The Florida Pediatrician

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Florida Chapter American Academy of Pediatrics

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In this issue.....

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Dear Colleagues

Once again the Annual Chapter Forum was an outstanding success! Our chapter was well represented by Dr. Debbie Mulligan-Smith and Dr. David Marcus. As you know the Chapter Forum is our opportunity as a Chapter and as members of the AAP to express our concerns and expectations to the AAP leadership. And I assure you that our voices are being heard! This year our chapter introduced only one resolution, dealing with smoking in films. Next year, I would like to see our chapter submit several more resolutions. I know that many of you have great ideas dealing with how we can improve the care we give our patients and their families, how we can improve the environment in which we work, and how we can make the AAP meet our needs better. Please begin to develop the concepts you would like to see introduced as resolutions at the 2003 Chapter Forum and forward them to you Regional Representatives as soon as you can. If you are not sure how to write a resolution, forward your ideas and we can help you with the format.

Once again the Florida Chapter was recognized with an Award in Excellence for all of your great work as advocates for children and the innovative programs you have developed at the community level. We should be proud of all the incredible things we do for children and families in Florida, without compensation, on our own time, and just because we want to do be sure that children in our state have every opportunity available to them. I am quite confident that if we continue on our current path and are more efficient at identifying these incredible grassroots programs that we will achieve even greater recognition next year!

* * * * *

"...Chapter was recognized with an Award in Excellence for all your great work..."

* * * * *

Now, by the time this edition of *The Florida Pediatrician* is published, we will have determined who will lead our state and nation for the next few years. Then again, maybe we will, and maybe we won't; after all this is Florida!

At this juncture I am not as concerned about who will lead the state because we have strong advocates for children on both sides of the aisle. My major concern is the effect passage of some of the proposed items will have on our budget. If the well intended, but misguided, costly amendments are successful, the entire budget could very well be gutted. These new programs will, out of necessity, be funded by eliminating many of the optional safety net programs which benefit so many of the children and families we serve.

With these threats and the potential of a continued down turn in our economy, it is more important than ever that the Florida Chapter of the American Academy of Pediatrics position itself to do everything we can to continue to advocate for families and children in our state. Once again, we will focus on improving the KidCare Program by streamlining eligibility, and insuring that managed care companies who participate in the program are held to the highest standard of care. We will also work to make sure that any Pediatric provider willing to participate in the KidCare and Medicaid Programs will do so without incurring a financial loss. Appropriate reimbursement for

FPIC ad

Fall is Here!

Well, here we are entering the fall/winter season. We have made it through the summer months, and now we can count our blessings, and our new problems!

As this editorial is written, we are facing an election (over by the time you receive this edition). In a group as large and as diverse as we are, there must be myriad wishes as to the outcome. We don't take sides in this column, but merely hope that 1) everyone will be, in true democratic fashion, able to live with the results and 2) we will have a successful two years till the next time. Hopefully, the bad publicity Florida has had in the past over election handling will not be repeated. We are not nearly as naive as some of our countrymen may think we are.

"...an election..."

Also, as this is written, we are standing on the brink of a situation in which some of us - or our offspring - will be precipitated into a conflict that none of us really wants. I cannot read what will happen between this writing and your receiving, but I think that we all share the deep-felt hope that a conflict will not be necessary. Let us hope that our national leaders, of both parties, will act in the best interests of all of us, with no politicization.

"..a conflict..."

The election soon to occur will help to shape our futures, at least for the next two years. The configuration of the State's Legislature will determine to an extent the efforts our society's legislative group will be expending in the next two sessions. So will the passage or failure of constitutional amendments/initiatives. We can only hope that, whichever group "inhabits" Tallahassee, the welfare of children will rise to the surface. Again, no results will satisfy all of our members, but still, in the democratic world in which we live, we should accept the results and unite to go forward.

"...THE advocates for children..."

After all, we are THE advocates for the children of our state, and we do not have any disagreements on this! We all wish for better health care for children, better social care for children, better support of education for children, and better support of the advocates. As the next year unfolds, let us go on with our job - to provide excellence of care and advocacy for the state's children.

And, speaking of going forward, go forward from here into the pages which follow, and enjoy the various departments which we try to bring to you in each issue. Compiling these contributions is a big job, and one which I enjoy. I hope you all enjoy reading them as much as I do setting them up.

