The Florida Pediatrician

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Florida Chapter American Academy of Pediatrics

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In this issue.....

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The President's Page

Dear Colleagues:

As we begin a new year, I am proud to say that our chapter and the Academy are well positioned to address the challenges which lie ahead. Although the level of our membership is stable, more and more of you are becoming active in the chapter and are willing to weigh in on issues with our state and national legislators. If we are to be successful we will need a large, active grassroots effort to make our issues known. Your involvement is critical.

I continue to be amazed with how much our members are doing in their communities. With all the pressures of practice and the changing environment, you still find time to make your community a better place for you and for the families you serve. The Chapter needs to continue to develop a mechanism which allows us to share these successes with our colleagues and others through the state. Along these lines, I am very proud to see that once again our members were successful in writing CATCH grants. With the four new awards, members of our chapter have received a total of nine CATCH grants in the last 2 years. I am particularly proud that two of these new grants were written by our residents! This accomplishment is certainly a credit to our training programs and the emphasis they are placing on resident involvement in research and the community. Finally, I am very proud of the AAP national leadership by Steve Edwards and Carden Johnston. Both are acutely aware of the issues facing all pediatricians and both are dedicated to doing what they can to significantly improve our practice environment and expand coverage to all children.

* * * * *

...a large, active grassroots effort to make our issues known...

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I also want to report to you that plans for our annual meeting are coming together very nicely. Under the leadership of Dr. David Marcus, this year's program will be even better than last year's. Once again we are honored to have the President of the AAP, Steve Edwards, as one of the key speakers. What a great opportunity! Come and hear some great talks and meet the leadership of your Academy! Save the dates: June 20th and 21st.

Before we meet in June we will be faced with some of the greatest challenges we have faced in a long time. This year's legislative session could be very contentious. One of the most important issues for all physicians is medical liability reform. The chapter will work closely with the FMA, the FHA, and other provider groups to achieve significant changes in our tort system, which will ameliorate the current crisis in the state. However, success can be achieved only if all of organized medicine and other providers remain together. We must resist attempts by various specialties and subspecialties to carve out temporary solutions for themselves because they are just that, temporary solutions. And quick solutions take the heat off the public and the legislature. This crisis must be dealt with once and for all. We must create a tort system which is fair to practitioners, which allows for affordable coverage, and still gives those who are harmed, reasonable recourse to capture appropriate compensation. Full scale reform is essential.

As a chapter we will continue to support legislation which deals with the safety of our children, improves the environment in which they live, improves access to care through and strives to help support families. We will work

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The Editorial Page

The Importance of Place and History

(A Guest Editorial)

The goals of this society are to improve the health and welfare of the children of Florida; to provide a means for furthering the art and science of pediatricians; to unite qualified pediatricians of Florida; and to encourage good fellowship among these pediatricians. The society will seek to promote the policies and objectives of the American Academy of Pediatrics and the Florida Medical Association." - John Curran, MD 1998

People live in the present. They plan for and worry about the future. Given all the demands that press in from living in the present and anticipating what is yet to come, why bother with what has been? Though the product of historical study is less tangible, sometimes less immediate, it should be studied because it is essential to individuals and to society, and because it harbors beauty. Knowing the history of the Florida Pediatric Society/Florida Chapter of the AAP will help us better understand the diverse needs of our membership and the society.

Then

In 1920, for every 1000 births, ten mothers died, 65 babies were stillborn, and over 100 infants died before they reached their first birthday.

Now

"When you take the long view, you see clearly how far we've come in combating diseases, making workplaces safer and avoiding risks such as smoking. As we take better care of ourselves and medical treatments continue to improve, the illnesses and behaviors that once cost us the lives of our grandparents will become even less threatening to the lives of our grandchildren."

- HHS Secretary Tommy G. Thompson

- By 2000, infant mortality dropped to a record low and life expectancy hit a record high.
- According to Health, United States, 2002, the 26th annual statistical report on the nation's health prepared by HHS' Centers for Disease Control and Prevention (CDC), deaths among children and young adults from unintentional injuries, cancer and heart disease are down sharply.

Demand:

Americans spent $1.3 trillion on health care in 2000, or 13.2 percent of the gross domestic product, far more than any other nation.

Supply:

Nationally the number of pediatricians has increased substantially over the last decades. Although Match Day results did show decreased numbers of pediatric residency positions filled in 2002, Pediatrics had done quite well in previous years. The relative percentage of pediatricians (as compared to all physicians) has increased from 5.7% in 1970, to 6.3% in 1980, to 6.8% in 1990, and to 7.5% in 1998.

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The Grass Roots

THE REGIONAL REPRESENTATIVES REPORT

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

Region II reports:

It has been an exciting and productive time in the District II Florida Pediatric Society/Northeast Florida Pediatric Society. It has been a period of great activity with several rewards that have validated our efforts and programs.

Our banner program, "Healthy Child Care/Jacksonville is flourishing. The program has won a sustaining grant from the Blue Foundation, which will ensure continued activity over the next two years. Feedback has been quite positive. The reviewers were impressed with the broad-based community support. The daycare centers have expressed a great deal of appreciation for the efforts on the part of the volunteer physicians. The physicians have responded with a great deal of enthusiasm and interest. This allows our group to expand into previously under-served areas as well as to ensure a medical home for the daycare clients. Further, it helps enhance the quality of the daycare experience for the children in Northeast Florida. It also serves as an opportunity for the residency program. Over 20 of the pediatric residents at the University of Florida/Jacksonville training program have opted to participate in this program. This gives them access to experiences in community health that is both unique and valuable. The success of this program has lead to multiple invitations to Dr. Threlkel and Jane Vaniard, the Directors of the Program, to speak and share experiences with other groups throughout the state and country.

Several of the pediatricians in District II have become involved with the Healthy America 2010 program. Specifically, the membership supplies the Chairman of the Childhood Obesity Coalition and the Childhood Fitness Coalition. This is a community based grass roots organization that is both evaluating and attempting to intervene in some of the factors associated with of the childhood obesity epidemic. Already contacts have been made with various community activist groups as well as the school board. Plans are made to interact with Head Start and the strategic planning in the processes is currently ongoing. We will look to the broad membership of the Florida Pediatric Society to provide support both locally and across the state for these activities.

The Children's Hospital Organization for Relief and Educational Services Program which has been functioning for more than a decade in Northeast Florida District II area and has had some fairly dramatic success. In addition to the medical mission, there has been print and broadcast media coverage of a young girl from Granada. Through the volunteer efforts on the part of Jacksonville Wolfson Children's Hospital, many physicians, ancillary medical staff, and nurses, ans with tremendous support by the public who donated funds, this girl is now able to walk. This has generated both national coverage as well as coverage in Granada. We are extremely proud and supportive of the efforts of this group to extend pediatric care not only locally, but also to the under-served internationally.

Page 6 *(See **Region II**, page 31 ▸)*

Region VI reports:

As newspaper articles may have informed many of you, one of the major issues impacting medical care in Central and Southern District VI is the financial viability of the Level II Trauma Center located at Lee Memorial Hospital in Ft.Myers. The defeat of a ½ cent sales tax to fund trauma, domestic violence and mental health care in Lee County last November 5th has resulted in uncertainty at the time of this writing whether, come January 1st, the Trauma Center doors will remain open.

Lee's Trauma Center is the only one between Miami and Tampa. Furthermore, this is the only trauma center in South Florida that receives no public funding. Medical staff members providing voluntary on-call rotations frequently are unreimbursed for their services, resulting in the decision to resign from trauma care if no funding solution is achieved by January 1, 2003. Consequently, the four full-time trauma surgeons would also leave.

The County Commissioners of both Collier and Charlotte Counties have recognized the grave consequences of losing the "golden hour" for their citizens and have volunteered partial funding. The Lee County Commissioners and hospital administration have been working to achieve a short-term as well as long-term remedy. Stay tuned for further developments.

On a happier – and more pediatric note --- ground-breaking for the new pediatric ER at the Children's Hospital of SW Florida occurred this Fall. The opening for the pediatric facility (which, incidentally, was funded totally by private donations) is tentatively scheduled for next September. The staffing issues for the Pediatric ICU have been resolved with the recruitment of two experienced intensivists. The medical staff of The Children's Hospital continues to grow with the addition of a pulmonologist and endrocrinologist, with other pediatric subspecialists waiting in the wings.

The shortage of pediatric beds -- even during the off-season -- at The Children's Hospital is a plague which, I am certain, most of you have already contracted at your hospitals. We are seeking creative solutions to this problem.

Newsworthy events from Collier County include the scheduled opening of the new addition to the CMS Building in Naples where pediatric subspecialists will now see private, as well as CMS, patients starting in April 2003. All patients report difficulty getting appointments with pediatric physicians secondary to an inadequate supply of providers. The CPT Team remains very busy and has undertaken a capital campaign for facility expansion.

In closing, please join me in welcoming back to work our Alternate Regional Representative, Dr. John Donaldson, after having sludge in his coronary and carotid arteries remedied.

Fortunately, he suffered no cellular damage to either his CNS or myocardium.

Bruce H. Berget, M.D., FAAP
District VI Regional Representative□

From the Department Chairmen

The Department of Pediatrics at the University of Florida College of Medicine

Terence R. Flotte, M.D.
Chairman, Department of Pediatrics
University of Florida College of Medicine

It has been my honor to assume the Chair of the Department of Pediatrics at the University of Florida, succeeding Dr. Douglas J. Barrett who served in that position for 11 years prior to assuming the role of Vice President for Health Affairs here at UF. During the past 6 months, we have witnessed continued growth and expansion of our clinical, education, research, and service missions, working in coordination with the strategic goals of the University of Florida. Our department has been central to several of the top priorities for the university-wide strategic plan as enunciated by President Charles Young, including, neurosciences, genetics, cancer, and children/family issues.

Pediatric Neurology has been a top priority in our department since Dr. Paul Carney, a national leader in epilepsy research and clinical care, joined us as Division Chief, and has quickly expanded the division. In clinical care, we welcomed one new faculty member, Dr. David Suhrbier, who will assist in expanding specialized neurologic services to the children of Florida, focusing on epilepsy and associated conditions such as learning and attention deficit disorders, and will collaborate with health professionals of the ADHD and MDT Programs, as well as the Comprehensive Epilepsy Program. The Division has expanded its epilepsy service to include vagus nerve stimulation for children with medically refractory epilepsy. The Division anticipates submitting an application for a pediatric neurology training program, which would be the only one in the state of Florida. In research, the Division has partnered with members of the McKnight Brain Institute and School of Engineering to develop a close-looped seizure prediction system for children and adults with difficult to manage epilepsy. Similar studies there are aimed at studying epileptogenesis in animals.

Several units within the department are active within the campus-wide Genetics Institute. The Division of **Pediatric Genetics** maintains a broad research and clinical role, providing genetic evaluation and counseling for patients with possible genetic issues including metabolic disease, with similar services at satellite genetics clinics for Children's Medical Services in Pensacola, Panama City, Tallahassee, Orlando, Daytona and Rockledge. A genetic telemedicine program is being developed for the panhandle, providing a program at the Florida School for the Deaf and Blind as well as the autism center in Jacksonville. The UF Cytogenetics laboratory is state-of-the-art for prenatal pediatric and cancer cytogenetic studies and is a consultation center for these services. Cancer cytogenetics has undergone significant expansion within the past year. The possibility of gene therapy for metabolic conditions like PKU is being studied. The Pediatric Genetics Division also provides a teratogen information service.

