The Florida Pediatrician

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

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In this issue.....

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COMMITTEE STRUCTURE

Key Strategic Plan Chairmen

Advocacy Committee

Dear Colleagues:

Congratulations to all of you who wrote letters, sent emails and picked up the phone to weigh in on the proposed physician Medicaid budget reductions which surfaced during the last special session of the legislature. As most of you know Medicaid Physician Fee Reimbursement was scheduled to take three cuts: 1) a 33% reduction in the case management fee under MediPass; 2) a 1% across the board reduction in the Medicaid Physician Fee schedule; 3) elimination of the special fee increase for the 0-21 age group. Because of the rapid and sustained response from our membership all three of these proposed cuts were reversed. Without a doubt these contacts were key in getting the message to the legislators: pediatricians must be appropriately compensated in order to continue to ensure access to care for children. However, we will not stop here. Rest assured that the Florida Chapter of the American Academy of Pediatrics reaffirms its resolve to work on this issue until payment for Medicaid equals that of Medicare for the 0-21 population. Once we achieve this we will work with the rest of our physician colleagues and the FMA to ensure that all physicians providing services to Medicaid program patients are reimbursed at least at the Medicare level.

* * * * *

...all three of these proposed cuts were reversed...

* * * * *

As we are preparing for the regular 2002 legislative session, physician reimbursement is the number one budgetary issue on our list. Nevertheless we will continue to work to protect other programs important to children such as those within Children's Medical Services and KidCare.

We will also work diligently on several non-budgetary items. Topping the list is the restructuring of the KidCare program so that there is a single point of entry for all the programs under KidCare and a single office within state government responsible for eligibility determination and setting standards. The Florida Chapter of the American Academy of Pediatrics is pleased to work with Representative Jerry Maygarden (R-District 2) and Senator Steve Wise (R-District 6) as major co-sponsors in the House and Senate of our efforts. We recognize that this is a daunting task, particularly during this legislative session, however, we feel that streamlining of the KidCare program is essential if we are going to retain and attract new pediatricians into the KidCare program.

The Florida Chapter of the American Academy of Pediatrics' legislative impact is a direct result of the legacy and reputation upon which this Chapter has been built. It is my great pleasure to inform you that this year the Florida Chapter will receive an AAP award for Chapter Excellence for 2001. This award, a testimony to Dr. Ed Zissman's leadership over the past two years, will be presented during the 2002 District meeting which is scheduled to be held in Orlando. In addition, I was very pleased to learn that Dr. Gerold Schiebler will receive the AAP's Special Achievement Award recognizing, his outstanding work for the American Academy of Pediatrics, for guiding child health care policy and advocacy in the State of Florida for over 30 years and serving as an outstanding educator and mentor. Finally, Dr. Louis Cooper, President of the AAP will be the Gerold L. Schiebler lecturer at this year's combined meeting of the Florida Chapter AAP and Florida Pediatric Alumni Association meeting, June 21-23, 2002 in Orlando.

*(See **President**, page 23 ▸)*

FPIC ad

A New Year - and New Year's Resolutions

Not long ago, the year "two thousand and anything" seemed a world away. However, the third "two thousand and..." is upon us. Like so many others, I have, over the years, made - and forgotten (but of course never broken!) many resolutions.

With all that is transpiring now, a few new resolutions are in order for 2002. Let's try:

Number 1 - Improve the lot of children. For this, we must push for and support as many programs for our children - and the world's children - as we possibly can. This will require commitment by each of us to be proactive in contacting whoever is leading a particular drive. This fits with our Academy's emphasis as advocates for children.

...the lot of children...

Number 2 - Improve the lot of the pediatrician. It can be argued, and correctly so, that pediatricians are helped when children are helped, and this is true. However, in the present era, we must not lose sight of the well-being of the pediatrician and the family he or she has opted for and/or which has opted for him. Since our financial well-being is often related to state budgets, we must be vigilant and must support our Legislative Committee in its constant work in Tallahassee.

...the lot of the pediatrician...

Number 3 - Improve the system. It can be argued that number 1 + number 2 = number 3. To a degree, this is true. However, the "system" is there: the HMO. For years now, we have included in this newsletter a column on "Managed Care", attempting to present both sides. My resolution requests that those who support the system be active in so-doing, that those who think it needs to be refined should be active in so-doing, and that those who feel it should be changed completely be active in so-doing. Only by these means can we have meaningful colloquy and effect any necessary changes.

...the system...

And Number 4 - Improve as necessary our view of diversity. Pediatricians are by nature understanding people. We know that tolerance - be it ethnic or religious - is not really a desirable quality. Tolerance suggests putting up with something we really do not like or agree with. Acceptance of diversity is desirable, since it means that we agree that the other person has a right to his heritage and/or religion. We must do all we can to spread this view, and to assure that all with whom we communicate get this message.

...diversity...

Happy New Year, and Successful Resolutions!

Herb Pomerance
Editor□

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THE REGIONAL REPRESENTATIVES REPORT

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

Region IV reports:

Region IV of the Florida Chapter of the AAP has experienced a 9% increase in membership for the period of January 2, 2001 to October 31, 2001. There are now 298 members residing in Region IV. FCAAP dues are current for 266 members. A Region IV representative has attended all monthly and quarterly meetings held by FCAAP executive leadership during the past year. During the recent special legislative session Region IV membership was active in contacting our state legislators to assure that the FCAAP point of view was heard. We anticipate continued budget threats from the legislature that may lead to decreased access for patients as interim committee meetings are scheduled to resume the week of January 7, 2002 and the next regular session starts on January 22, 2002.

Regional educational activities continue in several venues led by the Central Florida Pediatric Society. Community Pediatricians in the greater Orlando area meet regularly to share ideas, network, and learn about topics important to Pediatrics. For example, in recent meeting members received an update on the impact of bioterrorism in the care of children. The Region 4 IV membership has been notified as to the upcoming annual meeting of the FCAAP to be held June 21-23, 2002 at the Grosvenor Hotel in Lake Buena Vista and the availability of 9 CME credits as part of the meeting package.

Pediatric Residency outreach: Five ORH Pediatric Residents participated in the FCAAP web-based bulletin board for job listings and three were contacted by interested practices.

Reach Out and Read - Orlando, a resident run volunteer project, reached a milestone of distributing 5000 new or gently used books to indigent children. Established two years ago, the program promotes early literacy through a three-step approach:

- Volunteers read to children in the clinic's waiting room and model reading to parents.
- Pediatric residents inquire about age-appropriate developmental skills and advocate reading in the home.
- A new book is provided at health maintenance visits.

The program was recently awarded a $1350 grant from Central Florida Homebuilders' Association as well as a national sustainability grant of $2000. All monies received are used for the purchase of books to be distributed.

The ORH Pediatric residency program will be expanding in the coming year and is seeking to recruit 12 residents per year. The interviewing of prospective pediatric interns is nearing a conclusion.

Concerning local PROS: The Orlando Regional Healthcare Pediatric Outpatient Clinic and Nemours Children's Clinic have fielded a PROS team to join a national collaborative to improve the care of children with ADHD. They are among eight PROS practices nationwide developing and testing tools for the evaluation and management of ADHD.

David E. Milov, Regional Representative
Lloyd Werk. Alternate Regional Representative☐

Region VIII reports:

The University of Miami has a new President, Donna Shalala, the past Secretary of Health from the Clinton Administration. She has stated as part of her inaugural address and mission statement that her goal is to raise the University of Miami's Medical School to one of the top ranking Research Universities in the country. A major fundraising campaign will soon be announced to initiate this process.

The Chairman of the Department of Pediatrics at the University of Miami, Dr. R. Rodney Howell has announced his resignation after more than 10 years as Professor and Chief of the University Department of Pediatrics and clinical pediatric service at Jackson Memorial Hospital. A Search committee, chaired by Dr. Robert Quencer has been charged by the Dean to begin the recruitment process. Nominations as well as expressions of interest are welcome and encouraged.

The Greater Miami Pediatric Society remains active and serves as the coordinating program for Miami Pediatricians and the Cuban Pediatric Society in Exile. Quarterly business meetings with guest speakers, dinner, and social activities keep this society motivated and invigorated.

Early Intervention Programs (EIP's) that provide assessments and coordinate intervention services for infants from birth through 3 years of age are established at Miami Children's Hospital serving the South side of Miami-Dade County, and at the Mailman Center for Child Development, serving the North section of the county. These programs provide assessment and referral services to over 3000 infants each year.

Active efforts to maintain membership in the FPS and AAP by Region VIII pediatricians are continuously underway, as well as recruitment of new members. This effort is spearheaded by the Region 8 Alternate Regional Representative, Kimberly Schwartz, M.D.

All in all, Pediatrics is thriving in Region VIII.

Charles R. Bauer, M.D.
District 8 Representative☐

Note:

Visit our society's permanent website at:

http://www.fcaap.org

for all you want to know about our society, including a summary of The Florida Pediatrician.☐

Note:

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

http://www.aap.org/member/chapters/florida.htm. ☐

Report of Section on Women

American Academy of Pediatrics
Committee on Pediatric Workforce
Subommittee on Women in Pediatrics

WOMEN IN PEDIATRICS

Steps to Getting Involved in the American Academy of Pediatrics

Start gradually and learn the ropes:

- Belong. Join and maintain your membership in the national AAP, your local chapter, and a committee or section.
- Be informed. Know where the Academy and your chapter stand on major issues. Be aware of national and local initiatives addressing these issues. Find out how the organization is structured, decisions are made, and money is allocated.
- Be known. Make a special effort at the next Academy or chapter meeting to introduce yourself to other attendees. Speak with 2-3 influential leaders.
- Be heard. Attend a Women Pediatricians' Breakfast Forum at an AAP Annual or Spring Meeting. Share your views with your peers--someone will benefit from it.
- Be active. Build up your "volunteer" muscles slowly. Volunteer to work on an Academy initiative or a chapter project, such as organizing a Breakfast Forum for your chapter.

Take on leadership responsibilities. Set your own pace. Make sure the projects are specific, manageable, and yield results.

- Be published. Publish a paper in a peer-reviewed journal. Write an article for AAP News or your chapter newsletter on a subject about which you care.
- Be recognized. Look for ways to get your message and your name recognized among both the leaders and the membership. Write well-crafted and substantive letters telling your colleagues about your ideas. Speak at the chapter meeting. Become part of a peer network.
- Be a mentor. "Adopt" a first-year resident. Provide encouragement, advice and support to a woman physician just starting out. Find opportunities to talk to medical students about the importance of pediatrics and the factors that influenced your specialty choice.

Gather momentum and take your place in Academy leadership positions.

- Be involved. Get appointed to a committee on the chapter level for which you may have a long-term national aspiration.
- Be a liaison. If you are involved in another volunteer organization, look for ways to link it to the Academy on child health issues. You may help your chapter forge a new coalition on your volunteer investment. Obviously, make sure you are not placed in a conflict of interest position.
- Be essential. If leadership positions are at a premium in your chapter, you may need to begin with an essential but less glamorous volunteer activity, such as recruiting new members. It may appear as a lot of paperwork, but it is an excellent way to build name recognition among prospective and new members and to establish yourself as an important contributor to the growth of your chapter.

Work to Effect Change Through Active Participation and Creative Supportive Problem-Solving.

- Be influential. Get on the chapter nominating committee. This strategic placement could make your chapter more deliberate in considering qualified women for chapter leadership positions.
- Be a leader. Submit your name for nomination to an Academy committee. Run for chapter office. Don't be afraid of an unsuccessful bid…just try again.
- Be a positive force. Substitute complaints with proactive efforts to effect change. □

Shakra Junejo, M.D.
Appalachicola, FL

The American Academy of Pediatrics (AAP) Launches a New Web Page For and About Women in Medicine/Pediatrics

The AAP Committee on Pediatric Workforce (COPW) Subcommittee on Women in Pediatrics addresses topics related to the influence of gender on the pediatric workforce. The Subcommittee is pleased to announce its new Web page, sponsored by an educational grant from Beiersdorf, Inc. "This Web page contains a wealth of resources on women in medicine issues," notes COPW Subcommittee Chair, Debra R. Sowell, MD, FAAP. Visitors will find links to other organizations, AAP policy on the prevention of sexual harassment, and an on-line version of the *Women in Pediatrics Resource Packet.*

All Academy members are encouraged to take a moment to complete the short, 3-question survey on employment patterns that can be found under the heading, "Tell Us What You Think About. . . " The results of this survey and new questions will be posted every few months.

