monroe Counties, a vast and diverse area. Cohesiveness and social activism have been lacking for many years, which we hope to improve. Many local pediatricians are not members of traditional medical organizations, and reaching them will be important for us all.

The Greater Miami Pediatric Society welcomed its new President, Dr. Cathy Burnweit, a pediatric surgeon, at its fall meeting in September. Ron Hirschl, MD, from the University of Michigan presented his clinical research findings on liquid pulmonary ventilation of infants and children. At the winter meeting, Barbara Barlow, MD, from Harlem Hospital in Manhattan, presented her very successful program of community partnership with health care workers and commercial enterprises/industry to combat childhood gun violence by constructing playgrounds and safe areas at local parks and schools. Spring and summer meetings are still in their planning phases.

Miami Children's Hospital hosted its annual Allergy/Asthma conference and ongoing Post-Graduate course. The University of Miami's Department of Pediatrics held its annual Masters of Pediatrics conference, as well as those concerning Pediatric Nephrology and Critical Care Medicine.

The Region continues to experience the sudden attractiveness of children as patients and consumers. Several local hospitals have already or are in the process of developing "hospitals" and emergency rooms for pediatric services. The community pediatricians continue their trend of merging practices and selling outright to corporate or hospital entities. The managed care issues and financial concerns are similar to those in the rest of Florida, but may be heightened somewhat by the large population here. Health coverage for underserved and low income children still needs to be encouraged here. The tobacco company fines and Healthy Kids campaign may be good starts.

Regional Representative □

A new feature is proposed:

The "Ticked Off" Column.

If you are really "ticked off" about something in your practice or about medical economics in general, write about it and send it in. Any reasonable complaint will find its way into print! □

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**Report of the Committee on
Collaborative Research**

Lorne Katz, M.D.
Chairman

**Summary of PROS Research Coordinators Meetings
October 31-November 1, 1997**

Dr Wasserman reviewed the current makeup of the PROS Network, this presently being 464 practices with almost 1400 practitioners. In Florida, there are 19 practices with 36 practitioners. PROS has collected data on 10 studies and has generated or will generate several publications. More important, PROS is contributing towards improving child health care by conducting practice-based research addressing primary care issues.

Certain research projects' outlines were discussed and planned. These included:

- 1) improving quality of asthma care in pediatric practice
- 2) life around newborn discharge
- 3) stimulant treatment in Pediatric Primary care - outline of 1 year follow-up study
- 4) polio immunization study

Discussion was held regarding the feasibility of a telephone triage study, assessing telephone triage during and after office hours.

Data was presented from the Referral Study regarding referrals in fee for service vs HMO plans, and analysis of the breakdown of referrals. Five manuscripts are in progress.

Data was presented from the Child Behavior Study. This study collected data on approximately 22,000 patients. Psychosocial problems seem to be twice as common as they were 25 years ago. The studies are in press.

- 1) Insurance status and Recognition of Psychosocial Problems. Archives of Pediatrics and Adolescent Medicine, November 1997.
- 2) The Family Apgar Journal of Family Practice, January 1998.

In addition, 5 papers have been submitted for publication and 11 others are in varying stages of preparation.

Lastly, data was presented on the Febrile Infant Study. So far data has been collected on approximately 2500 infants, and we are continuing the study until we get data on 3000 infants. In Florida, 2 pediatricians are in the top ten - they are Diane Wilkinson MD and William Albritton MD of Pensacola. Kudos to these great doctors!!! □

Kudos...

to Dr. Jay Whitworth who has received the 1997 Excellence in Health Care Award, sponsored by KPMG, Jacksonville Business Journal, AvMed, Channel 30 and Channel 47. Chosen from a pool of 19 finalists, Dr. Whitworth received the award on November 7, 1997 in recognition of his Child Protection Program. *Congratulations!* □

School Health/Sports Fitness

David A. Cimino, M.D.
Chairman

[The following report is excerpted from the minutes of a meeting held on January 16, 1998]

This was the first meeting of the Committee on School Health and Sports Medicine as currently constituted. A number of topics were discussed.

TOPIC 1: Committee membership.

Two additional members for the committee were elected: Deborah Mulligan-Smith, M.D. and Onelia Lage, M.D.

TOPIC 2: School Health Conference

The proposed School Health Conference to be held in conjunction with the Florida Pediatric Society annual meeting on Friday, May 28, 1998 in Orlando was discussed. A tentative agenda was adopted. Further discussion via conference call was scheduled for January 20. This call would take place during a call involving the School Health Leadership training Program project advisory committee and the School Health Leaders from District IV.

TOPIC 3: General Agenda for the Committee on School Health and Sports Medicine for 1998

In addition to developing the School Health Conference for May 1998, the committee will support legislation being proposed by Senator Gennie Brown-Waite and Representative Les Miller to put a registered nurse in every elementary school. Dr. Cimino will contact the respective legislative offices. The legislative committee of the Florida Pediatric Society will be asked to support this legislation and include it as part of their agenda.

It is planned to provide a column in the Florida Pediatrician from the Committee on School Health on a regular basis, with regular contributions by members of the committee.

TOPIC 4: Sports Medicine Issues

Several members of the committee have a special interest in sports medicine, namely Drs. Hough, Abrunzo and Gereige. They will generally be responsible for sports medicine issues. For this year it was felt that there were 3 items that should be addressed:

1. Timing of the pre-participation physical and certification
2. Uniformity in the history and physical form used for exams
3. Uniformity in the performance of the exam and appropriate qualifications for the professional performing the exam. It was felt that anyone allowed to certify must be competent in performing a cardiovascular assessment and not just a musculoskeletal assessment.

It was felt that these goals could best be achieved by working with the Florida High School Athletic Association. Since each school district is different, the best opportunity to get uniformity is to elicit assistance from the FHSA to require these criteria for participation. Dr. Hough will contact the Florida High School Athletic Association to address these issues. He will establish meetings as necessary and request assistance from the other members of the committee and the Florida Pediatric Society as indicated.

Members: Jon Schneider, D.O., Rani Gereige, M.D., Gerard Hough, M.D., Tom Abrunzo, M.D., Diana Dameron, RN □

Managed Care is no Reason to Dodge Professionalism

Joseph R. Zanga, M.D., FAAP
President, American Academy of Pediatrics

(This Letter from the President appeared in AAP News, December 1997. Because of its importance, it is reprinted here with permission from AAP News.)

Dear Colleagues:

Sometimes a profound statement in the Sunday newspapers is found not on page one, but rather, in the Sunday comics. One of the best of these, for those of us old enough to remember Pogo, is the now classic statement, "We have met the enemy, and he is us."

I think about that a lot as I go about meeting our members and talking to pediatricians and politicians and patients. Are we our own worst enemy?

In telling me why he was not encouraging his children to follow his career in pediatrics, one of my professors told me many years ago that increasingly, pediatricians were becoming "traffic cops on the road to medical care." I argued that he was wrong. Yet, what are we when a parent says that her child is "spitting up", and in the face of excellent weight gain we refer the child to a gastroenterologist?

We tell the world that we are experts in the care of the newborn and young infant, and we say that "breast is best." Yet the majority of us spend little time counseling about breastfeeding, and even fewer of us demand that our hospitals be breastfeeding-friendly environments.

The public acknowledges us as probably the most competent physicians to deal with the ills of children. Why is it then, even in the face of increasing concern about overuse of antibiotics, that many of us provide the latest and often most expensive ones for illnesses that might best be treated with tincture of time, ours and the family's?

And how often do we make the point to managed care and others that we provide a true medical home for our patients? Most of us still do, and yet increasingly I hear of more and more physicians and practices signing out care to after-hours, mid-level provider telephone information services. Are they really just as qualified as pediatricians to provide care? Some people are, unfortunately, beginning to think so.

I am not naive enough to think that the "real world" is identical to the "ivory tower" in which I work. But I have worked for more years than I want to count in what is now the world of managed care, and I know that these issues are being addressed, and these questions are being asked.

We have met the enemy...is he us? Think about it and let me know.