The Pediatric Genetics faculty has had a long-standing special interest in genetic neurodevelopmental conditions, especially Angelman syndrome and Prader-Willi syndrome. The research group of Daniel J. Driscoll, Ph.D., M.D. in Pediatric Genetics and the Center for Mammalian Genetics has been studying these syndromes as model systems to better understand childhood obesity and the phenomenon of genomic imprinting (certain genes in the mammalian genome are expressed differently depending upon the parental origin). For the last decade they have focused on basic science questions. Now they have begun to do clinical research in the Clinical Research Center at Shands Hospital in order to translate basic science discoveries into clinical applications for the rational treatment of childhood morbid obesity. The Prader-Willi syndrome is the most frequent known genetic cause of obesity in humans, with obesity in this condition typically beginning at 2 years of age. Dr. Driscoll will be the Chair of the 2003 National Prader-Willi Syndrome Scientific Conference in Orlando in July 2003, where there will be a special dedication for Camilynn I. Brannan, Ph.D. who recently died of pancreatic cancer. Dr. Brannan, a faculty member in the department of Molecular Genetics and Microbiology and the Center for Mammalian Genetics, made several important contributions to the Prader-Willi field including the creation of a mouse model which will prove invaluable in our understanding of this condition.

Barry Byrne, M.D., Ph.D., in the Pediatric Cardiology Division, is now Director of the **Powell Gene Therapy Center** (PGTC). This Center has been a national leader in the development of viral vectors for gene therapy of single gene disorders affecting children, including cystic fibrosis, glycogen storage diseases (type I and type II), alpha-1 antitrypsin deficiency, phenylketonuria (PKU), Duchenne muscular dystrophy, limb-girdle muscular dystrophy, spinal muscular atrophy (SMA), Leber Congenital Amaurosis and hemophilia. The PGTC currently has 6 program project level grants from the National Institutes of Health (totaling almost $25 million in funding), and numerous other NIH R01s and grants from national foundations. Within the past year, Pediatric investigators in the PGTC received a new NIH grant making UF one of only 5 National Gene Vector Laboratories in the United States. This laboratory serves to complete final preclinical testing and clinical grade production of recombinant viral vectors necessary for entry into early phase clinical trials. Recently more clinical trials of gene therapy have been developed by partnership between the PGTC and the General Clinical Research Center (GCRC) here at UF, which has

recently been renewed for another 5 years. Gene Therapy successes on the GCRC have included 3 phase I clinical trials and the first prospective, placebo-controlled phase II clinical trial of an adeno-associated virus vector for CF gene therapy, which has shown evidence of short-term clinical efficacy for this very burdensome genetic disease.

The Division of **Pediatric Hematology/Oncology** continues to expand. Dr. Stephen Hunger, who joined the UF faculty in August 2001 as Chief, is an expert in treatment of

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children with leukemia. He directs a research laboratory focused on the molecular genetics of childhood leukemia and is also Co-Chair (Biology) of the Children's Oncology Group Acute Lymphoblastic Leukemia (ALL) committee, which designs and conducts clinical trials treating the overwhelming majority of US and Canadian Children with ALL. Since Dr. Hunger's arrival, two additional faculty members have joined the Division: Dr. Mark Mogul as Director of the Pediatric Stem Cell Transplant Program and Dr. William Slayton, an alumnus of the UF College of Medicine and the UF Pediatric Residency Program, now engaged in NIH-funded research regarding early events in hematopoietic differentiation, focusing on megakaryocyte and erythroid development. Recruitment is ongoing for this Division. In the past year, Dr. John Graham-Pole, a faculty member for over 20 years, has been appointed as the Pediatric Hospice Director of the North Central Florida Hospice, expanding his growing involvement in this critical area. The Hematology/Oncology program has also been approved for subspecialty fellowship training and is now considering candidates for July 2003.

Another rapidly expanding division is the **Pediatric Critical Care** Division, under the new direction of Dr. Arno Zaritsky, who has been actively involved in the development of the Pediatric Advanced Life Support Course and served as one of two senior science editors for all of the pediatric resuscitation materials produced by the American Heart Association in the last two years. In July, the Pediatric ICU moved into a modern, new 24-bed unit on the 10th floor of Shands Teaching Hospital. Dr. Zaritsky's clinical focus for the coming year is the assumption of a primary role in post-operative care of patients undergoing repair of congenital heart defects, an area in which he is a recognized national leader. Dr. Zaritsky has also attracted two dynamic, young physician scientists to his division and one additional faculty member who completed fellowship training at UF: Dr. Ronald Sanders came from the University of North Carolina and is studying the role of stem cells in the regeneration of injured lung tissue. Dr. Jose Pineda completed his fellowship at Duke University and has become actively involved in research focused on traumatic brain injury, serving as Associate Director of the Center for Traumatic Brain Injury in the McKnight Brain Institute. Dr. Ikram Haque completed fellowship training at UF and is focusing his research on the mechanisms and treatment of ischemia-reperfusion injury.

The **Pediatric Cardiology** Division, under F. Jay Fricker, has also welcomed new faculty recently, including Dr. Carolyn Spencer, a graduate of the UF Pediatric Residency program and former chief resident who recently completed a Pediatric Echocardiography fellowship at Harvard University/Boston Children's Hospital. She is establishing new programs in fetal and intraoperative echocardiography. Dr. Joseph Paolillo and Dr. Jose Ettedgui are working on ways to enhance and expand interventional catheterization techniques for non-operative correction of congenital heart defects. Dr. Paolillo received his Pediatric Cardiology Fellowship Training at Children's Hospital of Pittsburgh and

Interventional Fellowship Training at Children's Hospital of Philadelphia. Dr. Ettedgui was recruited from the University of Pittsburgh as Division Chief of UF's Pediatric Cardiology Program at Wolfson Children's Hospital. Drs. Ettedgui and Paolillo are both certified to perform transcatheter closure of atrial septal defects in both children and adults. Dr. Margaret Samyn from the University of Michigan and Pfizer Global Research Division will join the faculty in the spring of 2003 to direct clinical trials research, focus on preventive cardiology and support imaging technology in pediatric echocardiography and MRI.

Traditional strengths of the Department of Pediatrics continue to be nurtured, including the **Division of Neonatology**, led by Dr. David Burchfield. The NICU is in the early phases of renovation, complete by early 2004, that will add 2250 sq ft of patient care space. In addition to increasing square footage per patient, a goal is to enhance our ECMO program and Neonatal Surgical Programs with space to accomplish surgery on unstable, critically ill neonates. The Neonatology group continues its academic excellence with recent publications and research grant awards. Martha Sola-Visner, MD was recently awarded a 5 year NIH R-01award to study thrombocytopenia in neonates, and was recently notified of her acceptance into the Society for Pediatric Research. Mike Weiss, MD also received a new research award from the American Heart Association to study glutamate transporters in the injured brain. Joyce Koenig, MD was recently awarded an NIH R-03 award to study the mechanisms of neutropenia in neonates born to mothers with pre-eclampsia. Matthew Saxonhouse, MD, a second year fellow, was awarded a Research Fellowship from the American Heart Association. Steven Morse, MD has been added to the faculty. Dr. Morse is Board Certified in Neonatal-Perinatal Medicine, holds a Masters in Public Health, with research interests in health outcomes research and is teaming with the Perinatal Data Systems group at UF to study early determinants of special health care needs at school entry.

Under the leadership of the Dr. Janet Silverstein, chief of the Division of **Endocrinology** and Dr. Desmond Schatz, Director of the Diabetes Center, UF remains one of the pre-eminent programs in children's diabetes in the world. Primary research efforts include (1) immunopathogenesis, prediction, genetics, natural history, and prevention of type 1 diabetes; (2) curative approaches via gene therapy (Dr. Mark Atkinson) and stem cell therapy (Dr. Ammon Peck); and (3) new efforts in looking at endothelial function in children with both type 1 and type 2 diabetes. The Diabetes Program at UF has more than 12 federally funded grants, totaling approximately $5 million. In addition, investigators have approximately $400,000 in telemedicine grant funding from the State of Florida, with 3 components:

1. Outreach clinics currently serve 90 CMS children with diabetes (n=45) and other endocrine disorders (n=45) in

Daytona Beach using bi-weekly telemedicine clinics. Local nurses were trained to take a history and perform key parts of a physical examination, using our endocrine clinic forms. Lab data is downloaded electronically or faxed and both the patient and nurse communicate with the physician using high resolution equipment. This replaces the quarterly clinics, in which all patients were seen semi-

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annually with insufficient time to be able to provide optimal medical care. HbA1c levels have improved and patient satisfaction is high. Plans are for expansion of this program.

2. Virtual Diabetes Project Unit, in which patients have visits with the psychologist and frequent monitoring by a certified diabetes educator. This too has resulted in improved compliance and good patient satisfaction. The results of this component of the program are in press.
3. Education modules can be accessed by health educators, teachers and other school personnel, patients and their families, including fun, animated modules about all aspects of diabetes management. Pre- and post- tests are available to assess efficacy of the modules. This program has been presented at several national conferences and has received high praise. JDRF has contacted Dr. Toree Malasanos about using this as their education program. Drs Schatz and Silverstein hold leadership positions nationally and internationally in the JDRF, ADA, and AAP. Dr. Silverstein is leading a task force to develop guidelines for management of diabetes and its complications for the pediatric population and has been a member of the NDEP taskforce which is completing a manual on Guide for Diabetes in the schools. Drs. Rosenbloom and Silverstein have written, or are in the process of writing, chapters on diabetes in 2 major endocrine textbooks (Lipshitz and Wilkins) and a small book for the ADA. Dr. Schatz has written several review articles on such topics as Diabetes Prevention trials.

Another well-established division, the **Pediatric Renal** Dvision, has maintained a balanced program in teaching, patient care and research. Sixteen fellows have completed the program of whom five are division chiefs. Research funding has continued with multiyear NIH grants to study the role of *Ureaplasm urealyticum* as a precipitating factor in urinary tract infections in young women and newer treatments of congenital lactic acidosis in children. The clinical program is heavily involved in all aspects of renal disease, including dialysis and transplantation.

The Divisions of **Pediatric Gastroenterology** (under the direction of Dr. Donald Novak) and **Pediatric Pulmonology** (under Dr. Gary Visner) likewise continue to balance NIH-funded research with clinical care and very active solid organ transplantation services, for liver and lung respectively. In addition, the Pediatric Sleep Disorders Center and the Cystic Fibrosis Center are both directed by Dr. Abby Wagner, in the Pulmonary Division. Dr. Novak has obtained a new NIH R01 award for basic studies of nutrient transport in the placenta, in work highly complementary with the nutrition consult support role played by the clinical Pediatric Gastroenterology service. The Pediatric Pulmonology faculty has funded research for clinical and/or basic studies in the areas of gene therapy, cystic fibrosis, lung transplantation, asthma, lung anti-proteases, and pulmonary vascular disease. The Asthma Research Center is a collaborative effort between Pediatric Pulmonology and the College of Pharmacy, and is complementary to clinical service especially the severe asthma population followed by the division. Pediatric Pulmonology has an active fellowship program along with specialized pediatric pulmonary training for nursing, nutrition, social work, and respiratory therapy. The educational program is supported through a federally funded Pediatric Pulmonary Center, one of seven centers in the United States.