Please visit the Subcommittee on Women in Pediatrics' Web page at

www.aap.org/womenpeds □

Report

Since its inception, PROS has studied child health topics as diverse as the prevalence of preschool vision screening (*Pediatrics*, 1992; #89: 834-838), the onset of secondary sexual characteristics in young girls (*Pediatrics*, 1997; #99:505-512 and 2001: #108:347-353), the immunization status of children seen in private practice (Arch Pediatr Adolesc Med 1996; #150:1027-1031), the treatment of pediatric patients with psychosocial problems by primary care providers (*Pediatrics* electronic pages 2000: 106(4): e44) and the coordination of referrals to specialists (*Arch Pediatr Adolesc Med* 2000; 154: 499-506). The network is currently working on a variety of projects, including studies on the readiness of mother and newborn for postpartum hospital discharge, the diagnosis of child abuse in pediatric practice, patient safety, and the prevention of child violence.

The Orlando Regional Healthcare Pediatric Outpatient Clinic, with the help of Nemours Children's Clinic, has embarked on a critical quality improvement project; Our Orlando group and 7 other PROS practices across the U.S. are developing and testing tools to streamline and improve the diagnosis and management of ADHD as part of a National Initiative for Children's Healthcare Quality collaboration. The AAP anticipates the product (an ADHD toolkit) will be a useful resource for all pediatricians.

In an update from previous columns: 100 more practices are needed for the ambitious Life Around Newborn Discharge (LAND) study. This landmark study on the dynamics of physician decision-making and family care needs in an infant's first month is entering its final months of recruitment. Call 1-800-433-9016, extensions 7626 or 7867 to help inform newborn care.

Check out **PROS Pearls** (clinically relevant findings summarized from PROS studies), a feature of the AAP-PROS website (www.aap.org, click on Research and then Pediatric Research in Office Settings). For example: Reexamination of data from a 1997 PROS study on the emergence of puberty in young girls indicates that increased body-mass index (BMI), a measure of adiposity or fatness, is one factor associated with the earlier onset of puberty in girls - particularly in white girls. This applies not only to early breast development, but also to the early appearance of pubic hair, which hormonally is a distinct event. In addition, it appears that factors other than increased BMI - perhaps genetic and/or environmental ones - are needed to explain the higher prevalence of early puberty in black versus white girls.

New studies in the pipeline (child abuse recognition, describing the secondary sexual characteristics in boys, & a smoking cessation intervention for adolescents) will be recruiting practices soon. If you are interested in partnering at any level (enrolling patients to designing projects), contact us at pros@aap.org or through the AAP switchboard.

Respectfully submitted,

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F.Y.I.

FLORIDA WIC AWARDS NEW REBATE CONTRACT

Cheryl Miller
Florida WIC Program
Tallahassee, FL

Following an invitation to bid on the Florida WIC Program's infant formula rebate contract, **Nestlé USA** once again made the best rebate offer. **Nestlé USA** produces the **Carnation® Good Start®**, **Carnation® Alsoy®**, and **Carnation® Follow-Up®** brands of infant formula. They have held the rebate contract in Florida since February 1999, and the new three-year contract will go into effect in February 2002.

The Florida WIC Program receives rebates for all of the **Carnation®** formulas purchased at WIC authorized stores by WIC participants. The rebates result in savings to the Florida WIC Program of more than $50 million a year in formula costs. These savings are used to cover the food costs for serving approximately 100,000 additional WIC-eligible women, infants, and children in Florida each year.

If you have any questions regarding this issue, contact your local WIC office at the county health department or call the state WIC office at (850) 245-4202 or 1-800-342-3556.

WIC is an equal opportunity provider.

Kudos...

...to us, the Florida Chapter of the American Academy of Pediatrics, which will receive an Award of Chapter Excellence at the District X meeting this spring. We can all be very proud of our leadership!

A 'Typical" Day at the Office

Michael A. Middleton, M.D., Chief Resident
James M. Sherman, M.D., Professor of Pediatrics
Division of Pediatric Pulmonology and Residency Program Director
Department of Pediatrics, University of Florida

A Pre-article Quiz (self-graded)

- What is the first-line antibiotic treatment for 8 year old with pneumonia?
- When "everybody in the family has been sick" with a respiratory illness, is it more likely to be viral or bacterial? What are some clues to help you decide?
- What is so atypical about "atypicals"?
- Do we use macrolides too much?
- Do we use macrolides too little?
- How competent are you as a pediatrician at recognizing infections caused by "the Eaton agent"?

Case Presentation

It is wintertime, and your office, like other pediatric practices across the country, is busy. As you pick up the chart of the next patient to see, you notice that it is a 5-year-old male presenting because of a cough and fever – fairly typical for this time of year – and that the patient is new to your practice. The patient's mother says that her son began having symptoms approximately one month ago when he developed a cough and sore throat. At that time, he was seen by his prior primary care physician and was treated with amoxicillin. Mother says that he seemed to improve but then 2 weeks later again developed sore throat and cough, and this time the symptoms persisted and worsened. Three days ago, the boy started having fever up to 103° and started vomiting as well. Yesterday, the patient was seen at a local emergency department and a diagnosis of "viral illness" was made. Since then, the patient has been complaining of abdominal pain. While talking to the mother, you notice that she too has a cough, which she states she has had for about a week. When you ask about other members of the family being sick, she tells you that prior to this everyone has been fairly well except for her older daughter who had a "bad cough" 1-2 months ago.

When you examine the child, you find him to be somewhat ill-appearing but alert and in no apparent distress. He is tachypneic (RR 32). On auscultation of his chest, there are no crackles or wheezes but he does have decreased breath sounds posteriorly over the base of the right lung. His abdomen is soft and nontender, and the rest of his exam is normal as well. Your impression is that this child has pneumonia. As you are thinking this to yourself and preparing to share your impression with the mother, you suddenly have a flashback to your days as a resident and see one of your attendings asking you to name the most common etiologic agents and arguments for or against each. You try mightily to shake this mid-day nightmare out of your head, but being unable, you decide to answer the voice by saying …

One of the aspects of pediatrics that makes it interesting (and difficult at the same time) is our ongoing war against infectious diseases. Ideally, this war would be fought with weapons strategically directed towards the known offender; realistically, that is not always possible. This is particularly true with pediatric pulmonary infections since obtaining accurate and reliable cultures is usually not practical. Therefore, decisions as to what "weapons" to use must often be made without definitive identification of the enemy. Like a general drawing up a battle plan using knowledge of his enemy's previous tactics, our decisions regarding antibiotic selection are usually based on recognizing the most likely pathogen according to the differing aspects (often subtle) of the clinical presentation. The purpose of this article is to provide a review of *Mycoplasma pneumoniae* - a pathogen that seems to be 'making the pediatric headlines' more and more – and its role in pediatric respiratory infections.

Background

Almost 60 years ago (1944), the "Eaton Agent" was recovered from individuals with primary atypical pneumonia. (The term "atypical" referred to the predominance of generalized symptoms as opposed to just respiratory symptoms). This 'agent' was initially thought to be a virus and it was not until 20 years later that *M. pneumoniae* was identified and shown to be the etiologic agent of primary atypical pneumonia. (Having been found to be responsible for "atypical pneumonia", *Mycoplasma* and other agents such as *Chlamydia* have become referred to as "atypicals".) Even after this recognition, *M. pneumoniae* infection was thought to be relatively uncommon, and it is only in the last 25 years that its true prevalence has been appreciated.

In the world of pediatric infectious disease, *Mycoplasma* as a terrorist organization (actually a genus of the family Mycoplasmataceae) is not nearly as notorious as those other terrorist groups, *Staphylococcus* and *Streptococcus*. *Mycoplasma* are characterized by, among other things, their lack of cell wall (a characteristic that is important in understanding our enemy's vulnerabilities as will be discussed later). Interestingly, the name "Mycoplasma" refers to the tendency of the organism to have many different microscopic forms (pleomorphic nature), a trait due to this lack of rigid supporting structure. There are currently 10 *Mycoplasma* species that have
been found in humans, and clearly the head terrorist of the group at this point is *M. pneumoniae*.

(Continued next page ▸)

(◂ continued from previous page)

Epidemiology

M. pneumoniae infections occur year-round with no apparent seasonal distribution. This may be contrary to some clinicians' impression that it occurs more commonly in summer months. This "relative" summer predominance is most likely due to the fact that so many of the causes of pediatric respiratory illness are far less common during the summer. An analogy to illustrate this: if Mt. McKinley, the highest point is North America, was set among the Himalayas (the winter months), it would not seem particularly prominent; however, if Mt. McKinley was standing in the middle of the Sahara Desert (the summer months) it would seem quite a bit taller. The actual height of the mountain (seasonal incidence) is no different in either setting.

How useful is patient's age in determining the likelihood of *Mycoplasma pneumonia*? This has been commonly used as a clue, and it is important at this point to differentiate fact from fiction. Fact: *M. pneumoniae* is the number one cause of pneumonia in school-aged children (this is a take-home point!). Numerous studies have shown this to be true, and as will be discussed later, this has important therapeutic implications. When looking at age distribution of infection, the highest attack rate is 5-9 year olds and the 2nd highest group is 10-14 year olds. A dogma that has circulated through pediatrics is that *Mycoplasma* pneumonia is rare in children less than 5 year olds, and this is fiction. In fact, the attack rate in this age group is almost twice as high as in 15-19 year olds although not as high as in 5-14 year olds. The dogma may have some relative truth (remember Mt. McKinley) in that since there are so many other infectious respiratory diseases in young children (i.e. the mountains around it are taller), *Mycoplasma* constitutes a smaller percentage than in young adults even though the total number of cases is greater.

Previously, epidemics of *M. pneumoniae* have been documented to occur at 3-7 year intervals, with these epidemics lasting 1-2 years, but this phenomenon has not been seen as much recently.

Communicability/Incubation

M. pneumoniae is spread via respiratory secretions. Spread occurs slowly, and in the absence of close or prolonged exposure, transmission rate is probably low. This is illustrated by the fact that school spread does not seem to be significant while intra-family spread is extremely common (another take-home point!). The incubation period is 1-3 weeks with spread from one family member to another usually occurring at the longer end of this spectrum. Thus, one of the 'fingerprints' of *M. pneumoniae* infection is a history of a family member having a similar infection 2-3 weeks earlier. This is longer that what is typically seen with common viral upper respiratory infections. Also, for unknown reasons, spread of the infection within a family typically occurs to one member who then spreads it to another who then passes it to another, etc. This accounts for the characteristic description from patients of an infection "running through" their family over the last month or two. Again, this is somewhat different from what is usually seen with viral infections where one person simultaneously spreads it to all the other susceptible family members.

Understanding how the body's immune system responds to *M. pneumoniae* may be a key to answering such questions as: Why do some people get no symptoms at all while others get pneumonia, at times severe? Why is this infection more common in older children, as opposed to so many of the childhood infections that are most common in the first 3 years of life? The response of the 2 main arms of the immune system, the humoral response and the cell-mediated response, may play a role not only in protection but also is disease production. Studies seem to indicate that much of the disease manifestation is not due to direct action by the organism but rather the immune response, specifically the T cell response (reference 8). Infection seems to lead to both a humoral response (i.e. antibodies) and a cell-mediated response (i.e. T cells) – in balance – and appears to protect an individual from *M. pneumoniae* infection. Individuals likely become susceptible as time passes and their antibodies wane. With lowered antibody levels, infection can occur and lead to disease because cell-mediated immune responses are intact. This scenario seems to happen more often after age 5. Individuals who have had lower respiratory infection with *M. pneumoniae* are less susceptible (reference 9), likely because of a longer lasting humoral response. This is an area of active research and there is certainly more to come.

Diagnosis – "Trying to recognize the clues"

Like so many enemies, *M. pneumoniae* has a characteristic modus operandi when it strikes, and familiarizing ourselves with this "classic appearance" is perhaps the most important factor in our ability to make this diagnosis. The illness begins with a prodrome of headache, fever, sore throat, cough, and malaise. Rhinorrhea is usually noticeably absent. These symptoms are present for 1-3 days and then the illness progresses to the lower respiratory tract. Because of this "general" presentation, patients are often unable to pinpoint exactly when their illness started. One fact about the disease that may be somewhat surprising (in that it might be contrary to popular dogma) is that fever is present in the overwhelming majority of cases and is typically NOT low-grade. One study found that over 3/4 of patients had temperature greater than 102 (reference 1). Also, a significant number of patients (5-30%) will have an associated exanthem, which may be another clue suggesting *Mycoplasma* as the culprit.

Typical radiologic appearance

Bilateral and unilateral, focal and diffuse, alveolar and interstitial patterns have all been documented. Because of this

(See Scientific, page 24 ▸)

LEGAL PROBLEMS, DOCTOR ? ? ?