Joseph R. Zanga, M.D., FAAP
[Dr. Zanga's thoughts mirror the thoughts of many of us who practiced pediatrics before managed care, in the so-called "golden era" of medicine. Younger or older, all of us must have some feelings. Please relay them to Dr. Zanga. If you like, respond also to this Editorial Office and your opinions will find their way into this Newsletter. There is much food for thought here. -Ed] □

Central Florida Pediatric Society

Our society remains strong both in numbers and attendance at our quarterly meetings. Our members continue to enjoy meeting together to hear the lectures and socialize with each other.

We elected new officers for this and the coming year. Dr. Steven Rosenberg is president and Brenda Lewis, M.D. is our new Vice President.

We enjoyed some fine speakers in 1997. We suggest all of them for other societies to consider. We started the year off with Christopher Harrison, M.D., who came down from Creighton University School of Medicine. His topic was "Otitis Media into the 21st Century". Our presenter at the spring meeting was Elliot Ellis, M.D., who lectured on the "Advances in Drug Therapy of Allergic Diseases". Our fall meeting featured one of Florida's best known pediatricians. Edward Saltzman, M.D. talked about "Present Pediatrics: Cope, Grow, Compete, Refocus, or Retire!" Members of the audience kept Dr. Saltzman for an hour and a half after the meeting, discussing aspects of his presentation. We were delighted to have Florida State Senate President Toni Jennings for our November meeting. She discussed legislative concerns involving Florida's children and young adults. Senator Jennings was very well versed on the subject matter. Our special guest for this meeting was Florida Chapter President Edward Williams, III, M.D.

1998 should be another great year for our society. We plan a dynamic duo for the February meeting. Russell Steele, M.D., and Barbara Watson, M.D. will make presentations involving vaccine updates and varicella. We look forward to their presentations.

As with other areas, we see continual changes occurring in the pediatric medical environment. Dr. Saltzman's lecture seemed to cover what has to be done: "Cope, Grow, Compete, Refocus, or Retire!" We have seen all of these features happen this year.

Best wishes for a prosperous New Year from your Central Florida colleagues!

Jim Holt
Executive Director
Central Florida Pediatric Society □

Note: Visit our society's permanent website at:

www.flped.net/flped/society.htm for all members to learn about our society, including a summary of *The Florida Pediatrician*.

Note:

Another summary of *The Florida Pediatrician* is on the website for the AAP. The URL is:

<http://www.aap.org/member/chapters/florida.htm>.

FLORIDA ASSOCIATION OF CRITICAL CARE MEDICINE

The Florida Association of Pediatric Critical Care Medicine is the section of the Florida Medical Association formally recognized as representing those individuals with interest and expertise in pediatric critical care. Membership is not limited strictly to Pediatric intensivists and does include other individuals. Our group is relatively small and now numbers approximately 40 members throughout the State of Florida. Membership is open to those in the practice of pediatric critical care including pediatric intensivists, pediatric anesthesiologists, pediatric surgeons, pediatric pulmonologists, pediatric cardiologists, and others. We welcome application for membership, and interested individuals can contact Dr. Daniel Plasencia at Pediatric Medical Subspecialties, 2110 West Martin Luther King Blvd., Tampa, FL 33607, telephone number (813) 870-1995 for application material or further information.

There are four fully accredited fellowship training programs in pediatric critical care in the State of Florida, all four of which are represented in our organization. These programs are at the University of Miami School of Medicine, Miami Children's Hospital, and the University of Florida College of Medicine in Gainesville. The fourth program is run by the University of Florida in conjunction with Nemours Children's Clinic physicians at Baptist Hospital in Jacksonville.

Our group held its yearly meeting in conjunction with the University of Florida's Critical Care meeting on November 25, 1997 in Orlando. In an attempt to further improve attendance at that meeting in conjunction with the University of Florida's Critical Care Meeting, and also to allow participation by fellows in critical care, the decision was made to begin alternating locations for that meeting throughout the state. This will take place with next year's meeting, with the anticipation that the meeting will be held in the Miami area.

Our organization has identified three key issues which we feel are of importance to our organization, to the pediatric community, and indeed, to the general medical community throughout Florida, either directly or indirectly. The first of these issues was our organization's strong support for further development and ultimate functioning of a formal Emergency Medical Service for Children within the State of Florida. Several members of our group have participated in state Technical Assistance Panels (TAPs) looking at the development of this program. This is being looked at as a component of the Pediatric Facilities Standards, which are being developed by the Agency for Health Care Administration (AHCA). Again, a number of our members have been very actively involved in that process as well. It is hoped that the next year will see significant headway made in the development of these two programs.

The next issue that we have identified as needing attention is reimbursement for pediatric critical care services. In view of the very large percentages of individuals requiring critical care, services that are funded through Medicaid, we feel it is imperative to work with that organization to reach a more reasonable and equitable reimbursement arrangement for these services. We feel that the time constraints imposed by Medicaid (2 hours maximum on the first day, and one hour maximum on each of the following days) is quite unreasonable and fails to recognize the time often required and then to provide adequate

reimbursement for the services provided to those critically ill children and their families. The bundling of procedures under the heading of critical care prevents billing for these services and procedures individually. We are hopeful that continued interaction with individual from ACHA and others will result in more reasonable and equitable compensation for our services.

The third area identified by our group as needing involvement and support from the rest of the pediatric community, and indeed the entirety of the Florida Medical Association, is the concern regarding the very survivability of the subspecialty of pediatric critical care. Individuals practicing in this field are providing health care service to the most critically ill of Florida's children on a continuous basis and must be available around the clock. The level of reimbursement, the degree of outside influences and control, the involvement of managed care, and other issues are making it exceedingly difficult to perform these services, and remain viable while doing so. Essentially all of the various practices within the state, both university and community based, have been forced to look at their practice arrangements and affiliations, and take other steps to allow them to remain in the practice of pediatric critical care. It is the desire of all members of our organization to continue in the practice of pediatric critical care. It is our concern that, without appropriate support and compensation, the specialty will not survive. This leaves us with a great deal of concern as to who will then provide the needed level of care to the most critically ill segment of Florida's children.

Dr. Charles Schleien from the University of Miami was able to attend the FMA annual meeting in the summer and represented our group at that meeting. He was able to present the above issues to them for their consideration.

Our group is also involved in doing some follow-up studies after the enactment of the bicycle helmet law, which we strongly supported. We are working with the College of Public Health at the University of South Florida to determine the impact of that legislation on an ongoing basis. Dr. Rick Weibley of the University of South Florida is representing our group in that work.

Our group has also joined with the Breath of Fresh Air Coalition in support of the use of tobacco funds for health-related uses, as specified in Florida's settlement with the tobacco industry.

Our organization as a whole, and certainly by way of its individual members, maintains a great deal of interest in a number of other pediatric health care issues. We are certainly keenly involved with issues regarding health care needs of children with special needs. There is a great number of those children who frequently utilize services of the pediatric critical care unit. We are also interested in a number of ongoing research issues, legislative issues and other areas as well.

We welcome the opportunity to participate as a section of the Florida Chapter of the American Academy of Pediatrics and the Florida Pediatric Society, as well as the Florida Medical Association. We look forward to continuing our efforts, in conjunction with those of our colleagues, to further the health and well-being of our pediatric patients.

Munchausen Syndrome By Proxy

Enid Gilbert-Barness, M.D.
Professor of Pathology and Pediatrics
University of South Florida College of Medicine
Tampa, FL

The term 'Munchausen' was first used in the medical literature in 1951 by Asher in describing a syndrome in which patients traveled from hospital to hospital obtaining admission and often treatment by fabricating symptoms, signs and medical histories. The name derives from Baron von Munchausen, an eighteenth century German soldier who was known for his exaggerated stories. In Munchausen syndrome the adult victim suffers from self-induced harm that is usually sublethal. Unfortunately the complex and contrived stories that are fabricated by patients suffering from Munchausen syndrome result in wastage of medical resources with a great number of unnecessary tests, investigations and hospital admissions. Equally unfortunate are the number of unnecessary surgical treatments resulting in considerable patient morbidity.

Munchausen syndrome by proxy in contrast is a condition in which a parent or caretaker deliberately simulates or creates disease in a child in order to attract the attention of the medical profession. There have been increasing numbers of patients reported from a variety of countries since the original description by Meadow in 1977.