The **General Pediatrics** Division likewise continues to be strong in all areas of clinical care, education, and research. Dr. John Nackashi has assumed leadership roles in a number of key departmental activities which intertwine all three missions including the new Children's Medical Services Integrated Care System, a managed care model program for children with special health care needs and the newly redesigned pediatric behavioral and developmental unit. The Division also continues to embody the strength of the Pediatric resident continuity clinic, the faculty practice clinic, the adolescent clinic and the birth defects clinic. New research vigor is brought to the division by members of the Institute for Child Health Policy, under the local direction of Dr. Betsy Shenkman and her colleagues, recognized national leaders in outcomes research.

The future of the Department of Pediatrics appears to be very bright as we anticipate the arrival in May of Melissa Elder, M.D., Ph.D., as the new Division Chief of Pediatric Immunology, Rheumatology, and Infectious Diseases. Dr. Elder will join us from the University of California, San Francisco, where she served as Associate Professor for the past several years. She has extensive experience in fundamental research on mechanisms of primary immune deficiency and is a board-certified Pediatric Rheumatologist as well. New fellowship training programs in Rheumatology and Infectious Diseases are anticipated within the coming year.

Finally, we look to the future with a number of department-wide initiatives. These include the embodiment of a new Child Health Research Institute, which was recently approved by the UF Board of Trustees to provide a single point of focus for investigators interested in child health related questions, whether inside or outside of the Department of Pediatrics. In addition, we have looked to strengthen the fellowship component of our educational mission with the new Children's Miracle Network-sponsored Douglas J. Barrett Academic Fellowship Awards which combine financial relief with well-deserved recognition for our best and brightest post-residency scholars. And in our most important mission, the clinical mission, we continue to work toward better integrated regional networks for children in North Central Florida, hoping to provide ready access to the highest quality care for all the children and families we serve. □

ANNUAL MEETING: See page 31

Collaborative Research and PROS

Report

The PROS network of 580 practices (>1600 pediatric practitioners) focuses on projects that are meaningful to the practicing clinician. Past projects have tackled determining the timing of the onset of secondary sexual characteristics in girls, coordination of referrals to specialists, identifying predictors of future problems for newborns and their mothers, and more. Other projects have helped define how best to provide care for children with the common conditions of asthma and ADHD.

Analysis in the PROS Febrile Infant Study (Arch Ped & Adol Med 2002; 156: 44-54) reveals in infants (<3 months of age), the characteristics most predictive of UTI relate to gender (uncircumcised boys and female sex); higher fever & fever lasting > 24 hours; lack of ill family member; and lack of significant respiratory symptoms. Yet, in practice, clinicians were likely to fail to obtain a urine specimen when faced with uncircumcised boys, girls, and infants with fevers of longer duration. What an opportunity to learn from each other!!!

Anticipatory guidance is among the core activities that we do as pediatric providers. However, do we know if our good counsel actually works? It is a practical question and one that the PROS network is tackling with our latest project "Safety Check". Pediatricians will test some new, brief screening and counseling tools for violence prevention and reading promotion. The project involves minimal paperwork and lasts only 2 – 4 weeks. Its results will lead to new recommendations on how we as pediatricians provide guidance on these and other safety & developmental issues.

Another common task is more difficult: recognizing and reporting child abuse. PROS CARES (Child Abuse Recognition Experience Study) seeks to describe how experienced practitioners approach this challenging task. Clinicians complete a postcard size survey when seeing children presenting with an injury and a longer survey if the child has a high likelihood of abuse. Outcomes are then monitored. By collecting this information from many practices across the nation, we expect a pattern to emerge that will help improve our decision-making.

We are still recruiting clinicians for our current projects: Safety Check and PROS CARES. New projects in the pipeline include identifying timing of pubertal changes in boys and a trial to examine the effectiveness of interventions to help teens stop smoking. Keep an eye out for future developments.

If you are interested in working on a PROS study at any level (enrolling patients to designing projects), contact us at pros@aap.org or call 800-433-9016, extension 7626. Further, please contact me if you are interested in having a 12 minute slide presentation about PROS at your local hospital or pediatric society meeting.

Lloyd N. Werk, MD, MPH, FAAP
Email: LWERK@nemours.org Ph. 407-650-7177□

In Memoriam

[adapted from Miami Herald, Nov 20, 2002]

Charles H. Pegelow, M.D., 59, died Monday, November 18, 2002, after a courageous battle with lymphoma. He will be greatly missed by his family, friends, colleagues and patients. Charles was born 4/8/43 in Midland, SD. Following graduation from a Canadian high school, he enlisted in the US Navy, where he received training as a Hospital Corpsman and Pharmacy Tech. This began his love for medicine. He graduated from the University of Minnesota Medical School in 1970 and completed a fellowship in hematology-oncology at USC-LA County Medical Center. Following several years in private pediatrics in Vancouver, WA, he joined the Children's Cancer Research Institute in san Francisco. In 1983 he returned to academic medicine by joining the faculty of the University of Miami School of Medicine. Here he demonstrated a true professional commitment to all he was involved with, whether it was writing a grant, participating in research, teaching students, or providing patient care. His greatest passion was serving as Director of UM Sickle Cell Center and Director of the Pediatric Residency program at the University of Miami/Jackson Memorial Medical Center. Charles was nationally and internationally recognized as a leader in research about sickle cell disease, where he contributed to a better understanding of the natural history of the disease, prevention of life-threatening infection in young children, prevention of stroke, and reduction of the debilitating consequences of pain. His 17-year local, state, and national leadership in the care of children with special-care needs, particularly sickle cell disease, resulted in his recent selection for an Outstanding Achievement Award by the American Academy of Pediatrics. Charles was foremost a devoted family man...The family requests that donations be made to the UM Department of Pediatrics, with designation to the

Sickle Cell Fund or the Pediatric Residency Education Fund, Office of Development, Department of Pediatrics, PO Box 016820 (D-820), Miami, FL 33101.□

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The Scientific Page

BREAST-FEEDING RATES AT A MEDICAID CLINIC

Jennifer Cohen Takagishi, MD
Luis Maldonado, MD, MPH
University of South Florida College of Medicine

As most pediatricians know well, breastfeeding (defined as providing breast milk either via the breast or bottle) has proven beneficial to both infants and mothers. Breast-fed infants have fewer respiratory and diarrheal illnesses [1, 2] and possibly higher IQ [3]. Nursing mothers have lower incidences of certain cancers, faster return to baseline weight, and fewer work absences due to ill children [4]. Despite these advantages, the rate of breastfeeding in the United States is very low, and is even lower within certain populations.

"Healthy People 2010" [4] has established goals for breastfeeding rates in the United States for infants at birth, 6 months and one year of life. These goals are much higher than 1998 baseline rates of breast-feeding[4]: 64% of all women in the early postpartum period, 29% at 6 months, and 16% at one year. The goals are 75%, 50% and 25% respectively. More striking, however, is that the current rates are much lower within certain minority populations. In Black/African American women, the current rates are 45%, 19% and 9% respectively, and among Hispanic or Latinos, the rates are 66%, 28% and 19%. Within the Caucasian community, the rates are 68%, 31% and 17% respectively [4].

As even these baseline rates seemed higher than what we were noting anecdotally, we sought to establish the baseline rates of breast-feeding at an urban hospital-affiliated clinic, at which Caucasian, African American/Black, Hispanic/Latino, and other (primarily Arabic) minority women and children are seen in an ambulatory pediatric setting. We then analyzed the data, by ethnic origin, to establish comparative breastfeeding rates.

We also sought to examine factors that might influence our breast-feeding rate, such as number of adults and children in the home, gravida status, early discharge from hospital, maternal age, and timing of introduction of solid foods, factors that had been previously noted in the literature.

We performed a chart review in the Genesis clinic, our urban hospital-affiliated clinic in Tampa, Florida. Tables I and II describe our population.

Table I: Demographics of Population

Maternal Age at Delivery

Maternal Age	Number	Maternal Age	Number
13	4	28	7
14	1	29	6
15	7	30	4
16	6	31	3
17	7	32	2
18	20	33	7
19	23	34	4
20	27	35	1
21	21	36	2
22	17	37	5
23	11	38	3
24	11	39	1
25	12	40	1
26	13	42	1
27	11	unknown	46

Medicaid insures 80% of our patient population. Every patient born in 1999 was eligible for inclusion in the study. Two hundred eighty four patients met

eligibility criteria, based solely in the completeness of the data available for analysis. Due to the low number of exclusively breastfed patients in this population, we chose to define 'some breastfeeding' as a patient given any amount of breast milk on a consistent basis at the time of the patient visit. We defined 'no breast-feeding' as a patient that was never breast-fed.

We looked at the feeding patterns of our children at the following well-child visits: 2 weeks, 2, 4, 6, 9 and 12 months, using a standardized intake form, and then attempted to describe associations or trends between the mother's breast-feeding habits and different socio-biological variables.

The mean maternal age was 23 years (median 22). The mean maternal gravity was 2.57 (median 2). Fifty five percent of our cohort was African-American, 28% Caucasian, 15% Latino and less than 1% Arabic. Seven percent of the index cases had an early discharge from the hospital after birth.

Using the before-mentioned breast-feeding criteria, we discovered that at the 2-week visit, only

*(See **Scientific**, next page ▸)*

Scientific

(◂ continued from page 11)

Table II: Demographics of Population

Other Variables

Ethnicity	No.	Gravity	No.
African-American	121	1	78
Caucasian	67	2	69
Latino	31	3	33
Arabic	2	4	29
Unknown	63	5	20
		6	5
		7	3
		8	3
		10	1
		unknown	43

Discharge Status	No.
Regular	222
Early	14
Unknown	48

Adults in Household	No.	Children in Household	No.
1	56	0	75
2	135	1	73
3	335	2	57

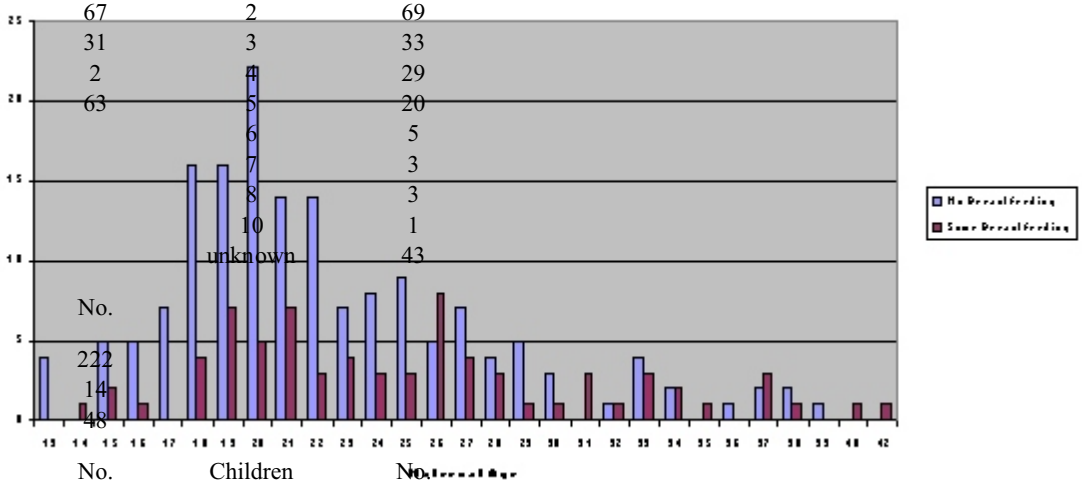

Figure 1: Maternal Age and Breast-feeding Habits: Older mothers are more likely to breast-feed their babies.

