THE FLORIDA PEDIATRICIAN

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

Volume XX, Number 2 *May 1997*

THE PRESIDENT'S PAGE

Greetings from Tampa. As this is being typed, on the eve of one of the most widely honored special days in the United States (April 15), I am the vice president of your Society. By the time you read this, barring impeachment, I will have stepped into the capacious shoes of John Curran as president for the next two years. This is a somewhat daunting position for anyone who is aware of the Promethian efforts and considerable talents John has brought to the task, and I beg for support and contribution from the membership in order to carry on the efforts of the Society and the Florida Chapter of the AAP on behalf of children and pediatricians.

For those who do not know me, I have been a full time practicing primary care pediatrician since 1973, about equally divided between solo and group practice. I have been active in FPS/FCAAP affairs for about the past ten years. I am an Associate Professor in the clinical (volunteer) faculty in the USF College of Medicine. I am married (29 years) and have three children. I have several hobbies, including sailing, scuba diving, undersea and hyperbaric medicine, and classical guitar. I am an instrument-rated pilot. And

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"...a number of initiatives...to see continued during my tenure..."

* * * * *

as some of you may have noted, I enjoy writing... sometimes to the chagrin of our esteemed editor. [No way! Keep it up! -Ed.]

There are a number of initiatives I would hope to see continued during my tour: we have established a Women's Section in the Florida Chapter; there is activity in the Senior Section, which was largely founded by one of our members, Bob Grayson (and is well represented by the editor of this publication); I intend to carry on the effort so expertly promoted by Dr. Curran at the national AAP for redistricting, to obtian more balanced representation for the growing membership of our region; the Society is supporting the development of a Youth (health) passport; we are working with pediatric interest groups at the four schools of medicine/osteopathy in the state; and of course, we continue to work in the legislative arena on any number of issues, the most current of which are available for your perusal on our web site.

Speaking of the legislative efforts, I should point out that the Florida society/chapter is generally recognized around the country as one of the most effective state pediatric advocacy groups, in spite of the fact that we don't always get our way. I sometimes hear grumbling about the failure of one or another of our efforts, and would remind one and all that there are a LOT of agendas that come to the Legislature, sometimes with potent political and financial support, which have little vestiture in children's (or pediatricians') issues. When you are asked for the investment of a little of your time (or cash) as a Key Contact or for PAC purposes, please keep this is mind.

John Curran has generously agreed to continue his efforts as a legislative liaison for the next year, and as this is being prepared, three of our members, Tom Abrunzo, Debbie Mulligan-

*(see **President**, page 18 ►)*

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THE EDITORIAL PAGE

Another Plateau Is Reached

Another year is well on its way. Another Spring-time is here, said to be a time for renewal. We are no different , and so we come to another renewal-milestone in the life of our Chapter. The once "sleepy giant", now big enough to have started the ball rolling towards rearrangement of the Districts, is now also roaring like the lion it is.

The "baton" is changing hands again. Another leader is in process of taking over. Reflections on the past are always in order at a time like this. We owe a lot of our present status to the efforts of Ken Morse and Dave Cimino, who, as joint presidents, spearheaded the successful integration of the Florida Pediatric Society and the Florida Chapter of the American Academy of Pediatrics into one organization. And we owe a ton of thanks to John Curran, our outgoing president, who took over the difficult job of being the first leader of the conjoint organization, and has led us forward to new and dazzling heights (and also into the world of computers and e-mail). I am delighted with the amount of material for this newsletter which comes to me electronically!

"...our new President... Bill Williams "

Now, as this newsletter goes to press, we have our new president taking over: Bill Williams. Bill (some folks call him "E.T.", but only because those are his initials!) is no novice to the job. He has "worked his way up" to the position, and knows well its trials, its troubles, and its pitfalls. He will lead us through the next two years to greater heights still. Best wishes, Bill. If things seem rough at times, just remember that 20 years ago, my term as a Chapter President (called Chairman then) was six years, not two!

Seriously, Bill will lead us gently but definitively forward for the next two years, but he needs the support and help of as many of us as is possible, to serve on his committees, and to attend general meetings and Executive Committee meetings (member attendance is welcomed).

And, speaking of committees, I hope everyone has noticed how many of our committees are very active and making very significant contributions to the success of the society. New committee members are always welcome, particularly from among the younger members, who need to participate now in preparation for leadership rôles later on.

"...committees are active and making very significant contributions to ...the success" ment/child

If one needs any proof of the active nature of our legislative committee and legislative liaison, one need only read back through last year's report of the plethora of accomplishments during the legislative session. What more could we want?

Finally, I must take notice of the growth of this newsletter, *The Florida Pediatrician*. This growth is directly proportionate to the tremendous cooperation of our members in providing your editor with the material necessary to create success. Please note our continuing "Emphasis" section and our continuing colloquium on Managed Care. And further on, do not fail to read about the growing voice of women in Medicine and in Pediatrics!

A new biennium is upon us. Let's do it! □

-The Editor

THE REGIONAL REPRESENTATIVES REPORT

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

Region I reports:

This has been a quieter year in Region 1, as opposed to other years. We have been seeing some of the changes in managed care players, but not as much as in other places. In the western part of the region, Sacred Heart Hospital is now in its new building. The University of Florida Department of Pediatrics and the Nemours Clinic have established relationships for subspecialty care at Sacred Heart. The new CMS building has opened and was named for Drs. Reed Bell and John Whitcomb.

In Tallahassee the legislative committee is busily at work, as the legislature has been in session.

Primary care programs seem to be going well. As a side note, Dr. Judy St.Petery has been the Medical Staff President at Tallahassee for the 1996-1997 year. □

David Jones M.D.
Regional Representative, Region 1

Region V reports:

The most dramatic news in the region has to do with a proposal to relocate the services (clinical and teaching) of Tampa General Hospital and the University of South Florida College of Medicine to the University campus, some 10 miles north of the present downtown location. Concerns about funding the new academic center, care for the poor, and impact on other hospitals near the campus have created heated discussion and demonstration. A final decision will apparently be made after community hearings. The potential impact on pediatric care in the region is unclear. The Tampa Children's Hospital at St. Joseph's Hospital and All Children's Hospital in St. Petersburg will surely be affected. Perhaps the time is right for increased dialogue and cooperation. Complementary services would likely benefit both patients and providers.

Pediatric practices in Tampa, Brandon and St. Pete continue the trend to joining with larger organizations: hospitals, clinics, Wall Street firms, or local alliances. It appears that the disappearance of the solo practitioner in the region is not far off.

The Hillsborough County Pediatric Society met on March 20. We enjoyed an entertaining and enlightening presentation on allergy management by Dr. Allen Halsey. □

Thomas Abrunzo, MD, MPH
Regional Representative, Region V

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(A directory of Officers, Executive Committee, and Committee Chairmen)

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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.]

Kudos

...to **John S. Curran** , outgoing President, for the outstanding job he has done as President of the Florida Pediatric Society/Florida Chapter American Academy of Pediatrics. In his two years, he never slowed down one bit in his devotion, even when he was confronted with overwhelming new duties as Executive Associate Dean for Academic Affairs at the University of South Florida College of Medicine. *Congratulations!*

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Report of the Committee on Environmental Health, Drugs, and Toxicology

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

ACETAMINOPHEN TOXICITY
A RETROSPECTIVE

At times it may pay to look over our shoulders. Reflections of the past may make clear our vision of the future. A recent article drew my attention: "Outcome of Acetaminophen Overdose in Pediatrics[1], acetaminophen (APAP) being, perhaps, the most popularly used medicine, antipyretic/analgesic in infants and children. It became the preferred antipyretic/analgesic upon the association of Reye Syndrome with aspirin.

Records of 73 patients, ages <= 19 years with a diagnosis of acetaminophen overdose were reviewed, at the University of California in LA. Twenty-eight (38%) had abnormal liver function tests initially. all developed severe hepatotoxicity and 6 (21%) required liver transplantation. Twenty-two were managed medically. Seventeen (77%) received N-Acetylcysteine with good response. Most of the patients with abnormal liver tests were among the younger patients. Nine patients received multiple overdoses for teething and fever. It seems suicidal tendencies were seen mostly in those =>11 years. The other factors contributing to severe hepatotoxicity included covert multiple overdosing, delay in referral and management and concomitant ingestion of hepatotoxic drugs.