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One Man's Opinion

David A. Cimino M.D. FAAP, FSAM
Past President, Florida Chapter, American Academy of Pediatrics

Note:

The Florida Pediatrician has had and continues to have a policy to print an article on Managed Care in each issue. This policy will be adhered to so long as suitable articles are submitted. Both sides of the issue will be represented.

Publication of an article does not indicate any endorsement of the opinion by *The Florida Pediatrician* or by the FCAAP/FPS.☐

I have practiced medicine for 35 years. During this time there has been enormous change both in the science of medicine and in the financing and delivery of health care. Advances in the science of medicine - new immunizations, more antibiotic choice, early detection of cancers, advances in chemotherapy, pharmacologic management of mental illness, increased newborn screening, organ transplantation, improved equipment and improved medical and surgical techniques - have in most cases not only extended the duration of life but also the quality of life. And medical science is on the edge of major scientific breakthrough in the field of molecular biology and stem cell research.

In regard to financing and delivery of health care services, the picture is not so rosy. Science and delivery do not equate and do not add up to overall improvement in health for many of our people. We are all aware of the daily frustrations of physicians (not providers) and patients (not clients) with being second guessed and obstucted in the delivery of and receiving of health care. We have the most expensive system of health care in the world. We have the highest administrative cost and yet we do not come close to having the healthiest population or the best over all outcomes as measured by most standards.

We have too many people who are uninsured or underinsured or intermittently insured, leaving those of us who are insured to pick up the cost through a huge "hidden tax" in the form of our high premiums and inflated cost for the services we receive. Ten million children in this country are without medical insurance and we are all aware of the flaws in the coverage that many others have. We play musical doctors with patients having to change their medical home on a very frequent basis. We have an inordinate number of people who seek medical care in emergency rooms. We once again have soaring medical malpractice premiums and we have highly qualified physicians refusing to see unassigned patients in emergency rooms. We have seasoned physicians who are refusing to mentor younger colleagues and we are seeing a generation of physicians who are, out of frustration, retiring before ther time.

In regard to health care coverage for children there is a light on the horizon. It is the MEDIKIDS HEALTH INSURANCE ACT (S.827/HR1733). In contrast to previous attempts at health care reform this act has had significant medical input. It assures that every child and young adult is covered by a comprehensive health care insurance plan. It is not a single payor plan for services. It leaves room for evolution and control of administrative cost. I believe the strong points in this legislation are: 1. Universal Coverage 2. Automatic Enrollment 3. Strong Physician Input. 4. Simplified Administration 5. Availability of Choice .

We cannot allow the naysayers to hide behind the false issue of cost. As I mentioned earlier, we are all paying for care in the form of an unfair hidden tax. We need to get it out into the open and manage it properly. I urge every pediatrician to become familiar with this legislation. The status quo should not be acceptable. The only way in which this reform will become reality is if we go directly to our constituents, our parents and children, and convince them that this is in the best interest of the health of our nation's children. This is a cause that will have to be championed in every pediatric practice in the country. Only then will congress act.

I am in the twilight of my medical career. I help to train new pediatricians. As our fore-runners in pediatrics did for us, we all have an obligation to leave our younger colleagues with a decent legacy for the future. And most important, as has been the philosophy of the American Academy of Pediatrics, "this is what is best for children".☐

[Contact the Washington office of the AAP for a packet on this issue. -Ed.]

Please complete the survey on page 31!

[In each issue, we will focus on one of the State's Residency Programs. In this issue, we feature the Miami Children's and Jackson Children's programs.]

The Miami Children's Hospital Program

Diego Ize-Ludlow MD

Miami Children's Hospital

After having celebrated its 50th anniversary Miami Children's Hospital continues to be the only licensed specialty hospital exclusively for children in south Florida. Its Residency program offers experience in all facets of pediatric care to 54 residents.

With more than 185,000 pediatric patients treated each year, as residents we are exposed to a very diverse clinical experience, with emphasis on general pediatrics and exposure to more than 40 pediatric specialties and subspecialties as well as cardiac, neonatal and pediatric intensive care units. Miami Children's Hospital residents play an active role in the Health on Wheels program of the Division of Preventive Medicine that offers preventive medical, dental and mental health services to juveniles detained in residential facilities of the Miami-Dade County Department of Juvenile Justice. This program has served over 12,000 adolescents in residential care and through the Juvenile Assessment Center. During the third year we participate in the Miami Children's rural community pediatrics program, which serves migrant families.

The expertise and dedication of our faculty and staff as well as the hard work and commitment of our residents to the children's care was recently recognized by Child Magazine which acknowledged Miami Children's Hospital as the Top Pediatric Hospital in Florida.☐

Spotlight on University of Miami - Jackson Children's Hospital

There are sixty Pediatric residents and sixteen Med-Peds residents who are trained at the University of Miami/Jackson Children's Hospital. Located near downtown Miami, a multi-cultural city that serves as a hub to many international destinations, we serve a large and varied patient population. Our medical center provides us with a plethora of resources that include the Mailman Center for Child Development, Louis Pope Life Center, and the newly opened Batchelor Children's Research Institute. As residents we are exposed to a diverse clinical experience. This includes participation in a General Pediatric Clinic one afternoon a week, outreach rotations that enable us to bring health care to local high schools, and a pediatric mobile clinic that serves the under-privileged children throughout Miami-Dade County. Our faculty have also developed an elective that will focus on health care advocacy. The strengths of this program are multifaceted: a knowledgeable faculty that is eager to teach and residents that are hard-working and resourceful, and are reflected in the fact that we are named one of the top 25 Pediatric Hospitals in the U.S. News and World Report annual guide.☐

FYI - Resident Job Site

The resident section of the Florida Pediatric Society welcomes you to visit our website. There, you have access to a job posting directory. Simply fill in some simple information regarding the position you have available, and residents completing their programs from all over the state will have instant access to your information. How to enter the info? Go to the home page - fcaap.org, and click on "residents". From there click on the icon for employers to enter info. It's as easy as that. Thank you for your help - we hope it helps you! -the resident section☐

More on Resident Section: *(See **Resident**, page 28 ▸)*

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 or Membership Director. 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 child health advocacy.☐

[The Florida Physicians Insurance Company (FPIC) is endorsed and sponsored by the Florida Chapter of the American Academy of Pediatrics as its exclusive carrier of malpractice insurance for its members. In each issue, FPIC will present an article for our readers on matters pertaining to risk management]

The Perfect Storm: the Current Medical Malpractice Crisis

Terence McCoy, M.D.
Immediate Past President, Florida Medical Associateion

The medical malpractice industry in Florida is experiencing dramatic changes as a result of the hardening of the marketplace. In the past 36 months, nine carriers operating in Florida have either been liquidated, forced into rehabilitation, or have decided to stop selling medical malpractice insurance altogether. The insurance companies formerly known as Unisource, Gulf Atlantic, Caduceus, Frontier, Reliance, and PHICO are extinct, while St. Paul, Scottsdale, and Fireman's Fund have decided to get out of the medical malpractice line of business. A tenth carrier, Clarendon, has ended its affiliation with Gulf Atlantic and is no longer writing in Florida. In addition, three more carriers have been bought out by another company (PPTF by ProNational, ProNational by Medical Assurance, and Medical Protective by General Electric).

In the mid 1990s, carriers were flooding into the state of Florida but today there is a mass exodus. Three years ago, five professional liability insurance carriers were headquartered in Florida; today there is only one. During those three years, rates have increased on average by 50%. In the past year alone, the average rate increase by all carriers still operating in Florida is more than 25% and rate increases in 2002 are expected to be above 25% once more.

The following scenarios have contributed to the malpractice crisis:

- Erosion in patient loyalty attributed to the increasing presence of managed care
- Decrease in communication between physician and patient
- A shift from cases tried for committed acts to a world where omitted acts are equally important
- More trial lawyers today than ever before
- Jury panel selection criteria has changed – a potential juror now only needs to be 18 years of age and have a driver's license
- Television shows such as "Who Wants to be a Millionaire" have lessened the aura of a million dollars
- The average malpractice settlement in Florida has increased dramatically
- Jury verdicts are the yardstick by which all cases for settlement are measured and the average jury verdict

has increased 57% in the last five years nationally, from $2 million to $3.5 million

With all this bleak news, what is a physician to do?

An important thing to do is become insured with a stable carrier that will be with you during the good times and the bad. FPIC, the FMA's endorsed carrier, has been the only continuous carrier in the state of Florida since 1975 and is now the only carrier still headquartered in the state.

In addition to stability, you want a carrier who will fight for you in the courtroom and defend you against frivolous lawsuits. At FPIC, 83% of all cases are settled with no indemnity payment and 84% of all cases taken to trial are won.

Finally, you want a carrier who will fight for you on Capital Hill. Only FPIC and ProAssurance have an active lobbying force in Tallahasee.

When selecting your professional liability carrier it is extremely important to select one that will weather the storm and be there for you in both the courtroom and in the halls of the Capital.□

A Report

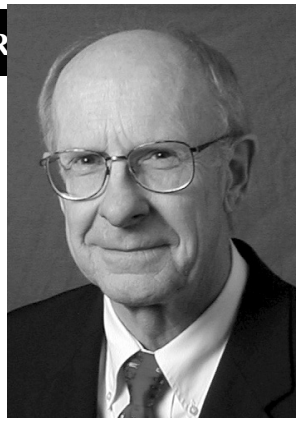
As we publish this newsletter, a report on **Lewis Barness** is indicated. Most of us know that Lew has been very ill following emergency cardiac surgery for an aneurysm of the ascending aorta. As of now, he is recovering well, and by the time this reaches the reader, he will have been the subject of a tremendous tribute by the University of South Florida. Good Health, Lew, and Congratulations.

and

Additional Kudos...

...to **Lew Barness**, who is scheduled to receive an **Honorary Doctor of Science Degree** from the University of Wisconsin, in May 2002. □

FR



THE 2002 ELECTION

[Each candidate for President-elect of the American Academy of Pediatrics was asked the following question. Their answers appear below. Short biographies of the candidates follow their responses]

WHAT ARE THE MOST SIGNIFICANT CHALLENGES FACING THE AAP IN HE NEXT FIVE YEARS?

*(See **Duncan,** page 16 ▸)*

Paula Duncan, MD, FAAP

Challenge is opportunity!! With this in mind, the AAP can target several important goals over the next five years. This will require continued strategic focus and flexible innovative strategies addressing changing factors such as priorities of our members, scientific breakthroughs, political decisions, new funding streams, and most importantly the evolving health needs of children, youth and families.

Economic constraints at national and state levels must not stall AAP progress towards health insurance for all kids (Medikids) and fair reimbursement for high quality care.

Community led efforts that tap the expertise and vigor of families and neighborhoods will substantially influence the next generation of health improvements for children and youth. Of the top ten 2001 AAP Forum resolutions, five can't be achieved without our community partners in education, mental health, dental health, public health, law and youth serving organizations. Reimbursement for substantial pediatrician involvement in these community and state efforts is key.

We must create an environment where every AAP member can say with conviction, "This is my Academy." The AAP, as it stands today, is of enormous value to pediatricians. While adhering to our most effective current activities, we must actively seek ways to welcome the voices of all our members and meet their needs.

Terrorism since September 11th has added new urgency to the issues of violence and its effects on children, youth and families. Our nation will continue to call on the AAP and its members as child health experts and leaders, to reach out to support parents guiding their children through this time of fear and threat. In order to appropriately both "sound the alert" and be the "voice of reason," pediatricians need rapid access to the best scientific information formatted for immediate sharing with patients, families and communities. We have the opportunity to capture the spirit of connection and generosity, using it to partner with parents everywhere, to provide each child with a home, school and community free from violence of any kind. □

Carden Johnston,MD, FAAP

The President of the AAP should create opportunities, rather than just face challenges.

Opportunity for Financial Access to Quality Care for All Children: For the 8 ½ million uninsured children (about 10% of my patients) enrollment must be automatic even before birth, and should be continuous even if the parents move, lose or change jobs. Choices of coverage must be available. Having pediatricians and our patients support **Medikids** is an opportunity.

Opportunity for Adequate Reimbursement: Coverage is not enough; reimbursement must be adequate. Delivering the message that children deserve at least the same reimbursement for same diagnostic code as the elderly creates an opportunity. Inadequate reimbursement correlates with inadequate access to quality health care for children.

Terrorism: Opportunities will exist to emphasize the impact of terrorism on children, which society is overlooking. The science of bioterrorism, treatment of PTSD, counseling and avoidance of entrepreneurs will be opportunities. Terrorism will escalate the already excessively high incidence of **violence** in our children. My patients are experiencing violent injuries with increasing frequency.