A high percentage of parents involved in the perpetration of Munchausen syndrome by proxy have had histories of factitious illnesses. It involves the deliberate harming of a child with a reported mortality rate of 33 percent in one series of infants with induced recurrent apneic episodes. The mortality rate in siblings in the same series was even higher at 55 percent. There is a considerable morbidity rate in Munchausen syndrome by proxy with a significant incidence of subsequent hypoxic cerebral damage and behavioral disturbance.

The range of presentations of Munchausen syndrome by proxy is extremely varied; however, certain characteristic features are present which enable the diagnosis to be made. The essential findings are the creation by a caretaker, usually the mother, of a spurious or real illness in a child, with repetitive attendances for medical assessment, investigation and treatment. The illness either speedily resolves or the episodes requiring investigation cease, once the perpetrator is separated from the child. A large number of clinical services have often been consulted during the episodes, with a wide range of often arcane diagnoses being proposed. Munchausen syndrome by proxy is worth considering in the differential diagnosis of any case that appears to defy medical logic.

As the victim often presents with a typical history of an 'apparent life threatening event' (ALTE) the diagnosis of imposed upper airway obstruction in infancy may be extremely difficult to make. These episodes appear frightening to an observer, in which the infant is observed to be limp, cyanotic or pale, and apneic. There are, however, a wide range of unrelated conditions which can cause ALTE, including epilepsy, infection, gastroesophageal reflux, hypoglycemia, tracheomalacia and brain stem neoplasia. ALTE may also be related to

sudden infant death syndrome (SIDS), although it has been estimated that only 7 percent or less of infants who subsequently die of SIDS have experienced a significant apneic episode. In infants who are experiencing recurrent ALTE, and in whom organic illnesses such as epilepsy and reflux have been excluded, the diagnosis of imposed airway obstruction must, therefore, be seriously considered. Imposed airway obstruction may differ from classical forms of Munchausen syndrome by proxy, in that parents do not always seek out a variety of different doctors for treatment.

A characteristic feature of induced recurrent apneic or cyanotic episodes is that they always commence in the presence of the same person, although others may become involved after the episode has been induced. The perpetrator may go to considerable lengths to conceal this fact, including disconnecting monitors until apnea has been induced, reconnecting the monitor, and then leaving before the alarm sounds. Episodes will also recur in hospital if the perpetrator is unaware of surveillance, and this may be particularly so if discharge is thought to be imminent.

The monitors demonstrate a typical pattern during induced episodes of an obstructive event associated with considerable body movement artefact. Between events there are no cardio-respiratory or electroencephalographic abnormalities, and therapeutic failure is also characteristic, with medications such as respiratory stimulants or anticonvulsants having no discernable effect on these episodes.

Careful examination of the family history is essential as there may be a history of 'SIDS' in a previous sibling. If the infant dies, the autopsy findings in intentional homicidal asphyxiation in infants are more often than not identical to those found in SIDS. A good example are the 5 cases in siblings described by Steinschneider in his paper on prolonged apnea and SIDS in 1972, which initiated the use of monitoring to prevent SIDS. Subsequent investigations in 1995 and confession of the mother revealed that these deaths were due to intentional asphyxiation. When more than one case of so-called SIDS occurs in a family the index of suspicion should be raised and other conditions such as metabolic diseases and child abuse should be investigated.

Other features which may help to identify a case of Munchausen by proxy may be the older-than-usual age, and unwillingness on the part of the family to be interviewed or counseled. Frequent changes of hospitals, or doctors, for the delivery of babies, and for the management of subsequent symptoms may be noted. This may include moving between cities and states.

Interviewing other family members may be worthwhile, as they may provide histories which are not consistent with the perpetrator's account of the episodes. For example, the perpetrator may state that another person was present at the commencement of the

event, whereas the person may indicate arrival only after the episode had started. Similar contradictory information may be forthcoming regarding other elements of the home life and previous children's histories. However, collusion between the spouse and the perpetrator has been reported.

Although occasional reports have documented a grandmother or father as the perpetrator, the vast majority of cases reported have involved mothers. Unfortunately, it is difficult to get a clear understanding of the psychological profile of the abusing mother due to conflicting and incomplete data reported in the literature. Psychotic

(see *Munchausen*, page 17 ▶)
Page 9

(Our "Emphasis" section for the year 1998 begins this month, with a stimulating article submitted by David Cimino. Emphasis on the prevention of abuse with tobacco will continue through the year.)

A UNIQUE PARTNERSHIP

J'Aime Conrod

Coordinator Community Education

All Children's Hospital, St. Petersburg, FL

Submitted by: David A. Cimino, M.D., Chairman

Committee on School Health/Sports Medicine

Tobacco use is the single most preventable cause of premature death and disability in our society. Most teenagers already know the dangerous health consequences associated with tobacco use, and some are already experiencing symptoms. Yet, each day nearly 3,000 more young people start smoking, for a total of more than one million kids every year.

The growing popularity of tobacco products among minors is a major concern for parents, health care providers, and school system administrators. Messages in educational curricula are clear: smoking causes heart disease, lung cancer, and premature births. With so many anti-tobacco messages in the schools, why then do so many young people continue to smoke? Education alone is not the answer, but neither is punishment.

All Children's Hospital and the Pinellas County School System have developed a unique alternative to meet this challenge. Tobacco Free Schools "Alternative to Suspension Program" is designed for children ages 11 to 18 who have been caught smoking on or within 1,000 feet of school grounds. In lieu of a three-day out-of-school suspension, first-time tobacco offenders are required to complete the two-evening, six hour program at All Children's Hospital.

Throughout the program, students and health care professionals discuss the health complications associated with tobacco use, tour All Children's NICU and oncology units, and learn valuable stress management and relaxation techniques. Additionally, students learn about the cycle of addiction and how they can take control of their habit. Parents are encouraged to attend the program with their child to learn effective ways they can help the child break free from addiction. A three month follow-up survey is conducted to gauge changes in the students' tobacco use or behavior patterns.

Since the program began in March of 1997, about 50 students a month have participated, and the results have been interesting. Being removed from a school setting, the teens feel at liberty to discuss their smoking habits, including use of illegal drugs, without fear of retribution. Many of the students are experimenting with marijuana and other dangerous substances, such as cocaine and ecstasy, sometimes even mixing them in strange and potentially deadly combinations. A segment of the program is designed to address the dangerous health consequences of these more illicit drugs. This is a golden opportunity not only to educate the teens about the serious medical consequences of these drugs, but also to inform pediatricians and school system administrators as to the current drugs of choice.

The main objective of the "Alternative" program is to give the teens a forum to openly discuss the dangers of tobacco and other substances and to help them recognize their motives for engaging in these risk-taking behaviors. We would be naive to assume that six hours of an anti-tobacco program are adequate to help a teen conquer

tobacco addiction. However, it is an effective first step in helping teens make an informed decision, and it has proven to be a very successful collaboration between the health care provider and the school system in understanding the needs of our adolescents. □

MEMBERSHIP ALERT!

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 made 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 child health advocacy. □

TECHNOLOGY IN MEDICINE

Susan Zucker Capobianco, Ph.D.

Director of Education, Department of Pediatrics
University of South Florida College of Medicine

The revolutionary changes in information transmission and reception ushered in by the Information Age have affected virtually every segment of our society, including medical education. Alone and in combination with other new advances, information technology is among the major forces shaping medicine today. Modern, complex health care requires rapid, up-to-date knowledge and advice. The potential for technology to facilitate the organization, retrieval, and communication of information holds promise both for freeing physicians from overdependence on memory and for fostering the development of newly needed knowledge, skills, and attitudes. Gorry and Frisse (1992) indicate that benefits from these technologies can be maximized only if physicians and academic medical centers rethink research, patient care, and education. Strategies must be developed so that information technologies are used effectively.

Changes in Medicine and Medical Education

As a result of a rapid increase in the body of scientific information in the post war decade, medicine is becoming both quantitatively and qualitatively different from what it was in the past. All components of medical tasks involve processing and/or communicating this overwhelming amount of information. The automation of hospital information management, which began over thirty years ago, exemplifies a transition in communication and information access systems. The medical library which stores, retrieves, searches, and analyzes biomedical information exemplifies a computerized system that has a tremendous effect on healthcare professionals' practice. The biomedical library has been successful in developing access to bibliographic database retrieval systems to physicians and students who perform searches directly. As computers have been introduced into the non-medical environment, their impact has been felt both in non-medical related areas and clinical areas of the hospital environment (Shortliffe, 1990).

