

THE FLORIDA PEDIATRICIAN

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

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May 1995

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A NEW ERA FOR FLORIDA'S PEDIATRICIANS

The Annual Meeting has just been held. With it began a new phase in the life of Pediatrics in Florida.

Organized Pediatrics has flourished here for almost 60 years. The Florida Pediatric Society originated in April 1936 as a very small society, which met in the shadow of the Florida Medical Society. It was close-knit, with no more than fifteen members at any time. A new charter was written in 1940, and a period of major growth followed, only to be interrupted by Pearl Harbor and World War II.

At the same time, the American Academy of Pediatrics was developing and rapidly increasing in its scope. Thomas Buckman and William McKibben were among the founders. In 1951, Florida's Warren Quillian was elected President of the American Academy, a singular honor for him and for the State. The very next year, the Florida Chapter of the AAP was formed in accordance with the Academy's wishes. Immediately, the two societies began to work together. By a By-Laws change, the State Chairman (presently called State President) became a member of the Executive Committee of the Florida Pediatric Society. The combined

organization became a

**"...the old order changeth,
yielding place to new..."**

-Alfred, Lord Tennyson

force not only for Pediatric progress but for political change on a State level. Active committees were common, including Accident Prevention and Poison Control, with Bob Grayson as its first chairman; Fetus and Newborn Committee, first chaired by Henry Morton; Committee on the Handicapped, started by Howard Engle.

The two societies essentially merged in 1967, when Bob Grayson was charged with creating a new Constitution and By-Laws. Greater strides followed. Then, with the advent of a third medical school, at the University of South Florida, it became obvious that these schools had a major rôle to play. Their involvement increased, the three Department Chairmen joined the Executive Committee, and the Society established an annual award for a senior medical student in each school.

Probably one of the few down-side events was a confusion over membership in the FPS/FCAAP. As the numbers of pediatricians moving to Florida from other areas increased, and others took up primary location in Florida, for private practice and for academic employment, there needed to be a simplified method for Fellows of the Academy to transfer their membership from other states and for others to become members. This was accomplished in the late 1980s. The Florida Chapter soon became one of the largest chapters in the country. To the surprise of many, the Chapter remained very unified despite the large numbers and the geographical separation of many of the members. This oneness was enhanced by the development of a network of elected Regional Representatives who are in constant touch with their constituents and who sit on the Executive Committee to share their concerns and news.

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PRESIDENT'S MESSAGE

On May 20, 1995, I will assume the Presidency of the combined Florida Chapter, American Academy of Pediatrics and the Florida Pediatric Society. As a representative for organized pediatrics, I will represent your concerns and interests in AAP, governmental, educational, and legislative activities at the state and national levels.

I owe a sincere debt of thanks to Dr. Ken Morse of Ocala and Dr. David Cimino of St. Petersburg, who have served with distinction and taught me much in the last several years about the realities of change in pediatric practice and many of the issues potentially confronting pediatric practitioners to the year 2000. Join me in thanking them for their selfless devotion in the promotion of pediatrics and their tireless efforts to represent us well. Likewise, I owe a great debt of gratitude to my mentors, Gerald Schiebler, M.D., of Gainesville, peerless child advocate and former Chairman of the Department of Pediatrics at the University of Florida, and to Lew Barnes, M.D., founding chairman of the Department of Pediatrics at the University of South Florida, who convinced me to change from Internal Medicine to Pediatrics many years ago. In the coming year, the Chapter will be ably assisted by Louis St. Petery, Jr., M.D., of Tallahassee, the Executive Vice President of the Chapter.

On May 19th to 21st, we will have our annual meeting and scientific meeting in Orlando. Almost certainly, we will have a time of learning, exploring new opportunities, and networking with our colleagues to share experiences and to advocate for our patients, the children. It will be one of my objectives to assure that we continue to have high quality educational sessions for our membership, but I would like to actively solicit input from the membership with regard to topics and unique opportunities for all of our members, including the unique needs of young practitioners and our pediatricians who have children and their needs to be considered in our scheduling.

Shortly, the Executive Committee will convene to address one of the major issues confronting pediatric practice today. The issues surrounding managed care, contracting, calculation of capitation, risk sharing, and the alphabet soup generated by hybrids of various types, require careful examination by the Chapter to develop appropriate policies, procedures, education programs for members, and legislative initiatives to assure access and quality for our patients. Examples abound of systems gone amok, such as TennCare of Tennessee, and the abuses associated with Medicaid Managed Care HMOs in Florida. There will be intense efforts to create integrated health systems for children which may provide unique opportunities. The AAP Committee on Child Health Financing has just published a loose-leaf notebook on "Practitioners Guide to Managed Care" that is a unique, timely, and practical reference that should be part of every practitioner's knowledge base. Pragmatic pediatricians have developed this manual with input from all areas of the country. I personally think that it is the most appropriate document to be reviewed by every practitioner prior to signing agreements to participate in various managed care endeavors. Copies can be obtained from the American Academy at a cost of \$59.95.

Shortly, as Chapter President, I will be joined by Dr. Edward Williams in travelling to Chicago for the Annual Chapter Chairman's Forum, to discuss issues relevant to pediatricians from Florida, District IV, and throughout the United States. The format to achieve national study and development of policy is through the submission of Chapter resolutions. If you have a "hot issue" that

PRESIDENT'S MESSAGE (Cont'd)

(continued from page 2)

telephone at work (813)272-3792, or my telephone at home (813) 876-5130, or for those of you who are computer literates, my internet address is "jcurran@com1.med.usf.edu". I promise a reply, discussion, and fair consideration. It will also provide me an overview of issues important to those who are really in the "trenches" in order to influence national health policy.

It is possible that the entire Medicaid system may be altered, both in its requirements and its funding, under the concept of "Medicaid Block Grants", a topic which is currently being discussed in Washington. Under such proposals, funding would be transferred to the State, with fewer strings attached for contracting for Medicaid services, but without \$ growth. Children, and individuals under 21 years of age, consume about 18% of the dollars spent by Medicaid in Florida. They are greatly under-represented and hence most vulnerable, because of their inability to vote, as compared to support of nursing home care and SSI disability income and care. Nationally, the AAP will be developing a strategy that, if Medicaid Block Grants are inevitable, will generate a cap to provide protection for children and assure access and reasonable compensation for children's care.

I am happy to report that four nominations from Florida for membership on national committees have been endorsed by District IV and forwarded to the respective Committee Chairs for consideration. Those nominated include: David Cimino, M.D., Committee on School Health; John I. Malone, M.D., Council on Pediatric Research; Charles Weiss, M.D., Committee on Environmental Health; Jaime Frías, M.D., Committee on Genetics. We will continue to advocate on their behalf and hope that Florida will be well-represented when final selections are made in mid-summer.

Elections for the District IV Alternate and District Chairman have been held this spring. Both Dr. Steve Edwards of North Carolina as Chairman and Dr. Charles Linder of Georgia as Alternate Chairman are accomplished pediatricians with major commitments to child health advocacy and substantial track records on behalf of children's affairs within the Academy. Dr. Bob Hanneman of Indiana has been elected to the position of President-Elect of the Academy.