Advocacy and Prevention: Prevention, the cornerstone of Pediatrics, must be emphasized continuously. Our success in **immunizations** is being attacked by misinformation to the public, high prices by manufacturers, and inadequate reimbursement by payors. The epidemic of **obesity** combined with other unhealthy life styles like **tobacco**, **alcohol** and recreational **drug** use creates opportunities. The confusion and complexities of the rapidly changing **car seat** technology must be simplified for efficient and effective communication by practicing pediatricians.

Women's and Minority's Issues: As a consistent facilitator at the AAP's Women's Breakfast, an advocate for the Women's Subcommittee and the Task Force on Minorities, I have witnessed their increased involvement in the AAP. More opportunities must be created.

Media: Creating health television segments for 10 years, I intimately

understand the importance and opportunities for correct timely communications to our patients…a common source of medical information.

There will be challenges that seem impossible. But the AAP has seen impossible challenges in the past, created opportunities and made the world better for our children. We can make a difference together.☐

*(See **Johnston**, page 16 ▸)*

Duncan

(◂ continued from previous page)

Paula Duncan, MD, FAAP
Essex Junction, VT

Dr Duncan is Professor of Pediatrics at the University of Vermont School of Medicine, Youth Health Director for the Vermont Child Health Improvement Program and faculty with the National Initiative for Children's Healthcare Quality. She graduated from Manhattanville College and the Medical College of Pennsylvania. She has three children and two grandchildren. She and her husband, an emergency physician, live and work in Northern Vermont.

In earlier years, Dr Duncan practiced in Lowville, NY and Burlington, VT. She was Vermont AAP Chapter Vice President and the first Vermont CATCH Facilitator. At Stanford, she completed her residency and adolescent fellowship, and as faculty, directed the well-baby nursery and community rotations, and provided care to adolescents. More recently, as Vermont''s Maternal Child Health Director and then Planning Director, her focus has been public health, results oriented planning and community—state partnerships. During her years on these partnership teams, Vermont has made significant progress on child abuse, adolescent pregnancy, teen smoking, health insurance for children and practice-based quality improvement efforts.

Nationally, she's the past chair of AAP's School Health Committee, current chair of the Community Pediatrics Action Group and a member of the Council on Committees Management Team. She has worked on national initiatives in early childhood, adolescence and school health with MCHB, CDC, foundations, and school health organizations. Dr Duncan received the AAP Senn School Health award, the AAP Special Achievement award for public private partnership work on WIC and immunizations, and the Vermont Chapter's "Green Mountain Pediatrician" award. ☐

More from the AAP

Be aware:

Plans are underway for the next phase of the national Babies First initiative. As many of you are aware, Babies First is an ongoing initiative between AAP, Wal-Mart, and the Pampers Parenting Institute to educate parents and caregivers across the country about issues surrounding their children's health and wellness.

This phase will focus on educating parents on the importance of communicating with their children and with their pediatricians and will take place from February 27--March 10, 2002. The AAP brochures "Television and the Family," "Your Child's Growth: Developmental Milestones," "You and Your Pediatrician," "Helping Your Child Learn to Read," "Temper Tantrums: A Normal Part of Growing Up," and "Newborn Hearing Screening and Your Baby," have been revised, redesigned, and printed for this effort. In addition,"Your Child's Growth: Developmental Milestones," "You and Your Pediatrician," and "Helping Your Child Learn to Read," will be made available in Spanish in some stores. These materials are scheduled to appear in Wal-Mart stores by February 26. At this point, it looks like events taking place for this initiative will occur the weekends of March 2 and March 9.

Public relations activities supporting this initiative will include a satellite media tour on February 26 with AAP President Dr. Louis Cooper and deaf actress Marlee Matlin, who has agreed to serve as a celebrity spokesperson. A press kit also will be developed and distributed to national and local media outlets mid-February to promote this

(continued next column ▸)

Johnston

(◂ continued from previous page)

Carden Johnston, MD, FAAP
Birmingham, AL

Dr Carden Johnston, a practicing Pediatrician, has a breadth of experience. Practice experiences include General Pediatrics in rural Alabama, Kaiser Permanente in Hawaii, and being a Flight Medical Officer in the USAF in Texas and Alaska. Carden's residency was at Tulane with additional education in Seattle, CHOP and London. Clinical responsibilities include having been director of ambulatory care, fellowship director, clerkship director, ward attending, and division chief. Currently he practices Emergency Medicine at the Children's Hospital in Alabama. Carden is a member of District X, which includes Georgia, Florida and Puerto Rico.

Carden has depth of experience having been President of his Chapter, Chair of the Annual Chapter Forum Committee, Chair of the Section on Pediatric Emergency Medicine, member of COPEM, Chair of District VII and served on the Board of Directors of the AAP. Currently, he is co-chair of his chapter's Women's and Minority Issues Committee. Carden, for 10 years, has helped other practicing pediatricians by creating television news health segments now syndicated and called KidsMD. These 500 stories about children reinforce pediatricians' educational efforts in their offices and their communities. Selected segments have been distributed on a CD-ROM nationally to teachers of medical students to augment their educational experiences.

A member of the AOA, Carden has received the Section on Emergency Medicine Outstanding Achievement Award, and Outstanding Service Awards from the AAP as well as the Council on Sections.

Carden and his wife Susie have three children, and have been foster parents to 18 others.☐

(◂ from previous column)

initiative. In addition, in-store radio spots on newborn hearing, you and your pediatrician, and learning to read will be produced and air continually

in stores.

Some chapters may be interested in getting involved in local campaign activities at Wal-Mart and we wanted to ensure that you are aware of this upcoming activity and to apprise you of an opportunity to participate at the local level. There is no obligation for your chapter to participate. We understand that there is a very short time line associated with the project and that not every chapter will be able to participate in the Babies First campaign in March 2002. But if you are interested, AAP PR staff is ready and available to assist. It is our hope to develop an ongoing relationship with Wal-Mart and the Pampers Parenting Institute that will allow for future collaboration. If you are interested, please contact AAP public relations so we can get information
to you for this outreach. Materials also will be posted on the Members Only Channel press room as they are finalized.

Finally, please note that most Wal-Mart managers and associates will not be up-to-speed on this initiative until the end of January.

Carolyn Kolbaba
Public Relations Manager
AAP Office of Public Relations
X7945 □

From the FCAAP

Philip Oscar Lichtblau, M.D.
A Memorial

By Gerold L. Schiebler, M.D.

God, Country, Community, Family and Children's Medical Services! These were Phil Lichtblau's priorities; and he observed them every day.

Just several days prior to his unexpected demise, I spoke to Phil in Orlando at a state meeting of the Medical Directors of Children's Medical Services. He was his usual self - full of life, intensely committed to the operations and programs of Children's Medical Services (a key unit of the Department of Health); and always with that special sparkle in his eyes accompanied by his droll sense of humor.

We spoke of several items, but in particular the wonderful evening just several weeks prior to our conversation that Myrna and he, and Audrey and I had spent together at our Amelia Island condominium.

After the appropriate libations at our condominium, we went to the Fernandina Beach home of Maxine and "Bud" Tanis - a home that is a virtual museum of treasures. We were joined by Bonnie and Gary Bong and later had dinner at a local restaurant. Phil was very comfortable in the company of pediatricians. After all, he was an Honorary Member of the Florida Pediatric Society - one of very few. It was in retrospect one of those special evenings - a night to savor and remember.

Phil's unexpected passing away several weeks later is another reminder for each of us that "Each day is a gift from God".

Some of my special recollections of my time with Phil Lichtblau included:

- Visits to West Palm Beach to see the Children's Medical Services building dedicated in his name. His work with Children's Medical Services programs and staff was an intrinsic component of his daily life.

- Organizing a cadre of physicians and health professionals to examine every Indian child on the reservations located in southeast Florida - at no cost to the state.

- His ability to engender respect and trust in many different components of our society - including educators such as Dr. Edward Eissey of Palm Beach Community College, former State Senator and Senate President Phil Lewis and former Congressman Harry Johnston from the political scene, Drs. Eddie Stephens and Bernie O'Hara from the local pediatric community, and religious leaders of various denominations. Each of these as individuals, and collectively as a group, represented the finest of their professions.

- The evening he spent at our home in Gainesville. In his impeccable "old world" tradition, he always brought a gift when he was invited to your home. This time he brought a bottle of Chianti wine. Only it was three feet tall with a long narrow neck. He waited eagerly to see if I could pour the wine without spilling any - when you

reached the key stage when the air bubble would reach the main vessel - with the danger of wine suddenly cascading everywhere.

- He carried pictures in his wallet of his family and his grandchildren. Of particular pride were the pictures of the sculptures of his daughter Renee - especially the statue of the soldier at the West Palm Beach Veterans Hospital facility and the outstanding creation situated in the midst of the Medical Plaza at the University of Florida's Shands Hospital. He knew, as I know, that God grants these artistic creative gifts to only a very few.

Throughout his life, Phil adhered to the adage - "To really live, one must love people and use things, not love things and use people". In every sense he represented the very best of our medical profession - impeccable ethics, committed professionalism, and adherence to the concept that the interests of the individual patient are paramount - regardless of economic, gender or racial status.

Recently, I completed my memoirs as part of the American Academy of Pediatrics Oral History project. This initiative was instituted to capture the history of Pediatrics in this nation by interviewing a cadre of pediatrician leaders throughout the country.

I mentioned Phil in this publication, as he was one of my professional guideposts throughout my medical career. I had to ask him, because the editor of the project requested I do so, what the O. stood for as his middle initial. Reluctantly, he said it stood for "Oscar"; but he reminded me that he never used the name, as he didn't really like it.

*(See **Memorial,** page 25 ▸)*

More from FCAAP

SENATOR DEBBIE WASSERMAN SCHULTZ
FLORIDA'S CHILDREN'S SAFETY QUEEN

On January 17th, Senator Debbie Wasserman Schultz received the Good Housekeeping Award for Women in Government. Her nomination by the FPS/FCAAP is excerpted herein:

In Florida, drowning in residential swimming pools is the number one cause of death for children under the age of five. The numbers are staggering—upwards of 75 children die *each year* in residential pools, and *four times as many* have a near drowning experience possibly leaving them permanently brain damaged. And it is not necessarily a matter of parents failing to take precautions—more than 40% of these incidents occur in someone else's pool. In Broward County, Senator Wasserman Schultz's district, an average of 16 children die every year.

Senator Wasserman Schultz worked against great odds to create a comprehensive drowning prevention program in the State of Florida. This safety package included heightening awareness, educating parents, identifying and targeting children who could not swim, educating children on how to swim, and passing legislation that made residential swimming pools more safe. Her diligent work has saved, and will continue to save children's lives and has earned her the title of "Florida's Children's Safety Queen."

Senator Wasserman Schultz and I first worked on this issue when she was a board member of the National Safety Council and I was the chair of the Florida Safe Kids Coalition. During a presentation on children's safety issues at one of our regular meetings and as we listened to the statistics, we were both that there was currently no law in place to protect these innocent victims. We found that drowning prevention was a very complex issue, and while various components of a plan had been proposed in the past, none had been truly successful in Florida because of their piecemeal nature. There was no comprehensive drowning prevention program.

In 1998, Senator Wasserman Schultz filed the Residential Swimming Pool Safety Act. The filing of the bill marked the

beginning of a three-year battle. The bill required that all residential swimming pools be equipped with a pool barrier fence.

Despite the attention the legislation received, as you might imagine, the then State Representative (now State Senator) had an incredibly difficult road ahead of her. Florida was undergoing a massive political evolution; the legislature had just shifted from Democratic control to Republican control and regulatory legislation was not exceptionally popular. Additionally, the spa and pool industry was not only entirely opposed to the legislation, they were also completely unwilling to even acknowledge the need for any type of safety devices on residential swimming pools.

It isn't in Senator Wasserman Schultz's nature to take no for an answer, and would not allow this important issue to be swept under the rug. She demanded a full and fair hearing on the

issue and began a grass roots effort, along the way meeting two amazing women, Carole de Ibern and Cathy Ward. Carole was the mother of Preston, a near-drowning victim at age four who was left severely brain damaged from the experience, while Cathy was the grandmother of McKenzie Merriam, a two-year-old little girl who drowned in the swimming pool at her parent's home.

These women and many others made this bill a priority and helped Senator Wasserman Schultz to force the 1998 Legislature to address the issue. While the legislation did not pass in both chambers, it *was* heard in committees in both the Florida House and Senate - no small victory. Additionally, Senator Wasserman Schultz, working with then Broward County School Board Member (now Broward County Commisioner) Diana Wasserman-Rubin and Broward County Commissionere Ilene Lieberman, was successful in securing $200,000 for the Broward County School Board to create an educational swimming program called Swim Central, whose stated mission is to make "Every Child a Swimmer." Each year Swim Central has grown exponentially and this year successfully taught *20,000 children* how to swim. In addition, Senator Wasserman Schultz and Commissioner Wasserman-Rubin worked to require that all Broward County parents be asked if their children can swim during the regular school registration process, effectively allowing Swim Central to target children who desperately needed swimming education.