31% of the patients were receiving some breast milk. From there on there was a steady

50% decline in the number of subjects being breast-fed. Due to the low number of breast-feeding patients after the 2-week visit, we decided to search for associations between the above variables and breast-feeding habits in only the 2-week cohort.

We found statistically significant associations between maternal age and breast-feeding status (QMH = 11.58, p=0.0007), non-early discharge and not breastfeeding (QMH=4.036, p=0.0455), and African-American ethnicity and not breast-feeding (Chi-sq=29.96, p<0.05). Figures 1-3 graph these results.

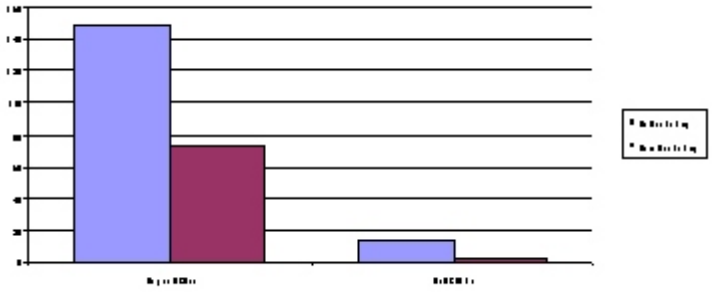

Figure 2: Early discharge status and breast-feeding habits: infants discharged from hospital at less than 48 hours were more likely to be breast-fed

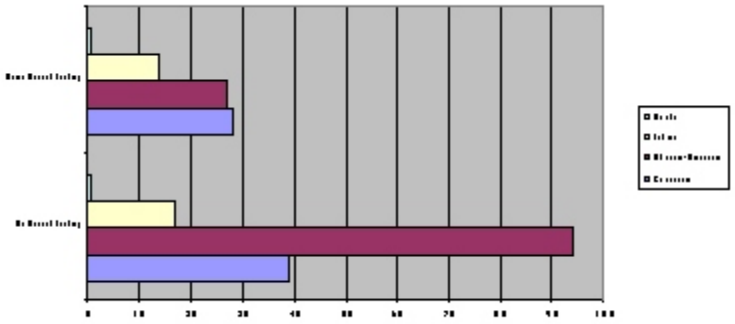

Figure 3: Ethnicity and Breast-feeding habits: African-American mothers are less likely to breast-feed their infants

We do not know if our very low breast-feeding rates (31% at two weeks post-partum and declining 50% per visit subsequently) are typical of all urban clinics with predominantly Medicaid insured patients. However, if they are, this means we are far away from reaching US Department of Health and Human Services "Healthy People 2010" goals. Our results suggest that breast-feeding education and encouragement must begin prior to the first pediatric visit, before a large proportion of women have discontinued breast-feeding. That might entail collaborative efforts between obstetricians and pediatricians to discuss this issue with mothers prior to the infant's birth.

*(See **Scientific**, next page)*

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Scientific

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In addition, certain factors also appear to be significantly associated with breastfeeding. Older women and mothers of infants discharged at less than 48 hours of life are more likely to breast-feed. We postulate that these mothers may have breast-fed prior infants, and are more comfortable with so doing, or are less interested in the "intrusive" hospital setting, and prefer to be home in a more natural setting in order to

breastfeed. In contrast, and reflecting national trends,[7] African Americans are much less likely to breast-feed This information may help us target our breast-feeding education to populations in which breast-feeding mothers need more support and encouragement.

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Report of Committee on Environmental Health, Drugs, and Toxicology

Charles F. Weiss, M.D.
Committee Chairman

LEAD

As explained below, funding has constrained the progress of the Lead Poisoning Prevention Program. The following should be of special interest to you who practice in Duval, Miami-Dade, and Pinellas counties.

The Childhood Lead Poisoning Prevention Program is preparing for an extremely competitive grant application process with the Centers for Disease Control and Prevention, beginning in late January. This year marks the end of separate grant funding for county-based programs. Thus, the Duval, Miami-Dade, and Pinellas County Childhood Lead Poisoning Prevention Programs will be absorbed by the state. The statewide lead program's success in procuring grant funds for fiscal year July 1, 2003 through June 30, 2004 will steer activities in each of the three counties, and throughout the state. The statewide lead program will continue to encourage health care providers to use the childhood lead poisoning screening guidelines.

For further information regarding lead screening, or to obtain a copy of the guidelines, contact Ms. Trina Thompson, Coordinator of Lead Poisoning Prevention Programs at the Florida Department of Health. PHONE: (850) 245-4444, Ext 2869 or SUNCOM 205-4444, Ext 2869. E-mail:trina_thompson@doh.state.fl.us.
Web: www.doh.state.fl.us/environmnt/nsee/lead/index/.html

The Insidious Hazards of Lead Paint Surfaces

(Excerpts from an editorial with thoughts on findings in a Rhode Island lead paint trial:)

Critical elements in the state's case were the problematic and transitory nature of "intact lead paint surfaces" and the ineffectiveness of "maintenance" in preventing lead paint "hazards" over the long term. All currently deteriorated lead paint surfaces were once intact surfaces. All currently intact surfaces with lead paint will ultimately become future deteriorated surfaces through diverse environmental and/or socio-economic circumstances. Hazards of lead paint to child health are scientifically defined as an intrinsic risk through a chronologically open-ended presence in the environments of successive populations of children. Present risks to present-day children are not frozen for all time merely because present lead paint surfaces in studied housing are deemed "intact."

Children encounter lead paint through various exposure mechanisms, ...chewing on intact lead paint surfaces, ingestion of lead particles escaping "intact" but chalking surfaces in seemingly well-maintained housing. These two routes . . . render ineffective any remedies favoring simple surface maintenance. . .Paul Mushak, Ph.D.

SMOKING

Taking a Smoking Lead From Parents
By ERIC NAGOURNEY

Parents who smoke may be encouraging their children to try smoking by asking them to do things like lighting their cigarettes or cleaning out their ashtrays . . .

A study that looked at the children for a year concluded that they were . . . more likely to experiment with tobacco, the lead author, Dr. Rafael Laniado-Laborin, told a conference of American College of Chest Physicians in San Diego.

The researchers surveyed 3,624 seventh and eighth graders in

San Diego, asking them about their smoking patterns, if any:

- whether their parents engaged in what the study refers to as "smoking prompts."
- having the children light the cigarettes for the parents (sometimes in a child's mouth)
- take cigarettes to the parents
- go to the store and buy them

The study then focused on 292 parents who smoked, and their children. When the children were interviewed a year later, those whose parents gave them prompts were more likely to have tried cigarettes ...

The study also found that many parents were not aware of what they were doing:

- When asked, for example, whether they had their children bring them cigarettes, 25 percent said yes.
- When their children answered the question, the figure was 59 percent.
- Just less than 9 percent of the parents said their children cleaned their ashtrays.
- Almost half the children said they did so.

Children whose parents smoke are already known to be more likely to try smoking. When children have easy access to cigarettes, the risk increases, Dr. Laniado-Laborin said.

Ed. Comment: Numerous articles confirm less smoking among children and adolescents who are counseled by a physician, nurse or their parents.

Adolescent cannabis use linked to increased risk for adult mental illness

Last Updated: 2002-11-21 18:01:46 -0400 (Reuters Health)

NEW YORK (Reuters Health) - The use of cannabis during adolescence and early adulthood is associated with an increased risk for anxiety, depression and schizophrenia, according to three reports in the November 23 issue of the British Medical Journal.

In the first paper, Dr. George C. Patton from Murdoch Children's Research Institute, Victoria, Australia, and colleagues report that frequent cannabis use is associated with an increased risk for depression and anxiety among teenage girls. The researchers collected data on 1601 students, 14 to 15 years of age, from 44 schools in Victoria. The cohort was followed for seven years. By 20 years of age, 60% of the subjects had used cannabis, with 7% reporting daily use. Among women, the daily use of cannabis was associated with a fourfold increase in the risk for depression and anxiety (odds ratio 4.2), the researchers found. For women who used cannabis weekly, there was a twofold increased risk for depression and anxiety (odds ratio 2.3), they add. Anxiety and depression, however, were not predictive of daily or weekly cannabis use. Dr. Patton and colleagues conclude, "These findings contribute to evidence that frequent cannabis use may have a deleterious effect on mental health beyond a risk for psychotic symptoms." They add that "strategies to reduce frequent use of cannabis might reduce the level of mental disorders in young people."

In the second report, Dr. Stanley Zammit from the University

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Committee

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of Wales College of Medicine, Cardiff, UK, and colleagues collected data on 50,087 Swedish military conscripts. The researchers studied reported cannabis use and admissions to hospitals for schizophrenia and other psychoses. The men were followed for 27 years.

"Men who had used cannabis by age 18-20 had an increased risk of developing schizophrenia over the next 27 years," Dr. Zammit told Reuters Health. This increased risk was dose-dependent, he added.

Dr. Dammit said that men who used cannabis more than 50 times had a 300% increased risk for schizophrenia, whereas those who used it less than 10 times had a 40% increase in risk compared with non cannabis users.

"We cannot be certain that this increase in risk is due to cannabis itself, although we adjusted for other factors that we felt might explain the association (such as personality traits or use of other drugs)," Dr. Dammit said.

. . . People who use cannabis should be made aware of this risk, especially if they have other risk factors for schizophrenia. "Although at an individual level the actual risk of getting schizophrenia may still be low even if you use cannabis, at a population level even a small increase in risk is important," he said.

In the third report, Dr. Terrie E. Moffitt from King's College, London, and colleagues examined a representative cohort of 759 young New Zealanders, who they studied prospectively from their birth in 1972 until age 26 in 1998. The researchers looked at whether adolescent cannabis use increased the risk for adult psychoses. In an interview with Reuters Health, Dr. Moffitt said, "we found that young adolescents who used cannabis, and especially those who started before age 15, had more symptoms of schizophrenia in adulthood than nonusers." Adolescents who began using cannabis by age 15, but not those who started at age 18, were four times more likely to be diagnosed with schizophreniform disorders in adulthood than their peers, . . . "Among individuals who used cannabis before age 15, 10% developed schizophreniform disorder by age 26, compared to 3% of the remaining cohort," he added.

Increased schizophrenia outcomes among young adolescent cannabis users were not limited to those young people who had psychotic symptoms in childhood before smoking cannabis, Dr. Moffitt explained. "Prior childhood psychotic symptoms explained some of this risk, but not all of it," he said. "Cannabis use among a small group of psychologically vulnerable young adolescents should be strongly discouraged by parents, teachers, and health practitioners alike. Policy makers need to concentrate on delaying the onset of cannabis use at least until late adolescence," Dr. Moffitt said.