Topics to come in my next report will be development of legislative issues for 1996, the naming of a new legislative chairman, developments with regard to lead in the environment, and issues involving immunization and initiatives to promote greater communication among us.

I look forward to serving you, but can only do so well if I hear from you. Please use the numbers above as my contact points.

John S. Curran, MD.
President

Florida Chapter AAP/Florida Pediatric Society

Note for the Executive Committee

(Executive Committee, Committee Chairpersons, Liaison Representatives, and Local Pediatric Society Presidents)

The Executive Vice President has announced a change in date for the **Annual Executive Committee Planning Retreat**, and Executive Committee Meeting. Please mark your calendars. The new date is:

Saturday and Sunday, September 9-10, 1995

The retreat will be held in the Orlando area, actual site to be decided.

John Curran (l.) accepts the office of President from Ken Morse, outgoing president.

GENERAL PEDIATRIC UPDATE IV

May 3-5, 1996

SCIENTIFIC SESSION

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BUSINESS MEETING

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FRIDAY NIGHT RECEPTION

For more info call: 904-877-9131

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**Report of Committee on Childhood Disabilities
Developmental Disabilities - 1995**

There probably is nothing so painful to the heart and soul as being told that your child is not perfect. The physician having the responsibility to inform parents of their child's handicap may have a very difficult time. He or she may find and experience feelings that are quite unexpected. One commonly sees feelings of helplessness, anger, sorrow, and guilt. By knowing what to expect, the professional can help the family learn to pass through the reactions of shock, denial, anger and finally grief. The physician who makes the diagnosis of a serious developmental disability should be prepared for a painful experience.

After the initial disbelief is past, the professional should outline for the family an individual habilitation plan, taking into account other family members such as siblings and grandparents. One must recognize the need to prevent an obsession to find a cure or another diagnosis that families often carry out by visiting many different specialists, looking for anything that can help. This often creates a new handicap that I call a financial one. The normal siblings must continue to receive adequate nurturing and quality time with their parents.

Since parents all are unprepared for this diagnosis, many parent support programs exhibit nation-wide at little or no cost to the family. Often these parents can better guide the family through the process of grieving and help them through their own stories of disbelief, anger, and guilt, leading towards practical solutions that work. These parents often recognize the professionals in their community who really understand a certain disability. There are numerous programs, books and well-established treatment programs for a variety of developmental problems. One can order *The Directory of Organizations Interested in the Handicapped* from the People to People Committee for the Handicapped, 1522 K. Street NW, Suite 1130, Washington, DC 20005 or from Exceptional Parent Magazine, by calling 1-800-EPARENT.

It is the author's intent to have professionals who see and care for children direct children with special needs to an established developmental specialist, who can work as a key player in outlining a plan for any exceptional child.

Harry M. VonTobel, M.D.
Chairman, Committee on Childhood Disabilities
Jacksonville, FL

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

The following information should be of paramount importance to members who will be using the new *Varicella Vaccine (Varivax)*.

Merck and Co., **the manufacturer**, reports that the vaccine, which has been approved for use, will be available for shipment soon. Orders are being accepted now.

Remember that this is a frozen, live attenuated vaccine. It requires **storage** in a freezer at an average temperature of -15°C (+5°F) or colder, or in a frost-free freezer with an average temperature of -15°C (+5°F) or colder.

The **American Academy of Pediatrics** has made the following recommendations:

"The Academy recommends varicella vaccine for routine use in children over 12 months of age who do not have a history of varicella. A single dose should routinely be given between 12 and 18 months of age. Older children may be immunized at the earliest convenient opportunity, also with a single dose. Healthy adolescents past their 13th birthday who have not been immunized previously and have no history of varicella infection should be immunized against varicella by administration of two doses of vaccine 4-8 weeks apart."

The Academy also states as follows:

"Of the 3.9 million estimated cases of varicella annually, about 90 fatalities are reported in the United States. ...Morbidity is not inconsequential. In addition, social and economic costs (estimated \$399 million annually) are significant and include an average of 8.7 days lost from school and 0.5 to 1.8 days of adult caretaker time lost from work. [There is] significant protection...even after household exposure (70%) and greater protection (95%) against more severe disease. ...No evidence of loss of immunity has been noted in the 6-10 years of follow-up of healthy children. A cost-benefit analysis estimates a \$384 million annual savings from routine, universal use..."

Financial considerations: If immunizations are paid as a separate service, a CPT code of 90716 is available.

A CAVEAT:

Ever mindful of the membership and of changing health care practices, our President, John Curran, offers the following cautions:

-Under many insurance policies, varicella may not be an automatically covered benefit, and parents may need to know this.

-Many managed care organizations have stipulated vaccinations in accordance with AAP schedules. This can be used to advantage with commercial insurance plans.

-Those pediatricians who may be providing immunizations under capitation should review their capitation contracts with regard to policies involving new vaccines or new technology, and their potential fiscal responsibility. If they do not have such a clause, it would be wise to negotiate same in the future. Otherwise, they may find themselves giving varicella vaccine without additional compensation.

Some organizations have carved vaccines out from capitation, others have included them. **Be on guard!**

THE "GRASS ROOTS"

THE REGIONAL REPRESENTATIVES REPORT

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

Region I reports:

Many changes have occurred in Region I since my last report. The Pediatric Residency Program at Sacred Heart has officially affiliated with the University of Florida. Dr. Wilson, Director, University of Florida College of Medicine Department of Pediatrics Sacred Heart Program, reports a very successful recruiting year. The Sacred Heart Program filled 5 of 5 positions through the match this Spring. Dr. William Blanchard is the Associate Director and there are currently four full time faculty members.

The new Children's Hospital at Sacred Heart now has concrete and steel up two stories. The planned completion date for the new facility is the Fall of 1996. The 26th Annual Pediatric Symposium presented by Children's Hospital at Sacred Heart will be held May 27-29 at the Sandestin Beach Hilton in Destin, Florida.

One of the big surprises this year was the announcement that the Nemours Foundation was closing its rural primary pediatric care clinics. There was a total of five such clinics in Region I. Several of the pediatricians from these clinics are being integrated into other practice opportunities in the area.

Dr. Reed Bell has agreed to be Program Director for the 1995 meeting of the West Florida Pediatric Society. This meeting will likely be held at the Indian Bayou Country Club in Destin, Florida.

There are currently three different CMS primary care projects in Region I. The Pensacola-based project is the Emerald Coast Pediatric Primary Care, Inc., and the current enrollment is approximately 2100. There are currently 12 providers in the Pensacola area, and the number is expected to increase to 18 in the near future. There is a total of 42 providers in Region I, with a total active enrollment in all programs of roughly 17,000. The Tallahassee Pediatric Foundation, Inc. and the Florida Pediatric Foundation, Inc. (Panama City) are the oldest Primary Care Projects in the State.

Thomas G. Mignerey, M.D.