In 1999, Senator Wasserman Schultz re-filed the newly named "Preston de Ibern/McKenzie Merriam Residential Swimming Pool Safety Act," with modifications to include additional safety feature options, an educational component, and limitation to only new residential swimming pools. In 1999, the bill had much more momentum, and newspapers across the state endorsed the legislation. Legislators became more aware of the drownings in their districts. As a result, Senator Wasserman Schultz was able to successfully pass the bill out of the House, but unfortunately the bill died on the Senate Calendar in the last days of the Legislative Session.

In 2000, Senator Wasserman Schultz had the support of multiple child advocacy groups, as well as the endorsements of the Florida Medical Association, Florida Safe Kids Coalition, Florida Association of Emergency Medical Technicians, Florida Hospital Association, Florida College of Emergency Physicians, Florida Pediatric Society, Florida's Department of Health, State Farm Insurance, and many others.

She quickly passed the bill through the five committees of reference in the House, and the Senate passed the bill early in the Session with unanimous consent. Unfortunately, the heavily partisan House of Representatives - led by then-Speaker John Thrasher - would not allow Senator Wasserman Schultz to have her bill heard on the floor, despite calls from hundreds of concerned parents, and pleas from powerful lobbyists that

*(See **Safety**, page 26 ▸)*

Karen H. Toker, MD
Deise Granado-Villar, MD
Florida CATCH Co-Facilitators

C.A.T.C.H

The Florida state and regional CATCH (Community Access to Child Health) Facilitators continue to promote medical homes for children, particularly underserved children, around the state. In the past few months the CATCH program database on the FCAAP web site has been updated to reflect new programs, new addresses and new phone numbers. This data base contains all the CATCH(CATCH funded) and CATCH-like(not funded by CATCH) programs in Florida which provide medical homes for children. It also includes medical access programs, literacy programs, breast-feeding promotion projects, and Healthy Child Care America projects in Florida. Please take the opportunity to look at this site (under "CATCH" at the site), and if there are any further corrections or additions please let either Dr. Granado-Villar or Dr. Toker know. Below, please find an article on one of the CATCH programs started through a CATCH Planning Grant from the 2000 grant cycle year: Healthy Child Care Jacksonville. We are also proud to announce the 2001 recipients of the CATCH Planning Grants and, after the Healthy Child Care Jacksonville article, you will find a list of those grants which were approved for funding, some with definite funding as of January 1 and others approved but pending funding as of that date.

Healthy Child Care Jacksonville

Healthy Child Care Jacksonville is a local initiative based on *Healthy Child Care America*, the nationwide campaign initiated by the U.S. Department of Health and Human Services. Coordinated by the American Academy of Pediatrics, the national initiative has as its goal to promote safe and healthy child care environments for all children. *Healthy Child Care Jacksonville* also seeks to foster cooperation between child care providers and parents and ensure that all children in child care have a medical home. Our mission statement is "to create and support partnerships between pediatricians, the child care community, and families to promote the health, development, and safety of children in child care." Our goals include:

Safe and healthy child care environments

- Linkage of children in child care to a medical home
- Improvements in health outcomes for children in child care
- Linkage of children, families and child care centers to community resources
- Health and safety consultation, support, and education for children, families and child care providers

The planning phase of our program, which was funded by a CATCH Planning Funds Grant to Robert Threlkel, MD and Jeff Goldhagen, MD, has been successfully completed. The objectives accomplished by the planning committee include mapping by zip code the location of child care centers and pediatric practices, as well as income, infant mortality rates, SIDS deaths, child abuse and other child health related indicators within the Jacksonville/Duval County area. Another key to program planning was to identify the health and safety needs of local child care providers and to explore the views and experience of area pediatricians regarding child care health and safety issues.

The survey of 413 licensed child care centers in Duval County produced a response rate of 22.3%, (92 facilities representing 6,798 enrolled children). Generally, there was little relationship between the response rate of each zip code and the health indicators, although the zip codes with the top five mortality rates demonstrated a response rate much higher than the average (32.7%). The survey indicated that over half (53.3%) of all the centers provide special medical services to enrollees. The survey also showed that very few of these programs have a regular source of advice on health and safety practices for the children in their care.

The pediatrician survey was mailed to 168 practicing and retired pediatricians. The 62 respondents (36.9% response rate) reported that an average of 55.7% of their patients spend time in a child care setting. The survey demonstrated a gap between the pediatricians' attitudes regarding providing services to child care centers and their own knowledge or use of resources. Almost 60% believe that they have a role in serving child care, but less than 25% use available resources designed to improve child care and only 25.4% reported that they had provided some type of on-site service or consultation to child care programs within the past five years. The majority (77.4%) said that they would like to have further education that focuses on pediatric involvement in child care.

Healthy Child Care Jacksonville has recently launched a pilot project of 6 pediatricians who have each begun serving a child care center. This group will provide feedback for further curriculum and resource development. The full program will be implemented in January 2002. Funding for continuation of the program is currently being sought through various local, state, and national sources. *Healthy Child Care Jacksonville* looks forward to giving local pediatricians the opportunity to utilize a valuable point of access to gain insight into the factors affecting the health

*(See **CATCH**, page 27 ▸)*

The Department of Pediatrics at the University of Florida: 2001 Year-at-a-Glance

Douglas J. Barrett, M.D.
Chairman of Pediatrics, University of Florida

The beginning of a new year is always a time for reflection on where we are and where we are going. For the Department of Pediatrics at the University of Florida, the over-riding theme of the 2001 academic year was 'change through growth and development.' This is especially fitting since pediatrics is based on the fundamental precept that change resulting from growth and development is natural and indeed healthy. Thus, 2001 was a year characterized by exciting additions to our faculty, significant growth in our research activities, expansion of our clinical services, and new developments in our educational programs.

Scope and Leadership.

The University of Florida Department of Pediatrics consists of over 140 pediatric faculty in Gainesville, Jacksonville and Pensacola. In addition, 28 pediatric subspecialists in other medical and surgical departments at UF hold academic affiliate appointments in our department. Pediatric practitioners in every subspecialty provide care and teach at UF's various sites. In addition to our residencies in categorical pediatrics, we offer advanced training in eight pediatric subspecialty fellowships. Thus, the University of Florida Department of Pediatrics encompasses the "A-to-Z" of pediatric services and training opportunities.

2001 brought opportunities for changes in the Department's leadership team and those changes bring new ideas and new vision. Dr. Rick Bucciarelli assumed duties as the University of Florida's Associate Vice-President for Health Affairs for Government Relations. Dr. James Sherman, our Vice Chair for Pediatric Education and Residency Training Program Director accepted the responsibilities as our new Associate Chair. New division chiefs were recruited or appointed to lead three of our 11 established academic sections. In 2001 we created a brand new section of pediatric critical care medicine. Dr Gary Visner, an expert in pulmonary vascular biology and lung transplantation took over as Chief of the Pediatric Pulmonology Division. Dr. David Burchfield assumed responsibilities as Chief of Neonatology, the largest division in the department. Dr. Burchfield is expanding the developmental biology and neonatal neuroscience focus in the division. Dr Steven Hunger joined us from the University of Colorado as Chief of Pediatric Hematology-Oncology, bringing expertise in leukemia biology. Dr Arno Zaritsky came to UF to establish our new Critical Care Division, bringing experienced leadership and instant national visibility for our program. Dr. Zaritsky came from the Children's Hospital of the Kings Daughters in Norfolk where he also chaired the Department of Pediatrics at the Eastern Virginia School of Medicine. Dr. Zaristky is known for his work on acute asthma management and pediatric advanced life support systems. Other talented new faculty members have joined our Divisions of Critical Care, Endocrinology, General Pediatrics, Hematology/Oncology, Immunology, Infectious Diseases, Neonatology, and Pulmonology.

Change can also result from a strong tradition of fostering the development of academic leaders. In 2001 two members of our faculty assumed positions as chairs of academic Departments of Pediatrics: Dr Robert Christensen at the University of South Florida and Dr. Bernard Maria at the University of Missouri. We are obviously sad to see these faculty members leave UF. At the same time, we are proud of the fact that they represent the 15th and 16th UF pediatric faculty members to become the chair of a major academic department.

Clinical Services.

The clinical programs of the Department of Pediatrics at the University of Florida and Shands Children's Hospital have expanded in breadth and depth. Each year patients and their families come to UF clinics and Shands Children's Hospital from every county in Florida, approximately 40 states and nearly 20 foreign countries. Faculty physicians from the Department of Pediatrics were involved in almost 75,000 outpatient visits on campus in 2000-2001. Faculty traveled from Gainesville to 18 different cities and local communities throughout Florida to provide an average of 2.5 outreach clinics a day. Highly complex care teams provide the absolute best and most advanced care for children referred with special problems. For example, UF's liver transplant program ranks as the 8th busiest in the nation and we are the 11th busiest in total solid organs transplanted. In recent months, UF surgeons and pediatric gastroenterologists performed a successful liver transplant for North America's smallest transplant recipient.

The Shands HealthCare System also changed in 2001. Mr. Tim Goldfarb became the new CEO of Shands HealthCare. Mr. Goldfarb came from the University of Oregon Health Sciences Center bringing with him a deep appreciation for the value that a strong and diversified pediatric service adds to a large health system. He understands the unique requirements for delivery of contemporary and world-class pediatric health care. Shands Children's Hospital's clinical services continue to grow.

This year construction began on Shands Children's Hospital's new Pediatric Intensive Care Unit and Intermediate Care Unit on the 10th floor. Plans are underway for the complete renovation of inpatient child and young adult units on the 11th floor. More change in our facilities, especially in the neonatal, surgical, and recovery areas, will be needed as we continue to expand our clinical programs.

Education Programs.

Change is also inevitable and indeed desirable in the educational programs as medical students, residents and fellows complete their training and graduate, and as new students and trainees join us. What does ***not*** change is our absolute commitment to excellence in education. Some interesting facts about our education programs are:

*(See **Chairmen**, page 28 ▸)*

SAVE THIS DATE

June 21 - 23, 2002

General Pediatric Update VIII

and

Florida Chapter AAP
Annual Business Meeting

National Speakers include:

David Skoner, M.D.
Department of Allergy/Immunology
Children's Hospital of Pittsburgh

Joseph E. Dohar, M.D.
Pediatric Otolaryngologist
Children's Hospital of Pittsburgh

David B. Granet, M.D.
Pediatric Ophthalmologist
Shiley Eye Center, University of California - San Diego

Also: Alumni Meetings will be held for the Florida Pediatric Alumni Association, Inc.,
University of Miami/Jackson Memorial Hospital Pediatric Alumni
University of South Florida Pediatric Alumni
APH Pediatric Alumni Association, Inc.

Location: Grosvenor Hotel
Lake Buena Vista, FL
Call early for hotel reservations, at 1-800-624-4109
(Mention Florida Pediatric Society block of rooms!)

(CME Credit Available) (Registration details later)

INVESTING IN OUR CHILDREN: An Advocate's Perspective

Jack Levine, President
Center for Florida's Children

For the past 22-years, my job has been to speak up for children and families. Who listens? I'll speak to anyone who'll listen and has the power to act on children's behalf. While most of the time I talk with reporters, legislators, and business leaders, I also do my best to learn from those who know first hand the challenges kids face - parents, grandparents, teachers, doctors and nurses, for example.

Although my office is in Tallahassee, the Center's network of community friends is our vital link for information and inspiration. I am thrilled that the Florida Pediatric Society has agreed to partner with the Center and an impressive group of Florida advocates to unite their good works for children and strong commitment to families.

Over the course of a year, I visit more than 60 schools, hospitals, clinics, children's centers, foster homes and teen shelters. It's important for me to hear from the experts - those who hug, heal, and help our children face the future. While we at the Center do our share of statistical research, I know it's no accident that the word number begins with "numb". We are numb to numbers, but who can deny that may children do not have the safe home, caring adults, and secure future that every child needs and deserves?

Children are not statistics - they are arms that hug, or desperately need to be hugged. They are legs that run, sometimes with the help of braces. They are voices that sing, and I've heard a chorus in sign language. And most of all, children are sets of eyes that will look at pictures of us when we're gone, and judge us for the quality of life we left.