Scheduling, order entry, computerized medical records, and related techniques have been recently introduced. Healthcare professionals' ability to use computer systems has become critically important as the electronic patient record has been widely adopted in the hospital environment. The Internet is expected to have greater potential for education and greater influence on the teaching function of medical academicians as information technologies are researched, assimilated, and incorporated into curriculum. The growth of information technologies, the development of intranets (private versions of the World Wide Web that employ browser technology), and the increasing computer literacy of the medical school population is promoting the use of the Internet in medicine. Blumenthal (1996, p. 1148) stated, "Very soon, physicians will need computers on their desks to practice medicine optimally. Without such workstations they will not receive the most timely data or the most current information on their patients (laboratory and radiology results and consultant findings)".

Medical Informatics

The role of computer-based learning technologies has shifted significantly in the past decade. In the 1980's the computer was regarded as an agent of change, the computer was used to learn from and to learn

about, and technology was expected to have a major and direct impact on student learning and skill acquisition. Expectations for the technology were reduced as mixed results came in regarding the impact on student learning. This led to the perspective of the 'computer as a tool', whereby the technology was viewed as a way to bring about new and better kinds of learning. Jonassen (1996) offered a similar perspective when he wrote, "computers are used to learn with". When learning is scaffolded, meaningful thinking occurs, learners are engaged and are supported in their thinking. Jonassen insists that computers should help learners construct knowledge. Effective use of technology, as with all other tools, is dependent on the relationship between practices, purposes, and situations.

As a result of healthcare reform and the rapid application of information technologies a paradigm shift has occurred in medicine. "Medical Informatics (MI) is the use of technology in the organization and applications of information in all aspects of medicine. This new discipline is certain to affect the future of medical practice, education, and research" (Khonsari & Fabri, 1997, p. 547) and in fact modern medicine requires integration of the full spectrum of medical informatics into medical practice and education.

New options for information access and ease of communication are available to physicians and medical educators because of the increasing popularity of telecommunications and the rapid advances and availability of computer-based systems such as virtual reality, multimedia and the Internet. These technologies can be used clinically and instructionally and can alter and improve the way medical treatment and training are delivered and received. The Internet provides fast, high capacity digital transmission of voice, data, still images, and video over worldwide fiber and telephone networks. Enhanced by multimedia, which encompasses CD-ROM technologies, graphics, video, audio, text, simulations, CAI, and more, the Internet enables realtime, interactive communication and allows physicians to view work and exchange information simultaneously.

MI in medicine and medical centers can aid in appropriate patient care, foster research, and integrate instruction (Gupta, Klein & Mehl, 1996). The methodologies for processing and communicating information may be viewed both as tools for the science and as vehicles for the technology. MI serves as a bridge between the subject domain of medicine and the science and technology of computing.

LIST OF REFERENCES

- Blumenthal, D. (1996, October 10). Quality Care Management: Part 4. *New England Journal of Medicine*, 22, 15, 1146-1148.
- Gorry, A. & Frisse, M. (1992). Medical informatics: information technology and the academic medical center. *Academic Medicine*, 67(1).
- Gupta, S.C., Klein, S.A., & Mehl, D.C. (1996). Medical informatics technologies for education and training. *Medical Simulation and Training*, 1:17-18.
- Khonsari, L. & Fabri, P.J. (1997). "Integrating medical informatics into the medical undergraduate curriculum". *Medicine Meets Virtual Reality*. K.S. Morgan et al. (Eds.), IOS Press.
- Jonassen, D.H. (1996). *Computers in the classroom*. Englewood Cliffs, NJ: Prentice-Hall.
- Shortliffe, E.H. (1995). *Medical informatics meets medical education*. World Wide Web:

http://sunsite.unc.edu/horizon/mono/higher_ed/ □

ELECTION 1998

Candidates' answers to membership question

There is one key question asked of candidates:

- *What should the American Academy of Pediatrics be doing to ensure that the State Child Health Insurance Program (SCHIP) is implemented to the greatest benefit of the most children.*

Donald E. Cook, M.D.
Greeley, CO

One of the greatest challenges, if not the greatest, for the AAP this year will be to help our state chapters implement the State Child Health Insurance Program (SCHIP). It will be difficult be-cause each state will require a somewhat different solution

to the problems they face with SCHIP. How can the Academy manage their efforts so children in all states will receive the maximum benefits possible? The initial planning or organization given to the solution of the problem by the AAP will be the key.

The work group previously appointed to work in this area should be reactivated to act as an advisory group to the Council on Government Affairs (COGA) and the Committee on State Government Affairs (COSGA), the bodies who should lead the Academy's efforts in the legislation.

The effort will be more effective if it is localized within the Academy in this manner. Involving more committees will only diffuse, and confuse our efforts. At the same time, the Academy, through its regular channels, should encourage each state to organize their own leadership to work on SCHIP with their own state officials.

After the states have organized, one large conference or preferably four smaller regional conferences, should be held using COGA and COSGA and their staff as leaders. Pertinent information about SCHIP, as well as information about how to proceed with individual state problems, would be addressed at these meetings.

Following the initial conference, communication between the national and state committees could be maintained in various ways. Direct communication by telephone, fax, or e-mail could be maintained as necessary. Conference calls could also be utilized as necessary. Information could also be distributed through a Web page on the internet and chat rooms could also be used for more direct communication between individuals at the state and national levels.

Using these methods of communication will maximize the exchange of information in the AAP and between the AAP and its state chapters. It will improve the flow of information between states and should enable children throughout the country to receive maximum benefits from the SCHIP legislation.□

Carden Johnston, M.D.
Birmingham AL

These are exciting times for Pediatricians helping more children have access to pediatric services. Seldom does an opportunity like the State Child Health Insurance Program (SCHIP or Title XXI) offer itself. Not only is this a

chance to provide coverage for an additional 5 million children and put 24 billion dollars into child health, it is also a unique opportunity for Pediatricians to gain more visibility as health advocates for children, if we can successfully implement SCHIP, we should be able to find additional monies to meet the health needs of children and their families. SCHIP is an opportunity.

My strategy would be to have the American Academy of Pediatrics aid Pediatricians and state chapters implement SCHIP through an acronym FRED; **F**acilitation of communications, **R**ecognition of Regional differences, **E**ducation and **D**esigning.

F. Facilitation of communications. Pediatricians must be at the table. While many of our chapter leaders know, understand and work with many of their state leaders, barriers to communication will develop. The AAP will help identify and obtain access to decision makers that are less familiar with chapter leaders and SCHIP captains.

R. Recognition of regional differences. Each of our chapters will run into various difficulties when implementing SCHIP. Sharing solutions will give chapter leaders a variety of choices to try in their states. Not every solution will be exportable to every state, but some solutions will be exportable to some states. Just like at the Annual Chapter Forum, ideas are copied when they are felt they will work locally. Ideas regarding SCHIP can be shared the same way.

E. Education. Educating Pediatricians about SCHIP is essential for effective implementation. Also, purchasers, payers, the public and politicians will have to be educated about child health. The AAP will provide educational instruments.

D. Design. The AA.P has to be a thought tank using members and staff to conceptualize, debate, recommend and publicize strategies which have the best chance of being successful.

SCHIP can be the stimulus Pediatricians need to become highly visible advocates in our communities and society. These are indeed exciting times for children and Pediatricians.□

Lost and Found

I was very excited to reestablish ties this fall with one of the original C.A.T.C.H. programs in the state of Florida. The Jacksonville Central Health Plaza for Women and Children, which was formerly known as Pearl Plaza Pediatrics, was initially established in February 1993 through the efforts of Dr. Prentiss Findlay's Rural Recruitment Program, via Nemours Children's Clinic in Jacksonville. From the outset, children in the city of Jacksonville who were not insured or who were covered only by Medicaid, and who were followed by the pediatric subspecialists of Nemours Children's Clinic, were referred for primary care to the Pearl Plaza Pediatric Clinic. The referral source resulted in a skewed population of children with multiple handicapping conditions or chronic illnesses. Drs. Karen Toker and Cliff David provided comprehensive primary care for these children. In 1995, Nemours gave control of this urban clinic to the Duval County Health Department, to become one of its six comprehensive care pediatric clinics. The association with the Duval County Health Department resulted in the influx of some healthy newborns, such that the mix of healthy to chronically ill children is now 50:50.