Best of luck in your election wishes. Best of luck in your national wishes. Best of luck as advocates for children.

- The Editor□

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THE REGIONAL REPRESENTATIVES REPORT

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

Region V reports:

Several exciting events have occurred in District V during the past year. The first is that Dr. Lewis Barness has received the degree of Honorary Doctor of Science from the University of Wisconsin. Dr. Barness continues to teach actively in the USF Pediatrics program as one of our most beloved faculty. Congratulations!

For the second time since the inception of the Resident Committee of the AAP, a University of South Florida Pediatric Resident was elected as the Region 10 Chair of this committee. Dr. Laura Stadler is in her third year in our program. She has been active in advocacy issues for children in our region through her efforts with the Resident Committee as well as her efforts in submitting grants to increase services for children in rural Manatee County. Congratulations to Dr. Stadler.

The AAP and Maternal Child Health Bureau awarded a SCHIP grant to Beth Ann Gemunder, MD and Rani Gereige, MD to use an outreach worker to assist families in the enrollment of their children in Medicaid programs. Since March, 250 families have been enrolled in Manatee County – a resounding success. Dr. Gereige is the Assistant Residency Program director for the USF-All Children's Pediatric Residency Program. Dr. Gemunder is a third year pediatric resident. On a similar note, Dr. Gereige was awarded the Humanism Award by Medical Students at the University of South Florida. This is a prestigious award and we congratulate Dr. Gereige on his achievement.

The Department of Pediatrics at USF was awarded the Teaching Award for Best Teaching by a Clinical Department by the third year medical students from the class of 2003. Finally, Dr. Lynn Ringenberg has been elected the Alternate Regional Representative for District V of the Florida Chapter of the AAP. Congratulations!

On the community front, District V continues to promote improved access to care for children through its volunteer activities at events such as the Back to School Physical Examinations provided at many locations throughout the Region. These programs are successful because of the participation of many community physicians.

The Hillsborough County Pediatric Society continues to hold its quarterly meetings, which provide continuing education to its members on topics ranging from Immunization Updates to Advances in Minimally Invasive Surgery. At our most recent meeting, Dr. Tom Abrunzo was recognized for his contributions to the Hillsborough Society as well as to the Florida Chapter. Dr. Abrunzo has been tireless in his advocacy for children. A Job Well Done And Recognition Well Deserved!!

Carol Lilly, M.D.
Regional Representative, Region V☐

Region I reports:

Region I is in a state of flux right now. Randall Reese is the new Regional Representative, proceeding from the post of Alternate Regional Representative, and succeeding Tom Truman, who has spent two years in the post. For this reason, there is not much to report for the Region, and I have taken this opportunity to let members in the region as well as in the State know that Region I is alive and well, and will provide a full report in the next cycle.

-Editor☐

Note:

Visit our society's permanent website at:

http://www.fcaap.org

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

Note:

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

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

Note:

If you are a Fellow of the American Academy of Pediatrics, you are automatically a member of the Florida Pediatric Society/Florida Chapter of the American Academy of Pediatrics, and you automatically receive *The Florida Pediatrician*. If you have not already done so, please pay your annual Florida dues, billed through the Academy Office. ☐

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

Robert D. Christensen, MD
Lewis A. Barness Professor
Chairman, Department of Pediatrics
University of South Florida College of Medicine

Considerable growth occurred this past year in this Department in federal research funding and in faculty size. The largest of our new federal awards ($4 million over three years) was for the development of a Pediatric Clinical Research Center (PCRC) at All Children's Hospital. This new grant will provide the USF faculty, from any college or department in the Health Sciences Center, with the infrastructure support needed to facilitate investigator-initiated clinical studies involving children. Such support includes expertise in biostatistics and data management services, including biomedical informatics, data analysis, assembly, and display. The PCRC grant also provides salaries for four pediatric/neonatal research nurses to help investigators identify eligible patients, to enroll them on approved protocols, and to complete the study procedures. An ancillary study-cost budget is also provided, to grant investigators limited funds for meritorious pilot projects. A Scientific Advisory Committee, chaired by Dr. Darlene Calhoun, will set the scientific direction of the PCRC. That committee has been charged with conducting a national search for a PCRC Program Director, and we intend to attract an experienced pediatric clinical researcher by offering an endowed chair as well as new research space.