This report struck a consonant chord. A 1973 PEDIATRICS Pharmacology for the Pediatrician, Editor's Note[2] stated:

> "ACETAMINOPHEN: POTENTIAL PEDIATRIC HAZARD
> Acetaminophen, long popular in Europe, has received increasing use in the United States as an analgesic and antipyretic, ...because of concern over the side effects of aspirin, ...interference with blood clotting mechanism, ...(Reye Syndrome associated later). Pediatric use was facilitated by the development of a stable suspension. ... 1973 tables ...list some 200 brand names of products containing this compound ... in the United States. ...'Although package inserts characterize this drug as having exceptional safety in recommended doses, ingestion of moderately large quantities can cause kidney and liver damage resulting in death. It is therefore important to alert practitioners to the potential toxicity, symptomatology and procedures fror handling overdose'".

Following this commentary was an article in which Goulding[3] reported 29 over-dosage deaths due to APAP.

> "...the total number of deaths from acetaminophen relative to its usage when compared with aspirin is still very small. ...they represented a steady increase in the number of deaths per year... over time. At this time the consumption of APAP in Great Britain was about 50% that of aspirin."

Present American yearly use of aspirin is about 30 billion tablets per year. Twenty years ago the FDA approved acetaminophen (Tylenol, and numerous other brands and generics) in doses of 325 and 500 mg for OTC sale. This does not include the many pediatric formulations: cough and cold medicines, syrups, drops, chew tablets, etc. The present PDR lists over 130 trade names, most with multiple strengths and composition. Not all companies list their products in the PDR. Neither does this include the Yellow Book (OTC).

APAP and aspirin are comparable in the relief of mild-to-moderate pain and in antipyretic properties, but less so in soft tissue injuries, such as muscle strains and sprains. Some feel it has less effect in arthritic discomfort. The FDA recently revised the warning label on acetaminophen to advise people who drink large amounts of alcohol that acetaminophen taken in high doses can increase the risk of severe liver damage.

*(see **Acetaminophen**, page 18 ▸)*

GENERAL PEDIATRIC UPDATE V

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

SCIENTIFIC SESSIONS

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

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Annual Business Meeting and Luncheon: Sep 20, 12:00-2:00 PM
Women's Section Breakfast: Sep 20, 7:00-8:00 AM
Saturday Night Reception: Sep 20, 7:30 PM (Free)
For more information call (904) 224-3939
Hotel: Amelia Island Plantation (800-874-6878 or 904-261-6161)

Note:

If you are a Fellow of the American Academy of Pediatrics, you are 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.

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.

IMPLEMENTATION OF SUPPLEMENTAL SECURITY INCOME (SSI) REGULATIONS

[The following is a Special Alert from the Department of Government Liaison of the American Academy of Pediatrics. It is of serious import to the members, and therefore given special attention in the newsletter.]

Philip Ziring, M.D.
Chairman, AAP Committee on Children with Disabilities

After months of delay, the Supplemental Security Income (SSI) program for children regulations were published in the February 11, 1997, Federal Register (web site: www.ssa.gov/odhome click on "childhood disability"). They are considered "Interim Final Rules with Request for Comments," which means the Social Security Administration immediately began reviewing new and old SSI cases based on these rules but the public has until April 14, 1997, to comment before they go into effect.

The American Academy of Pediatrics' position on the new rules is that they are a fair and reasonable interpretation of the new law. However, the Academy is eager to improve the rules by offering specific recommendations and welcomes pediatricians' written comments (deadline: April 1, 1997) for inclusion in the AAP document. Pediatricians are also urged to review and comment on the regulations directly to the Social Security Administration.

The New Disability Standard: The new law established an SSI definition of disability if it causes "marked and severe functional limitations" and eliminated the Individual Functional Assessment (IFA). Based on the Administration's interpretation of Congressional intent, the severity level in the new rules requires either 1)"marked" limitation in two different areas of functioning or 2) "extreme" limitations in one area of functioning. The Administration also incorporated three changes intended to help better evaluate children under the new law:

- A motor domain was added to the initial four domains of impairments to cover the physical disabilities, such as difficulty in walking. There are now five domains (motor; cognitive/communication; personal; social; concentration, and persistence or pace)
- Reviewers will be required to fill out an additional form to ensure they do a functional test rather than stopping after the medical listings.
- The regulations include a provision to ensure that review of episodic conditions, such as asthma, takes both the frequency and severity of episodes into consideration in establishing whether the condition is truly disabling.

Impact on Children:

It is important to note that the SSI program continues to exist for children with disabilities - the new law simply changes some of the eligibility standards. The process for children entering the SSI program will remain largely the same, though the new rules provide additional guidance and stricter criteria for eligibility.

All children who apply for SSI benefits, beginning on August 22, 1996, will be evaluated under the new rules. In accordance with the law, 263,000 children currently receiving SSI will be redetermined under the new SSI regulations. It is estimated that when these redeterminations are completed (deadline: August 22, 1997), only half of these children will continue to receive SSI benefits. For those children found ineligible for the benefits under the new rules, benefits will not stop before July 1, 1997.

Role of Pediatricians:

There is a tremendous backlog of children who are awaiting evaluation to determine if they are eligible for SSI benefits under the new rules. The Social Security Administration is in critical need of pediatricians who can assist in providing medical evaluations for both children who are new to the SSI system and those who must have their eligibility redetermined.

An important role for pediatricians to continue to play in the SSI program is that of Consultative Examiners (CE). In the absence of sufficient medical evidence, Social Security may request that a child receive an additional examination by a physician, psychologist or other health professional. These examinations are paid for by Social Security at a rate set by each state (fees vary from state to state). Pediatricians who perform these examinations must have a good understanding of the SSI program and its evidentiary requirements.

The Social Security Administration is eager to provide information to pediatricians and other physicians about the new rules. Attached is a state-by-state listing of Social Security Medical Relations officers*. These individuals will be an important resource in areas such as:

- Providing a Social Security representative to make a presentation on the new SSI rules at a Grand Rounds, AAP Chapter meetings, local health care settings, etc.;
- Answering specific questions on the types of medical evidence/documentation that is most useful in expediting a child's access to SSI benefits;
- Offering your services as a Consultative Examiner, or to learn more about the SSI program requirements, contact your state SSA medical relations officer.

Another role pediatricians can play is to remind families that they might qualify for Medicaid even if they are not eligible for SSI because of the new disability standard. Those families should contact their local Medicaid office. Also, President Clinton included a provision in his proposed FY 1998 budget to continue Medicaid benefits to those children who currently receive SSI benefits but will lose them under the new law.

The Academy encourages all pediatricians to contact your state Social Security Medical Relations officer to receive the most detailed information available about changes to the SSI program. Your active participation in the SSI program will enable thousands of children with disabilities to access this important program. If you have questions, please contact Elaine Holland, Assistant Director in the AAP Washington Office at 800/336-5475.

*The list of Social Security Medical Relations Officers in Florida is on page 22, *q.v.*

SOME RAMBLING THOUGHTS ON MANAGED CARE

Edward T. Williams, III, M.D.
Tampa, Florida

Page 8

Our esteemed editor has asked me to add my two cents to the ongoing discussion in these pages regarding managed care issues. We have had at least one of our members speak in glowing term of his experiences with HMO care. Others of us have had less salutary experiences. We have also had a detailed summary from Dr. Leomard Kutnik, a Board member of the AAP, of the Academy's plans for addressing managed care, educational efforts for the membership, etc.

I thought this time I might just ramble through a few thoughts that keep recurring, at least to me. First of all, a few bits of "managedcarespeak" I have run across lately:

"It's managed cost, not managed care."

"Value = Quality/Cost"

"It's cost that counts; quality is assumed"

This latter is a quote from an article in Medical Economics, but unfortunately also a quote heard from one of the administrators involved in a contract negotiation with a hospital-based physicians' group. Fundamentally, the purchasers of care are operating on the assumption that no matter how tightly squeezed, physicians and other care givers will never let quality of care wane. I have every confidence in the ethical backbone of most physicians, but I have to say I believe that assumption to be a risky one. Articles are already beginning to appear indicating sagging outcomes measurements in certain HMO environments, which I think notable considering the length of time required just to obtain that sort of information.

Again from Medical Economics, in the last ten years (since the major onslaught of managed care), overall premium expenditures have doubled. Physician and hospital income have decreased. Insurance and managed care companies' profits are WAY up. Managers of the third-party companies are getting top dollar. It doesn't take a John Maynard Keynes to figure out this situation, and while purchasers of care are beginning to notice, they don't always have affordable alternatives presented to them.