The Pearl Plaza Pediatric Clinic has now been merged with the Duval County Health Department's Women's Clinic to become the Center for Women and Children at the Jacksonville Central Health Plaza. The Clinic provides twenty-four hour availability, seven days per week for approximately 1,600 underserved urban children in Jacksonville, Florida. In addition to comprehensive primary care services, this clinic provides comprehensive developmental screening and an early literacy intervention program via a Reach Out and Read Grant.

Please wish Dr. Toker the best of luck during their upcoming C.A.T.C.H. site evaluation in February 1998.

For further information on the Jacksonville Central Health Plaza Center for Women and Children, please contact:

Karen H. Toker, M.D.
Pediatric Clinic Medical Director
or
Jeffrey Goldhagen, M.D.
Medical Director, Duval County Health Department
515 W. 6th Street
Jacksonville, FL 32206
Phones: (904)630-3380 (clinic)
(904)630-3220 (Dr. Goldhagen) □

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.

1997 C.A.T.C.H. Planning Grants

The review process for the 1997 C.A.T.C.H. Planning Grants is currently in progress. I was pleased with the increase in the number

of applications for these funds from pediatricians in our state. There were six worthy applications from the State of Florida, ranging from patient education programs to adolescent health programs, as well as drowning prevention and tobacco prevention programs. Let us keep our fingers crossed and hope for some C.A.T.C.H. grant funds to find their way back to our state and to these worthy programs. □

C.A.T.C.H. Update

I look forward to meeting any Florida pediatricians interested in C.A.T.C.H. at the next annual meeting of the Florida Chapter AAP/Florida Pediatric Society. Meanwhile, reach me at:

Patricia J. Blanco, M.D.
3675 W. Waters Avenue
Tampa, Florida 33614
(813)931-1679 □

Kudos

The American Academy of Pediatrics has announced the appointment of Deborah Mulligan-Smith, M.D., of Fort Lauderdale, to the Committee on Pediatric Emergency Medicine (COPEM). This appointment was retroactive to July 1, 1997, and carries the potential for two additional two year terms on the committee.

This appointment recognizes the importance of the work which Dr. Mulligan-Smith has carried out within the State of Florida, as Co-Chairman of the Chapter Committee on Pediatric Critical Care and Emergency Medicine.

Our congratulations and best wishes to Dr. Mulligan-Smith. □

**MISSION STATEMENT
FOR THE WOMEN'S SECTION OF THE
FLORIDA PEDIATRIC SOCIETY/FLORIDA CHAPTER,
AMERICAN ACADEMY OF PEDIATRICS**

Shakra Junejo, M.D.
Section Chairperson
Tallahassee, FL

MISSION:

The Women's Section of the Florida Pediatric Society/Florida Chapter, American Academy of Pediatrics is dedicated to empowering women pediatricians to assume a more proactive role in improving children's health services in the state of Florida.

The Organization Strives to Attain This Goal By:

1. Enhancing professional development and leadership skills of its members;
2. Encouraging active involvement of the members in policy development and formulation of legislation that relates to children's health services and providers;
3. Team building and developing consensus, the Section reflects a unified voice on the Academy;
4. It provides a forum for open discussion of issues specific to members' work environment and of special interest to women pediatricians. The purpose of these discussions is to identify solutions to common problems for local implementation and/or propose legislation to effect change.

The Current Priority Issues Are:

- A. Promotion of a work environment that is free from hostility and discrimination and allows adequate flexibility in work schedule to pursue other areas of professional and personal interest.
- B. Promotion of breast feeding.
- C. Improvement of accessibility and availability of high quality affordable child care.
- D. Improvement of access to child health services by improvement of child health insurance coverage.
- E. Promotion of adolescent health and expansion of efforts to reduce teen pregnancy.
- F. Development of partnerships with other private and governmental agencies and collaboration with other medical organizations to achieve common goals.

How We Are Organized:

We are governed by the Bylaws of the Florida Pediatric Society/Florida Chapter, American Academy of Pediatrics and the American Academy of Pediatrics. We elect our chairperson annually. She serves on the Executive Committee of the Chapter as an ex-officio member. Issues which surface at the Annual Section Meeting are prioritized by the members and committees are formed of volunteers to address the top priority issues. The leadership places great emphasis on communication and accepts the challenges of diversity. Telephone conference calls are planned to be held quarterly and as needed to discuss issues. The newsletter and electronic mail are other communication resources of proven effectiveness. □

[This information is excerpted from the latest AAP statement from the Committee on Infectious Diseases. For the full statement, please see Pediatrics; 1998 (Jan.) 101:154 and AAP News]

Minor changes clarify 1998 recommendations

Infectious Diseases committee issues immunization schedule

The Recommended Childhood Immunization Schedule, a product of the AAP, the Advisory Committee on Immunization Practices (ACIP) and American Academy of Family Physicians (AAFP), is updated every January. There have been some minor changes since January 1997.

1. The third dose of OPV may now be given between 6 and 18 months, with no particular preference. The graphic schedule indicates this. In January 1997, the Food and Drug Administration approved a modification in the package labeling for IPV to allow a schedule of 2, 4, and 6 to 18 months of age. If IPV is used for the first two doses, clinical trials have demonstrated that either IPV or OPV may be given at 6-18 months of age to infants who received IPV at 2 and 4 months of age. The ACIP still recommends the first dose of OPV at 12-18 months. The AAP gives no preference for any of the three acceptable schedules and recommends for children who received IPV at 2 and 4 months of age that the third dose (of either IPV or OPV) be given at 6 to 18 months of age. [Giving the first OPV at 6 months of age answers the objection of some who have felt that the child would be left too long without "gut" immunity.-Ed.]
2. The recommended age for the second dose of MMR is now 4 to 6 years. See the January *Pediatrics* for rationale. [This change brings this schedule into agreement with ACIP, which has always recommended this age, while the AAP recommended 11 to 12 years of age. - Ed.]
3. The 11-12 year visit is an important time to assure that all children have received two doses of MMR beginning at or after 12 months of age, one dose of varicella vaccine, a dose of adult diphtheria-tetanus, and have at least begun the series of three injections of Hepatitis B vaccine. The need to routinely administer the tetanus and diphtheria toxoids (Td) is stressed.
4. The three licensed *Haemophilus influenzae* type b vaccines which are licensed are now considered interchangeable for primary as well as booster vaccination. Excellent immune responses have been achieved when different manufacturers' vaccines have been interchanged in the primary series..
5. Recommendations for timing of the third dose of Hepatitis B vaccine for children born to HbsAg negative women and the need for two doses of varicella vaccine for susceptible persons 13 years of age or older are clarified.

The statement clearly points out: *The recommendations in this statement do not indicate an exclusive course of treatment or procedure to be followed. Variations, taking into account individual circumstances, may be appropriate.* □

symptoms are not usual and the parent often gets on well and is helpful with hospital staff, appearing superficially quite plausible. Frequently the caretaker has some medical background such as nursing or record room personnel, pharmacist, dietician, etc. While 'personality disorders' were found in all of the abusing parents described by Samuel et al, they acknowledge that this often ill-defined label is of little use in developing an understanding of parental psychopathology. On the other hand, Rosenberg found personality disorders in only a minority of cases. Histories of previous parental psychiatric treatment, eating disorders, factitious illnesses, and sexual, physical or emotional abuse have been elicited.

Why this type of behavior occurs is difficult to determine. In some cases, simple attention seeking may be the driving force, although the nature of the actions suggests that more complex dynamics exist. Resentment against another family member (spouse or parent) may be taken out on the child, or the 'attack' may be used to bring back a spouse who has left, or who is threatening to leave. Ambivalent feelings towards the injured child have been reported. Whether homicide is truly intended in children who die may be difficult to determine, as death may have resulted from a miscalculation of the degree of hypoxia necessary to produce an ALTE without lethal consequences.