Regional Representative

Region I

Region V reports:

Most of the activities I have to report relate to Hillsborough County, since that is where I am located and that is from whence most folks report news/concerns/issues to me. As is true of all the regional representatives I know, I am most interested in news from the other corners of the area, and solicit any comments you would like to make, to be considered at state or even national level, as well as any commentary on legislative issues at all levels. I think this journal is becoming an arena where pediatricians statewide can air their concerns and be absolutely certain they will be considered by the Executive Committee of your society. So, speak up.

The Hillsborough County Pediatric Society has recently hosted a joint meeting with the Polk County and Pinellas County societies, honoring the establishment of the "Boggy Creek Gang". This is a camp for kids with a variety of chronic medical problems, which is in process of being established northeast of Orlando, and which is free of charges (thanks to Paul Newman, General Schwartzkopf, and

others). There are many opportunities for volunteer service for

pediatricians and health professionals of all descriptions. The HCPS made a donation to the cause. It looks like a great medical camp - they've got it all.

The next Hillsborough County Medical Association meeting will be entitled "The Vision for Pediatrics in the Year 2000". This will be an opportunity for the CEOs of the local hospitals providing pediatric services in the region (TGH, ACH, SJH, UCH) to discuss their concepts of what pediatrics will be like in the near future and their plans to accommodate these needs. In my view, this should be a really colorful presentation and I heartily recommend your attendance.

The HCPS Executive Committee voted to endorse the following legislation:

HB853: This is a bill to require insurance companies to cover food products required by children with medical/metabolic needs, such as PKU. [see page 11]

Bicycle Helmet Law: Bills have been introduced by Senator Sullivan and Representative Casey, concerning bicycle safety, and the Executive Committee has voted to support this legislation.

HB9503: This bill, dealing with licensing of foreign medical graduates, was discussed and felt to be beyond the expertise of the group. No action was taken.

Further legislation dealing with EMS/EMC services was received in draft form and will be reviewed in future meetings.

The Hillsborough society has further sponsored an issue of the Tampa Bay Family Journal, including an educational and a promotional piece having to do with child health and pediatrics.

By the way, most of these accomplishments are the result of the efforts of Rick Weibley, the current president of the HCPS. If you have any spare kudos lying around, send them his way. Again, the folks you elect to office really want to serve your interests. Tell them what you need.

Now I have an editorial comment for which I desire responses.

In the most recent HCMA Bulletin, there was an editorial discussing the issue of HMOs, and specifically capitation. The gist of the message (at least the part I want to talk about) was that the FMA has a policy statement on the books that capitation is unethical. (The editorial further points out that there is a plan to offer a capitation arrangement to involve the state IPA, or whatever).

My personal opinion, and the reason I do not personally belong to any capitated plans, is that the editorialist is right. I think there is nothing wrong with paying a fixed rate for care to an insurance company, or one of the state-ordained conglomerates that are supposed to "fix" the system, or even perhaps to an "AHP", whatever that turns out to be. But I think it is terribly wrong to force a physician into the position of being "gatekeeper", whose primary purpose is to protect the financial institution's fiscal well-being. This is done by making his/her economic welfare dependent upon minimizing care that may be costly to the stockholders, regardless of the patient's welfare.

How about some comments? [Letters to the Editor welcome!-
Ed.]

Edward T. Williams III, M.D.

Regional Representative

Region V

THE HEADDSS INTERVIEW

Identifying & Reducing Risks in Adolescents

Dawn M. Grinenko, M.D.

Medical Director

Adolescent/Young Adult Program

University of Florida, Gainesville

Motor vehicle accidents, homicide, suicide, and miscellaneous injuries account for 80% of deaths in adolescents in our state¹. Pregnancy, sexually transmitted diseases, substance abuse, violence, eating disorders and school failure have continued to contribute to mortality and significant health morbidities in our adolescent population.² Pediatricians play a critical rôle in identification and intervention to reduce these high risk behaviors. Further, the *Healthy Youth 2000 National Health Objectives* and the *AMA's Guideline to Adolescent Preventive Services* provide strong mandates for pediatricians to expand the traditional medical model to incorporate more health education, counselling and anticipatory guidance into their practices in order to reduce these "New Morbidities".^{3,4} Unfortunately, significant barriers exist for pediatricians interested in providing such a level of care, namely lack of time and inadequate compensation.^{5,6} This second article, in a series focusing on adolescent medicine, will acquaint pediatricians with the HEADDSS psychosocial interview⁷, a time-efficient technique for identification and intervention to reduce health risks in adolescents.

The HEADDSS psychosocial interview was developed in 1972 by Harvey Berman and later modified by Eric Cohen. HEADDSS is an acronym which stands for: Home, Education, Activities, Diet, Drugs, Stressors/Suicide and Sex. The approach described has been further modified to include the dietary component. The interview progresses from the least to the most invasive topics. This allows time to develop rapport and confidence and to put the teen at ease. The approach provides structure and focuses on issues of importance instead of being an open-ended, rambling conversation. The interview should be completed in 10 to 30 minutes, requiring 30 minutes only in complex new patients. The interview should be conducted between the teen and the pediatrician, alone and in a confidential manner, with the process and confidential nature explained to both the parent and the teen.

The first area of the interview addresses the Home. The goal is to identify what is important or of concern to the teen at home. Questions as basic as where the teen lives and with whom begin to construct a picture for the clinician. Relationships within the family, parental jobs, recent moves or changes in the home are other helpful issues to discuss. During subsequent visits, when a stronger relationship exists between the teen and the pediatrician, questions about violence, thoughts of running away, and financial stresses may be appropriate.

The second group of questions relates to Education/Employment. If we ask teens global questions about where they go to school or how they like school, we end up with a very shallow understanding of the child scholastically. The goal of this group of questions is to obtain a clear picture of how the child functions at school and whether the ado-

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The Florida Association of Pediatric Surgeons (FAPS) was incorporated in 1969. The first president was Dr. Albert Wilkenson, of Jacksonville, who was elected in 1969. There were nine founding members of the society. Today, FAPS has 31 active members and six affiliate members.

There are several purposes and objectives of FAPS. FAPS unites the Pediatric Surgeons in the state of Florida in an effort to advance the science and art of our specialty. We encourage superb surgical care for the children of Florida. Our group provides for the exchange of attitudes, ideas, and techniques concerning the practice of Pediatric Surgery. We cooperate with other medical groups and the medical profession at large. In addition, FAPS implements programs with the American College of Surgeons, the surgical section of the American Academy of Pediatrics and the American Pediatric Surgical Association on a state-wide basis. We also sponsor and assist in sponsoring scientific meetings for continuing education in Pediatric Surgery. Recent speakers at our meetings have been Tom Lobe, M.D., who spoke on Laparoscopic Surgery in Infants and Children and Dennis Lund, M.D., who presented recent work at the Boston Children's Hospital. The Association will meet in May, in Boca Raton.

Richard D. Signer, M.D. President,
Florida Association of Pediatric Surgeons

Advertising

FROM THE LOCAL PEDIATRIC SOCIETIES

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

THE PALM BEACH COUNTY PEDIATRICS SOCIETY

The Palm Beach County Pediatrics Society has been in existence for over a decade. Its membership is comprised of the majority of practicing pediatricians and nurse practitioners in our county.