Physicians are generally being advised to band together, form alliances, and try to present a more united front not only for financial bargaining but also to try to regain some of their traditional ability to call the shots as to the best treatment plan for their patient, hopefully with a minimum of interference from the 1-800-algorithm types charged with care denial. How?

One scenario is the "vertically-integrated" regional system, usually centered around a hospital, with ancillary services, perhaps including physician services, owned or contracted by the hospital system, which contracts with the purchaser for a " global" fee. This has the potential for eliminating the MCO middleman, and is widely favored by those in hospital administration, especially those where MBAs are rapidly replacing more traditional employees, such as nurses. This would certainly be a recommended choice for those physicians who are willing to entrust their future welfare to the generosity and probity of the MBAs.

The other scenario involves the formation of an alliance or network of physicians who contract with each other and perhaps other care givers such as home health agencies, laboratories, perhaps hospitals, etc. to present a package of health care services, initially to MCOs, but perhaps eventually to purchasers directly. This might also eliminate the third parties as middlemen, though they might be used on a contract basis for MSO services. This would allow for a physician-directed organization which might be able to redirect some of the 25-40% profits some of the MCO's currently keep to patient care.

Personally, I like the latter scenario better, though it does have some inconveniences associated with it.First of all, it requires physicians to assemble into a cogent organization (herding cats, etc, etc.); it also requires the development of actuarial data, management systems, and negotiating and contracting skills, among others. It is not a simple task, but in my opinion is the most palatable option of those currently available, and seems to be the general scenario favored by some prominent health care economists, such as Uwe Reinhardt. Efforts to form such groups are ongoing in a number of areas of the country as well as several communities in Florida, as many of you who attended the managed care seminar at the last FPS/FCAAP Annual Meeting will recall. I hope the membership will keep an open mind regarding developments in the structure of medical practice, as I feel the winds of change are far from depleted.

For an admirable analysis of capitation as it relates to the physician please see "Capitation or Decapitation-Keeping Your Head in Changing Times". Bodenheimer TS, Grumbach K. JAMA October 2, 1996, Vol 276, No 13. The same issue has one of the HMO outcome studies referenced above.

Keep a stiff upper lip. □

[Ed.: Dr. Williams is our incoming president of the Florida Chapter American Academy of Pediatrics/Florida Pediatric Society/ See also his Presidential Message on Page 1]

Did You Know?

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

Note:

Visit our summary of *The Florida Pediatrician* on the Internet. The URL is http://www.aap.org. Look for Membership Services, then Chapters. This summary will be changed with every issue of the newsletter.

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

MORTALITY FROM SICKLE CELL DISEASE IN FLORIDA

Charles H. Pegelow, MD
Professor of Pediatrics
Director, Residency Training Program
University of Miami School of Medicine

A recently published study found the mortality rate for children with sickle cell disease in Florida was more than double the national average[1]. The national rate was 6.8 deaths per 1,000 patient years compared to 16.2 in Florida. While high, these rates were calculated for children with both sickle cell anemia and hemoglobin SC disease. The latter diagnosis comprises one third of the patient number but contributes little to mortality in the age studied. This means the rate for children with sickle cell anemia could have been as high as 24 deaths per 1,000 patient years for the period studied.

While these data are troubling, it should be noted that sickle cell disease management has changed since their collection. First, in 1988, Florida instituted newborn hemoglobinopathy screening allowing early identification of affected children. Parents of those infants found to have an abnormal electrophoresis are contacted, the diagnosis confirmed and counseling and therapy initiated. These activities are carried out primarily through the seven C.M.S. Hematology/Oncology centers.

Now that managed care plans will include Medicaid recipients, pediatricians may be assuming more responsibility for the care of children with sickle cell disease and must become familiar with the unique problems they present. Its relative rarity (approximately 1:640 African American children[2]) will result in a typical practice having only a few affected children. This may result in their unusual characteristics being lost amongst the problems of the other children for whom the practice is responsible.

The most common cause of death associated with sickle cell anemia during the first five years of life is overwhelming pneumococcal sepsis[3]. Early loss of splenic function results in a 20-30% mortality rate for those who develop *S. pneumoniae* bacteremia[4].

Penicillin prophylaxis has decreased but not eliminated this problem[5]. It should be initiated as soon as the diagnosis is made. As with any chronic medical regimen, compliance with prophylaxis is imperfect. Even with specific efforts to reinforce its importance at each patient encounter, we have found that children receive as few as 50-60% of the doses prescribed. In spite of this, great benefit is derived from penicillin prophylaxis although it forces the physician to approach each febrile event as if no prophylaxis had been provided.

Since it is often impossible to determine its cause at onset, all febrile children with sickle cell anemia who are under five years old must be treated with parenteral antibiotics until pneumococcal bacteremia can be excluded. Standard practice requires hospitalization until cultures are shown to be negative at 48 hours and the child is clinically stable[6]. An alternate approach has been suggested for selected patients wherein following blood culture and intravenous ceftriaxone the child is discharged and reexamined at 24 and 48 hours[7]. In the study, children were selected for this approach only when investigators believed they were not toxic, their parents understood the need for early reevaluation should the child's condition deteriorate and had access to transportation to return to the hospital if needed. The approach has been shown to be satisfactory for children who are ultimately found not to have bacteremia but its safety for those ultimately found to have bacteremia remains to be determined. While it is tempting to adopt a regimen that avoids hospitalization, we must proceed with caution in view of the sudden and catastrophic deterioration typical for such children.

The emergence of resistant strains of *S. pneumoniae* creates new concerns. In some communities, resistant organisms are sufficiently common to lead to the use of vancomycin as the initial antibiotic[8]. This decision should be approached with caution to avoid overexposure to what is currently the only antibiotic to which the multiply resistant organisms are susceptible.

Another frequent cause of death is splenic sequestration[9]. This problem develops when the spleen rapidly enlarges and traps a significant volume of blood. The child presents with pallor and weakness. Hypovolemic shock may develop which if not promptly recognized and treated with transfusion, results in death.

The final major cause of death in these children is pneumonia or "chest syndrome"[10]. The latter term was coined to acknowledge that pneumonias encountered in sickle cell disease can be due to causes other than infection, i.e. lung infarction and bone marrow embolism. Whatever its underlying etiology, the resulting hypoxemia causes hemoglobin S to sickle and further disrupt blood flow. The problem can result in rapid pulmonary deterioration which cannot always be supported by mechanical ventilation. Blood transfusion must be considered for those whose pulmonary status appears to be deteriorating with care taken not to raise the total hemoglobin concentration above 12 Gm/dl until hemoglobin S is reduced below 30%.

In conclusion, the mortality rate for children with sickle cell disease in Florida has been shown to be excessive in recent years. We must do whatever is necessary to allow the provision of appropriate medical care for these children. Pediatricians must assume responsibility for providing education for the parents of such children since their ability to detect and respond to early signs of illness is critical for therapy to be successful. In addition, the appropriate medical management of the problems encountered by this group of patients must be carefully considered.

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EMPHASIS ON THE RIGHTS OF CHILDREN

Standards for Pediatric Care Givers

J. Dennis Sexton
President, The All Children's Hospital
St. Petersburg, FL

Shortly after taking office for his first term as President of the United States, Bill Clinton announced his plans for major health care reform in our country. A number of health care providers were invited to Saturday meetings at the White House to discuss the President's vision with administration leadership. It was my pleasure to attend one of those meetings as the then chairman of the National Association of Children's Hospitals and Related Institutions (NACHRI).

At the conclusion of our meeting day, one of Ira Magaziner's aides asked if anything had been missing in the discussion of the Clinton Plan. My quick and accurate response was one word: "Children!" The response? "Oh, yes! You're from the children's hospital group. We have little data and less vision on children's health care needs. We kind of thought you people would work on the children's portion and advise us."

The reason? Children comprise a small portion of the nation's health care expenditures. Kids are basically a well population with the notable exception of the 5-8% of chronically ill children who consume some 80% of the country's expenditures on pediatrics. Our national and state governmental agencies concentrate their major efforts on adult-oriented DRG systems that are not reflective of the needs of sick children.

NACHRI, the American Academy of Pediatrics and a large number of pediatric professional groups acknowledged the Clinton Administration's challenge about pediatric health care. We admitted to ourselves that little was available in the way of standards for pediatric care givers and facilities in the changing American health care delivery system. We also found the proposed Medicaid Block Grants had no requirements from a federal perspective that children under Medicaid be cared for by primary care providers trained in pediatrics. Notably absent was any requirement that children with complex problems had the right to be seen by a pediatric subspecialist.