Detection of suspected cases is often extremely difficult and even in hospitals it has been estimated that the presenting illness has been successfully reproduced in up to 95 percent of cases. For this reason, in Great Britain, a number of centers have set up covert video surveillance of the suspected parent in a hospital ward. It has on occasion been the only technique available that can provide sufficient evidence of abuse to ensure adequate protection of the child. In the United States this would be considered an infringement of parental rights.

Samuels et al, who have the largest experience to date in this area, have documented the protocol that is used for the institution of video surveillance at the Royal Brompton Hospital in London. The two features that initiate covert video surveillance in their hospital are suspicious episodes that begin in the presence of only one person, and episodes which demonstrate the characteristic pattern of airway obstruction with marked movement artefact on monitoring. For this purpose, they use long term multichannel physiological recordings which monitor arterial oxygen levels, heart rate, nasal airflow and breathing movement, and may also include an electroencephalograph. Once the decision to monitor has been taken, 24 hour surveillance by police officers is undertaken, in conjunction with a senior member of the nursing staff who remains available to assist the patient in the event of an episode. Fourteen cases of imposed airway obstruction have been successfully detected at the Royal Brompton Hospital utilizing this system. Recently, by covert video recordings, Southall et al reported on 39 children, ages 2 to 44 months, 33 of whom were documented as child abuse with intentional suffocation observed in 30.

Parents who are accused of inducing an illness in their child invariably deny the charge and often withdraw the at-risk child from medical care.

It has been proposed that deliberate suffocation accounts for up to 10 percent of so-called 'SIDS' deaths. With the recent fall in numbers of SIDS deaths following the "back to sleep" campaign in

1992, it should be recognized that there has been a relative increase in the number of other causes of sudden death in infants. It should be stressed that full investigation is mandatory in all sudden infant deaths and those in whom there have been reported attacks of apneic episodes as well as similar episodes in siblings.

REFERENCES

1. Asher R: Munchausen's syndrome. *Lancet* 1:339-41, 1951.
2. Alexander R, Smith W, Stevenson R: Serial Munchausen syndrome by proxy. *Pediatrics* 86:581-5, 1990.
3. Bass M: The fallacy of the simultaneous sudden infant death syndrome in twins. *Am J Forensic Med Pathol* 10:200-5, 1989.
4. Brooks JG: Infantile apnea and home monitoring. *Pediatrician* 15:212-6, 1988.
5. Byard RW, Beal SM: Munchausen syndrome by proxy: repetitive infantile apnoea and homicide. *J Paediatr Child Health* 29:77-9, 1993.
6. Byard RW, Bumell RH: Covert video surveillance in Munchausen syndrome by proxy - thical compromise or essential technique? *Med J Aust* 160:352-6, 1994.
7. Cashell AW: Homicide as a cause of the sudden infant death syndrome. *Am J Forensic Med Pathol* 8:256-8, 1987.
8. Cohle SD, Byard RW: Nonaccidental death. IN: *Sudden Death in Infancy, Childhood and Adolescence*. New York, Cambridge University Press, 1994, pp 83-87.
9. Diamond EF: In five consecutive siblings sudden infant death. *Ill Med J* 170:33-4, 1986.
10. Epstein MA, Markowitz RL, Gallo DM, Walker Holmes J, Gryboski JD: Munchausen syndrome by proxy: considerations in diagnosis and confirmation by video surveillance. *Pediatrics* 80:220-4, 1987.
11. Hunt CE, Brouillette RT: Methylxanthine treatment in infants at risk for sudden infant death syndrome. *Ann NY Acad Sci* 533:119-26, 1988.
12. Levin AV, Sheridan MS. *Munchausen Syndrome by Proxy: Issues in Diagnosis and Treatment*. New York, Lexington Books, 1995.
13. Makar AF, Squier PJ: Munchausen syndrome by proxy: father as perpetrator. *Pediatrics* 85:370-3, 1990.
14. Meadow R: Munchausen syndrome by proxy. The hinterland of child abuse. *Lancet* ii:343-5, 1977.
15. Meadow R: Factitious illness - the hinterland of child abuse. IN: Meadow R (ed.) *Recent Advances in Paediatrics*. No. 7. Churchill Livingstone, Edinburgh, pp 217-32, 1984.
16. Meadow R: Management of Munchausen syndrome by proxy. *Arch Dis Child* 60:385-93, 1985.
17. Meadow R: Suffocation. *Brit Med J* 298:1572-3, 1989.
18. Meadow R: Suffocation, recurrent apnea, and sudden infant death. *J Pediatr* 117:351-7, 1990.
19. National Institutes of Health Consensus Development conference on infantile apnea and home monitoring, Sept. 29-Oct 1, 1986. *Pediatrics* 79:292-9, 1987.
20. Ophoven JJ: Pediatric forensic pathology. In Gilbert-Barness E (ed.), *Potter's Pathology of the Fetus and Infant*, Mosby Publishing Co., 1997.
21. Parker G, Barrett E: Factitious patients with fictitious disorders: a note on Munchausen's syndrome. *Med J Aust* 155:772-5, 1991.
22. Perrot LJ, Nawojczyk S: Nonnatural death masquerading as SIDS (Sudden Infant Death Syndrome). *Am J Forensic Med Pathol* 9:105-11, 1988.
23. Rahilly PM: The pneumographic and medical investigation of infants suffering apparent life-threatening episodes. *J Paediatr Child Health* 27:349-53, 1991.
24. Rosenberg DA: Web of deceit: a literature review of Munchausen syndrome by proxy. *Child Abuse Neglect* 11:547-63, 1987.
25. Samuels MP, McClaughlin W, Jacobson RR, Poets CF, Southall DP: Fourteen cases of imposed upper airway obstruction. *Arch Dis Child* 67:162-170, 1992.
26. Schreier HA, Libow JA: *Hurting for Love: Munchausen by Proxy Syndrome*. New York, Guilford Press, 1993.
27. Southall DP, Samuels MP, Stebbens VA: Suffocation and sudden infant death syndrome (letter). *Brit Med J* 199:178, 1989.
28. Southall DP, Plunkett MCB, Banks MW, et al: Covert video recordings of life-threatening child abuse: lessons for child protection. *Pediatrics* 100:735-760, 1997.
29. Steinschneider A: Prolonged apnea and the sudden infant death syndrome:

clinical and laboratory observations. *Pediatrics* 50:646-54, 1972.

30. Valdes-Dapena M: The pathologist and the sudden infant death syndrome. *Am J Pathol* 106:118-31, 1982. Page 18

31. Williams C, Bevan VT: The secret observation of children in hospital. *Lancet* 1780-1, 1988. □

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**ANNOUNCEMENT OF NEWLY FUNDED
HEALTHY TOMORROWS PARTNERSHIP
FOR CHILDREN PROGRAM GRANTS**

Healthy Tomorrows Partnership for Children Program (HTPCP), is a collaborative grant program of the federal Maternal and Child Health Bureau (MCHB) and the American Academy of Pediatrics (AAP). Funding for the 10 new community-based projects begins October 1, 1997. The goal of this partnership is to improve the health status of mothers, infants, children, and adolescents by increasing their access to health services. This program stimulates community planning and problem solving at the local level through its unique

program requirements which include: pediatrician involvement, a two-thirds matching funds requirement to ensure project sustainability, an evaluation component, and an advisory board comprised of local community members, families and program participants.

8% Early Intervention Project-Health Care Program in *Orange, CA*, will focus on serving the unmet health care needs of youth offenders through assessment, health education, and linkage to a medical home.

San Diego Kids Health Assurance Network in *San Diego, CA*, will improve access to care for San Diego children and their families, who have no source of medical care, through the development of a county-wide automated information and referral infrastructure that will match participants to health care providers.

Infancia Feliz in *San Diego, CA*, aims to improve health status of low income medically underserved infants, during the period from birth to two years of age, by development of an enhanced perinatal support program.

Project TELL: Teens Educating, Learning, and Leading in *Chicago, IL*, focuses on improving the outcomes of adolescent childbearing through inter-generational education, support services for the whole family, and linkage to a medical home and other community services.