"The shown dose-response relation for both schizophrenia and depression highlights the importance of reducing the use of cannabis in people who use it," Drs. Joseph M. Rey and Christopher C. Tennant from the University of Sidney, Australia, comment in a journal editorial. (BMJ 2002; 325;1183-1184,1195-1201,1212-1213.)

Ed. Comment: How many articles do you see on the safety of marijuana? Do you see this?

Smoking and Folate levels in Pregnant Women Who Smoke.

. . . Among women who smoked, folate levels were 22.7 nmol/L, significantly lower than among those who did not smoke (29.4 nmol/l, p=0,001), . . . Women who smoked also had lower red blood cell concentrations of folate (765 nmol/L versus 90r nmol/L. This difference was not (interpreted) as significant. . . .Dietary intake of folate did not differ between groups, and neither did the level of homocysteine, . . . A difference in folate levels in women who smoked that was related to their genotpe of methylenetetrahydrofolate reductase (MTHFR). The lowest levels were seen in women homozygous for the mutant methylenetrahydrofolate reductase 677 allele (18.6 nmol/L in pregnant women who smoked versus 24.2 nmol/L in pregnant women who did not smoke).

They concluded that the "increased incidence of adverse obstetric outcomes in pregnant women who smoke may be, in part, due to lower folate concentrations that are mediated by possibly low MTHFR enzymatic activity."

The researchers contemplate evaluation of randomized controlled trials to "determine the effect of high-dose folate in terms of attenuation of the detrimental effects of tobacco exposure on perinatal mortality rates." McDonald, S D, Am Gynecol 2002;187:620-625.

CDC Highlights Nonfatal Choking Risk in Children

More than 17,000 adolescents and children were treated in US emergency deatments in 2001 for choking on candy, coins or some other substances according to a CDC report. This is the first time the CDC has conducted an analysis of non-fatal emergency department visits for choking-related risk.

"All children are at risk for choking because food is a choking risk. . . . Parents need to be aware of it" (Dr. Julie Gilchrist of the CDC National Center for Injury Prevention and Control)

The new findings are based on an analysis of data from the National Electronic Injury Surveillance System-all Injury Program. Significant findings are listed:

- 17, 537 adolescents and children aged 14 years and younger were treated in US emergency departments for choking.
- > 100 emergency department visits for every one choking death.
- In the year 2000, 160 children aged 14 years or younger died due to choking in the US.
- ~ 60% of the patients in this study, including three quarters of the 5 to 14 year olds, choked on food, including substances such as candy or gum. 1 in 4 children in that age group had a choking episode associated with candy or gum.
- Hard candy caused the majority of candy-related episodes.
- Chocolate candy, gummy candy and chewing gum was also involved.
- Almost 1/3 of the children choked on nonfood substances.
- Eighteen percent aged 1-4 were treated for coin-related choking episodes.
- Choking most common among infants aged 12 months or younger and decreased with children's age.
- The majority of patients were treated in the emergency department and released soon afterwards.
- 10.5 % were hospitalized or transferred to another facility for care.

MMWR 2002;51:945-948

In a final comment, I have heard (anecdotally) of Florida families seriously inconvenienced by repeated attempts in the removal of black mold from their housing. Would like to accumulate these reports.

[Ed. Comment: All interested in participation in this Committee are welcome. Let me know your problems.] □

From the Resident Section

Laura P. Stadler, M.D.
Resident Chairperson for FL
USF Program Representative

[In each issue, we will focus on the State's Residency Programs and/or on issues affecting all programs.]

Spotlight on Orlando

The Orlando Regional Healthcare (ORH) Pediatric Residency Training Program at Arnold Palmer Hospital for Children & Women, is one of seven training programs found at the downtown campus of Orlando Regional Medical Center. Our program emphasizes the development of a well-balanced knowledge in pediatric care within a unique combination of community and academic medicine. As a major clinical campus, we provide general and specialty pediatric education for 3rd and 4th year medical students from the Florida State University College of Medicine and visiting 4th year medical students from across the United States. The strength of our program is a combination of modern facilities, a dedicated and diverse faculty and most importantly an active group of outstanding residents.

Our residents obtain inpatient clinical experience at Arnold Palmer Hospital for Children and Women and at Orlando Regional Lucerne Hospital. Arnold Palmer Hospital (APH) has 269 inpatient beds for women, children and infants and serves as our main teaching hospital. APH continually ranks high among the labor and delivery centers in the nation, with more births than any other hospital in the state of Florida for the past four years and over 9,500 last year. Lucerne Hospital provides 20 additional pediatric beds and a firsthand experience at a community hospital for our residents.

In a partnership between ORH and Nemours Children's Clinic, residents see a diverse cross section of patients. The ORH Pediatric Ambulatory Center provides residents with an outstanding, on-campus location for their weekly continuity clinics and is home to the Acute Care Center. With more than 28,000 outpatient visits annually, the residents provide vital pediatric care to the community under the educational direction of a dedicated faculty of pediatric generalists. At the Orlando campus of Nemours Children's Clinic residents work directly with sub-specialty providers caring for children with unusual and chronic illnesses.

Our program is currently in a period of growth. We recently expanded to 12 categorical pediatric residents per year. Including our medicine-pediatric residency training program, the house staff now totals 44 residents. We have enjoyed an active period of recruiting starting in November with interviews scheduled to finish in mid February. In March we anticipate another successful match and continued growth within our program and community. Recent state approval to build a new 130 million-dollar, 9-story building next to the current hospital underscores our commitment to improve healthcare services for the children and families of central Florida.

Resident activities are also making an impact in the local and national pediatric community. The resident led reach-out and read program provides books for children during well-child visits to our clinic. Dr. Cindy Carmack, a second-year pediatric resident, participated in a national collaborative project designed to improve the recognition and treatment children with ADHD. Several other residents actively participate in clinical efficacy and safety trials conducted in our clinics. Dr. Robin Chaize, a third year resident, worked with faculty on the national PROS study Life after Newborn Discharge (LAND).

Our residents volunteer time working with Habitat for Humanity and providing medical care in community clinics. Several ORH residents provide medical support for The Boggy Creek Gang Camp, a national non-profit foundation that provides children with chronic medical needs an opportunity to attend camp each summer and fall.

Finally, our residents continue to be successful in life after residency with an equal number of residents entering private practice and sub-specialty training. Recent graduates have obtained fellowship positions in Hematology/Oncology, Endocrinology, Critical Care, Pulmonology and Rheumatology at prestigious institutions in Philadelphia, St. Louis, Los Angeles, Cincinnati and San Francisco. We are proud of our program and I invite each of you to remember us on your next visit to Orlando Florida.

Dr. Robert Sutphin
Sutphin7@att.net ☐

Congratulations...

...to Miami Children's Hospital Pediatric Resident, Celina Maria Carillo, M.D. and her mentor Ziad Khatib, M.D., FAAP, for receiving an AAP research grant award in support of Dr. Carillo's pilot study: "Plasma Levels of Brain Natriuretic Peptide as a Marker of Cardiac Dysfunction in an Adolescent Population with Sickle Cell Disease☐

Congratulations...

...on receiving a Florida 2002 CATCH Community Access grant

...to Laura P. Stadler, M.D. and Marisa Lejkowski, D.O., Tampa/St. Petersburg

…to Robin Klaczkiewicz, M.D., Gainesville☐

One Possible Solution?

Herbert H. Pomerance, M.D.
Tampa, FLorida

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.☐

O

ver the years, this column has held many thoughts, both in favor of and against the concepts of managed care. Most writers have been quite vocal and very opinionated, as is the right of all members of our group. In some cases, solutions have been offered, ranging from status quo to total overhaul to total scrapping, and again, this was done with a great deal of honest feeling.

One of the concepts noted has been that of the "single payer system". Interestingly enough, this concept has now risen to the discussion level again, with very little explanation as to what it really is. This is most understandable, since the term is one that can be applied to several different ideas - or systems.

Given these conditions, I thought that it might be nice to step down from my magnificent title of "Editor" to write some explanatory words. Since my bias has to come through a little, I hasten to note that I speak here as clinician and not as Editor.

There are, and will be, numerous versions of "single payer", and I do not wish to be an encyclopedia. What follows is one idea of how it could work

This concept, like all, I suppose, creates the need for four forces to work together:

Government:

The federal government would not run a health care plan. To this extent, then, this is not a form of socialized medicine.

The government becomes a repository for premiums:

- If an employer provides health care coverage for employees, he pays the established premiums into the repository.
- If the employee works for an organization which does not provide health care coverage, then the individual has the privilege of paying the premiums directly to the repository.
- If the individual is unemployed, or cannot afford the premiums (poverty level), the government places the dollars into the repository. (Does this sound like some kind of universal access?)

The Insurance Companies

The government then approaches the health insurers, offering participation in the plan if certain qualifications are met:

- Acceptance of conditions which must be met, such as what diagnoses will be covered
- Any caps on annual spending
- Any caps on coverage of conditions.
- An actual fee schedule, to be addressed by the insurers and the providers.

The Providers

- Physicians (and other appropriate providers), represented by the major professional organizations, would participate in the setting of an appropriate fee schedule. Government would act as moderator in these discussions. (Does this sound somewhat like, and perhaps even an improvement on traditional Medicare practices?)
- The providers would not work for the insurers, but be independent agents, willing to participate or not. And, with a reasonable system, they would work hard to make it succeed.
- Providers would have the privilege of accepting a universal fee schedule (not restraint of trade since it is a multidisciplinary effort), or of opting out and negotiating with patients directly for any residual fee. The system could live or fall on the basis of acceptance of the essentials of the fee schedule.

The Insured:

The patient, that individual who always seems so

*(See **Managed**, page 18 ▸)*

Managed

(◂continued from previous page)

lost in the present system, is the fourth link.

- The patient is now essentially his own gatekeeper. In a reasonable system, the individual can, I am sure, be trusted to make appropriate use of the system, remembering what went before..
- The patient selects his own physician (WOW!), no panels, no denials, no firing for seeing too many patients, or for spending too much time, and no patients switched from one group to another with little or no notice.)
- The physician fills out a form (oh well, at least it would be a standard form), sends it to the patient's insuring agency, and the physician is paid, while the insurer transfers the equivalent from the federal repository.

Sound simple? It isn't that simple. There are lots of pitfalls, and lots of details which will need to be worked on. It has to take some time for the system to gear up, but when it does, it will revolutionize our [redacted]

Note:

Visit our society's permanent website at:

http://www.fcaap.org

for all you want to know about our society, including a [redacted]

Note:

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

[redacted]

FYI

The AAP will no longer print the tax deductibility disclosure statement on the membership dues invoice. Since we are incorporated as a 501 (c) (6) organization, we are required by the IRS to notify our members of the amount of dues that can be deducted as a business expense:

Dues remitted to the Florida Chapter are not deductible as a charitable contribution but may be deducted as an ordinary necessary business expense.

However, 30% of the dues are not deductible as a business expense for 2002 because of the chapter's lobbying activity.