During this past year, our faculty members obtained over $4 million in other new federal grants. One of the largest grant totals received this year was to Dr. Patricia Emmanuel's programs in Pediatric Infectious Diseases, particularly HIV, totaling over $1.6 million from the NIH's Pediatric AIDS Clinical Trials Group. Other large grants included $1.4 million from NICHD and NHLBI awarded to Dr. Darlene Calhoun and I for studies of neonatal hematology and developmental biology, and over $260,000 awarded to Dr. Ben Pollara for vaccine studies.

The Departmental faculty received several distinctions this year. Our founding Chairman, Dr. Lewis A. Barness, was awarded an Honorary Doctorate by the University of Wisconsin. Dr. Rani Gereige of the General Pediatric Division, and Associate Director of our Residency Program, was awarded one of the highest honors by the graduating class of the College of Medicine, the "Humanism in Medicine" award, for his outstanding example of personal and professional characteristics. For the first time in the history of the USF College of Medicine, the Pediatrics Department was the recipient of the award for the "Best Teaching Department" (ending eight straight years where the Department of Internal Medicine won this award). It was no coincidence that this award was given during the year Dr. Ellyn Theophilopoulos was placed in charge of the Pediatric Clerkship program and made Associate Chairman for Medical Student Education. (The first year the "Best Teaching Department" Award at the University of Florida, Gainesville, was given to the Pediatric Department was the year Ellyn was Chief Resident in that program).

Three Endowed Chairs were filled during this past year and three remain to be filled, we hope during the next quarter. Dr. John Sleasman, Professor of Pediatrics and Chief of the Division of Allergy-Immunology-Rheumatology-Infectious Diseases at the University of Florida College of Medicine accepted the Robert A. Good Chair in Immunology. Dr. Lisa Simpson, currently the Deputy Director of NIH's Agency for Health Care Quality, accepted the All Children's Hospital Guild Chair in Pediatric Health Policy. Dr. Darlene Calhoun accepted the Thelma and Maurice Rothman Chair in Developmental Biology.

Other faculty members recruited to our Department during the year include Dr. Carmine Lopez-Pena, a Rheumatologist from the Duke/UNC program, joining our Division of Allergy/Immunology/Rheumatology, Dr. Diane Straub, an Adolescent Medicine specialist from the University of California, San Francisco, joining our General Pediatric Division, and Dr. Stacey Levitt also from the University of California, San Francisco joining our Division of Neonatology.

*(See **Chairmen**, page 26 ▸)*

Report

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 last 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 inform our decision-making.

For those clinicians apprehensive of large, involved projects – I can offer you reassurance that these projects are not like that. The Safety Check and CARES projects have been extensively pilot tested and are designed to be simple and fast for participating doctors. Both are great "entry-level" studies on issues important to pediatricians and worthy of study.

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.

Respectfully submitted,

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(August 30, 2002)

Rani Gereige, M.D.
Assistant Professor of Pediatrics
USF College of Medicine

[As recipient of the Humanism in Medicine Award, Dr. Gereige was the speaker at the White Coat Ceremony for the first year students at USF. The following were his remarks.]

President Genshaft, Dean Daugherty, Fellow Faculty, Students, Families and Friends:

It is a great honor for me to stand here before you to address the class of 2006 on this special day. I am very grateful for this opportunity. Thank you.

Members of the Class of 2006:

Today marks the closure of your "Profession of Medicine" course and the beginning of your "Profession of Medicine" life. Today is YOUR day, a day to honor you, your determination, drive and perseverance to get to where you are now, and you made it. Welcome; it is good to have you.

The White Coat Ceremony is more than about receiving your coat. It is about adopting the symbolism of the white coat and what it stands for. Earlier in the history of medicine, clerical caretakers in hospitals donned black robes, a color that conveyed a sense of mourning since hospitals were sadly regarded as houses for dying. Later, lab coats were beige. It was not until the 20th century that hospitals were considered institutions of healing. In the late 19th century, physicians adopted the coats and white was appropriately chosen for the times. Why white? It represents purity and goodness. It is a visual reminder of the physician's commitment to do no harm. In addition, white conveys cleanliness and connotes a purging of infection. The coat symbolizes seriousness of purpose and serves as a symbolic barrier of the professional physician-patient relationship. Most importantly, the white coat is a cloak of compassion.