As the initial four years of the Clinton Administration unfolded and the competitive concept overpowered his vision, it became apparent that moving children to Medicaid Managed Care or HMOs could result in children being absorbed into an adult system with no standards or requirements that the unique needs of children be recognized. Each state could decide whether pediatric training and expertise was necessary for managed care plans and Medicaid caring for the pediatric population. The easy answer was, "Let the marketplace decide!"

As a result of what many pediatric care givers saw as a major threat to quality driven children's health care, NACHRI and other organizations have now established a beginning baseline for children in their new publication, "Pediatric Excellence in Health Delivery System." Published first in October, 1996, the booklet describes how an integrated children's system of care from prevention through tertiary and quaternary care should be provided, with descriptions of qualifications for care givers and ways to insure outcomes constantly improve. It acknowledges that "one size does not fit all" in pediatrics--a fact well known to the pediatric practitioners of this country. Unfortunately, it isn't as well known to state government officials, Medicaid and HMOs unaware of the crucial adjustments that need to be made for a patient whose weight is measured in grams rather than pounds.

Our collective efforts as pediatric care givers and children's advocates must now be directed toward insuring the emerging health care delivery system in the United States hears and acknowledges the special needs of children. NACHRI and the many sponsoring pediatric organizations have provided a template for health care plans to follow in providing care for our nation's children. It's up to each of us to educate the public, the payers and our legislative leaders about the difference between children and adults when it comes to health care delivery.

Florida has historically been a national leader for pediatric standards through the Children's Medical Services (CMS) guidelines used for state-supported patients with complex medical problems being served by physicians and hospitals throughout the state. One of the earliest areas of national recognition came through the Regional Perinatal Intensive Care Center program established over 20 years ago in Florida. Our system of regionalized care for high risk mothers and infants in a standards driven, outcomes measured statewide program serves as a beacon for pediatric care givers throughout the nation.

Guidelines for pediatric cardiac care long established in Florida for state supported children demonstrated their value in a recent published article comparing outcomes of children's cardiac surgery based on payer. In all states reviewed except Florida, state supported patients had higher mortality and morbidity statistics than did indemnity insured or HMO covered children. Florida Medicaid had the lowest mortality and morbidity statistics--due largely, one suspects, to the fact that state supported children are treated at annually reviewed children's cardiac centers meeting approved standards.

Unfortunately, the Florida standards for children's specialized care are in danger of disappearing over the next few--very few--years. The privatization of Medicaid into commercial HMOs and the disappearance of CMS from the payer scene is resulting in care based on price. "Let the marketplace decide" is the rallying phrase of those wishing for an unfettered business approach to health care, The suggestion is often made that consumers will move toward quality programs once they find the service and outcomes are less than desirable in a system absent of standards.

That particular attitude may be acceptable on Wall Street but it isn't acceptable for the care of my two grandchildren. I want them to have unencumbered access to physicians and nurses trained in pediatrics. Over 25 years at All Children's Hospital have convinced me that children are different when it comes to health care. One size does not fit all! Nowhere in health care is it more apparent than in the pediatric environment.

A number of us in Florida, long recognizing the muffled voices of children and their advocates are rarely heard in today's society, are strongly advocating the establishment of pediatric standards for care givers and facilities in our state. The changing envirolunent of HMOs, PPOs and whatever comes next requires those of us believing children are special to advocate legislatively that standards be written for children. And, most importantly, that those standards be written by doctors, nurses and technicians trained in children's health care! It's a daunting but not impossible task! Perhaps the most daunting portion is the pediatric tendency to remain on the sideline while others less qualified decide the health care system of the 21st Century. Pediatric advocates must be the voice for children's health in Florida or an adult system will absorb kids not as a special segment of the population but as another "per member per month" in an adult capitation system. I can't let that happen. Neither can you! Our best collective effort should concentrate on establishing--or reestablishing--pediatric standards for Florida's children, written by pediatric experts.. Then we've protected the child by insuring every provider and insurer in Florida wishing to care for children meets appropriate standards. Then we compete on price based on child standards of acceptable care!

Kids don't vote! Kids don't speak out! If those of us dedicating our personal and professional lives to children with complex and specialized health needs don't speak up .... who will? It's truly up to pediatric care givers to insure our nation and Florida recognizes the need for pediatric excellence in whatever system of health care finally emerges in the United States. □

1996 ANNUAL CHAPTER FORUM RESOLUTION ON TOBACCO/ALCOHOL USE AT YOUTH ATHLETIC EVENTS

A resolution concerning tobacco and alcohol use at youth athletic events was passed at the American Academy of Pediatrics' 1996 Annual Chapter Forum. The resolution was submitted by the Hawaii Chapter and calls for the Academy to contact major youth athletic organizations to request that they initiate an effort to discourage the use of alcohol and tobacco products by coaches, parents and other attendees at practices and events which include children.

A second component of the Resolution aims to involve AAP chapters by working with major youth athletic organizations within their states to discourage the use of alcohol and tobacco products by coaches and parents, and other attendees at practices and events that include children.

The AAP national Committee on Substance Abuse (COSA) recently developed the policy statement, "The Role of Schools in Combatting Substance Abuse" (Pediat 1995; 95:784-785). The statement encourges interaction among members of state and local chapters to promote awareness of the harms caused by drug use.

The statement also recommends that pediatricians assist schools in establishing a "zero tolerance" policy against tobacco, alcohol, and other drug use that applies equally to both students and staff, not only at school, but at all school-sponsored and sanctioned activities. Pediatricians should serve as a focal point for community-wide efforts promoting nonuse of tobacco, alcohol, and other drugs. A final recommendation involves the prohibition of sponsorship of school-related activities by companies involved in the marketing of alcohol and tobacco products and the advertising and promotion of such products on school property and at school-related activities.

The COSA encourages use of the policy statement in negotiations with youth athletic organizations within each state. For your information, see further the policy statement referenced above. For additional information regarding this resolution or other COSA policy statements, please contact Jill Mallin at 800/433-9016, ext. 7941. □

NATIONAL TV-TURNOFF WEEK

[This message was received too late for active participation in TV-Turnoff Week. However, it has an important message and it is included here none-the-less.]

During the last week of April 1997, thousands of families, schools, libraries, and community organizations will join together to encourage people to leave their televisions off for one week. The American Academy of Pediatrics is one of 40 national organizations that support the third annual National TV-Turnoff Week. The event, sponsored by TV-Free America (TVFA), will take place April 24-30.

The huge success of the previous TV-Turnoffs (more than 4 million people have participated) shows that a solid one-week recess from TV helps establish conditions that allow for more family interaction, reading, volunteering, exercising, enjoyment of nature, playing of sports, taking part in community affairs, thinking, creating, and doing! The hope is that after TV-Turnoff week has ended, people will continue to spend more time on such activities.

Organizing a TV-Turnoff is not hard to do and does not require a great deal of time. Talk with parents, teachers, school administrators, health educators, and other adults you know and encourage them to join this important event. To learn how to organize a TV-Turnoff in your school, library, hospital, or community, contact TV-Free America, 1611 Connecticut Avenue, NW, Suite 3A, Washington, DC 20009, Tel: 202/887-0436. Fax 202/518-5560. TVFA will help you get started, and for a $10 donation, send you an Organizer's Kit that includes a guidebook, posters, bumper stickers, pledge cards, and an information packet. □

ACADEMY MEMBERSHIP

The Academy office recently released the latest figures on membership in the American Academy of Pediatrics, as of December 31, 1996. To better understand these numbers, following is an explanation of the various categories of membership:

Voting Fellows: Fellows, Specialty Fellows, Life Members, CPS/AAP Dual Fellows.

Non-Voting Fellows: Corresponding Fellows, Emeritus Fellows [except for Life Members Emeritus, who retain voting privileges], Honorary Members, LA/AAP Members, Medical Missionaries, Leave of Absence.

Resident Fellows: Any pediatric resident enrolled in a general or combined training program approved for credit toward certification by the ACGME (including chief residents).

Candidate Fellows: Any Board eligible pediatrician who completed his or her 3rd year of pediatric residency less than 4 years ago and is no longer enrolled in a pediatric residency training program.

Post-residency Training Fellows: Any pediatrician who completed an accredited pediatric residency training program and is currently enrolled in a pediatric subspecialty or research-oriented fellowship training program.