Our Society meets semiannually for social and educational meetings. Our next big event will feature Dr. Ellen Wald, from the University of Pittsburgh. She will discuss "Sinusitis".

We have tried, in our Society, to be proactive in Pediatric issues and concerns. Our Society has been involved with the Healthy Mothers/Healthy Babies Project, volunteering for telephone telethons and participating in Hurricane Andrew assistance. We have been active in Drowning Prevention, and have dedicated our spring educational meeting in 1994 to that subject.

Pamela Y. Rogers, M.D.

President, Palm Beach County Pediatrics Society

WELCOME TO OUR NEW MEMBERS

Stacey A. Clark, M.D. (Wellington)	Maria L. Miller, M.D. (Oviedo)
Jose A. Garrido, M.D. (Miami)	Yvelice A. Moreno, M.D. (Miami)
Rubon Gonzalez-Vallina (Miami)	William I. Muinos, M.D. (Miami)
Fouad M. Hajjar, M.D. (Orlando)	Antonio R. Prats, M.D. (Miami)
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A New Era for Florida's Pediatricians

Another need recognized was for the Society to reawaken its academic life, by reinstating an annual scientific session. This had faded away during the major growth period. Bob Manniello and Doug Short brought success to this meeting for 1993 and 1994, and this year also we have had a great meeting, engineered by Doug Short. [more in next issue!].

A major height was reached in 1993. when the Florida Chapter received the Large Chapter Award for Excellence, given by the American Academy of Pediatrics. This well-deserved recognition followed a succession of innovations: pushing Florida to become the first state to require insurance contracts to cover routine care of newborns and children; spearheading seat belt legislation so that Florida was among the first states with such legislation; pushing enactment of the first hot-water heater legislation in the nation; and currently working to abolish corporal punishment in all of our schools.

Part of the background for this award was a recognition that the evolutionary process is an ongoing one. As a famous writer once said: "the old order changeth, yielding place to new". The result was another revision of the By-Laws, approved in 1993, so that, beginning with the meeting just held, there is to be only one set of officers for the Florida Pediatric Society/Florida Chapter AAP.

Where do we go from here? We are in a time of great change, both in the knowledge required of us, and in the way we will be practicing our profession. This issue of *The Florida Pediatrician* is full of important information in both areas. Who can better define our directions than our new President, John Curran? Page 2 contains his inaugural message, and says much about his dedication to his job. We can also see that the job will leave him little or no free time. He will work hard - I know, I have been there!

The Editor

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.

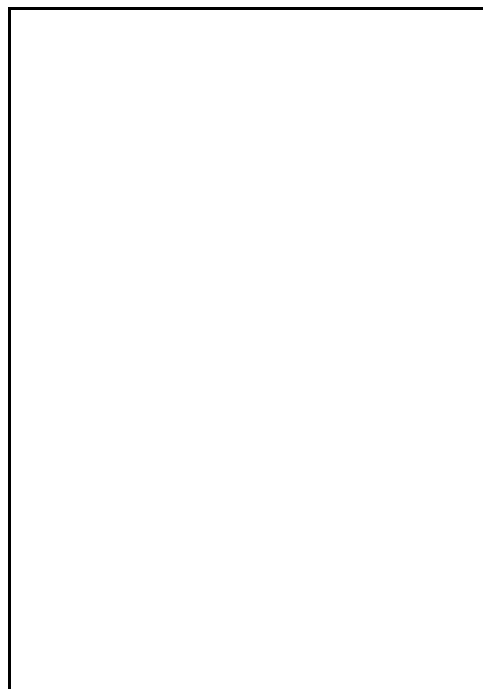
Military Associate Member: An active duty member of the Armed Forces stationed in Florida and limiting practice to pediatrics.

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



LewBarness (l) and Gerry Schiebler share thoughts in the hallway at the Annual Meeting

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.

Advertising page

A NEW KIND OF FISH IS ALL OVER FLORIDA

R. Rodney Howell, M.D.
Professor and Chairman
Department of Pediatrics

University of Miami School of Medicine

Florida is legendary throughout the world for fresh and saltwater fish; many of our colleagues devote their entire free time to the sport of catching (or trying to catch) them. Throughout Florida, there is a great deal of attention to a new kind of FISH, which involves neither fresh nor salt water, and the people working on this FISH are scientists with high-priced fluorescent microscopes. The FISH I am talking about is *Fluorescent In-Situ Hybridization*, an incredibly powerful new technology that is finding uses in many areas of clinical medicine.

In-situ hybridization (ISH) was one of the earliest methods used to "map" the location of specific genes to specific chromosomes. This hybridization takes advantage of the highly specific ability of a DNA pattern to bind or hybridize to an exactly matching sequence. If, for example, a piece of DNA with a known sequence is radioactively tagged (a "DNA probe") and is mixed with chromosomes, it will find its exactly complementary sequence, which then can be recognized by its radioactive signal. This then becomes a "map" site for the original probe. This has been a very powerful tool in mapping genes to chromosomes. As of 1992, over 900 of the 3800 mapped human genes were done by this method. When the sequence hybridized to its complementary sequence on a chromosome, it could be detected as a radioactive signal. This methodology, however, is expensive, time-consuming, and because of the radioactivity involved, potentially hazardous. For these reasons, a fluorescent label has replaced the radioactive label, and hence the technology has become known as Fluorescent In-Situ Hybridization, or FISH.

For this technique, tissues are prepared as for traditional cytogenetic analysis. The slides on which the chromosomes then lie are processed so that double-stranded DNA is denatured, thereby producing a single-stranded DNA that is able to hybridize and bind complementary DNA. The DNA probe, which is synthesized to be complementary to a gene of interest, and to which is attached a fluorescent label, is applied to the slide, under conditions that will enhance hybridization. The slides are then washed, and any DNA probes that are not firmly attached (hybridized) are washed away. By examining the slides under a microscope, equipped with fluorescent lighting apparatus, the bound probe lights up brightly; chromosomes can be stained and the area of the bound probe can be accurately determined. By using a variety of fluorescent tags (which will be different colors in the fluorescent light), one can simultaneously examine more than one gene in a slide.

This technique has become a very powerful clinical tool when determining the presence or absence of a specific DNA sequence, particularly a chromosomal deletion. If you are looking for a deletion, for example, and apply a fluorescent probe complementary

to the deletion, the following may occur.

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If the probe binds to both chromosomes, there is no deletion; if only one chromosome is labelled, there is a deletion mutation in the other chromosome. It provides a clear answer.

This tool has been particularly informative in the syndrome described by Angleman in 1965 as the Puppet Children. These children demonstrate mental retardation, hypotonia, ataxia, seizures, dysmorphic facial features and importantly, inappropriate laughing. It is estimated to occur with a frequency in the range of 1 in 20,000 live births. Over half of these patients have visible chromosomal deletions in chromosome 15. However, when one uses molecular techniques (FISH) it has been demonstrated in 80% that this syndrome is associated with a deletion mutation in the long arm of chromosome 15 which is derived from the mother. The remainder of patients have other chromosomal mutations in the same "critical" region. Therefore, in the majority of children with this clinical syndrome, highly specific genetic tests can establish this diagnosis in the large majority of cases.