It is my honor to be a statewide spokesperson for the children who have no powerful voice of their own, and for parents who may not know that they have strength in numbers. The Center for Florida's Children works to influence powerful leaders to believe that children are an important ingredient to a safe and prosperous future. Florida can become a more child and family-friendly state, but it will take the personal passion and persuasive action of many of us - parents, grandparents, professionals, neighbors and friends - to act as if children are the only future we've got.

Progress Made - Promises to Keep

Florida's child and family well-being has improved. In 1990, our state ranked a dismal 48th on the prestigious Kids count index, published annually by the Annie E. Casey Foundation (www.aecf.org) . In the 2001 report, Florida's ranking has improved to 35th - the best improvement over the decade of any state in the nation. This progress did not come easy or without financial investment.

The lesson learned is clear and convincing - investments for pre-natal care, immunizations, and parent outreach services have paid bountiful dividends. Florida has

finally learned that we cannot balance our budget with two-pound babies. Excellent programs like Healthy Start, which conjoin the disciplines of medicine, public health, and education are models, not only for Florida - but nationwide.

Florida must make a bi-partisan commitment to improving the key arenas of early health care and education. None of today's 564 Florida newborns is born Democratic or Republican - and public policy initiatives for children must be non-partisan. But we have a long way to go. While our state ranks 35th in our children's Kids Count index, we rank 20th in per capita income. Making future progress will require additional up-front resources - not money spent but resources invested wisely. When it comes to kids, it's not whether we pay, it's when. Why pay for failure when we have the knowledge to invest in success?

Community Connections and United Action

While there is strength in diversity, there's power in unity. I believe that every community has the opportunity, and the obligation, to act decisively, not relying solely on Washington or Tallahassee to solve home-town problems. While we rely on the leadership of policy makers - at every level of government, there are home-grown solutions within our reach to promote the quality of life for our children:

- Quality preventive health care and early childhood care, including infant, toddler, preschool and elementary-aged service, are essential to building a future for our children and our society. Parents should not have to beg, barter, or borrow to access health care and safe, secure early learning opportunities for their children. Programs for our youngest children are important and need community support.
- Florida needs to expand mentoring in schools where young students can learn about life beyond their own experience. Programs for middle-school aged students build relationships between kids and positive role models by matching students with business and community volunteers who serve as mentors. Many thousands of young people are desperate for the supportive concern of adults, but are forced to do without such contacts.
- Recreational facilities need to be built or refurbished so kids can play in safety. High school, community college and university students can be hired as youth development leaders to build the confidence of children in sports, the arts, and creative pursuits.
- Retirees can be recruited to share their talents and the treasures of their experience with young people. How many pianos, cameras and paint sets are collecting dust instead of being shared with eager young hands? One -to - one, we can bridge the generations by matching

(See *Investing*, page 27 ▸)

MEDIA FORUM ACTIVITIES

Even though the Media Forum is not recognized by the AAP as yet, we've enjoyed accomplishments - activities traditionally undertaken by an AAP Section.

At the annual meeting in San Francisco the program sponsored by the Media Forum and arranged by Carden Johnston, "Strategies for Vaccine News Stories", was excellent and attracted an audience of about 50. This despite our inability (because of our unofficial status) to promote the session in the convention program. We've been assisted greatly by AAP staff - notably Jennifer Stone and Lisa Reisberg.

In 2002 in Boston, the Media Forum will collaborate with the Section on Injury and Poison Prevention to present a program on "Childhood Injury: Communicating the Complexity with Sound Bites." And for 2003, program chair Vic Strasburger is developing a program on advertising.

HISTORY AND WHERE WE ARE

The original intent was to develop a new Section on Media within the existing section structure of the Academy. This concept has been derailed by a moratorium on the creation of new sections imposed largely because of financial constraints which have not eased. Groups such as ours are being urged by the AAP Board of Directors to come up with new models which would be less expensive and put fewer demands on staff.

In May 2001 the steering committee decided to organize ourselves as a Media Forum attached to and under the umbrella of the Committee on Public Education. The precedent for this arrangement with COPEd has been set by the Los Angeles-based Media Resource Team.

In August we developed a formal proposal on behalf of the now almost 200 pediatricians who have expressed interest in the group. The AAP Executive Committee decided to bundle our request with those of two other groups seeking to combine with existing committees and to have all three proposals acted on by ACBOCS (the board oversight committee for committees and sections) in January.

That's not going to happen- at least in January. The proposal was reviewed by COPEd and I was invited to participate on a conference call with the committee in December to discuss the details. Concerns were raised that the Media Forum would merely duplicate activities already undertaken by the Academy. I was unsucessful in communicating our position over the phone.

The Council on Sections Management group (COSMAN) will meet with the Council on Committees Management group (COCOMAN) in March. After that meeting we hope to have a better idea whether we can pursue our original plan of seeking Section status, or if we reapproach COPEd, requesting a presence at their next meeting in April, to see if we can reach an understanding that will benefit the Academy, its members, and the children we care about. If neither of these works, the steering committee will look for alternatives. Your ideas are welcome!

So, although disappointed, we're not discouraged. As Jennifer Stone observed, "It would be a shame to let such an enthusuastic and knowledgeable group of people go to waste!" And we're determined not to let that happen.

Gil Fuld□

F.Y.I.

The John Whitcomb Outstanding Florida Pediatrician Award

It is time to solicit nominations for the annual John Whitcomb Outstanding Florida Pediatrician Award, which is presented each year during the Annual Business Meeting to the pediatrician identified as deserving of recognition by his/her peers for his/her outstanding service to the children of Florida. Previous winners include:

Dr. Reed Bell - 1997
Drs. George Dell and Dominick Reina - 1998
Dr. Arnold Tanis - 1999
Dr. F. Floyd Humphries - 2000
Dr. Pat Woodward - 2001

The Annual Business Meeting is scheduled for June 22, 2002, at the Grosvenor Resort in Lake Buena Vista.

The mechanism for selection of the recipients involves soliciting nominations statewide. A one-page summary supporting your nominee needs to be submitted to the FPS office via fax 850/224-8802, e-mail to Edie Lovingood at edielov@cs.com, or to Dr. St. Petery at lstpetery@attglobal.net, or mailed to Florida Pediatric Society, 1132 Lee Avenue, Tallahassee, FL 32303.

The deadline for submission of nominees is March 15, 2002. The list of nominees will be reviewed by the Executive Committee officers and Past Presidents via a conference call, with a nominee selected to receive the statewide award.

We look forward to receiving your nominee and one-page supporting summary prior to March 15, 2002.

Louis B. St. Petery, Jr., M.D.
Executive Vice President□

President

(◂ *continued from page 3)*

With this foundation and the new energetic members of our Chapter I am quite confident that we will continue to be recognized in the state and nationally as one of the most productive Chapters in advocating for pediatricians, children, and their families.

I thank you for giving me the opportunity to serve as your President.

With warmest regards,

Richard L. Bucciarelli, M.D.
President, Florida Chapter AAP□

(◂ continued from page 10)

myriad of possible appearances, chest x-ray is rarely able to confirm diagnosis. Although focal infiltrates confined to one lobe can be present, it has been reported that dense, homogenous lobar consolidations are rare in *Mycoplasma* (reference 7). X-ray findings in conjunction with a typical clinical appearance can increase diagnostic accuracy

Diagnostic Testing

Even understanding the typical presentation of *M. pneumoniae*, there will still be times when a diagnostic test is needed. After all, we can all attest to the fact that "classic cases" occur in textbooks and board exams, but the cases we see in our clinics and hospital wards are not always as clear-cut. As a general principle of infectious disease, culture is "the gold standard" for diagnosing infection, equivalent to apprehending the terrorist "in the act". However, culture is not practical in suspected *Mycoplasma* infections because the organism is very slow-growing, at times requiring 1-3 weeks.

The most commonly used methods of specific diagnosis have been antibody tests, particularly complement fixation (CF) antibodies. However, in order to be sufficiently accurate, these antibodies need to be present in extremely high titers (1:256) or sera need to be obtained both in the acute and convalescent phase (1 - 4 weeks apart). An immunofluorescence (IF) test allows determination of specific IgM levels. This too has limitations as IgM levels do not become elevated until approximately 1 week into the illness and remain elevated for several months. Thus, since *Mycoplasma* infections are fairly common, paired sera are needed to definitely link this evidence to the infection investigated rather than being coincidental.

The presence of serum cold agglutinins is a commonly discussed diagnostic tool for *Mycoplasma* infection. These are, as opposed to the previously mentioned specific antibody tests, nonspecific antibodies directed against red blood cells (specifically, the I antigen of RBCs). These antibodies were found to be present in most cases of primary atypical pneumonia even before M. pneumoniae was found to be causal agent. The antibodies are present in the majority (approximately 2/3) of cases of *Mycoplasma* pneumonia and their presence tends to correlate with severity of disease (reference 3). The test is often done "bedside" as well, in these instances using a more subjective means of quantifying the positivity (e.g. "strongly positive", etc.). The test is performed by adding patient's blood to a tube containing anticoagulant (typically same tube as one used for CBCs) and then placing the tube in ice water for 30 seconds – 1 minute. When tube is removed, a positive result in indicated by observing speckled clumping of the blood when tilting the tube to the side (reference 1). (To see an example of a positive result, see picture in Zitelli's *Atlas of Pediatric Physical Diagnosis* or see the following web address - *http://www.peds.ufl.edu/residency/MornReport/Archive/010917pic.htm* that is part of our pediatrics' department's web page).

This test does have some important limitations. As previously mentioned, the antibodies are only present in 2/3 of cases. Thus, the test is moderately insensitive, "missing" a significant minority. Additionally, a variety of viral respiratory infections (EBV, CMV, and Adenovirus, to name a few) can cause low titers of cold agglutinins; therefore, specificity might be not be terribly high in younger children when the prevalence of these "other viral infections" is presumably higher. In order to improve the test's specificity, a cutoff for titers of 1:64 should be used. The "bedside" cold agglutinins will generally only be positive if the antibodies are present in high titers. Although clearly "circumstantial", when used appropriately (consistent clinical picture, titers 1:64, older children, etc.), cold agglutinins testing can be certainly a helpful piece of evidence.

As culture of *Mycoplasma* is not practical, perhaps the next best diagnostic test would be direct detection of some antigen of the organism. Recovering DNA of the suspect from the crime scene argues strongly for conviction, and new PCR testing for *Mycoplasma* appears to have both high sensitivity and specificity. As this test becomes more readily available, it will likely become the diagnostic test of choice.

Treatment

Once the enemy has been clearly identified as *M. pneumoniae*, a decision must be made regarding treatment. After all, in medicine the punishment must not only fit the crime but also the criminal. This is where understanding the structure of the organism is clinically relevant. Since *Mycoplasma* has no cell wall, it stands to reason that antibiotics directed against cell wall synthesis (i.e. Beta-lactams) will be ineffective (another take-home point). Three classes of antibiotics are generally recognized as appropriate choices for suspected or confirmed *M. pneumoniae* infection – macrolides, tetracyclines, and fluoroquinolones. All of the macrolides have been shown to have excellent in vitro activity against *Mycoplasma* and numerous trials have demonstrated that these antibiotics are clinically beneficial as well. (reference 1, 10). Because of the better tolerability, the newer macrolides (azithromycin, clarithromycin) are generally chosen instead of erythromycin, but all seem to be equally effective. Tetracyclines are limited by their contraindication in younger children. Fluoroquinolones are also not indicated for younger children, and their use also raises concern about developing resistance in other organisms.

In discussing empiric therapy for the child with pneumonia, it is worth reviewing two of our take-home points: first, *M. pneumoniae* is the number one cause of pneumonia in school-aged children; second, beta-lactam antibiotics are not effective against *M. pneumoniae*. When selecting treatment for outpatients in the 5-14 year old group, a macrolide antibiotic is the first-line therapy. In patients with disease that is severe enough to be hospitalized, empiric treatment with a macrolide + a beta-lactam (2nd or 3rd generation cephalosporin) is a reasonable regimen. The argument for the combination in these patients is twofold. First, there is less margin for error (i.e.

*(See **Scientific**, page 25▸)*

(◂ continued from page 24)

cannot afford to "guess" wrong as to the etiologic agent) in these sicker patients. Second, since *Mycoplasma* pathologically causes a destruction of the ciliated epithelium of the respiratory tract, there is at least a theoretical risk of *Mycoplasma* pneumonia leading to a secondary infection (e.g. pneumococcus) and thus a more severe clinical picture.

Complications

Although typically thought of as a rather benign illness, there are a variety of complications that can occur and be quite serious. The pneumonia itself can be diffuse and severe particularly in patients with sickle cell disease, and parapneumonic effusions may occur. There are also a variety of extrapulmonary complications (e.g. hemolytic anemia, Guillain-Barre, Stevens-Johnson Syndrome). When this is the case, a history of a preceding *Mycoplasma*-like illness can usually be elicited and can be a clue to suspecting the "atypical" organism in these especially-atypical presentations. Less commonly, these extrapulmonary manifestations may be the presenting sign of the infection.