Covington Young Families Project: A Community responds to the Health and Social Support Needs of Adolescent Mothers and Their Children in *Edgewood, KY*, has as its goal to improve the health status and reduce the risk for abuse and/or developmental delays for adolescent mothers and their children through the development of a mentoring program.

Family Care Center Home Network in *Lexington, KY*, will provide intensive home visitor services to at-risk adolescent families and link families to appropriate community services.

FOCUS at Ele's Place in *Lansing, MI*, aims to reduce the physical and emotional adverse health outcomes that children may suffer when they lose a loved one to death. This will be addressed by improving access to bereavement services and increasing the understanding and intervention skills of health care providers of bereavement issues for children.

Healthy Tomorrows Partnership for Children in *New York, NY*, will improve the health of children with asthma by intervening in the home environment to eliminate or control asthma allergens through home visiting, case management, and health education.

Harlem Adolescent and Child Total Services in *New York, NY*,

seeks to increase the health status of pregnant and parenting adolescents and their children in Central Harlem by providing a community-based medical home for adolescents and their children. **Parents, Peer Educators & Head Start: Building Healthy Tomorrows** in *Burien, WA*, will improve the health status of children using a peer health education model and teaching about health care and selfcare skills.

Since its inception in 1989, a total of 94 HTPCP grants have been awarded; 43 of the 94 projects have been completed. To be eligible for funding, projects must represent a new initiative within the community or an innovative component that builds upon existing community resources. Healthy Tomorrows grant awards are for approximately \$50,000 per year for a 5-year project period.

For more information about the Healthy Tomorrows Partnership for Children Program, please call Jane Bassewitz, MA, Program Manager, Division of Community-based Initiatives at 800/433-9016, ext 6750.□

SCHEDULE OF MEETINGS OF THE AAP

Spring Session:

Atlanta, Georgia

April 4-7, 1998

Annual Meeting:

San Francisco, CA

October 17-21, 1998

Pediatrics Celebrates

50th Anniversary

"It's the journal's 50th birthday in 1998! We will, during this coming year, be looking back, trying to evaluate what's been published in *Pediatrics*. In July, we will publish a special supplement edited by Dr. Birt Harvey that will contain articles and items of historic interest about the birth, the early years, and the adolescent phase of *Pediatrics*, plus the current and future years. We've come a long way and can be proud of what's been accomplished to date. The future looks promising. We may even make a few predictions about what's ahead."

-Jerold F. Lucey, M.D.

Editor-in-Chief, *Pediatrics* and *PEDIATRICS electronic pages*
[Editorial in the January *Pediatrics*]□

Note:

If you are a Fellow of the American Academy of Pediatrics, you are automatically a member of the Florida Pediatric Society/Florida 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.□

Add a 'pearl' ...from Chuck Weiss

Problems in Ensuring Accurate Pediatric Dosing Of Liquid Medication

For years, the inaccuracy of the oral dosing of elixirs, syrups, and suspensions has been recognized by pediatricians, pharmacologists, pharmacists and pharmaceutical manufacturers. Sadly, there have been few significant improvements. Many pediatricians have tried ingenious methods to insure the accuracy, with less than hopeful success.

While not very imaginative, a group of pediatricians reported a study (McMahon SR et al. *Pediatr.* 1997; 100:330-333) in a population of Spanish-speaking children from largely indigent families, proving the value of their methods. The group was divided into three sub-groups:

Group 1 patients received the prescription and verbal instructions.
Group 2 received the prescription and a syringe, along with a demonstration of the correct dose.

Group 3 patients received the prescription, a syringe with a line marked at the correct dose, and a demonstration..

On returning from the pharmacy, parents administered the medication under observation. One month after the initial visit, the patients were seen again and parents demonstrated how much medication they had given:

Group 1 patients received 32-147% of the correct dose.

Group 2 patients had been given the correct dose 83% of the time.

Group 3 patients had been given the correct dose 100% of the time.

After this observation, all were given a syringe with a line marked at the correct dose. At the follow-up, 23 of 26 parents demonstrated the correct dose. This extremely simple method seems to prove effective in this population. In any questionable dosing situation, it might be considered a good alternative.

[If any of our readers have a better, simpler solution, please send it to *The Florida Pediatrician*.]
C.F.W.□

And, another:

The Revised CDC Guidelines for Screening for Lead Blood Levels were released in November 1997. In a telecon with Ms. Nancy Tipps of the Blood Lead Level Branch of CDC, I learned that only 17,100 copies of the guidelines were distributed. If you wish a copy, they are available upon request from the CDC at 1-888-232-6789.

An Academy of Pediatrics Statement on Blood Level Screening for lead is imminent. Keep watch for it in *Pediatrics*. The requirements have changed and have seen somewhat relaxed.
C.F.W.□

President

(←continued from page 1)

care of children not be forgotten in the process. Please note that a good deal of the effort at the last Retreat was directed to exactly those issues. Again, see the last *Florida Pediatrician*.

The 1998 Annual Meeting, scheduled for May 28-31, shows every sign of being action-packed, with a variety of academic activities in the works. Try to make time for this ... if you haven't been to one lately, you may be pleasantly surprised at the quality of the presentations and activities. And the price is right.

The redistricting issue is at present in the hands of the AAP Board of Directors. Our information is that redistricting will indeed take place, with the exact timing and details of distribution still to be nailed down. In any case, the component Chapters of the current District IV should end up more equitably represented at the national level. The District IV meeting as of this writing is yet to come, so stay tuned.

Edward T. Williams III, M.D.

President□

Ed. Zissman reports:

The American Academy of Pediatrics recognizes that CPT, *et al*, have created a lot of consternation and frustration among the members. In response to this, the Academy has established a **FAX BACK** system, to better serve the members. The system responds to member inquiries related to **CPT, ICD, RBRVS, AND DSM-PC**. The following are available:

FAX BACK Resource List

A list with short description of the Resources currently available from the Academy. Some are identified for sale, and can be found in the AAP Publications Catalog, available through the Academy's Department of Marketing and Publications at 800/433-9016. All others can be received by contacting the Division of Physician Payment Systems or by completing the request form. Fax inquiry to 847/228-6432.

FAX BACK Request Form

This lists the various materials available. Fax inquiry to 847/228-6432

FAX BACK Inquiry Form

Provides space to list type of question or difficulty, with a description of the problem the member has. Fax inquiry to 847-228-6432

FAX BACK Response Form

This form provides the response from the Academy to the inquiry, with related information attached. Fax further inquiry to 847-228-6432

Further inquiries may be directed to the American Academy of Pediatrics, CPT/ICD/RBRVS FAX BACK, 141 Northwest Point Boulevard, Elk Grove Village, IL 60007-1098. Voice comments to Matthew Katz at 800/433-9016, ext. 7931.

[*Ed Zissman is not only our Vice President, but also Chairman of the Committee on Child Health Financing and Pediatric Practice. He is constantly on the look out for ways to help his fellow members through the muddle that is this subject. For this we are greatly indebted to him. -Ed.*] □

911 Emergency Training Guide

The 911 Emergency Training Guide is now available in both English and Spanish versions. You may obtain a supply by contacting the Chapter office at 1132 Lee Avenue, Tallahassee, FL 32303, or by phone at (850) 224-3939, or E-mail at edielov@ibm.net. The guides were made possible by a grant from the Hansen EMS Foundation and are designed for children and families. They are excellent tools for education in the use and access of the EMS system.□

[Each year, in February, we will publish Resolutions submitted by members of the Chapter for consideration to be submitted to the Chapter Presidents' Forum later in the year. A list of resolutions approved by the Executive Committee will then be published in the June issue]

Resolution

Title: Investigating the Ezzo Program and the FTT Infants associated with it.

Submitted by:

Robert G. Dillard, M.D., F.A.A.P. Breastfeeding Coordinator, North Carolina Chapter, AAP

Arnold L. Tanis, M.D., F.A.A.P., Past President, Florida Chapter, AAP (1985-1988); Breastfeeding Coordinator, Florida Chapter, AAP.