Please consult your tax advisor for specific information.☐

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.☐

[redacted]

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. ☐

[redacted]

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!☐

aventis

aventis

Risk Management

[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]

Effective Communication Can Prevent Claims

Cliff Rapp, LHRM
Vice President Risk Management, FPIC

Effective communication and rapport with patients are developed skills that require the same professional approach, degree of learning, and practice as the technical aspects of medicine. Below are suggested behavioral skills that can lead to improved rapport and communication with patients.

It is important to begin the relationship correctly from the initial contact with the patient. When first meeting a patient introduce yourself by name, make eye contact, and shake hands. Also ask the patient how they would like to be addressed. It is extremely important to explain what you will be doing instead of charging in and performing the task on the patient. Allow the patient to ask questions if they do not understand or are unclear about the procedure. One of the most necessary communication skills involves listening. When the patient speaks, listen and look at them. Another technique to create good rapport is to not turn your back to the patient while speaking with them.

Questioning is also important to establish open lines of communication with patients. Remember to use open-ended questions whenever possible unless the patient is unable to speak. Ask questions one at a time and allow the patient to respond in their own terms.

The facilitation of effective communication is vital to the physician/patient relationship. The physician should encourage the patient with verbal facilitation, such as "Go on." Nonverbal facilitation such as nodding your head should also be practiced. If necessary paraphrase or restate what the patient has said for clarification. Allow the patient to speak uninterrupted and identify with and reflect the feelings of the patient in your statement. Avoid paternalistic or authoritarian statements (e.g. "Don't worry, you don't understand what this is all about" or "I know what is best for you"). To aid in understanding, reword technical medical terms into lay language but avoid being too simplistic for educated patients.

Additional rapport and patient techniques for effective communication are:

- Project a caring attitude.
- Relate to the patient as a person, not just a clinical condition.
- Adjust your level of explanation to match each patient's understanding of medical terminology.
- Encourage the patient to ask questions and be willing
- to explain procedures and answer questions.
- Be courteous to relatives and be willing to answer general questions about the patient's condition without compromising confidentiality.
- Return phone calls promptly.
- Give the patient in front of you your full attention. Patients resent interruptions.
- Respect patient confidentiality even in social situations. Instruct staff on the importance of confidentiality in all settings.
- Accept without judgment a patient's refusal to follow recommendations (document, but don't criticize).
- Reprimand staff away from the patient's presence.
- Avoid criticism of another physician's care to the patient.
- Resolve complaints and misunderstandings about care, the bill, or other matters yourself before resentment builds.

Effective communication with patients is an easy way to prevent claims. If patients fully understand all procedures, diagnosis, and treatment options, they are less likely to result in claims. The patient should be made to feel that the physician truly cares about their well-being.

[Information in this article does not establish a standard of care, nor is it a substitute for legal advice. The information and suggestions contained here are generalized and may not apply to all practice situations. FPIC recommends you obtain legal advice from a qualified attorney for a more specific application to your practice. This information should be used as a reference guide only.□]

gsk

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN

2002 Vice President/President-Elect Candidates Biographies

Carol Berkowitz, MD, FAAP
Torrance, CA

Dr Carol Berkowitz, born in New York, attended Barnard College, Columbia University College of Physicians and Surgeons, and did her pediatric training at Roosevelt Hospital. After a number of years in practice, she joined the full-time faculty at Harbor-UCLA Medical Center in Torrance, CA, where she is currently Professor and Executive Vice Chair in the Department of Pediatrics.

Carol's clinical interests have been in general and emergency pediatrics, with a focus on child maltreatment. Academically, she has been active in the area of Women in Pediatrics, having founded the Women in Medicine Special Interest Group of the Ambulatory Pediatric Association. She also served as the APA's President.

Carol currently serves on the AAP's Committee on the Pediatric Workforce, and its subcommittee, Women in Pediatrics. She spent six years on the Board of Directors of the American Board of Pediatrics, serves on the Program Directors Committee of the ABP, and helped develop the Resident Program on Professionalism in Pediatrics. She was a pediatric program director for 20 years, and currently serves on the Accreditation Council on Graduate Medical Education. She was the Academy's representative to the Residency Review Committee in Pediatrics, and was the Chair of the RRC and of the Council of RRC Chairs. She is currently the AAP's representative to the Council of Medical Specialty Societies.

She is the author of multiple articles and the editor of *Pediatrics: A Primary Care Approach* – a text used by many medical students and residents in their continuity clinic.☐

Francis E. Rushton, Jr, MD, FAAP
Beaufort, SC

Dr Francis Rushton, throughout his 24 years as a practicing pediatrician, has successfully balanced a busy private practice with numerous child advocacy efforts, academic endeavors, and involvement with the American Academy of Pediatrics. Currently, Francis is senior partner of Beaufort (SC) Pediatrics, a member of the AAP Committee on Community Health Services, chapter CATCH facilitator, and Clinical Associate Professor of Pediatrics at the University of South Carolina's Institute for Families in Society. In recent years, he participated on the Academy's Nominating Committee, served as president of the South Carolina Chapter of the AAP, led the state legislative committee, and chaired the Alliance for South Carolina's Children. Dr. Rushton authored the book, *Family Support in Community Pediatrics*, and worked as a visiting professor at Okinawa Chubu Hospital in Japan for three months. Still seeking avenues to promote child health issues, he ran for – but lost by four votes – the SC House of Representatives in 1998.

In 2001, Governor Jim Hodges presented Dr Rushton with the Order of the Palmetto, South Carolina's highest citizen award, for his commitment to children and pediatricians. In 2002, the Georgetown University Communities Can! Program recognized Beaufort's collaborative early childhood team as one of five outstanding community programs nationally.

Dr Rushton attended Phillips Exeter Academy, University of Florida, Georgetown University, and University of Miami School of Medicine before completing a pediatric residency in Birmingham, AL and serving three years with the National Health Service Corps in Tennessee. He is married to
Margaret and has three teenage children.☐

HOW WOULD YOU ADDRESS PEDIATRICIAN AND PEDIATRIC SUB-SPECIALIST CONCERNS REGARDING REIMBURSEMENT?

[Each candidate was asked: How would you address pediatrician and pediatric subspecialist concerns regarding reimbursement?]

Carol D. Berkowitz, M.D., FAAP

While there are many issues of concern to the pediatric community, the disparity in the rate of reimbursement for pediatricians, generalists as well as medical and surgical subspecialists, is a major one. FOPE II specifically identified poor rate of reimbursement to pediatric specialists as one factor negatively impacting recruitment to pediatric specialty fellowships. The discrepancy in reimbursement rates to pediatricians is particularly paradoxical since training time to achieve board certification in pediatric disciplines equals or exceeds that of our adult colleagues.

What drives the disparity? Is it that healthcare for children is reimbursed in a manner similar to medication dosing – on a per kilo basis, less reimbursement for smaller children? I think there are a number of contributing factors. First, children as a "political" entity are disenfranchised. While there are groups, including the American Academy of Pediatrics, who lobby on behalf of children, we have sometimes been remiss in not lobbying for ourselves. Inadequate physician reimbursement negatively impacts on pediatric healthcare access. Secondly, reimbursement by Medicaid, private insurers, and managed care is based on RBRVS fee schedule originally developed for Medicare, not for pediatric care. Lastly, we may have inadvertently contributed to the problem through our willingness to compromise and accept unfair rates to insure our own viability. While the issues are complex, a physician shouldn't need an MBA to insure a successful practice.

Much has already been done, spearheaded by the AAP, locally and nationally. The Task Force on Reimbursement and the RBRVS Project Advisory Committee have defined strategies including pediatric-specific CPTs as a means to rectify inequalities. Aligning with other organizations, like the AMA and other specialty societies, such as occurred with a recent letter to Aetna, provides additional power to our cause. Chapters have also fought. District IX was recently successful in repealing a bill that would have rolled MediCal reimbursement back to 1985 rates! Sometimes the threat of a lawsuit is the only means by which legislators take notice. We can learn from states and chapters where battles have been waged and won – and lost, acknowledging state differences and applying winning solutions to advance our goals.☐

Francis E. Rushton, Jr. MD, FAAP

No issue gets more to the core of our obligation to children than the problem of paying for health care. Any efforts to promote universal health insurance coverage by necessity must include attention to provider payments. Appropriate reimbursement assures children access to health care by promoting an adequate supply of qualified pediatric generalists and sub-specialists. The Academy and its Task Force on Reimbursement must continue to be at the center of the effort to ensure appropriate funding for pediatricians from both private and public payers.

Barbara Starfield's new book, *Primary Care,* provides ample evidence to support the cost effectiveness of pediatric practice. My own article, *Medicaid and Primary Care*, documents that adequate reimbursement for pediatricians leads to equal access for children's health care and ultimate savings for Medicaid programs. These arguments make an impression on the public and on payers. We have used them in my own state and have been rewarded with Medicaid primary care capitation rates that are better than most private insurance programs.

Pediatric generalists can only provide quality care with the cooperation of qualified sub-specialists. Pediatric sub-specialists who provide comprehensive services to their patients not only improve life span and quality of life, but also reduce costly morbidities, some of which can last a lifetime. Unfortunately, it's often the economic argument that seems to make sense to policy makers, both in my own state and elsewhere.

Reimbursement drives access. Other children's advocacy groups are following our lead. Legislators are often more willing to listen to broad-based children's groups explaining the importance of reimbursement levels than only to providers. Working with coalition partners is difficult; it requires give and take and a willingness to fight for our common interests. But, coalitions are effective.

The current economic downturn makes this fight that much more important and difficult. Both at the federal and state level, we in the Academy need to continue to speak out to make sure that children's health coverage and reimbursement stays on a par with that of adults. That is only fair. Using the economic arguments, working together with our partners, we can be successful.☐

From the FCAAP

F.Y.I.

Information has been received from Children's Medical Services announcing a final rule that will update physician payment rates under the physician fee schedule for 2003. The final rule was published in the December 31 Federal Register and will be effective on March 1, 2003

The FPS/FCAAP Listserv

I want to be sure that each of you knows about the FPS/FCAAP List Server. This provides the opportunity for you to communicate with other FPS/FCAAP members about topics of mutual concern. Recent discussions have revolved around the requirement for prior authorization for certain medicines under Medicaid. The following explains how to sign up for the FPS/FCAAP List Server.

- The FPS/FCAAP has a list server, FCAAP, to provide a forum for discussion among members of the FPS/FCAAP about any topics of mutual interest.
- The FPS/FCAAP List Server is a mailing list exclusively for members of the Florida Pediatric Society/Florida Chapter of the American Academy of Pediatrics
- (FPS/FCAAP). FPS/FCAAP members are free to post anything relating to the care of children, activities of the FPS/FCAAP, meetings, etc., and anything else you feel is useful or relevant to your fellow FPS/FCAAP members.
- The only restriction is that commercial messages are not allowed.

Subscription requests should be sent to majordomo@listbox.com. To subscribe to FCAAP, send a message to majordomo@listbox.com with a blank subject line and "subscribe fcaap" in the body of the message. You must be a member of the FPS/FCAAP in good standing, with dues current, to subscribe, and all requests are approved manually. Therefore, expect to receive confirmation of your subscription a few days after you send the request. If you do not receive the confirmatory message in a few days, please check to be sure that your email software has your correct return email address. If you continue to have problems, email Edie Lovingood, the FPS/FCAAP Membership Director, at edielov@cs.com.