Understanding certain human malformations and syndromes will be greatly enhanced with these technologies. For instance, lissencephaly (smooth brain) has been studied in a group of children. Twenty-five probands with the Miller-Dieker syndrome (an autosomally-recessively inherited disorder with microcephaly, small mandible, bizarre facies, failure to thrive, retarded motor development, dysphagia, decorticate and decerebrate postures and death at 3 and 4 months) and 65 probands with isolated lissencephaly sequence (ILS) have been recently studied. Fourteen of the 25 Miller-Dieker syndrome had visible cytogenetic deletions. In addition, another nine had submicroscopic deletions, detected with FISH. Deletions not visible under the microscope were detected by FISH in 8 of 45 patients with ILS alone. Deletions of the lissencephaly critical region in chromosome 17p13.3 appears to be the most frequent cause of lissencephaly. Furthermore, molecular cytogenetic studies with FISH should be performed in all such patients.

The FISH technology will have rapidly expanding roles in clinical medicine. In addition to detecting deletion syndromes (see above), it is possible now to use fluorescent probes complementary to other important genes, and demonstrate the presence or absence of such materials. For example, studies underway in Miami are using identical technology to identify the presence of the important breast-cancer gene, BRA 1, in tissues. The presence of such genes will be important in the future of genetic counselling for recognized oncogenes, as well as for genes associated with other forms of genetic diseases.

The value of FISH in cancer and radiation biology is rapidly expanding, and is likely to have increasingly important value in physical mapping, cancer diagnosis and prognostication and in radiation biology.

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Elk Grove Village, IL 60009-0927
800/433-9016 FAX: 708/228-1281

[Note: Floppy disk version available soon - inquire!]

[Ed: It may sound "fishy", but this is an area in which we all must obtain some basic understanding. It is part of the wave of the future!]

FROM THE A.A.P.

Promoting Policy Statement on SSI

The Committee on Children with Disabilities has requested that we publish the following information in an effort to educate as many health professionals as possible regarding this issue.

-The Supplemental Security Income (SSI) program for children is an important part of the federal government's social benefits for children with special needs. The SSI program is a nationwide program administered by the Social Security Administration that does the following: provides monthly cash payments based on family income; qualifies the child for Medicaid health care services in many states; and assures referral of SSI child beneficiaries into the state Title V Children with Special Health Care Needs program's system of care.

-An AAP policy statement entitled "Why Supplemental Security Income is Important for Children and Adolescents" was published in the April 1995 issue of *Pediatrics*. The policy statement addresses financial/resource eligibility criteria, the Zebley decision, determination of eligibility for SSI, the four-step evaluation process, and what to tell families about SSI application, disability determination, and appeals procedures.

-Reprints of the policy statement are available through the Academy's Division of Marketing and Publications (1-800-433-9016). If you have any questions regarding the policy statement, please contact Michel Esquivel at 1-800-433-9016, ext. 7935.

The 1995 Policy Reference Guide

The Academy is pleased to announce the availability of the **1995 Policy Reference Guide**. This new edition gives you current information on where the Academy stands on a wide range of child health issues:

Injury/poison prevention
Bioethics
Health financing
Environmental hazards
Infectious diseases
Nutrition
School health
and many more...

The **1995 Policy Reference Guide** contains over 1000 pages and provides the full text of AAP Policy Statements and Practice Parameters issued through December 1994, and includes a complete listing of those statements that have been retired. An Appendix to this edition provides a copy of Model Legislation developed by the Academy. This valuable reference tool is available to members for \$49.95 (\$79.95 nonmembers). To order contact:

American Academy of Pediatrics
Attn: Publications
PO Box 927

FROM THE LEGISLATURE

[A more complete report on legislative activities during the 1995 session will appear in the August issue of *The Florida Pediatrician*.]

Nancy Moreau reports that the following were among the bills enacted during the session:

HB 2581 - Infant Screening Program

Modifies program to require assessment of hospitals for the cost of laboratory testing and administration of this program up to 3000 births per hospital. Effective July 1, 1995.

SB 1754 - Pharmacy-Controlled Substances

Authorizes pharmacies to dispense controlled substances on receipt of an electronic facsimile (FAX) of the original prescription. Effective July 1, 1995.

CS/HB 1385 - Substitution of Medicinal Drugs

Revises standards for the prescription and dispensing of ephedrine to permit over-the-counter sales of certain products. Effective July 1, 1995.

CS/HB 72 - Sexual Misconduct

Requires AHCA to deny admittance to licensure exams and to deny licensure to any candidate who has been disciplined for sexual misconduct in the practice of their profession. Effective October 1, 1995

CS/HB 502 - Domestic Violence

Requires physicians and other designated professionals to receive one hour of continuing education in domestic violence upon initial licensure and as a part of biennial re-licensure. This education is to include information on screening and referral to community resources. Effective July 1, 1995.

HB 2519 - Pesticide Registry

Requires the Department of Agriculture and Consumer Services to maintain registry of persons who require prior notification of the application of pesticides. Effective July 1, 1995.

SB 486 - Health Insurance/Cancer Drugs and Diabetes

Requires health insurance policies covering cancer to pay for FDA approved drugs used for treatment, whether or not such drug was approved for cancer treatment. Requires health insurance policies to cover medically necessary diabetes outpatient self-management training. Effective July 1, 1995.

CS/HB 1745 - Health Insurance/Enteral Formulas/Fraud

Requires health insurance policies to offer at additional cost coverage for prescriptions and non-prescription enteral formulas which are physician prescribed as medically necessary; extends to food products modified to be low protein; coverage limited to \$2500 and extends through age 24. Details authority of the insurance commissioner in the area of insurance fraud. Effective July 1, 1995.

CS/HB 495 - Outpatient Dialysis Services/Medicaid

Allows the Medicaid Program, with specific appropriations, to pay for outpatient dialysis services, including services delivered in the patient's home, upon order of a physician. Effective July 1, 1995.

CS/HB 1373 - School District/Medicaid

Allows school districts to receive Medicaid reimbursement for physical, occupational and speech therapy provided students eligible for Medicaid via special education programs in the schools. Requires evaluation by AHCA and the DOE of implications of expanding EPSDT outreach and case management to allow reimbursement to DOE for administrative services. Effective July 1, 1995.

CS/HB 2023 - Juvenile Sexual Offenders

Requires the Department of Juvenile Justice to establish juvenile sexual offender programs, creating a family service system approach to address reports of child-on-child sexual abuse. Effective date October 1, 1995

CS/HB 1536 - Child Welfare

Combines several bills on child welfare issues. Creates an eleven member Task Force on Family Safety. Requires review of training curriculum of abuse hot-line staff and training of staff responsible for child protective service to determine if changes are needed. Requires child abuse reports to be retained for seven years or until the child is 18. Other changes. Effective October 1, 1995.

CS/HB 665 - Developmental Disabilities

Amends developmental services program to include "Prader Willi Syndrome"; exempts independent living education and alternative living centers from 1000 foot radius requirement. Effective upon becoming law.