WHEREAS the infant management program developed by Gary and Anne Marie Ezzo and promoted in the books *Preparation for Parenting* and *On Becoming BABYWISE* is used by over half a million parents, and

WHEREAS this program outlines an infant feeding schedule inconsistent with AAP recommendations, and

WHEREAS a hospital committee including two Fellows of the Academy and a county child abuse prevention council have detailed multiple causes for concern with the program, and

WHEREAS over 100 health care professionals across the country including 19 AAP Fellows have asked the Academy for feedback on this potentially harmful program, and

WHEREAS numerous physicians, lactation professionals, midwives, pastors, and parents have reported cases of FTT in infants associated with this program, and

WHEREAS the church where this program was developed has publicly disavowed all association with it,

RESOLVED that the American Academy of Pediatrics investigate the infant management program outlined in *Preparation for Parenting* and *On Becoming BABYWISE* and determine the extent of its potentially harmful effects on infant health, and

RESOLVED that the American Academy of Pediatrics alert its members, other organizations, and parents of its findings and inform healthcare providers how to discern when the program is in use and how to facilitate patient care while on the program..

REFER TO: Annual Chapter Forum

AUTHOR/CONTACT PERSON: Arnold L. Tanis, M.D., FAAP Ph (954) 966-8000, fax (954)966-6614 □

forwarding of the preceding resolution:]

What are *Preparation for Parenting* and *On Becoming BABYWISE*?

These books outline an infant management program developed by Gary and Anne Marie Ezzo, distributed by Growing Families International (GFI) in over ninety countries, and used by over half a million parents. Though almost identical in wording, *Preparation for Parenting* (PFP) is distributed in churches and *On Becoming BABYWISE* (BW) is sold only in bookstores. They outline an essentially hourly schedule for infants, birth past sixteen months. Healthcare professionals have observed dehydration, slow growth and development, and failure to thrive among babies associated with this program.

The "basic rule" is to feed the baby for approximately a half hour, have a "waketime", and then put the baby down for an enforced nap of at least 1½ hours. Parents must conduct activities in that specific order (called PDF, Parent Directed Feeding). According to this schedule, babies are fed only every three to four hours and nighttime feedings are eliminated at eight weeks of age.

What advice do they give that contradicts conventional medical practice?

A neonatologist and a pediatrician (both FAAP) and a review committee at a hospital in North Carolina reviewed the medical claims in PFP and BW and

outlined eleven areas inadequately supported by conventional medical practice. Their findings included (bolding added, explanatory comments in italics):

■ **"Regarding SIDS: the information concerning sleep position for infants is erroneous".** *GFI's materials say the research on back sleeping "is not conclusive, and the method of gathering supportive data is questionable" and warn parents "should be concerned with the possibility that their baby could aspirate vomit...if he is placed on his back". (p184PFP, p. 166 BW)*

■ **"Controlled feedings in the first weeks of life can lead to dehydration and should not be encouraged."** *GFI claims its routine is flexible, but says if a two week old baby "does not eat at one feeding, then make him wait until the next one" (p. 194 PFP, p 180 BW) and that "if a baby falls asleep at his scheduled feeding time parents should "put him down to sleep, but do not feed him before the start of the next cycle (p 129 PFP, p 115 BW)*

■ **"We recommend observation of both voiding and stooling frequency as a means of monitoring infant intake.** Only frequency of voiding is mentioned by the authors". *Emergency room physicians and nurses have been concerned about the babies on this program that they have seen with dehydration, slow growth and development and failure to thrive syndrome.*

■ **"The authors fail to give any scientific evidence to support their claims. What are their qualifications?"** *GFI has no Internationally Board Certified Lactation Consultants on staff and none have gone on record to support them. Gary Ezzo is a pastor with no medical background. Anne Marie Ezzo is described as having "a background in pediatric nursing" but her experience as best can be verified involves a very short time of work as an RN many years ago in a setting that was not specifically pediatric.*

■ **"The terms "hunger metabolism" and "digestive metabolism" are not defined or scientifically supported.** Where is the concern for low blood glucose levels in the newborn?" *GFI coined the term "metabolic confusion" to state that in demand feeding "the lack of regularity sends a negative signal to the baby's body, creating metabolic confusion that negatively affects his hunger, digestive, and sleep/wake cycles" (pp 55-56 PFP, p 43 BW). They also tell parents "If your baby seems to be hungry all the time, the problem is not with the routine (PDF) in general, but with your routine...you may not be milk-sufficient" (p 155, PDF).*

■ **"Guidelines are not always age specific. Specific needs of neonate (0-2 weeks old) are not addressed. Rigid scheduling of feedings prior to maternal milk letdown can lead to low success rate of breastfeeding".** *Lactation consultants across the country have anecdotally confirmed an unusually high incidence of unnecessary breastfeeding failure among mothers using PDF or BW.*

In addition, GFI claims that **babies with jaundice do not normally need to be fed more often than every three hours.** GFI ties demand feeding to **learning disabilities, colic, metabolic disorders, neurologic disorders, behavioral problems, sleep disturbances, separation anxiety, infant chronic fatigue, and postpartum depression, lack of strength, and anxiety for the mother.**□

Region IV

(← continued from page 3)

Regional Medical Center all have plans to expand offices in Oviedo.

Region IV is interested in two specific projects. Paternity "identification" in the hospital and handgun control issues related to children are two major issues that are being addressed this year. We will work with the hospitals and local governmental agencies regarding these issues.

The Central Florida Pediatric Society is one of the largest and most active in the state and we hold quarterly meetings for dinner. The society has not failed to have a quarterly meeting in several years. Dr. Steve Rosenberg is the current president and Dr. Brenda Lewis is our newly elected Alternate Regional Representative and has done an outstanding job scheduling speakers for the society.

Brenda B. Holson, M.D.
Regional Representative □

UPCOMING CONTINUING MEDICAL EDUCATION EVENTS

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

- Program:** Gulf Coast Pediatric Conference
Dates: February 27-28, 1998
Place: Holiday Inn Select, Ft. Myers, FL
Credit: 10 hours for Category 1 for AMA Physicians Recognition Award
Sponsor: University of South Florida College of Medicine, Dept. of Pediatrics
Inquiries: Ms. Rebecca Scott (813)272-2744 or FAX (813)272-2749
- Program:** Issues and Advances in Pediatrics
Dates: April 2-4, 1998
Place: Sheraton Sand Key Resort, Clearwater Beach FL
Credit: 18 hours for Category 1 for AMA Physicians Recognition Award
Sponsor: University of South Florida College of Medicine, Dept. of Pediatrics
Inquiries: Ms. Rebecca Scott (813)272-2744 or FAX (813)272-2749
- Program:** 1998 Legislative Conference
Dates: April 25-28, 1998
Place: Washington, DC
Credit: 9 hours for Category 2 for AMA Physicians Recognition Award
Sponsor: American Academy of Pediatrics Washington Office
Inquiries: AAP, call 1-800-336-5475 or (202)347-8600
- Program:** Meeting of American College of Sports Medicine
Dates: June 3-6, 1998
Place: Orlando, FL
Credit: 36 hours for Category 1 for AMA Physicians Recognition Award
Sponsor: American College of Sports Medicine
Inquiries: American College of Sports Medicine, (317)637-920
- Program:** "Beyond Limitations" Medical Conference on Down Syndrome, 1998
Dates: June 6, 1998
Place: Jacksonville, FL
Credit: Hour by Hour for Category 1 for AMA Physicians Recognition Award
Sponsor: Down Syndrome Association of Florida and Baptist Medical Center
Inquiries: Laura Watts (904)346-5100, ext. 228
- Program:** Pediatrics for the Primary Care Physician
Dates: June 26-28, 1998
Place: Amelia Island Plantation, Amelia Island, FL
Credit: 14 hours for Category 1 for AMA Physicians Recognition Award
Sponsor: Nemours Children's Clinic
Inquiries: Ms. Jacquelyn A. Nolan (904)390-3638 FAX (904)390-3699
- Program:** Cape Cod Conference on Pediatrics
Dates: July 31-August 2, 1998
Place: Tara Hyannis Hotel, Hyannis, MA
Credit: 13 hours for Category 1 for AMA Physicians Recognition Award
Sponsor: Nemours Children's Clinic
Inquiries: Ms. Jacquelyn A. Nolan (904)390-3638 FAX (904)390-3699