Receiving your white coats today carries with it the responsibilities of living up to the noble values it stands for. Initiated in 1993 by Dr. Arnold P Gold, the White Coat Ceremony has since been adopted by most medical schools as a rite of passage to the profession of medicine. Dr. Gold, who was a Pediatric Neurologist at Columbia University's College of Physicians and Surgeons, became aware that the recitation of the Hippocratic oath as students are graduated from medical school, came four years too late. Hippocrates administered the oath to students BEFORE their medical studies began, not after they were completed. Being one of the symbols of humanism, the white coat is presented to you in this ceremony as an induction into the profession of medicine.

So what is Humanism? Webster's dictionary defines it as "a doctrine, attitude, or a way of life centered on human interests or values, humanism is a philosophy that asserts the dignity and worth of man and his capacity for self realization through reason". The American Board of Internal Medicine states that "the three essential humanistic qualities for physicians

*(See **White Coat**, page 30 ▸)*

SUDDEN INFANT DEATH

Enid G. Barness, M.D.
Lewis A. Barness, M.D.
Tampa FL

Infants may die suddenly and unexpectedly. The cause of death may be determined at the time of autopsy, but if it cannot be determined, the term sudden infant death syndrome (SIDS) is applied. The cause of death should be ascertained whenever possible for adequate parental counseling, including genetic counseling, when applicable. SIDS is the most common cause of death in infants 1 to 6 months of age.

By definition, SIDS is the sudden death of an infant less than 1 year of age that remains unexplained after a thorough case investigation, including a complete autopsy, examination of the death scene, and review of the clinical history.

Well-defined causes of death after a complete autopsy are shown in Table I, and include cardiovascular conditions, respiratory conditions, gastrointestinal problems, metabolic disorders, and others..

Table 1
Well-defined causes of death after complete autopsy

- Cardiovascular
  - Myocarditis (usually viral)
  - Congenital heart disease
    - Congenital aortic valvular stenosis
    - Endocardial fibroelastosis
    - Anomalous origin of the left coronary artery
  - Cardiomyopathy
  - Rhabdomyoma (in tuberous sclerosis)
  - Cardiac arrhythmias - long QT syndrome*
- Respiratory
  - Bronchopneumonia
  - Bronchiolitis
- Gastrointestinal
  - Dehydration with fluid and electrolyte imbalance (usually due to diarrhea)
- Metabolic disorders
- Dehydration with overheating in cystic fibrosis
- Adrenal insufficiency
- Injury
- Abuse
- Suffocation

* May be frequent cause of sudden infant death.
Neonatal electrocardiographic screening has been suggested.

SIDS patients show a number of characteristic features, which are listed in Table II. These features embrace such things as occurrence time, birth order, sex and race.

Table II
Characteristic Features of SIDS

- Occurrence between 2 and 4 months: 85%
- Occurrence less than 6 months: 95%
- Occurrence between midnight and 9 AM: 90%
- Increases with birth order
- Males affected more than females
- Race: In the United States, incidence higher in Native Americans and African Americans

Several risk factors have been identified. The major risk factor, however, is the prone sleeping position. Table III lists these factors.

Table III
Risk Factors For Sudden Infant Death Syndrome

Infant	
	PRONE SLEEPING POSITION*
	Apgar scores < 6 at 5 minutes
	Intensive neonatal care requirement
	Neonatal respiratory abnormalities
	Bronchopulmonary dysplasia
	Anemia
	Twins
	Previous acute life-threatening event
	Sibling with SIDS
Maternal	
	Anemia
	Smoking*
	Alcohol and drug abuse
	Maternal age < 20 years
Other	
	Soft bedding
	Race
	Ethnicity
	Socioeconomic status
	Cultural influences
	Lack of breast feeding*
	Co-sleeping

* The most important risk factors

In 1999, the incidence of SIDS was 1.6 per 1000 live births in the United States. In the United Kingdom the incidence was 2.5 per 1000 live births. After adoption of the supine sleeping position for infants, the incidence fell to 0.7 per 1000 live births.

Metabolic disorders may be associated with sudden infant death which is not SIDS. When more than one infant in a family has died suddenly and unexpectedly, a metabolic disorder or child abuse should be suspected. True SIDS rarely, if ever, occurs month of life, when inborn errors of metabolism may be

(See **Scientific**, page 25▸)

Legislative Report

Report on the 2002 Legislative Session

Nancy Moreau
Legislative Liaison

[Second half of the report by Ms. Moreau on the 2002 Legislative Session, a continuation from the August issue.]