CS/HB 1627 - Pregnancy Prevention Program

Authorizes creation of the Florida Education Now and Babies Later (ENABL) program with goal of reducing incidence of childhood pregnancies through abstinence from sexual activity. Independent evaluation to be submitted to Governor and Legislature by January, 1999. Effective Date June 1, 1995.

SB 1934 - Prekindergarten Early Intervention Program

Reenacts the Florida First Start Program and the Prekindergarten Early Intervention Program. Requires prekindergarten programs to provide for health screenings and referral. However, programs are not to provide health care, but would be required to refer

SPECIAL ARTICLE

**CONGENITAL ADRENAL HYPERPLASIA-
NEONATAL SCREENING**

Allen W. Root, M.D.
Professor of Pediatrics
University of South Florida

The congenital adrenal hyperplasias (CAH) are a series of congenital metabolic errors in the synthesis of cortisol (hydrocortisone), the primary glucocorticoid product of the human adrenal cortex. CAH is transmitted as an autosomal recessive characteristic. Its most common form (deficiency of 21-hydroxylase activity) accounts for 90% of patients with CAH; it occurs with a frequency of approximately 1/12,000-1/15,000 live births. In Florida, we may expect approximately 12-15 infants with CAH to be born each year.

The adrenal cortex is controlled by the pituitary hormone adrenocorticotrophin (ACTH), and is the site of production not only of cortisol, but of aldosterone, a sodium retaining mineralocorticoid, and of androgens (and estrogens). As a consequence of an abnormality in 21-hydroxylase activity, the synthesis of cortisol is decreased and there is compensatory increase in the secretion of ACTH by the pituitary, leading to hyperplasia (increase in cell number) and enlargement of the adrenal cortex. In an effort to overcome the block in synthesis of cortisol, the enlarged adrenal cortex secretes excessive amounts of compounds immediately before the enzymatic block and those derived from the cortisol precursors (primarily androgens). 21-hydroxylase catalyzes the metabolism of 17-hydroxyprogesterone (17-OHP) to 11-desoxycortisol. The gene for this enzyme is found on the short arm of the sixth chromosome and is closely linked to the genes for the histocompatibility and complement systems. When the gene for 21-hydroxylase is abnormal (absent, partially deleted, otherwise mutated), it produces little or no active enzyme; therefore, 17-OHP accumulates. 17-OHP is a precursor for androgen synthesis; excessive amounts of 17-OHP are diverted to the production of androgens. 21-hydroxylase, is also necessary for synthesis of aldosterone; when this enzyme function is severely deficient, aldosterone cannot be produced. Without aldosterone, salt cannot be conserved and is wasted in the urine.

21-hydroxylase is necessary for synthesis of cortisol by the fetal adrenal cortex by eight weeks of gestation; when its activity is abnormal, the fetal adrenal cortex enlarges, accumulates large quantities of 17-OHP, and secretes excessive amount of androgens. In the female fetus, the adrenal androgens cause the labia minora and majora to fuse, leading to ambiguity of the external genitalia. Occasionally, the abnormality of external genital is so severe as to result in the appearance of male genitalia, albeit without descended testes. In the male fetus no abnormality of genital development occurs, but in the postnatal period a "salt-wasting" or "salt losing" state occurs if the deficiency of 21-hydroxylase activity is nearly complete (this occurs in the severely-affected female infant as well); the male child with CAH develops precocious sexual development (excessive linear growth, increased muscularity, increased penile size, early pubic hair growth).

Prior to initiation of neonatal screening for CAH, some female infants with ambiguous genitalia were not recognized and the sex of rearing misassigned. Many infant males with salt-wasting CAH died before or without being recognized. It is the purpose of the neonatal screening test for CAH to identify female infants with CAH whose genital ambiguity has not been recognized, and to detect males and females with CAH before the lethal consequence of salt-losing develops.

The neonatal screening study for CAH is performed by measuring

blood spot concentrations of 17-OHP, using the filter paper blood spots that are collected for screening for phenylketonuria, congenital hypothyroidism, galactosemia, and sickle cell anemia. When the concentration of 17-OHP is high, the possibility of CAH must be considered. Circulating 17-OHP, as determined by methods employed in neonatal screening programs is very high in premature infants and in full-term newborns on the first day of life. Therefore, normal 17-OHP levels in filter paper blood spots vary with the gestational ages of the infant.

Currently, the neonatal screening program is conducted as depicted in the table. There are three possible results: 1) normal; 2) borderline abnormal; 3) presumptive abnormal. In infants with

Evaluation of the Infant with an Abnormal Neonatal Screen for CAH Collect filter paper blood preferably after 36 hours of age	
<u>Borderline Abnormal</u>	<u>Presumptive Abnormal</u>
	BW > 2500 g; CA >12 h
17-OHP > 40 ng/mL	17-OHP > 90 ng/mL
Phone contact to MD	Phone contact to MD
Examination	Examination stat
Repeat CAH screen	Electrolytes, 17-OHP
Electrolytes + serum 17-OHP if ill	(Referral to Ped. Endocrine Center)
	BW > 2500 g; CA < 12 h
17-OHP > 70 ng/mL	17-OHP > 150 ng/mL
Phone contact to MD	Phone contact to MD
Examination	Examination stat
Repeat CAH screen	Electrolytes, 17-OHP
Electrolytes + serum 17-OHP if ill	(Referral to Ped. Endocrine Center)
	BW < 2500 g
17-OHP > 70 ng/mL	17-OHP > 150 ng/mL
Phone contact to MD	Phone contact to MD
Examination	Examination stat
Repeat CAH screen	Electrolytes, 17-OHP
Electrolytes + serum 17-OHP if ill	(Referral to Ped. Endocrine Center)

(Referral to pediatric endocrine center offered in infants with presumptively abnormal CAH screening tests and to other infants at the discretion of the primary care physician)

a borderline abnormal result, the primary physician is asked to examine the infant and to repeat the CAH screening study; if the child appears ill, serum electrolyte and 17-OHP values should be determined. When a presumptive abnormal test is recorded, the primary care physician is requested to examine the infant immediately, and to obtain stat electrolyte and 17-OHP values. Consultation with a pediatric endocrine center is available for all such infants. It is essential that infants at risk for CAH be evaluated rapidly and therapy with cortisol and a mineralocorticoid such as fludrocortisone be initiated as soon as the diagnosis of CAH has been established.

The neonatal screening program for CAH detects only those infants with the most severe defects in 21-hydroxylase activity. Infants and children with more mild deficiencies of enzyme activity are not usually detectable by this screening program. Therefore, the lack of an abnormal neonatal screening test for CAH does not eliminate the possibility of a less severe form of this disease in an older child (simple virilizing CAH, late-onset or non-classical CAH). It is also important to recognize that the screening test for 21-hydroxylase deficiency will not necessarily identify the infant with CAH due to deficiencies of other enzymes (cholesterol transporter, 3-β hydroxysteroid dehydrogenase/isomerase, 17-hydroxylase, 11-hydroxylase).