Summary

As with so much of medicine, we still have much to learn about this agent. There are many other fascinating and important aspects to this organism (e.g. its role in patients with Sickle Cell Disease, asthma, etc.), which are well beyond the scope of this review. And there are sure to be more interesting discoveries as our understanding of *Mycoplasma* continues to "grow up". It seems that this organism is like indiscretion in the political arena - the more you look for it, the more you find it.

Just as Eaton wasn't sure 60 years ago whether this organism was viral or bacterial, clinicians today are often left with the same question when the patients present in their office with signs of a lower respiratory infection. Being unfamiliar with this organism and the characteristic infection it causes can result in either of two mistakes: not giving the patient an antibiotic because "it's just a virus" or using an inappropriate antibiotic, thinking the infection to be due to one of the "typical" bacteria.

Without a doubt, crimes have been committed against our patients and mistakenly attributed to one of the other many "terrorists" with whom pediatricians come in contact while the true culprit is getting off scot-free. But as we learn more about *M. pneumoniae* and the way it operates, we are becoming better able to recognize its dirty work and consequently will be better able to protect our patients, making the world (at least the world of pediatrics) a safer place.

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Memorial

(◂ continued from page 17)

In whatever he did, he accomplished his missions and goals with rock-ribbed integrity, absolute commitment and always with that puckish sense of humor and the special twinkle in his eyes.

A wordsmith of yesteryear made this prescription about how to live one's life. It had three parts:

1) live every day as if it were your last,
2) live every day as if you would live forever, and
3) be wise enough to take equal parts of both.

Phil Lichtblau accomplished that with verve, insight, and incomparable class.

In recording my thoughts, it is difficult to remember Phil without tears. I can't (and won't) say "good-bye"; that word has such an element of finality. Thus, I say in the language of my parents, "Auf Wiedersehen" - until we see each other again!□

Add a 'pearl' ...from **Chuck Weiss**

"SHURE AM GLAD I WAS A FARM BOY!"

Growing up on a farm has demonstrated protection against allergic sensitization and development of childhood allergic diseases. "Early exposure to endotoxin, which is found in higher concentration in dust samples from the environment of farming families than non farming families, may affect the regulation of the immune system and confer protection from the development of asthma, hay fever and allergic sensitization."

Investigators at Children's Hospital, Salzburg, Austria did a cross- sectional survey of 2618 parents of children ages 6-13 years. Parental questionnaires were completed on asthma, hay fever and atopic eczema. Also children from farming families and random samples of non farm children blood specimens were measured for specific IgE antibodies to common allergens. Blood samples from children of farm families and a random sample of non-farmers' children specific IgE antibodies to common allergens were compared.

Exposure to children younger than 1 year compared with those 1-5 years, to stables and consumption of cow's milk was associated with lower frequencies of asthma (1% vs. 11%), hay fever (3% vs.13% and atopic sensitization (12% vs. 29%). There was no relation between protection from asthma and atopic sensitization. Continued, long term exposure to stables until age 5 years was associated with lowest frequencies of asthma(0.8%), hay fever (0.8%) and atopic sensitization (8.2%). Protection from asthma was independent of the state of sensitization.

How this finding may be applicable in the clinical practice situation is unclear. However, efforts should continue in the attempt to determine the protective mechanism.

Condensed from Riedler J et al. Lancet 358:1129-1133, October 6, 2001.

Ed. Comment: Would be hard to find a significant research sample in the US/FL? cfw☐

F.Y.I.

SOAPM's 2002 NCE Abstract Session

Richard Schieken, M.D., M.H.A.
Abstract Coordinator

The Section on Administration and Practice Management (SOAPM) will hold its Third Annual Abstract Session at the 2002 National Conference and Exhibition (NCE). The purpose of the sessions is not to present scientific treatises, but rather to present newer ideas for practice. The successes and failures of the practice implementing these novel approaches should be the focus of the presentations. Audience participation is lively. The Section welcomes all members of the Academy to come to present or discuss the presentations.

To submit an abstract to our sessions, follow the guidelines on the Academy NCE website. Abstracts may be submitted electronically through the website: http://www.aap.org, under "Professional Education". Print versions can be obtained by calling the AAP Faxback Service at 847-758-0391. Fill out the abstract form and select The Section on Administration and Practice Management (SOAPM) as the intended session. Authors will be notified by the Academy in plenty of time to plan the talk.☐

Safety

(◂ continued from page 18)

represented the endorsing organizations.

Just after 5:00 PM, the Speaker called Senator Wasserman Schultz to the rostrum and told her that he was prepared to hear the bill. The Speaker then called for a vote and the bill passed 109 to 8. Upon passage the Governor sent for the Senator, Cathy, and Carole to meet with him in his office and he wholeheartedly pledged his support and promised to sign the bill into law upon receipt. The law was to take effect on October 1, 2000.

Throughout the entire legislative process two organizations had spoken against the bill, the Florida Home Builder's Association (FHBA) and the National Spa and Pool Institute (NSPI), and were opposed to the legislation because they did not want to comply with the law and they believed it would make swimming pools more expensive. Just 3 days before the law was to take effect, a Tallahassee-based pool builder backed by FHBA and NSPI filed suit against the state calling the law unconstitutional. In the end the state was successful: the court upheld the law and dismissed the pool builder's case.

Since first filing this bill, Senator Wasserman Schultz has effectively heightened awareness of drowning prevention, required that the Florida Department of Health produce a curriculum to educate parents, changed policy to identify and target children who could not swim, secured funding for a free swimming lessons program, and passed legislation that made residential swimming pools more safe. Her hard work and determination will continue to reduce the number of drownings in Florida each year - it takes a giant step towards preventing the wound that never heals: the untimely loss of one's child.

As a result of her efforts, we strongly recommend Senator Debbie Wasserman Schultz for the Good Housekeeping Award for Women in Government. We cannot imagine a more deserving candidate for this honor.

Louis St. Petery, MD FAAP
Executive Vice-President
Deborah Mulligan-Smith, MD FAAP FACEP
President Elect☐

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 annual Florida dues, billed through the Academy Office. ☐

The *Ticked Off* Column.

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

Investing

(◂ continued from page 22)

retirees with children and teens.

- School administrators should open their doors to parental involvement so shared problems can lead to solutions. Schools should be seen as neighborhood centers of learning, offering parent education,

recreation, health access and other community services. Public service opportunities like environmental cleanups, house repair, senior-center visitation and child-care assistance should be part of every school curriculum. Credit for community projects promotes a sense of neighborhood and produces confidence and personal responsibility.

- Every civic and volunteer organization needs a strong public policy component of their community outreach activities. Direct care for children - either professional or volunteer - is best accomplished in the context of policy - laws, budgets, rules. Helping affect that policy, through active and articulate advocacy, is a great way of assuring maximum impact.

Giving young people a solid foundation of achievement does not have to be expensive. It will, however, take the creativity of business, government, religious and civic leadership to prove successful. To confront youth crisis, and prevent future problems, we must honestly assess our willingness to act on children's behalf.

Leaving the solutions up to someone else results in hopelessness and fear. Making the choice to act, and expecting elected leaders to act as if our future is at stake, is the best way to assure a future we are proud of - for our children and ourselves.

I invite you to contact us if you'd like more information about our work for children. My e-mail is jacklevine@floridakids.com . Our website is www.floridakids.com , call 850/222-7140- or jot me a note at PO Box 6646, Tallahassee, FL 32314.

Author's Bio Sketch:

[Jack Levine, a former teacher and urban youth counselor, has been President of the Center for Florida's Children since 1979. The Center is a statewide membership-supported not-for-profit advocacy organization. Jack holds a Master's Degree in Child Development and Family Studies from Purdue University. In 1990, Jack was named Floridian of the Year by The Orlando Sentinel for championing the cause of children. He and his wife, Charlotte, live in Tallahassee with their two sons, Aaron (20) and Josh (16).]☐

Please complete the survey on page 31!

C.A.T.C.H.

(◂ continued from page 19)

of children in our community as well as the training, resources and support to influence these factors.

Jane Veniard
Program Coordinator

Healthy Child Care Jacksonville
800 Prudential Drive
Howard Building, Suite 208
Jacksonville, FL 32207

2001 CATCH Planning Grant Recipients

1. Palghat Alamelu, MD, Hollywood, FL, for "Hollywood Kids" $4463
2. James M. Foster, MD, Key West FL, for "Assessment of Children's Dental Care Needs in Monroe County, FL $ 10,000

Resident Grants

1. Viviana Alvarado-Lavin, MD, Miami, FL, for "Early Childhood Development, Medical Home and Healthy Child Care America" $3000
2. Robert D. Karch, MD, Miami FL, for "Learn While You Wait" $3000

Additional Applicants Approved for Funding with pending status:

1. F. Lane France, MD, Tampa, FL
2. Abeer Khayat, MD, Jacksonville, FL
3. A. Robert Morelli, MD, Largo, FL ☐

...another 'pearl' ... from Chuck Weiss

Milan's pollution as bad as 15 cigarettes a day

FLORENCE, Italy, Jan 23 (Reuters Health) - Breathing Milan's polluted air exposes the city's residents to as much benzene as smoking 15 cigarettes a day, according to an Italian study released this week.

The report, published in the magazine "Attenzione," comes as smog-bound Italy is fighting pollution by banning private vehicle use in most northern cities. Dr. Piermario Biava, of the occupational safety unit at Sesto San Giovanni hospital, monitored Milan's urban police officers in order to measure levels of benzene and similar chemicals in their urine. As expected, urban police officers had a greater concentration of benzene than the "control" group, who had less exposure to polluted air on city streets. Those who also smoked had even higher benzene levels: 348 nanograms per litre compared to 174 nanograms per litre in nonsmoking policemen.

"Smoking doubles the expulsion of benzene. Considering that smokers smoked on average 15 cigarettes per day, we can say that breathing in Milan implies an absorption of benzene equal to the amount of benzene absorbed when smoking 15 cigarettes per day,". . .

Chairmen

(◂ continued from page 20)

- This year twice as many UF medical students choose careers in Pediatrics as compared with the national average for medical schools.
- UF medical students scored above the national average for each of the past 5 years on the pediatrics components of the USMLE national medical licensure exam.
- UF's first-year pediatric residents beat the national average scores on the residency in-training exam. Importantly, they also increase their margin above the national average in each successive year of their residency.
- Upon graduation from the UF training program, our pediatric residents consistently surpass the national average in total exam score and percent first-time pass rate on the American Board of Pediatrics certifying board exam.
- Sixty percent of UF residency graduates choose careers in pediatric primary care practice, and 40% of the graduates (twice the national average) pursue further subspecialty fellowship training . This is particularly important since a critical shortage of pediatric subspecialists is predicted for the coming decade. Of the 2001 residency graduates, 11 went into community-based primary care practice, 2 went into academic positions, and 4 went into subspecialty training programs.

1. The Department currently trains subspecialty fellows in the divisions of Cardiology, Critical Care, Endocrinology, and Gastroenterology, Infectious Diseases, Neonatology, Pulmonology, and Nephrology.
2. Two-thirds of the UF Pediatric residents come from medical schools outside the state of Florida. Upon graduation, two-thirds of our residents and fellows choose to stay in Florida to practice. Thus, the UF Department of Pediatrics is a "net producer" of practicing pediatric physicians, helping to meet the demands of our state's growing population.

Research.

UF Pediatrics' research enterprise continued to grow in size and expand in diversity in 2000-2001. This year nearly 50% of our total departmental budget came from extramural grants and contracts, the majority of which (2/3) is acquired through competitive grants to the National Institutes of Health and other federal research funding agencies. Total extramural funding from competitive research and training grants grew from 13 to 15 million dollars in the last year, up by 250% since 1996, and increasing 10-fold in the past 10 years. UF Pediatrics is now ranked within the top 25% of US Medical Schools in NIH research funding. This past year our faculty acquired new research grants in brain injury, epilepsy, genetics, heart diseases, immunology, lung diseases, nutrition, and transplantation.

The dramatic growth of research has been partially related to effective partnering with other multidisciplinary research programs within the College of Medicine such as the UF Genetics Institute, the Shands/UF Cancer Center and the McKnight Brain Institute. Our strategic plan focuses new departmental research investments in the areas of childhood cancer, developmental neurology and epilepsy, developmental hematology, molecular genetics and immunology/transplantation. The list of current grants and contracts at the end of the annual report gives evidence of the diversity and strength of the departmental research enterprise.

Conclusion.