SB 20E - Florida Education Code

(Chapter No. 2002-394) Effective Date: January 7, 2003

This legislation creates Florida's School Code and covers K-12, community college and university level education. The Code is reorganized into a different format to reflect changes made in governance by the Constitutional amendment of 1998 and the mandatory repeal of many sections of the code. Most areas of interest to physicians contain little or no change, but have been assigned to new sections of the statutes.

This legislation is massive (1786 pages) and covers all educational issues presently in statute and changes necessitated by the restructuring of the governance of the educational system. Some of the more relevant issues to pediatricians which are contained in the Code are listed below.

- School entry health examinations and immunization requirements s. 1003.22, F.S. (Page 323-328)
- Administration of medications and provision of medical services by district school board personnel s. 1006.062, F.S. (Page 645-647)
- Preparticipation physical examinations for interscholastic athletic competition s. 1006.20, F.S. (Page 682-684)
- Permission requirements for the use of inhalers by asthmatic students s. 1002.20, F.S. (Page 176)
- Guidelines for the use of corporal punishment s. 1003.32, F.S. (Page 347-348)
- Required instruction of comprehensive health education s. 1003.42, F.S. (Page 353)
- Requirement for eye protective devices in certain circumstances s. 1006.063, F.S. (Page 648)
- Vaccination against meningococcal meningitis and hepatitis B; information and requirements for vaccination of on-campus university residents s. 1006.69, F.S. (Page 761)
- University health services support organizations ss. 1004.29-1004.30, F.S. (Page 452-458)
- Diagnostic and learning resource centers s. 1006.03, F.S. (Page 637)

CS/SB 1276 - Health and Human Services Eligibility Access

(Chapter No. 2002-223) Effective Date: May 1, 2002

This legislation creates the Florida Health and Human Services Access Act which establishes a framework for improvements in the delivery of state-funded health and human services. The Agency for Health Care Administration (AHCA) is required to work with a designated steering committee to implement a pilot comprehensive health and human service eligibility access system (Florida 211 network) and develop coordinated care management for families and individuals with multiple needs. AHCA is authorized to seek federal waivers.

CS/SB 1766 - Shaken Baby Syndrome / "Kimberlin West Act of 2002"

(Chapter No. 2002-174) Effective Date: April 24, 2002

Hospitals, birthing facilities and providers of home birth services will be required, before discharge, to provide parents of a newborn with written information concerning the dangers of shaking infants and young children. The Department of Health must prepare a brochure that describes the dangers of shaking infants and young children, the causes that lead to shaking and ways to reduce the risks that can lead to shaking infants and young children.

This legislation also revises provisions relating to the abrogation of privileged communications in cases involving child abuse, abandonment, or neglect. The privileged quality of communications shall not constitute grounds for failure to cooperate with law enforcement. Authority is extended to law enforcement officers to petition a court for an order to gain access to specified records relevant to abuse allegations under investigation.

SB 592 - Adoption / Medical Assistance

(Chapter No. 2002-16) Effective Date: July 1, 2002

The Interstate Compact on Adoption and Medical Assistance is created by this legislation which authorizes the Department of Children and Family Services to enter into interstate compacts with other states to provide medical assistance for children with special needs. A process for facilitating reestablishment of Medicaid eligibility for families with special-needs under adoption assistance programs is provided. Non-Title IV-D children with special needs in the state funded adoption subsidy program are authorized to receive Medicaid from their state of residence as is presently provided to Title IV eligible children.

CS/SB 1272 - Child Support / Health Care Coverage

(Chapter No. 2002-173) Effective Date: April 24, 2002

This legislation authorizes Florida's use of the national medical support notice which implements a standard order and process for notifying an employer of the health care coverage required of a support obligation and institution of the non-custodial parent's health care coverage for their child.

CS/CS/SB 632 - Out-of-Home Care for Dependent Children

(Chapter No. 2002-219) Effective Date: July 1, 2002

A number of issues relating to the implementation of community-based care in Florida's child welfare system are addressed in this legislation. The Office of Program Policy Analysis and Government Accountability (OPPAGA), in consultation with the Department of Children and Families and the Agency for Health Care Administration, is required to review and report to the Legislature on the process for placing children for residential mental health treatment to determine whether changes are needed.