I. The academy membership, as of Decembere 31, 1996, totalled 53,476 members in all categories.

II. We reproduce here only the numbers for District IV, of which Florida is a part, at least for now.

District IV	A	B	C	D	E
Chap 00*	884	55	2	175	34
Florida	1136	256	332	209	23
Georgia	746	54	121	131	14
Kentucky	360	22	109	60	8
N. Carolina	762	101	197	136	25
Puerto Rico	139	19	97	98	8
S. Carolina	314	39	86	66	2
Tennessee	523	61	215	96	20
Virginia	861	89	187	120	20

*Chapter unspecified

A = Voting Fellows; B = Non-Voting Fellows/Members; C = Resident Fellows; D = Candidate Fellows; E = Post-Residency Training Fellows

[Ed.: note that Florida has about one-fifth of the total membership of the District; note also that the large number of non-voting fellows/members in Florida (and North Carolina) represents the retirement areas of choice for emeritus fellows!] □

Schedule of 1997 District IV Chapter Meetings

Date	State	Location	Contact	Tel./e-mail
June 13-14	TN	Gatlinburg	C. Fenner	615/383-6004 cmfenner@aol.com
June 19-21	GA SC	Sea Island	Rick Ward	404/876-7535 rwward@mag.org 803/798-6207
Aug 7-10		Asheville NC Asheville	D. Shealy	919/833-3836
Sep 5-7	NC	Atlanta	A. Skipper	404/876-7535
Oct.	GA		Rick Ward	

Dr. Robert E. Hannemann, President of the AAP, reports that on April 15, 1997, the Academy's Board of Directors approved sending the following letter to the bipartisan sponsors and co-sponsors of the Hatch-Kennedy Health Insurance Act ("Child Health Inssurance and Lower Deficit Act" - S.525). Co-Sponsors of S.525 as of 4/15/97 are: Republicans: Snowe (ME), Jeffords (VT), Collins (ME), Smith (OR), Campbell (CO); Democrats: Kerry (MA), Dodd (CT), Rockefeller (WV), Daschle (CD), Wellstone (MN), Bingaman (NM), Murray (WA), Reed (RI), Boxer (CA), Lautenberg (NJ), Durbin (IL), Reid (NV).

April 21,1997

[To Senators Hatch and Kennedy]

The American Academy of Pediatrics is pleased to endorse the bipartisan "Child Health Insurance & Lower Deficit Act" as a vehicle for alerting Congress and the nation of the need for quality comprehensive health care for this nation's children and adolescents. We commend you for your courage and leadership in taking this stand early in the debate, which calls attention to the urgency for such a proposal and your willingness to put politics aside when it comes to children's health.

We agree with you, and others, that this is an achievable goal, even in this time of deficit reduction. Indeed, providing children and adolescents access to quality health care with an emphasis on prevention should be viewed as a cost-saving investment in our nation's future.

Your bill, S. 525, addresses many of the barriers to care for uninsured children in a manner consistent with our own principles, which include:

- choice of plans for both families and providers
- reasonable cost-sharing provisions, with **no** cost-sharing for preventive services
- a benefit plan that is at least consistent with Medicaid's EPSDT program
- access to quality care delivered by providers specifically trained in the care and supervision of this population, utilizing, as appropriate, facilities best suited to meet their needs.

As pediatricians, we know first-hand that many of the current health care insurance plans for families and children promise quality and comprehensive services. While well intentioned, their coverage of preventive services is at best inadequate They create additional and unnecessary barriers to pediatric health care and only serve to frustrate access to services required by special needs children. Hence, families, government, and other payers are cheated of real value for their investment. These and other issues deserve additional attention.

As the public policy debate continues, the American Academy of Pediatrics and its 53,000 members are committed to continue to work with you and other members of Congress, in a bipartisan effort, to further develop and enact children's health policy in this session. We must also take advantage of this opportunity to help families with uninsured children and to make improvements in the system for all children. This will address not only the growing health care needs of today's children, but also those of tomorrow's child.

Sincerely,
[Robert E. Hannemann, MD]
[President] □

*(See related article, **Access to Care**, page 17)*

Women in Pediatrics

The number of women in the physician workforce has nearly quadrupled in the past twenty years. In 1970, women comprised a mere 7.7% of all physicians; by 2010, they are expected to represent 30% of the total physician population.

Demographic Characteristics

Numbers: As the number of women entering the workforce increases, the ratio of female to male physicians in allopathic medicine has steadily increased.

Physicians by Gender-Allopathic Medicine[1]

	1970(%)	1992(%)	2010(%)
Total	330,824 (100)	670,336 (100)	676,700 (100)
Female	25,507 (7.7)	125,899 (18.8)	198,000(29.4)
Male	305,317 (92.3)	544,437 (81.2)	477,800(70.6)

[1]All data are as of Dec 31 of each year; 1992 figures termed "1993) by AMA
Source: AMA, Physician Characteristics and Distribution in the U.S. (1994)

The most dramatic numbers are found in the number of women entering medical schools. Women represented less than 10% of first-year entrants in 1960, and today their numbers have grown to more than 42% of first-year medical school classes.

Female Medical School First-Year Enrollment, Selected Years[1]

AcademicYear	Total	Women	Women as % of Total
1960-61	8,298	786	9.5
1970-71	11,384	1,256	11.1
1980-81	17,186	4,966	28.9
1990-91	16,876	6,550	38.8
1991-92	17,071	6,804	39.9
1992-93	17,079	7,158	41.9
1993-94	17,121	7,230	42.2

[1]Includes new entrants and first-year repeaters
Source:Association of American Medical Colleges

Age: Women physicians are a relatively young group: in 1992, 31% of physicians under the age of 35 were women.

Physicians by Age and Gender - 1992[1]

Gender	<35	35-44	45-54	55-64	65+
Total	134,079	201,989	136,159	89,305	108,804
Male	92,362	154,266	116,284	81,645	99,916
Female	41,717	47,723	19,911	7,660	8,888
%Female	31.1	23.6	14.6	8.6	8.2

[1]All data are as of Dec 31 of each year; 1992 figures are termed "1993" by AMA
Source: Adapted from AMA, Physician Characteristics and distribution in the U.S. (1994)

Racial and Ethnic Diversity: Although the percentage of women entering medical school has markedly increased, women from ethnic and racial minority groups remain underrepresented. However, increases have been made even within the present decade. In the 1990-91 academic year, underrepresented minority female enrollment was only 12.8% of total female enrollment. By the 1993-94 academic year, underrepresented minority female enrollment had increased to 14.3% of total female enrollment.

[Source: Council on Graduate Medical Education, Fifth Report: Women & Medicine (July 1995); modified from AAP Fact Sheet]

*(See **Wom,en**.page 23 ▸)*

CATCH - A Historical Perspective

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

In Florida, our history is rich in CATCH-like activities and is tightly interwoven with the roots of the community access to child health movement. In fact, one of the national AAP CATCH founders, F. Edwards Rushton, M.D., was a leading pediatrician in Sarasota, Florida during the 1970s. Dr. Rushton formulated an unusual public-private partnership between his private pediatric practice and the Sarasota public health department in order to provide for the unmet health care needs of a large migrant pediatric population living in Fruitville, Florida. Fruitville lies only four miles inland from the plush condominiums and beaches of Sarasota. The Sarasota public health department did not have any pediatricians of its own, and therefore contracted with Dr. Rushton's pedliatric group practice to provide complete physician coverage for health department pediatric patients. The first contract was written in 1975. It was hailed as a simple, cost-effective solution for meeting the health care needs and for providing access to health care for previously underserved population of children. Because of its simple design, it has been utilized as a workable model for other communities.

There continue to be many Florida pediatricians who embody the pioneer spirit of CATCH and who have found working solutions to child health access problems in their communities. I invite interested pediatricians to share such programs and projects with others via the Florida CATCH network. □

F.Y.I.

At the October meeting of the Florida Board of Medicine, changes were made in the requirements for biennial license renewal. These requirements are detailed below.

For biennial license renewal:

40 hours Category 1 CME - Total

1 hour must be in HIV/AIDS

Up to five (5) hours MAY be in Risk Management. This will not be a requirement for license renewal. Should a physician attend a Board of Medicine meeting, he/she will receive five (5) hours of credit.

1 hour in Domestic Violence (need not be Category 1; "approved by any state or federal government agency, or national affiliated professional association, or any provider of Category 1 or 2 AMA Continuing Medical Education.")