HAS YOUR ADDRESS CHANGED IN THE LAST YEAR?

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

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

Some Thoughts about Capitation

Edward T. Williams, III, M.D.

Capitation is the insurance companies' (and the social policy planners') favorite plan for reducing medical care costs. This is because it "distributes risk" to the "health care provider", previously known as "physician", therefore supposedly making him (or her) less profligate in doing such things as ordering tests, doing procedures, hospitalizing patients, and generally providing medical care, especially of the more expensive varieties. It does this by directly or indirectly charging the physician for them.

This has several effects.

First of all, it allows the insurance company to totally abdicate its ONLY REASON FOR EXISTENCE, insofar as the policyholder is concerned, which is to function as a risk pool for funding serious medical problems. This further allows the company to attend to its real function, which is to create profits for its stockholders. Of course, without the policyholders, this would be much more difficult, as they supply the capital.

Largely, this is accomplished by marketing heavily to large employers, who supply most of the health insurance premiums nowadays, leaving the patient little or no choice. (This is because of federal tax policies, which make it advantageous for employers to increase benefits to employees in the form of insurance rather than wages). There is absolutely no question in my mind that if the patient were footing the bill directly, there would be no such entity as capitation.

Capitation is absolutely the favorite arrangement for insurers, who then have no risk to worry about, and governmental providers, ditto, and perhaps large corporations, who can count on a fairly fixed expenditure, no matter what. Perhaps the insured (our patients) will get the message a bit too late.

Capitation for the "provider" (Doctor?) is such an obvious conflict of interest that it is absolutely incredible to me that patients would tolerate it for a minute, if they were aware of it. My experience is that they are NOT aware of the meaning of the term, or whether their plan is involved in it. At least, when I have talked about the arrangement, the response has been incredulity.

Physicians should be accountable, first and foremost by doing the best for their patients. This means doing what is necessary for proper diagnosis and treatment, KEEPING IN MIND the cost/benefit considerations of what they do. They should NOT, in my opinion, ever be put in the position of having to consider the bottom line for some financial company in choosing their management, at risk of their own financial survival.

(Readers: It is obvious that Dr. Williams wrote this while very understandably upset about the situation. He has voiced, very clearly, his feelings about something he considers to be a problem of major proportions. There are obviously many others among the readers who have feelings just as strong, or stronger, in agreement or in total disagreement with the position of Dr. Williams. Our pages are open at all times for you to present your opinion. A short one can be a Letter to the Editor. But please feel free to write a longer article for inclusion here. -Ed.)

[Patricia Blanco, M.D., who is the Florida CATCH Facilitator, attended a District CATCH meeting in Williamsburg, Virginia. Drs. Lynn Ringenberg, Neil Wiggins, and Marie Weston also attended. Dr. Blanco filed the following report]

Goals for Future Direction of CATCH in Florida

Florida is geographically the largest state in District IV (AAP), and we vary immensely in our problems in child health access. Obviously, the problems that metropolitan Miami face are distinctive from those of Immokalee, Florida.

We are also a culturally diverse state, as has been illustrated by our CATCH delegation - yet, we share the common goal of desiring to improve the health care needs of our children.

In discussing the direction of the Florida CATCH program, we have decided that the following goals must be met:

1. To organize the state of Florida into CATCH districts which parallel the current 15 HRS districts, and to recruit Florida district CATCH facilitators, who will be responsible for stimulating and assisting CATCH activities in their respective districts. Also, they must report these activities to the Florida State CATCH facilitator.
2. To improve communication amongst other interested pediatricians and lay persons as well as to inform other Florida pediatricians of current CATCH activities utilizing vehicles already in place such as:
 - a) Florida Pediatric Society newsletter
 - b) the CATCH Express
 - c) the CATCH reporter
3. This may hopefully help to accomplish our third goal, which is to broaden the base of support for CATCH activities at the community and state levels.
4. To encourage public/private partnerships because repeatedly these collaborative efforts appear to be the programs which have been the most successful.
5. To develop sources of funding to accomplish our goals from the city, state, and private sectors.
6. To improve communication between the Florida CATCH program and our Florida State Chapter of the American Academy of Pediatrics.
- (Toward this end, I have begun discussions with our State leadership, in order to create a seat for the Florida State CATCH facilitator on the Executive Committee of the Florida Chapter AAP.)
7. To encourage accountability to the state, district, and national CATCH organization from each and every program that carries the meritorious designation of being a CATCH program.
8. To imbue the spirit of CATCH into the hearts and minds of our fellow pediatric colleagues and residents.

Patricia J. Blanco, M.D.
Tampa, FL
Florida State CATCH Facilitator

The HEADDSS Interview

lescent is developing reality-based career goals and plans for the future. Specific questions about favorite and least favorite classes, specific grades, number of days absent and participation in "special" classes are all very helpful. Special classes may be gifted or exceptional education classes. Another useful question is whether a child has ever been held back in school. Learning disabilities commonly present in the middle school population. If care is not taken, many children with specific learning disabilities receive a misdiagnosis of attention deficit disorder or behavioral problems.

Activities represent the third category of questions. The essential goal of this area is to determine whether the teen is at risk for injury or harm from his/her activities. Identifying children with significant boredom is important as these children are at risk for motor vehicle accidents, violence, pregnancy and delinquency, especially if unsupervised. Questions such as "What do you do in your spare time or for fun?" are useful. Teens who "hang out with friends" may be at higher risk than teens with structured after-school activities. If time permits, specific questions about TV viewing and physical activity are important from a preventive health standpoint.

Diet is the fourth component of the HEADDSS interview. The goal is to identify eating behaviors creating high risk for both obesity and eating disorders. Often these questions are forgotten or awkward to ask in a typical medical interview. Querying whether a teen has ever been on a diet, or has tried to lose weight are nice ice-breaking questions. Specific questions about utilization of diet pills, fasting, purging, or bingeing behaviors need to be asked in a non-judgmental fashion. Remember that anorexia nervosa is most common in early and late adolescents, whereas bulimia nervosa is common throughout adolescence. Obesity, if established and not reversed in adolescence, has a grim prognosis for improvement in adulthood.

The fifth component is Drugs. The goal is to identify substance use that may put the teen at risk for injury or dependence. The average age for initiating use of cigarettes is 11.6 years, for alcohol 13.1 years and for marijuana 13.4 years.³ It may be impossible to limit substance experimentation, but through improved communication we can increase internal loci of control. This will assist adolescents in developing limits and safer behavior. Questions may be answered more truthfully if phrased in reference to the child's peer group. Asking, "Have you or friends ever tried ...tobacco/alcohol/marijuana?" is another nice technique that is nonjudgmental.

Stressors/Suicide are addressed in the next group of questions. The goal is to identify significant features of depression or risk for suicide. Asking about stress, or two or three things the teen would change if he/she could, are concise methods of finding out what bothers the teen. Even though a teen may not report frank features of depression, it is important to ask specifically about thoughts of suicide. "Have you ever felt so bad that you have thought of hurting yourself?" works better than "Have you ever thought of suicide?" Asking about depression or suicide in friends or family members is also important.