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

Special Article

AAP CUSTOMER SERVICE CENTER

The Customer Service Center (CSC) has been established and is on its way to becoming a fully integrated "one-stop" service center. The Academy has transferred functions that were previously performed in separate areas to the CSC and we continue in our commitment to provide a seamless transition with no disruption to our members and other customers. We have blended your phone, fax, e-mail and regular mail inquiries into the service center to provide a consistent level of service and are handling about 650 contacts (phone, e-mail, fax and mail) per day. We handle most business functions, such as ordering Academy publications, subscribing to one of the AAP journals, changing an address, paying dues, and basic online assistance for our web sites (e.g., for meeting registrations, PediaLink.org, online journals, or paying dues online). In addition, there are fewer transfers necessary to handle requests and there has been less need to leave a message and wait for a callback.

We have a direct toll free number to reach the Customer Service Center, 866/THE-AAP1 (866/843-2271) and we look forward to continuing to enhance our service and the channels used to contact us. Hours are 7:00a.m. to 5:30p.m. Central Time, Monday – Friday.

The Academy truly welcomes your input to ensure the Customer Service Center provides the premier service and benefits AAP members and customers deserve. For questions or to offer your comments on the AAP Customer Service Center, call Chris Jenkins, (800) 433-9016, ext. 7150, or e-mail to cjenkins@aap.org.

ANNUAL MEETING: See page 31

From the Senior Section

[Our own Bob Grayson, whose efforts for the AAP and the Chapter are legion, recently wrote this piece for the AAP Senior Bulletin. We reprint it here in its entirety -Ed.]

Ten years and thirty issues ago I offered to edit this Bulletin [the Senior Bulletin]. Comes a time in the affairs of man when it is time to say "enough". This issue of the Bulletin will be my swan song, my last hurrah. I hope that some one of our 700 Seniors will take the helm and carry on. We have come from four pages to the twenties, from white paper to yellow, but don't call this "yellow journalism" It has been a learning experience for me, rewarding in some ways, and disappointing in others. My biggest regret has been that more of our members haven't been contributors. My sincerest thanks to the faithful few (you all know who they are), who have been regulars. Another regret is that my typing has not improved. These 83 year old fingers are all thumbs. Time and illness in the family are taking their tolls. No more deadlines, no more computer crashes (the latest on Tuesday last), no more coaxing, no more "please". Now, I will have the fun of writing letters to editor! Watch out!

For the present, some thoughts about this issue. We continue to offer financial articles from Joel Blau. Being a financial advisor must be the most frustrating job in the world these last two years. For the sake of the peds growing with their practices, we hope that they are conservative enough to spend little and invest wisely. Greed has destroyed many a happy retirement in my generation. Over- spending, over-building, the high living of the 90s has been a mistake. You, young seniors, be careful.

The imminent war frightens me. Recollections of WWII, Korea, 'Nam, Bosnia-Kosovo, Kuwait, Israel/Palestine, 9/11 worry me. Some of our patients did not and will not come home. Equalizing the wealth and opportunity throughout the globe might help. Exploitation destroys.

The small pox problem is still with us. To do or not to do is the question. If any of our leaders (medical and political) had seen actual cases of small pox, there would not be as much hesitancy in starting a vaccination program. In my practice, we vaccinated newborns (age 6 weeks) for small pox routinely, and though the numbers are probably in the low thousands, we had no problems. The secret is a careful family and patient history. A CT is no substitute for a few well placed questions. I would go ahead with the President Bush plan and get started before the first case of smallpox appears and the panic occurs. Also, the indecision on vaccination will influence groups to opt out of other routine immunizations. Preventable diseases will occur. Note, Boulder Colorado, and the little Island in Puget Sound where immunization rates have fallen significantly.

As I retire from the editorship, I recall leaving practice, not because of the effort of patient care, but because my view of the future of medicine predicted that we would become business people, the tools of greedy entrepreneurs, and bottom line and clock watchers. Managed care is not the cost saver it was intended to be, and is damaging American Medicine. Universal care as suggested in the article from California will surely come some time in the future. I am glad I opted out of practice before bitterness set in.

Note the several good articles about life on leaving practice. Chuck Miller, Jim Dick and Joel Merenstein. Happiness can lie ahead to those who are prepared. I leave the Bulletin, too, with only happy thoughts.

So, good friends, goodbye. Thanks for the memories.

Bob Grayson☐

ANNUAL MEETING: See page 31

The History Corner

PEDIATRICS IN FLORIDA
A TRADITION OF COMPASSIONATE CARING

Deborah Mulligan-Smith, M.D.
President Elect

[A continuation of the Guest Editorial}

The past causes the present, and so the future.

Our illustrious past:

Dr. Thomas Buckman, of Jacksonville and Dr. William McKibben, of Miami, are listed among the *Founders of the American Academy of Pediatrics.*

The Florida Pediatric Society
1935 - 1945

- April 27, 1936, aboard the Steamship Florida, the inaugural session of the Florida Pediatric Society was held. This meeting was concurrent with the sixty-third annual meeting of the Florida Medical Association.

"Many of us were seasick out in the Gulf Stream near Bimini until we anchored in a reef or coral atoll for our medical meetings. Gilbert Osincup told me afterwards that I looked bilious while reading my paper. The steamer was tossing so badly I had to hang onto a post while on my feet." All was not rough sailing; however, for he further says, "We spent the night in Havana, and didn't miss a trick." - Dr. McKibben

- The Pediatric Society is a closely knit informal group characterized by harmonious friendship and high camaraderie. Although there are no known existing minutes or rolls of membership, at no time were there over fifteen pediatricians in the organization. The spirit of mutual respect felt by the early members continues today.

1946 - 1959

The fifties were to see the development of altruistic medical programs that made Florida's organized pediatrics the most outstanding in the South and, in some fields, of the entire nation.

- 1951 Dr. Warren Quillian was installed as *President of the American Academy of Pediatrics.* As the first Southeasterner to hold this office, he brought to Florida pediatrics its highest honor.
- The Academy organization, requiring state chairmen, encouraged the *formation of State Chapters* in order to effectively out effectively committee and other activities for the benefit of children.
- The *Florida State Chapter* was formed on April 27, 1952. From the start, cooperation between the State Chapter and the Society has been excellent, and the existence of both organizations has benefited each.
- Dr. Warren Quillian served as Florida Medical Association Chairman of its committee on Child Health.
- The Committee on Child Health is an advisory group to the State Board of Health and the State Department of Education on matters pertaining to child care and school health.
- *The Florida Children's Commission* was created in 1947.

"I am amazed at the extensive effort you have made to promote accident prevention in Florida. Having reviewed the reports of most of the states, I can unequivocally state that your activities are more pertinent, more extensive and show greater imagination than any report I have reviewed."

-AAP Committee on Accident Prevention Chairman

- In 1954 Accident Prevention Chairman, Dr. Robert Grayson, was instrumental in forming *15 state poison control centers.*
- An original file system on poisonings and their treatment, developed by the committee, was distributed not only to Florida centers but was sold to over 50 other centers.
- The file system later became the prototype used by the *National Clearing House for Poison Control Centers.*
- As the fifties ended, a toy accident study conceived by Weil was started in cooperation

- with the National Safety Council and the Florida State Board of Health.

(Continued next page ▸)

History

(◂ continued from previous page)

- In 1956, Committee on the Handicapped Chairman Dr. Howard Engle, initiated a directory of mentally deficient children. Out of this interest grew the plan to catalogue all handicaps seen in all the numerous clinics in the State.

1960 – 1969

Significant developments affecting pediatrics took place during this decade. Perhaps the most far-reaching was the amalgamation of The Florida Pediatric Society with Florida Chapter of the American Academy of Pediatrics, which was consummated after two years of study and deliberation.

Gradually the Society/Chapter was changing from an educational and social group to an educational organization with a very active legislative and advocacy role.

- Spring meetings were held each year in conjunction with the Florida Medical Association. Dr. Gerold Schiebler, professor and chairman of the Department of Pediatrics at the University of Florida, Chaired the Conference Program Committee for five years.
- Meetings out of the state, in Jamaica in November 1960, in the Grand Bahamas in November 1963 and in Nassau in November 1965 were well attended not only by the membership but by a large number of colleagues from other states.
- The sixties saw a firmer tie established between the state's two medical schools and the Florida Pediatric Society. Many of the meetings featured presentations by faculty members of the Medical Schools.
- Two new committees were formed, notably the one on Adoptions, headed by Robert Grayson and another on Hospital Care with Norman Helfrich as chairman.
- The Society contributed two members to the *presidency of the Florida Medical Association*: Drs. Warren Quillian (1963) and George Palmer (1966). During Dr. Palmer's administration 34

pediatricians served on councils, boards and committees of The Association.

- By unanimous vote the Society established annual awards for a senior medical student in each of our medical schools. At the University of Florida the award was designated "The Luther W. Holloway Award for Excellence in Pediatrics" in honor of the Society's first president. At the University of Miami the award honors Warren W. Quillian, founder of the Society.
- The Head Start Project was instituted in 1965-66, and Florida joined in the effort.
- The legislature wanted to pass a law mandating testing the newborn for PKU, but the pediatric society favored voluntary programs of testing. It was hoped that local societies and hospitals would initiate programs of testing without government mandates. Unfortunately, the voluntary program was not adequate, and state legislation soon mandated testing for PKU and other metabolic disorders. *The opposition to mandates continues into the present and will always be an issue for debate.*
- The revision of the Constitution and By-laws which had been accepted on September 22, 1967 at the Annual meeting in Jacksonville, did not meet its full intent for many years because of the divided duties and responsibilities of the President of the FPS and the Chapter Chairman.
- During the latter part of the 60's and 70's, the FPS/Chapter held its annual meetings in many out of state locations, providing a pleasant ambiance for both the educational and social aspects. The minutes reflect that we met in Nassau, West End Island, Bermuda, Curacao, Mexico City (in conjunction with the International Pediatric Congress), Jamaica, and a "Song of Norway" cruise. After the IRS began to look more carefully at meeting sites, we stayed Stateside for the most part.
- The "Annual Post-Graduate Course," sponsored by Variety Children's Hospital (now Miami

Children's Hospital), and founded by Donald H. Altman, M.D., was "born" the week of March 9-12, 1966. The first faculty of ten guest lecturers included such legendary physicians as Drs. C. Everett Koop, Guido Fanconi, and Sydney Gellis.□ *[This is continued in next issue]*

The CATCH Corner

C.A.T.C.H.

There was no regular message provided by our CATCH facilitators for this issue of *The Florida Pediatrician*. We provide the following information relative to CATCH activity.

There were four CATCH grants approved in 2002. Two of these were to practicing physicians, and two were to resident physicians:

Physician Grants:

✓ Karen Toker, M.D., Jacksonville, received a $10,000.00 grant for "NE Florida Boards 2010 Express for CSHCN"

✓ Lloyd Werk, M.D., Orlando, was approved for a $9,950 grant for "Partnering with Parents." However, funding for the grant could not be secured.