Achieving the goal of being an academic Pediatrics Department with preeminence in research, educational and clinical care requires creativity, energy, commitment, flexibility, and vision. The sum of these elements drives the changes necessary to be successful in our relentless pursuit of excellence. As we look forward to the next year the one thing that will remain constant is our commitment to excellence in all we do, and the inevitable need for further "change".☐

Resident

(◂ continued from page 13)

The Florida Resident Section of the AAP is comprised of one representative and alternate from each of the seven pediatric residency programs in the state. This summer, speakers at each program were selected to present The AAP and you" to residents to introduce them to the organization and the role it plays in both residency and "the real world". Many did this at noon conferences as the year began. While most had active members of the AAP speak in their own format, a powerpoint presentation is also available on the AAP's website that can be used to help facilitate future presentations..

Last year's advocacy topic of child safety was addressed in many ways at different programs. Several groups served their community in providing school or sports physicals in July and August. Others took a traveling "show" to children to advocate for safety in the schools and community. Some targeted specific aspects of safety, such as distributing bike helmets and educating children on the importance of safety in the streets.

While at the AAP Conference in San Francisco, District X (AL, GA, FL, and Puerto Rico) decided that Child Obesity/ Healthy Eating Habits/ Active Lifestyle would be our targeted advocacy topic. In Florida, the residents are working on a resolution to present to the Academy regarding the amount of curriculum in public schools in which children and adolescents participate in moderate intensity physical activity and provisions for access to a safe environment in which to exercise.

Also at the AAP meeting in October of 2001, District X re-elected Joe Jung, DO (USF: Tampa/St Pete) as District Coordinator and elected Laura Stadler, MD (USF: Tampa/St. Pete) as Assistant District Coordinator.

During the holiday months, residents participated in a party for children, sponsoring families, canned food drive, and other "gifts" to the underserved community.

Currently we are selecting speakers for the Resident Section of the Florida AAP meeting in Orlando. Mark your calendars for June 21-23rd! We are requesting guests to speak to the residents on as well as asking any Resident who is willing to present an interesting case, challenging time, or unique experience such as overseas medicine. If you know of anyone willing to serve in this way, please email lpstadler@hotmail.com. ☐

Laura P. Stadler, M.D.

Letters to the Editor

To The Editor:

I was intrigued by the choice of articles printed in the November 2001 *Florida Pediatrician*.

One of these articles dealt with the timely issue regarding the increased premiums for malpractice insurance. The author did an excellent job of giving some history behind the exuberant increases we are facing in our premiums to "just show up to work" as a physician.

What was most disturbing to me is the inclusion of a reprint of an article criticizing physicians for refusing to cover emergency room calls citing that "money is at the root of the problem". H---- yeah, money is at the root of the problem. Physicians are being faced with increasing costs of "practicing" medicine while at the same time receiving less and less reimbursement for the services performed.

If a patient with a particular managed care plan presents to the ER and needs specialty care and the specialist on-call is not a participating provider, why should the physician accept the patient, treat, and risk being sued for a possible untoward event and never be paid for their services because "they are not a participating provider"? Whose ethics should be challenged here? The physician's? Why is it unethical to expect payment for services – especially in light of possible poor outcomes from the treatment? Why aren't the managed care companies being pursued for their unethical expectations – "why should they a pay a non-participating provider"? Why? Because that was the physician on-call that day for that particular specialty. That is why!

It is absurd to think physicians will be TOLD they are required to treat patients for "free" as a condition of their medical license. The practice of medicine is a business. Insurance companies will not accept higher risk people to insure – whether you are talking about car insurance, medical, life or disability insurance. Why should physicians be "forced" to accept higher risk patients without expecting reimbursement? When a physician begins to treat a patient, they are opening themselves to risks including possible lawsuits down the road. However, the physician is not even receiving compensation to help offset the costs of his malpractice insurance.

Our society is built on a money-exchange system for services. Last time I checked, we did not have a socialized medical system. Do not make the physician out to be "money hungry". A physician has spent a lot of time and sacrificed much to have the privilege of practicing medicine and should be reimbursed accordingly. We reimburse other service providers of our society: hairdressers, cleaners, auto mechanics, waiters, etc. to name a few. Why not physicians?

Let's put the responsibility back where it belongs – the managed care companies and the patients.

Kelly Komatz, M.D.
November 29, 2001 Orange Park, FL

Reply:

[A reply from Dr. Hopes was solicited after receipt of the above letter]

Emergency medical services in Florida's hospitals have experienced myriad problems in recent years. Some of these problems have been constants while others have not. But, for many of us in the medical profession it is hard to accept what many would refer to as a lack of compassion for patients, inferred by a specialty physician on call refusing to provide needed patient care in the hospital's emergency room, as determined by one's colleague.

Because of the gravity and crisis state of Florida's emergency medical services problem, the State's Legislature commissioned The Emergency Services Task Force in 2000. The Task Force's membership was made up of emergency physicians, specialty physicians, ambulance providers, and a member from the Board of Medicine, and hospital administrators. The Task Force was co-chaired by executives of the Agency for Health Care Administration and the Department of Health. The lack of response and availability of on call specialty physicians coming into the emergency room when need was identified as a significant problem with the system. This situation creates a cascading effect on the emergency room, which many times result in ambulances having to be diverted to other distant hospitals. And the problem continues like a histamine release.

Physician payment was also identified as a significant issue. S.641.513 Florida Statues directs HMOs to pay for emergency medical services provided by non-participating providers and at what rates. But, that does not mean the provider is getting paid. Representative Sandra Murman (HB 589) and Senator Skip Campbell are sponsoring Bills this session, which would force payment to providers. Major efforts are being made on the payment front. But, is money the root cause of all or even most of the problems with on call physicians' avoidance of the emergency room. Case in point, how would one explain the situation where specialty physicians are contracted and paid to provide on call coverage for the emergency room, and when the call comes from their colleague (the emergency physician) they are unavailable, unreachable, or basically say put a dressing on it and I will take care of it in the office (during normal business hours). This minority (we hope) puts the profession in a bad light and has the potential to pit the specialty physician's against the emergency specialists and please lets not forget the four year old child in her mothers arms in need of specialty care.

A dangerous triad of the specialty physicians, hospitals, and managed care organizations is spreading. I have to wonder what is the priority. If all specialty physicians had the attitude depicted in this Letter to the Editor, patients at the most critical time of need apparently would not be the focus of attention. Physicians historically have taken the high road, maintained a high level of respect in their communities and among their colleagues. Now is the time to take the high road, despite the perceived financial adversity. Each physician was one of a hundred or so out of 3,000+ selected and given the privilege and opportunity to learn how to heal the human body, a person, and fewer to become specialists and sub-specialists. Let us not forget the pledge to the Hippocratic Oath. And most of all our profession and our society should never allow nor accept finances to come between the care of an injured or ill child.

Scott Hopes, Ph.D.
Project Leader
AHCA/DOH EMS Task Force

FYI

Dues remitted to the **Florida Chapter** are not deductible as a charitable contribution but may be deducted as an ordinary and necessary business expense. However, **30%** of the dues is not deductible as a business expense for 2001 because of the Chapter's lobbying activities. Please consult your tax advisor for specific information.□

Upcoming Continuing Medical Education Events

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

Program: Pediatric Echocardiography
Dates: January 30-February 2, 2002
Place: Renaissance Vinoy Resort and Golf Club and All Children's Hospital, St. Petersburg, FL
Credit: Maximum of 23 hours for Category 1 for AMA Physicians Recognition Award
Sponsor: University of South Florida College of Medicine, All Children's Hospital
Inquiries: T. Sroka, C. Rose, (727) 892-8584

Program: 29th Pediatric Nephrology Seminar
Dates: March 1 - 5, 2002
Place: Fontainebleau Hilton Resort and Towers, Miami
Credit: 24 hours for Category 1 for AMA Physician Recognition Award
Sponsor: Department of Pediatrics, Division of Pediatric Nephrology, University of Miami
Inquiries: U. Miami Div. Of Continuing Education, (305)243-6716, Fax (305)243-5613

Program: Practical Pediatrics
Dates: May 16 - 18, 2002
Place: Eldorado Hotel and Sweeney Convention Center, Santa Fe, N M
Credit: Up to 16.5 hours for Category 1 for AMA Physician Recognition Award
Sponsor: American Academy of Pediatrics
Inquiries: American Academy of Pediatrics, (800)433-9016, ext 6796 or 7657

Program: Practical Pediatrics
Dates: May 23 - 25, 2002
Place: Hilton Head Marriott Beach and Golf Club, Hilton Head Island, SC
Credit: Hour for hour for Category 1 for AMA Physician Recognition Award
Sponsor: American Academy of Pediatrics
Inquiries: American Academy of Pediatrics, (800)433-9016, ext 6796 or 7657

Program: Practical Pediatrics
Dates: January 17-20, 2002
Place: Keystone Resort/Conference Center, Keystone CO
Credit: Up to 16.5 hours for Category 1 for AMA Physician Recognition Award
Sponsor: American Academy of Pediatrics
Inquiries: American Academy of Pediatrics, (800)433-9016, ext 6796 or 7657

Program: Practical Pediatrics
Dates: June 28 - 30, 2002
Place: J.W.Marriott Hotel, Washington, DC
Credit: Up to 16.5 hours for Category 1 for AMA Physician Recognition Award
Sponsor: American Academy of Pediatrics
Inquiries: American Academy of Pediatrics, (800)433-9016, ext 6796 or 7657

Program: Practical Pediatrics
Dates: August 30 - September 1, 3003
Place: Québec City, Québec, Canada
Credit: Hour for hour for Category 1 for AMA Physician Recognition Award
Sponsor: American Academy of Pediatrics and Canadian Paediatric Society, (800)433-9016, ext 6796 or 7657

IMPORTANT: PLEASE COMPLETE, DETACH AND RETURN THIS SURVEY

To: FCAAP/FPS Members

The FPS/FCAAP practice support committee has convened the Pediatric Council (managed care forum). Five MCO State Chief Medical Officers attend with us to discuss issues pertinent to pediatricians. The intention of this forum is to begin a regular dialogue between pediatricians and managed care in order to support and advocate for the pediatrician and her/his practice. We would like to gather your thoughts about which topics you feel are the most important and relevant for your practice. Please take the time to fill out the following short questionnaire and email it back to us by March 15th. Please feel free to contact Tommy at 561/627-0100 <DocTom101@aol.com> or Edward at 407/831-6200 or fax 831/1068 or email <ziss101@aol.com> if you would like to discuss this in greater detail. Thanks for your input and comments. Tommy Schechtman and Edward Zissman

1. Please rank the top five issues with 1 being the most important:
   a._____Recognition of new vaccines (e.g., PCV-7 or Prevnar)
   b._____Recognition of other new CPT codes/procedures
   c._____Reimbursement formulas for vaccinations (cost + administration)
   d._____Preventive Health Care reimbursement formulas
   e._____Reimbursement of in office procedure services provided
   f._____Reimbursement of in office laboratory services provided
   g._____Reimbursement for after-hours care
   h._____Reimbursement for best practice model (see below)
   i._____Establishment of pediatric pathways/protocols
   j._____After hours telephone triage
   k._____Access to pediatric specialty care
   l._____Referrals & authorizations' procedures
   m._____Distribution of nebulizers
   n._____Joint promotion of child health & safety issues
   o._____Management of chronic disease
   p._____Treatment of pediatric mental health problems
   q._____Treatment of developmental and school-based issues
   r._____Alternative Medicine in Pediatrics
   s._____Coding issues
   t._____Coordination of benefits
   u.OTHER:
   _____
   _____

2. If insurers were to pay a premium for recognition of practices maintaining "best practice" standards, then rank your top 5 criteria from the list below (with 1 being the most important):
   a._____Patient/family education programs and classes
   b._____In-office disease management training (i.e., respiratory, diabetes)
   c._____Pain management for immunizations and procedures
   d._____Attention to customer service and satisfaction programs
   e._____After hours availability
   f._____Community involvement
   g._____Use of protocols and critical pathways
   h._____Low specialty referrals
   i._____Availability of in-office procedures (e.g., I.V. re-hydration, LPs, suturing, OAE, venipuncture for outside labs, etc.)
   j._____Low/appropriate ED and hospital inpatient utilization
   k._____Office manuals for staff, procedures and practice management guidelines
   l._____Use of quality of care measurement tools
   m._____Pharmaceutical utilization
   n._____Access to pediatric ancillary personnel in the office (e.g., nutritionists, psychologists, therapists)
   o._____Immunization rates
   p._____Participation in AAP ACQIP program
   q._____CMEs
   r._____Appointment availability
   s.OTHER:
   _____
   _____
   _____

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