Initial licensees:

Risk Management is not required for license renewal with the exception of initial licensees. They must complete one hour during the first biennium of licensure as well as three (3) hours HIV/AIDS and one (1) hour Domestic Violence. Initial licensees are exempt from the 40 hour requirement for the first biennium of licensure and only need the mandated hours. □

Cultural Understanding Important When Treating Children From Ethnic Populations

An overview of traditional healing practices among Hispanic, Native American, and African American families was provided at a special presentation at the recent AAP Annual Meeting in Boston, MA. The presentation "Culture and Clinical Care: Traditional Medicine in Ethnic Populations," was moderated by Fred Mandell, MD, FAAP, Associate Professor of Clinical Pediatrics, Harvard Medical School, and member of the AAP Committee on Native American Child Health.

"As pediatricians we are able to see how culture affects our patients. For us as caretakers, it's important to have both a cultural sense and a medical sense of what the patient needs and believes," Dr Mandell said.

Lee Pachter; DO, FAAP, Director of Pediatric Inpatient Services, St. Francis Hospital and Medical Center, Hartford, CT, described common traditional practices and beliefs in the Puerto Rican community, including the role of maintaining balance, harmony and spirituality in health. "Biomedical beliefs can exist by side with cultural beliefs," Dr Pachter said. "In fact, santiguadoras (healers) often tell parents to take a child to a doctor before seeking folk medicine treatments".

"Physicians should become aware of commonly held ethno-medical beliefs, assess the likelihood that a particular patient may act on these beliefs during care, and find ways to coordinate these beliefs with medical care," Dr. Pachter said. He also stated that he introduces discussion on these remedies by mentioning that he has heard some people sometimes use these types of practices and asks the patient what he or she thinks about this.

Denise Cora-Bramble, MD, FAAP, Director, Division of Community Health, George Washington University, reported on traditional medical practices among African Americans. "It is important to remember that in many instances, traditional cultural practices are consistent with current health practices", Dr. Cora-Bramble said. "Pediatricians should include tradiltional health practice-related questions in patient histories and form therapeutic alliances. Come to the point where what you are prescribing therapeutically is acceptable to the patient and the parents in terms of their cultural traditions." She also emphasized the primary need to "do no harm", and to discourage only those cultural practices where there might be a medical contraindication.

Joseph Jacobs, M.D., Director of Vermont Health Access and Department of Corrections, Waterbury, VT, spoke on Native American traditional medicine. "Communication is the key to gaining trust', he said. "Dialogue with the family and the child to learn the extent of their beliefs in their traditional indigenous culture and be certain not to obstruct their spiritual needs."

This special presentation was sponsored by the AAP Committee on Native American Child Health, the AAP Committee on Community Health Services, and the AAP Section on Community Pediatrics. □

[Reprinted, with permission, from the CATCH QUARTERLY, Winter 1997]

Senior Notes

Bob Grayson, M.D.
Past Chair, Senior Section.

It has been several months since the last mention of the Senior Section of the AAP. The Senior Section (Section on Seniors, as it is named) is well established after its initial four years. There are new officers; Herb Winograd of Phoenix is the new Chair, and Bernard Feldman of Las Vegas and Avrum Katcher of Flemington, NJ have replaced Allan Coleman and Bob Grayson on the Executive Committee. The new Executive Committee will meet on Saturday, May 10 in San Diego. The next general meeting of the Section will be in New Orleans at the time of the Annual AAP meeting.

The Section last met at the time of the Boston Annual Meeting, November 1996, attended by about 125 members and guests. The general topic was that of financial and estate planning, a summary of which appeared in the January Senior Bulletin. The subjects of the 1997 meeting in New Orleans will include a report on the AAP Education II Task Force by Jimmy Simon, financial planning for travel, and panel sessions on professional education abroad while traveling and travel for enlightenment and enjoyment. It is hoped that many Floridians will attend because of the proximity of the meeting site. Members and guests are welcome.

The initiative of historical archiving is progressing well. Oral histories have been recorded on 15 prominent older pediatricians, and will be transcribed as soon as funds become available. The Section on Perinatology will fund the important neonatal interviews, and Procter and Gamble is funding the video interview of Berry Brazelton. A very worthy contribution to the Academy by any Senior or group of Seniors could be made to the Department of Development designated for oral history transcription. As the practice of medicine changes, it is important to record the past. I challenge the Florida Chapter and any part of the medical establishment to make this possible through your contributions.

Another activity with which the Seniors are actively involved is that of legislative advocacy. No group has done this better than the Florida Chapter, but the need is greater now than ever. Changes in federal and state budgets, attitudes, and legislation have threatened adequate health care for many children. We Seniors may be in the best position to advocate, by virtue of our political contacts, by our long experience in the delivery of health care to children, and by the fact that we may have more time to participate. Consult with our Chapter officers, with the Washington AAP office (202/ 347-8600), and volunteer your help.

Lastly, just as the National Academy found out that state chapters were necessary to change policy to actions, we Seniors need to establish State and local groups to implement our goals. There is still need for a Senior, or Seniors. to assume the role of organizing a Florida Senior Section to move things along. I would hope that of all the seniors here, there might be one or several who would assume s leadership role. If any of you are so moved, please contact me and I can start you off with suggestions. □

AAP Health Care Access Objectives

[The Department of Government Liaison of the American Academy of Pediatrics has provided the following list of AAP Health Care Access Objectives, as a guide to members in approaching their legislators. These objectives provide the backbone for all legislation we support.]

Health Care for all Children

All children should have access to age appropriate, quality health care. Health insurance coverage should be extended to children (through age 21) who currently do not have private health insurance and are not eligible for Medicaid. Families should receive income-based assistance for obtaining health insuranace for children.

Age Appropriate Benefits - Quality Care for all Children

For a health insurance plan to qualify for purchase with a federal subsidy, that plan must offer coverage for preventive care, traditional major medical care, and care for children with special needs, including case management services as outlined by the AAP. Qualifying plans should require no cost sharing for preventive services.

A Pluralistic System with Public and Private Insurance

All children need financial access to quality health care. A new system to help finance health insurance for children from lower income families should serve as a complement to the Medicaid program and existing private and employer sponsored insurance. No child should lose or have diminished coverage as a result of this process.

Choice for Patients and Physicians

Parents who purchase health insurance on behalf of their children with newly provided subsidies, should have the ability, within reasonable limits, to choose their children's physician and health plan. Additionally, physicians should not be forced to contract with one particular plan in order to provide care to newly insured children. Access to pediatric subspecialty care is a must.

Market Determined Compensation: Commitment to Cost Containment

In order to maintain the viability of pediatric delivery systems for all children, compensation should be market determined rather than government controlled. Physicians and other providers must recognize cost containment as a major goal.

Administrative Simplicity

Administrative burdens should be reduced for families, state and feveral government, physicians, hospitals and all other health care providers. Less time filling out paper work equates to more time providing direct quality care to patients, further lowering the cost of care.

Acetaminophen Toxicity

(◂ continued from page 6)

APAP is the first degradation product in the metabolism of phenacetin. All are marketed around the world as paracetamol. They have common analgesic and antipyretic properties and common target organs of toxicity, the liver and kidneys (common to most analgesics including aspirin). Interactions list the interference of phenothiazine in thermoregulation when used concomitantly with APAP under special circumstances. Phenobarbital is felt to enhance acetaminaphen hepatatoxicity. APAP alone is reported to cause hepatic and renal damage due to cumulative toxicity when used in excess of 90 mg/kg/day.[4]

Presently, the availability of n-Acetylcysteine (Mucomyst) proves effective in early diagnosed and milder cases of overdose, making early diagnosis of overdose imperative. This should take into consideration that during the first 48 hours symptoms are few though liver function tests reveal liver damage in the second 24 hours.