Resident Physician Grants:

✓ Robin Klaczkiewicz, M.D., Gainesville, received a $1,500.00 gran for "Healthy Choices: Obesity Prevention Program"

✓ Laura Stadler, M.D., Tampa/St. Petersburg, received a $3,000.00 grant for "CATCH Us at Asthma Clinic"

For comparison, the following are statistics for previous years:

In 1999, there were no resident CATCH grants (they had not yet been created), and 5 Florida pediatrician grants.

In 2000, there were two Florida resident grants, one of which was a regular CATCH grant, and two Florida pediatrician grants.

In 2001, there were two Florida resident grants and four Florida pediatrician grants.□

Add-a-Pearl

...from Chuck Weiss

PROMISING SMALLPOX IMMUNiZATION RESULTS

JERUSALEM (Reuters) - Israel's smallpox vaccination of 15,000 emergency workers in preparation for a possible US-led war on Iraq caused few side effects, a Health Ministry spokesman said on Thursday.

Four people were hospitalized as a result of the vaccination drive, according to spokesman Ido Hadari. These included the child of one worker and the spouse of another, who had come into contact with their family member's vaccine site, causing blisters and a mild fever. The other two were treated for minor side effects.

Hadari said Israel was sharing its results with the US which vaccinated 100 military medics on Wednesday in the first wave of a program to immunize millions of troops and emergency workers who could be called to respond to any smallpox attack.

Washington launched the drive amid concern some terror organizations may have developed smallpox into biological weapons. Israel and the US also fear Baghdad may have developed smallpox as a weapon. Israel is preparing for possible Iraqi missile attacks should the US launch an offensive against Baghdad.

Babies born in Israel were inoculated with the smallpox vaccine up until 1980, and all Israeli military conscripts were vaccinated until 1996. "You can expect that one case out of a million that gets the vaccination might die. In a population that has been vaccinated in the past, we can say there will be only one death for every two to four million," Hadari said. Israel has stockpiled enough doses of smallpox to vaccinate its entire population of six million. Hadari declined to say when the rest of the population might be vaccinated.

Reduction of the influenza burden in children.*

Committee on Infectious Diseases, AAP

Epidemiologic studies indicate that children with certain chronic conditions, such as asthma, and otherwise healthy children younger than 24 months are hospitalized for influenza...[and] its complications at high rates similar to those experienced by the elderly.. . .

Currently, annual influenza immunization is recommended for all children 6 months and older with high-risk conditions... To protect these children, increased efforts are needed to identify and [redacted] addition, immunization of children 6 through 23 months of age and their household contacts and out-of-home caregivers is now encouraged to the extent feasible... The ultimate goal is a universal recommendation for influenza immunization. The vaccine has proven effective in reducing influenza related morbidity among household contacts. Results have shown that vaccinating children helps reduce influenza and related morbidity among household contacts, particularly among school-aged contacts, by as much as 80%.

CDC has stated there should be funding for some segments of the child population.

*PEDIATRICS 2002;110:1246-52, JAMA 2000; 284:1677-82

Ed. Note: This recommendation is long overdue!

President

(◂ continued from page 3)

to improve the KidCare program for families and practitioners. We will work with ACHA to implement the provisions of presumptive and continuous eligibility for infants through age 5. In a broader approach we will redouble our efforts for an increase in Medicaid physician reimbursement. The chapter has been very active working with ACHA and other organizations to begin to create a mechanism to increase the state federal support to increase payment to physicians, utilizing a mechanism called the Physician Upper Payment Limit (UPL). Although the UPL is a complicated formula, the concept is simple; the federal government will provide additional funding to cover the difference between what Medicaid pays and the costs of providing that care. The major hospitals in the state have benefitted from this program for three years and as a result garnered hundreds of millions of extra federal funding. It is now time for physicians to participate as well. If the state does not support our efforts or if they choose to use the new federal money to cover other aspects of the budget, we will be ready to take the necessary action. At the next meeting of your executive committee, we are going to be joined by Dr. Robert Wright from Okalahoma and Mr. Tom Gilhool from Pennsylvania to discuss what other states have done and are doing to address underpayment for services by Medicaid. Following that meeting and this session, we will have a multifaceted strategy to address this very important issue.

Once again, the challenges facing our chapter and our profession are huge, but as a chapter and a group of professionals we are up to the task. When your chapter leadership calls on you for help with our agenda, I know you will be there and with your help we will achieve many of our goals.

Best wishes for a very health and productive 2003. As always, I appreciate you allowing me to be your President.

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

Kudos...

...to Edward Packer, D.O., Chairman, Department of Pediatrics, Nova Southeastern Univesity College of Osteopathic Medicine, and to his Department, for receiving approval for an Osteopathic Pediatric Residency at Palms West Hospital, effective July 1, 2003.

Editorial

(◂ continued from page 5)

Table I

	1970	1980	1990	1998
Pediatricians	18,819	29,462	41,899	58,409
All Physicians	330,824	467,679	615,421	777,859

Sources:
AMA Physician Characteristics and Distribution in the US, 2000-2001 edition.
http://www.aapnews.org/cgi/content/full/20/5/197

http://www.aap.org/profed/gmepw/NRMPData2002rev.ppt

On a state-level, Florida is consistent with National averages concerning the ratio of pediatricians to family practice physicians.

Table II

	General Pediatrics	Pediatric Subspecialist	Family Practice	Ratio of Gen Peds: FPs
Florida	2,297	423	4,207	.546
National	44,580	7,235	77,531	.575

Satisfaction:

Despite decreased incomes, general pediatricians report highest levels of satisfaction and least job stress of all four physician groups (pediatrics, pediatric subspecialists, internal medicine, internal medicine subspecialists) whereas pediatric subspecialists reported levels of stress and burnout that raise significant concerns for workforce of pediatric subpecialists in the future.

Reference:
Shugerman et al: Pediatric Generalists and Subpecialists: Determinants of Career Satisfaction. PEDIATRICS September 2001

We have a place, all of us, in a long illustrious history; a history we continue.

Deborah Mulligan-Smith, M.D.
President Elect□

[To continue this interesting exploration of history, please read the first installment, page 27]

Kudos...

...to Arlan L. Rosenbloom, M.D., of Gainesville, who will receive the 2003 Distinguished Physician Award from the Endocrine Society for outstanding contributions to clinical endocrinology.

Dr. Rosenbloom is Distinguished Service Professor Emeritus at UF, and was the founder of the university's Division of Pediatric Endocrinology. He is medical director for Florida's Children's Medical Services.

Region 2

(◂continued from page)

The pediatric residency-training program of the University of Florida/Jacksonville Campus was awarded the high prestigious DYSON foundation grant to support their activities in community pediatrics. This will provide an opportunity for the residents to have both clinical and research experience in community resources that can be brought to bear to improve children's care.

Despite these many great successes and the obvious progress being made there are still several areas of great concern to the pediatricians specifically and medical care providers in general. There is a great deal of concern about the potential impact of the HIPAA regulations currently scheduled to be put into place as of April 14, 2003. It is not at all clear how this will impact the variety of practices.

Spiraling costs for malpractice insurance as well as the decision of several insurers to leave the area has caused several pediatricians to even consider the viability of the future of practicing pediatrics. This is of course a grave concern to all of those with interest in children's care. There is generalized concern about the declining reimbursement rates and increased paperwork required to obtain reimbursement. Further, the black cloud of the pending insurance crisis with the skyrocketing numbers of uninsured patients hangs over us all. As usual, children are over-represented in the underinsured and uninsured population and we will be looking to both the State and Federal governments for support. The Florida Pediatric Society provides leadership.

At the current time the membership of the Region II of the Florida Pediatric Society looks forward to a prosperous, productive and pleasant 2003. With energy, enthusiasm and effort the obstacles that present themselves can be overcome. We strongly support the strategic plans and initiatives of our state and national leadership and look forward to fulfilling our mission.

Donald George, MD
Regional Representative□

In memoriam

Panayotis Kelalis, M.D., FAAP, of Ponte Vedra Beach, Florida, died in his sleep on October 25th, at age 70.

Add-a-Pearl

...from Chuck Weiss

Microwaved Microbes

Q. Does water boiled in a microwave have the same germ-killing abilities as old-fashioned boiled water? Does chicken cooked all the way through in the microwave get hot enough to kill Salmonella?

A. Because of the chances of uneven heating in a microwave and other factors, the answers are tricky, said Dr. Kathryn J. Boor, Associate Professor of food science at Cornell. The germicidal strength of anything, be it hot water or disinfectant, depends on temperature, concentration (for chemicals) and time, she said. Water boiled in the microwave is less likely to be hot enough long enough to kill germs outside it, though pathogens in the water would be killed as it came to a boil.

Microwaved water heats to 212 degrees quickly but also cools quickly because it is likely to be a small volume, she explained. A pot of water slowly and evenly coming to a boil over a conventional heat source stays hotter longer and "has more thermal destructive capability," she said.

By Claiborne Ray
http://www.nytimes.com/2002/10/22/health/nutrition/22QNA.html

Mark your Calendar

GENERAL PEDIATRIC UPDATE IX
& FLORIDA CHAPTER AAP ANNUAL BUSINESS MEETING
& FLORIDA PEDIATRIC ALUMNI ASSOCIATION, INC. ANNUAL MEETING

Save These Dates

June 20-22, 2003

Location:
Hilton Hotel
Lake Buena Vista, Florida

Jointly Presented by:
Florida Pediatric Society/FCAAP
& Florida Pediatric Alumni Association, Inc.

More Information to Follow!

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 Nephrology: Current Concepts in Diagnosis and Treatment
Dates: February 28-March 4, 2003
Place: Club Atlantic, Fontainebleu Hilton Resort and Towers
Credit: Hour for hour (up to 27 hours) for Category 1 for AMA Physician Recognition Award
Sponsor: University of Miami College of Medicine
Inquiries: Oscar Reyes, Div of CME, (305)243-6716 or (800)863-6263

Program: Practical Pediatrics
Dates: March 13-15, 2003
Place: Hilton Inn, Walt Disney World Resort, Orlando, FL
Credit: Hour for hour (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: Southwest Florida Annual Pediatric Conference
Dates: March 22-23, 2003
Place: Sanibel Harbour Resort and Spa
Credit: Hour for hour for Category 1 for AMA Physician Recognition Award
Sponsor: The Children's Hospital of Southwest Florida
Inquiries: The Children's Hospital of Southwest Florida

Program: Practical Pediatrics
Dates: May 16-18, 2003
Place: Anchorage Marriott Downtown, Anchorage, AK
Credit: Hour for hour (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: Pediatrics Symposium: Update 2003
Dates: May 24-26, 2003
Place: Sandestin Beach Hilton Golf and Tennis Resort, Destin, FL
Credit:: Hour for hour (up to 29 hours), for Category 1 for AMA Physician Recognition Award
Sponsor: Medical Educational Council of Pensacola/Sacred Heart Children's Hospital
Inquiries: Call (850) 477-4956

Program: 27th Annual Florida Suncoast Conference
Dates: June 27-29, 2003
Place: Trade Winds Island Grand Resort, St. Pete Beach
Credit: Up to 13 hours for Category 1 for AMA Physician Recognition Award
Sponsor: University of South Florida and All Children's Hospital
Inquiries: Terra Sroka, (727)892-8584

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