Last is the group of questions relative to Sex. The goal is to identify high risk sexual behaviors. Questions may start with issues of pubertal development such as menarche. Establishing whether a teen has had any sexual experiences can be difficult. Asking if the child has ever "had sex" can start the conversation. Then it is important to explore when this first occurred, whether it was volitional or coerced and what "having sex" consisted of. It is important to establish the number and characteristics of partners, condom usage and a history of previous sexually-transmitted diseases.

At some point within the HEADDSS interview, the pediatrician

(continued from previous column)

may feel compelled to give the adolescent a reaction or comment on the teen's risky behaviors. This must be done with extreme care, as it may serve to alienate the teen and end the honesty with which the teen has been attempting to communicate. Delivered with care,

however, expressions of concern about the impact of a high risk behavior show your honest interest and desire to help the adolescent.

Once the interview is complete, the pediatrician must decide which risks need intervention, and the best approach to take. A five step approach is useful. First, identify or review the individual adolescent's specific risks. Secondly, prioritize those risks into immediate or long-term dangers. Third, choose one or two risks to develop an intervention. If interventions for those risks fall outside your area of expertise or time constraints, make appropriate referral, usually to a psychiatrist or psychologist. Fourth, if appropriate, provide physician-limited intervention or basic counseling utilizing one of four techniques: 1) patient education, including motivation to change a behavior; 2) behavioral contracts; 3) facilitation of family communication; or 4) referral to an appropriate community agency such as Big Brothers, the Boys/Girls Club, or other support agencies in your area; 5) follow up the intervention during subsequent visits. If the initial risks have decreased, encourage the teen to choose the behavior or risk he/she would like to tackle next.

Keep in mind that adolescents have short attention spans and schedules that they perceive as busier than yours. Brief, frequent, or phone follow-up is more effective than drawn-out counseling sessions that neither you, the parent, nor the teen is prepared for. Give the HEADDSS interview a try next time you do a sports pre-participation physical or health care maintenance visit and see if you don't uncover some amazing information about a teen you thought you knew!

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[Another article in this series **Emphasis on Adolescence** will appear in the next issue of *The Florida Pediatrician*]

From Morbidity and Mortality Weekly Report (February 17, 1995)

BICYCLE HELMETS AND THE PREVENTION OF HEAD INJURY

The implementation of effective bicycle helmet programs could have a substantial impact on rates for fatal and nonfatal bicycle-related head injury. For example, from 1984 through 1988, if a presumed helmet-use rate of 10% had been increased to 100% (i.e., universal helmet use), an average of 500 fatal and 151,400 nonfatal bicycle-related injuries could have been prevented each year.

UPCOMING CONTINUING MEDICAL EDUCATION EVENTS

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

To the Editor:

I read Dr. Cimino's assessment of "managed care" in a publication sent to

Florida AAP members some months ago, and I am writing now to re-affirm his statements. As a pediatrician and a historian interested in health care systems, I have been dismayed at the growth of health care companies - most of which seem to view child (and adult) health as just another commodity to be manipulated for profit.

In Miami, the latest outrage involves HMOs that offer incentives such as free diapers to persuade Medicaid mothers to switch to their plan; what these mothers do not know is that they can no longer take their children to Jackson Memorial Hospital (or its clinics). Since the HMO often has very inconvenient clinic locations, many mothers do not use them. In turn, they are denied access to our clinics, then show up in the Emergency Room several days later with a much sicker child. The HMO usually declines to pay for the ER visit and requests that the child be transferred to a community hospital for necessary inpatient care. It is a great deal for the HMOs, since they continue to receive their monthly capitation fees regardless of how poor the services they offer.

I am sure that you know about such practices already; I guess it makes me feel a little bit better to have written you. If you have the opportunity to respond to this letter, I wonder if you would share your thoughts on why physicians seem blind to the value of a single payor system (such as the one proposed by the PNHP), or why Americans in general seem so eager to turn over control of health care to large profit-oriented companies.

Jeffrey P. Brosco, MD PhD
Department of Pediatrics
University of Miami

* * * * *

To the Editor:

I read [Dr. Cimino's] column and comments on the single payor system. I feel that adoption of this type of system may sound good but simple solutions often create even more problems that they resolve.

By definition, the single payor system is a monopoly. I cannot imagine politicians allowing any one other than themselves controlling it. Often politicians feel they are the only ones who know what is best for the American people. What government program has done what it said it would do, the way they said they were going to do it, on time and within the projected budget? Do you really feel that the bureaucracy would be less costly, more efficient, more responsive to patient needs? Do you feel that this bureaucracy would have a bigger "heart" and more understanding than the insurance companies?

It is now apparent that American society has decided that healthcare is a right. If we accept this premise, then there should be a basic, defined, health plan available to every American. However, I feel that we must have the right to upgrade our coverage if we so desire. It must be as much a right as healthcare itself. Yes, our choices and our patients' choices are limited now. Under the single payor system, there would be even fewer choices than we have today, even if they are not completely eliminated.

I also feel strongly that we should not confuse "managed care" with "Managed Competition" as Dr. Eindhoven and Professor Ellwood defined the term. Their plan is market-driven with limited bureaucratic involvement that allows for flexibility and innovation and in which changes are not dictated by politicians or their appointees. Innovation is one "product" that has allowed America to be the unique country it is. It must not be stifled by a government-controlled monopoly.

I am a firm believer that American spirit and entrepreneurship can do better than any governmental monopoly. If we are willing to think differently and become more informed, and realize that we must become involved in the decision-making process, we can move toward a better system. We must not leave the decisions to non-physicians. We must learn to work together to ensure that changes are for the better and not short-sighted. If we do not learn and thus become part of the solution, we will continue to be part of the problem.

(continued next column)

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

Program: Pediatrics for the Primary Care Pediatrician
Dates: June 23-25, 1995
Place: Amelia Island Plantation, FL
Credit: 13.75 hours Category I for AMA Physician Recognition Award
Sponsor: Nemours Children's Clinic
Inquiries: Angela Bradley, (904)390-3638/3561

Program: Cape Cod Conference on Pediatrics
Dates: August 4-6, 1995
Place: Tara Hyannis Hotel and Resort, Hyannis, MA
Credit: 13.75 hours Category I for AMA Physician Recognition Award
Sponsor: Nemours Children's Clinic
Inquiries: Angela Bradley, (904)390-3638/3561

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



(continued from previous column)

There are changes that need to be made in our healthcare system. The system may even need to be "re-engineered". However, I feel strongly that the single payor system, or any system that is without freedom of choice, that is bureaucratic, and that is a monopoly, would be worse than any of us could imagine.

I do not see the single payor system as a solution for the healthcare dilemma that we face. I see it as another of the "solutions" that will be worse for us, for the healthcare system in general, and for our patients in particular. We must look beyond the obvious. Problems that involve one-seventh of our economy cannot be solved simply and easily. It will take a lot of work, flexibility, cooperation and innovation. A government monopoly will not give us any of the key elements that are needed to allow us to offer solutions that are realistic and rational to avoid arbitrary rationing.

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