APAP is prescribed widely as an analgesic/antipyreretic in children, with near impunity. Many of the new brands and packages do not relate directly to APAP content, e.g., Alkaseltzer, Sudafed, Dimetapp suspension, Children's Panadol, etc., thus weakening the effectiveness of some warnings! It is reported to cause hepatic and renal damage due to cumulative toxicity when used in excess of 90 mg/kg/day.[4] There are no guidelines for use in children under 1 month of age, and it is recommended to be given only with physician advice under the age of two years. As I recall from practice days, this was the time of highest incidence of febrile episodes and discomforts. (Disregarding the OTC medications and their inherent dangers, there are parental difficulties in administration of the prescribed 0.4 ml (40 mg) to the infant under 3 months.) One study audited daily prescription charts of inpatients without hepatic or renal disease over a period of two months[4]. The maximum daily dose was calculated for each child and noted only if the dose exceeded 90 mg/kg/day. The trend was to use lower doses in the younger age group. More practitioners either did not use or did not know safe dosing schedules in children 3 months and younger. There were 823 prescriptions for infants >= 4 months, 85 for infants <=3 months and seven for <2 week old neonates. *(Glucuronidation is the primary metabolic pathway found deficient in the neonate with some other drugs).*[5] In the children 4 months and over, 25 of 140 prescriptions exceeded 95 mg/kg/day and two of six given to infants 3 months and younger. Perhaps the Rule of Six did not hold in this age group. 17% of prescriptions were above 95 mg/kg/day, although on 3% of children received these doses due to on-demand charting.

The literature reveals many studies evaluating many chemical compounds (including watercress) that may offer therapeutic value in APAP overdose..

SUMMARY

1. A commonly used medicine across all age groups may not carry the safety attributed.
2. The possibilities of renal and hepatic damage are real with overt or covert overdose.
3. Special warnings are issued in the case of concomitant use of alcohol, common in the contemporary adolescent.
4. The literature cautions that a pediatric dose below 95 mg/k/day should be maintained to avoid possible toxicity.
5. Early implementation of N-acetylcysteine therapy is most beneficial.
6. Some observers suggest these reports of acetaminophen hepatotoxicity may be the tip of the iceberg, since chart review is unreliable; aggressive antipyresis may result from

'fever phobia'. They also remind us that 19.6 % of US adults have reading skills below fifth grade level and that dosing instructions must be clear and understandable.[6] *(So too with physicians' instructions! cfw)*

References

1. Rivera-Pinera T et al J Pediat 130:300-304, Feb 1997
2. Weiss CF Pediatr 52, Dec 1973
3. Goulding R Pedatr 52. Dec 1973
4. Anderson B, Anderson M, Hestle B. NZ Med J 109: 376-378, 1960
5. Weiss CF et al. Chloramphenicol in the Newborn Infant. NEJM 262:287-294, 1960
6. Heubi JE, Rein JP. Personal communication, in Pediatric Notes, 21, No. 11, 1997 □

President's Message

(◂ continued from page 1)

Smith, and Lucian DiNicola are in Washington meeting with our national legislators and, under the wing of Jackie Noyes, the AAP Washington representative, learning their way around the halls of Congress. And we continue to be grateful for the efforts of Dr. (and Mrs.) Gerry Schiebler, Nancy Moreau, Paul Wharton, Reed Bell, Rick Bucciarelli, Louis (and Judy) St. Petery, and many others who have managed to find the time and interest to work the System.

Finally, let me remind you of the Annual Meeting and retreat in September, with the hope we will see you there for an exciting Scientific Program, to hear issues you would like to discuss, and to relax and meditate on plans for the future. □

Edward T. Williams III, M.D.
President

MEMBERSHIP ALERT!

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

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

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

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

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

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

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

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

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

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

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

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

FLORIDA DEPARTMENT OF HEALTH

Tuberculosis Program Managers and Surveillance Coordinators

Area	Counties	TB Manager	TB Surveillance Coordinators
1	Escambia Santa Rosa Okaloosa Walton Bay	Bill Morris Bureau of Disease Intervention 1317 Winewood Blvd, Bldg 6, Room 402-A Tallahassee, FL 32399-0700 (904)487-6597 or SC 277-6597 FAX (904)414-0038 or SC 994-0038	John Menge BayCounty Health Department 17109 Panama City Beach Pkwy Panama City, FL 32413 (904)233-5175 or SC 770-5175 FAX SC 770-5167
2	Holmes/Liberty Washington/Franklin Jackson/Leon Calhoun/Wakulla Gulf/Jefferson Gadsden/Madison Taylor	Bill Morris Bureau of Disease Intervention 1317 Winewood Blvd, Bldg 6, Room 402-A Tallahassee, FL 32399-0700 (904) 487-6597 or SC 277-6597 FAX (904)414-0038 or SC 994-0038	John Menge Bay County Health Department 17109 Panama City Beach Pkwy Panama City, FL 32413 (904)233-5175 or SC 770-5175 FAX SC 770-5167
3	Hamilton/Suwannee Columbia/Union Lafayette/Gilchrist Dixie/Levy Alachua/Bradford Putnam	Chuck Pearce 1000 NE 16th Avenue, Box 19 Gainesville, FL 32601-4598 (352) 955-2289 or SC 625-5789 FAX (352) 955-5775 or SC 625-5775	Laurey Gauch 2801 Kennedy Road Palatka FL 32077 (352)329-0420 or SC 869-0420 FAX (352) 329-0401 or SC 869-0401
4	Baker Nassau Duval Clay St. Johns	Don Bertram 900 University Blvd. N, Suite 506 Jacksonville, FL 32211 (904) 630-3300 x 4063 or SC 853-3300 FAX (904) 745-3011 or SC 882-3011	Richard Doggett 900 University Blvd N. Suite 506 Jacksonville, FL 32211 (904) 630-3300 or SC 8533-3300 x 3338 FAX (904) 630-3231 or SC 853-3231
5	Pasco Pinellas	Rob Berger Pinellas County Health Department PO Box 13549 St. Petersburg, FL 33701 (813) 824-6900 or SC 539-6900 x2270 FAX (813) 893-5600 or SC 594-5600	Lori Johnson Pinellas County Health Department 500 7th Avenue S., 4th Floor St. Petersburg, FL 33701 (813) 824-6900 or SC 539-6900 x 2398 FAX (813) 893-5600 or SC 594-5600
6	Hillsborough Manatee	Bill Hite 4000 Martin Luther King Blvd. Tampa, FL 33614-9990 (813)871-7173 or SC 542-7173 FAX (813)873-4751 or SC 542-4751	Adelbert Jones Hillsborough County Health Department 1105 E. Kennedy Blvd. Tampa, FL 33602 (813)272-6200 or SC 543-6200, x 4036 FAX (813) 272-7169
7	Seminole Orange Osceola Brevard	John Miller 400 W. Robinson, Suite 912-S Orlando, F 32801-1782 (407)245-0460 or SC 344-0460 FAX (407) 245-0580 or SC 344-0580	Rick Stevens Orange County Health Department 832 W. Central Blvd. Orlando, FL 3280055-1895 (407) 836-2531 or SC 356-2531 FAX (407) 836-2519 or SC 356-2519
8	Sarasota DeSoto Charlotte Lee/Collier Glades/Hendry	Winnie Holland 2295 Victoria Avenue Ft. Myers, FL 3301 (941) 338-1565 or SC 722-1565 FAX (941) 338-1676 or SC 722-1676	Bonnie D'Artagnan TB Control Regional Service Ctr. P.O. Box 60085 Ft. Myers, FL 33906 (941)338-1247 or SC 722-1247 FAX (941)338-1250 or SC 722-1250
9	Palm Beach	Jim Cobb Palm Beach County Health Department 301 Broadway Riviera Beach, FL 33404 (561) 882-3263 or SC 263-3263 FAX (561) 845-4467 or SC 263-4467	Juan Ortiz Palm Beach County Health Department 301 Broadway Riviera Beach, FL 33404 (561) 882-3243 or SC 263-3243 FAX (561) 845-4467 or SC 263-4467
10	Broward	Marie McMillan Broward County Health Department 2421 SW 6th Avenue Ft. Lauderdale, FL 33515-2613 (954) 467-4816 or SC 453-4816 FAX (954) 467-4934 or SC 453-4934	Kesner Accime Broward County Health Department 2421 SW 6th Avenue Ft. Lauderdale, FL 33515-2613 (954) 467-4880 or SC 453-4880 FAX (954) 467-4898 or SC 453-4898

Tuberculosis Program Managers
(◂continued from previous page)

11	Dade Monroe	Ann Zani, R.N. Dade County Health Department 1501 NW North River Drive - (DCMA Bldg.) Miami, FL 33125 (305) 325-3687 or SC 473-3687 x 101 FAX (305) 325-3241 or SC 473-3241	Sherry Moss Dade County Health Department 1350 NW 14th Street Miami, FL 33125 (305)324-2462 or SC 473-2462 x 3011 FAX (305) 324-5959
12	Flagler Volusia	Marguerite Runyon Volusia County Health Department P.O. Box 9190 Daytona Beach, FL 32120 (904)947-3425 or SC 380-3425 FAX (904) 947-3468 or SC 380-3468	Richard Doggett Duval County Health Department 900 University Blvd. N., Suite 506 Jacksonville, FL 32211 (904) 630-3336 or SC 853-3336 x 2383 FAX SC 853-3219
13	Marion Citrus Hernando Sumter Lake	Johnny Lloyd 1601 W. Gulf Atlantic Hwy. Wildwood, FL 34785 (904) 330-6268 or SC 895-6268 FAX (904) 330-1357 or SC 895-1357	Johnny Lloyd 1601 W. Gulf Atlantic Hwy. Wildwood, FL 34785 (904) 330-6268 or SC 895-6268 FAX SC 668-1375
14	Polk Hardee Highlands	Don Biemiller 1290 Gulfview Avenue Bartow, FL 33830 (941) 533-4276 or SC 520-4276 FAX (941) 534-7046 or SC 549-7046	Bill Gaudet 1749 Holt Road Auburndale, FL 33823 (941) 965- or SC 577-6259 FAX SC 577-6262
15	Indian River Okeechobee St. Lucie Martin	Judy Maughn St. Lucie County Health Department P.O.Box 580 Fort Pierce, FL 34950 (407) 462-3864 or SC 259-3864 FAX (407) 462-33865 or SC 259-3865	

State Professional Relations Officers in Florida
(see related article, page 7)

Name Title	Phone FAX*	Agency/DDS Mail Address
DeLeo, John Professional Relations Officer	813-975-4222 813-975-4817*	Office of Disability Determinations 3450 W. Busch Blvd, Suite 395 Tampa, FL 33684
Drake, James Professional Relations Officer	407-897-2970 ext.220 407-897-6497*	Office of Disability Determinations 3438 Lawton Rd., Suite 127 Orlando, FL 32803
Duque, Maria Professional Relations Officer	305-596-3020 305-596-3035*	Office of Disability Determinations 9495 Sunset Dr. Suite B-100 Miami, FL 33173
Hudson, Bill Professional Relations Officer	904-390-4600 904-390-4622*	Office of Disability Determinations 4140 Woodcock Dr., Dew Bldg. Jacksonville, FL 32202
Kemp, Ann Professional Relations Officer	904-488-9060 904-487-6775	Office of Disability Determinations Building 2, Suite 301 2729 Fort Knox Blvd Tallahassee, FL 32399-2350
Rumbley, Bob Professional Relations Officer	904-488-3870 904-921-8579	Office of Disability Determinations Ashley Building, Room 100 1321 Executive Center Dr., East Tallahassee, FL 32399-2350

F.Y.I.

At the October meeting of the Florida Board of Medicine, changes were made in the requirements for biennial license renewal. These requirements are detailed below.

For biennial license renewal:

40 hours Category 1 CME - Total

1 hour must be in HIV/AIDS

Up to five (5) hours MAY be in Risk Management. This will not be a requirement for license renewal. Should a physician attend a Board of Medicine meeting, he/she will receive five (5) hours of credit.

1 hour in Domestic Violence (need not be Category 1; "approved by any state or federal government agency, or national affiliated professional association, or any provider of Category 1 or 2 AMA Continuing Medical Education.")

Initial licensees:

Risk Management is not required for license renewal with the exception of initial licensees. They must complete one hour during the first biennium of licensure as well as three (3) hours HIV/AIDS and one (1) hour Domestic Violence. Initial licensees are exempt from the 40 hour requirement for the first biennium of licensure and only need the mandated hours. □

FYI

A letter received by Dr. Edward Zissman, Chairman, Committee on Child Health Financing and Pediatric Practice:

Dear Dr. Zissman:

The purpose of this letter is to update you on the Comvax immunization code. As you recall, in February the local code W2172 was developed for this immunization. The description reads: "immunization, active; Haemophilus Influenza B (HIB) and Hepatitis B (HBV) combined".

We have just become aware that HCFA has developed a temporary HCPCS code for Comvax - Q0158. That code became effective March 1, 1997, and will remain in effect until January, 1998. The 1998 CPT will contain a "real" procedure code for this immunization. Until January 1, 1998, BCBSF will accept either code W2172 or code Q0158. Hopefully, this will eliminate confusion for those physicians who have already set up their billing system with W2172.

The systems changes required to ensure these codes are properly processed under BCBSF's well child benefit have not yet been implemented. Until those changes occur, the codes will process, but the well child specifications (such as non-deductible) will not be systematically applied. I apologize for the continued inconvenience.

Finally, I've accepted different responsibilities within BCBSF, so I will no longer be contactfing you with society issues. My replacement is Karen Evans, Senior Health Services Analyst. Her telephone number is (904) 363-5960; her address is the same as mine, below. I have enjoyed our association, and appreciate the time and attention you've provided.

Thanks.

Sincerely,

Alicia Rothschild
Senior Health Services Analyst
Blue Cross Blue Shield of Florida
8657 Baypine Road, HCS
Jacksonville, FL 32256

[Dr. Zissman adds: "reported reimbursement is "reasonable" - increased from initial inadequate reimbursement for this vaccine. Other companies are being surveyed]. □

Please Note: **Visit our temporary web site on the internet:**

http://otto.cmr.fsu.edu/~stpete_l/fps.html

Women in Pediatrics

(◂ continued from page 15)

American Academy of Pediatrics
Practice Characteristics of the Membership
Male versus Female 1994

Average Percent of Time in General Pediatrics and Subspecialties*

General Pediatrics:	Male: 63%	Female: 70%
Subspecialty:	Male: 37%	Female: 30%

Patients' Source of Payment*

Private/Commercial:	Male: 58%	Female: 61%
Medicaid:	Male: 35%	Female: 30%
Uninsured:	Male: 9%	Female: 9%

Average Number of Hours per Week in Professional Activity*

	Male	Female
Self-employed:	20	10
Salaried:	19	28
Administration:	6	4
Academic medicine:	5	5
Research:	3	2
Fellowship Training:	4	4

Percent of Pediatricians in Age Groups*

	Men	Women
≤ 29 years	6%	14%
30-39 years	28%	45%
40-49 years	33%	28%
50-59 years	20%	12%
≥ 60 years	13%	1%

Average Distribution of Payment System Type Among Insured Patients (Public & Private)**

	Male	Female
Managed Care (HMO,PPO,IPA,etc)	55%	61%
Non-Managed Care Traditional Fee for Service	45%	38%

* Source: American Academy of Pediatrics, Division of Child Health

UPCOMING CONTINUING MEDICAL EDUCATION EVENTS

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

Program: Practical Pediatrics
Dates: May 23-25, 1997
Place: Sanibel Harbour Resort and Spa, Sanibel Island FL
Credit: Hour by hour for Category 1 for AMA Physicians Recognition Award
Sponsor: American Academy of Pediatrics
Inquiries: AAP, call 1-800-433-9016, ext 7657 or 6796

Program: Practical Pediatrics
Dates: June 20-22, 1997
Place: The Capital Hilton, Washington, DC
Credit: Hour by hour for Category 1 for AMA Physicians Recognition Award
Sponsor: American Academy of Pediatrics
Inquiries: AAP, call 1-800-433-9016, ext 7657 or 6796

Program: 21st Annual Florida Suncoast Pediatric Conference
Dates: June 27-29, 1997
Place: Trade Winds Resort, St. Pete Beach, Florida
Credit: 15 hours Category 1 for AMA Physicians Recognition Award
Sponsor: University of South Florida College of Medicine Department of Pediatrics and All Childrens Hospital
Inquiries: Ms. Penny Rowe, ACH Conference Administration (813)892-8834

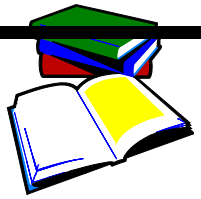
Program: Pediatrics for the Primary Care Physician
Dates: June 27-29, 1997
Place: Amelia Island Plantation, Amelia Island, Florida
Credit: 14 hours Category 1 for AMA Physicians Recognition Award
Sponsor: Nemours Children's Clinic
Inquiries: Sheryl Trammell, Continuing Education Coordinator (904)390-3638

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

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

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

Program: Space Coast Pediatric Conference
Dates: September 26-27, 1997
Place: Melbourne Beach, FL
Credit: 10 hours for Category 1 for AMA Physicians Recognition Award
Sponsor: University of South Florida and Holmes Regional Medical Center
Inquiries: Ms. Rebecca Scott (813)272-2744 or FAX (813)272-2749



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