CS/HB 261 - Motor Vehicles / Safety

(Chapter No. 2002-20) Effective Date: July 1, 2002

This legislation addresses transportation laws and includes revision of statutes related to regulation of motorized scooters and Segway, driver education program funding and penalties for alcohol, drug and tobacco offenses by persons under 18 years of age.

Section 316.003, F.S. is amended to add a definition for "motorized scooter" which is defined to be a vehicle not having a seat and no more than three wheels which can reach speeds greater than 30 miles per hour. An "electric personal assistive mobility device" (Segway) is defined as a two-nontandem-wheeled device to transport only one person the maximum speed of which is less than 20 miles per hour. A person who is under the age of 16 years is required to wear a bicycle helmet while operating an electric personal assistive mobility device. Restrictions are placed on where these devices may be used,

however no requirements for helmets, etc. were placed on motorized scooter riders. The Dori Slosberg Driver Education Safety Act is created to allow the boards of county commissioners to require, by

*(See **Legislative**, page 27 ▸)*

Committee Reports

Report of Committee on Environmental Health, Drugs, and Toxicology

Charles F. Weiss, M.D.
Committee Chairman

Small Pox Response Plan

CDC is releasing an updated version of the post-event Smallpox Response Plan and Guidelines. This is the second revision to these guidelines since they were released in November 2001.

Version 3 of the guidelines contains an important addition---the "Smallpox Vaccination Clinic Guide." This guide provides the operational and logistical considerations associated with implementing a large-scale, voluntary vaccination program as part of a multifaceted response to a confirmed smallpox outbreak. Following a confirmed smallpox outbreak within the United States, rapid, voluntary vaccination of a large segment of the population might be required to 1) supplement priority surveillance and containment control strategies in areas with smallpox cases, 2) reduce the at-risk population for additional intentional releases of smallpox virus if the probability of such occurrences is considered significant, and 3) address heightened public concerns about access to voluntary vaccination.

The most important component of smallpox containment is the rapid identification, isolation, and vaccination of close contacts of infected patients and contacts of their contacts (i.e., ring vaccination). This strategy involves identification of infected persons through intensive surveillance, isolation of infected persons, vaccination of household contacts and other close contacts of infected persons (i.e., primary contacts), and vaccination of household and other potential contacts of the primary contacts (i.e., secondary contacts).

The clinic guide will assist planning for larger-scale, post-event vaccination when exposure circumstances indicate the need to supplement the ring vaccination approach with broader protective measures. The clinic guide describes the activities and staffing needs associated with large-scale smallpox vaccination clinics, including suggested protocols for vaccine safety monitoring and treatment. The clinic guide provides an example of a model smallpox clinic and provides samples of pertinent clinic consent forms and patient information sheets that would be used at a clinic. The clinic guide and the Smallpox Response Plan and Guidelines, Version 3 are available at http://www.cdc.gov/smallpox.

CDC will take additional steps to increase preparedness to respond to a smallpox exposure of any magnitude, including updates to the Smallpox Response Plan and Guidelines. Updates on infection control, in-hospital isolation recommendations, post-event vaccination protocols, and outbreak response strategies are under way and will be posted on the CDC website. ☐

Guest Article

Breastfeeding and Breast Cancer

Jennifer Highland, MPH, RN
Contract/Quality Manager
Coordinator of the Breastfeeding Data Partnership
Healthy Start Coalition of Sarasota County, Inc.

Recently published results of a landmark breast cancer study from Oxford University found that THE NUMBER ONE REASON BREAST CANCER RATES HAVE CLIMBED IN INDUSTRIALIZED SOCIETIES IS BECAUSE OF REDUCED CHILDBEARING AND LACK OF BREASTFEEDING.

Now, playing a role more important than genetics, breastfeeding just 6 months can lower the chance of breast cancer by 5%, even if there is strong family history. The magnitude of protection was the same for all women, regardless of other characteristics, such as ethnic origin, drinking habits and age at menopause.

Breastfeeding rates in the United States continue to be rather stagnant, and are much lower than the Healthy People 2010 plan objectives, as stated by the United States Department of Health and Human Services. The true contraindications to breastfeeding are rare, but we suffer from numerous social barriers which discourage women from breastfeeding.

What can we do? We all need to increase our efforts to promote breastfeeding beginning before a young woman considers having children, and continue throughout the child-bearing years. Look at the environment: What are young women learning about feeding babies? They get many powerful messages about formula feeding on TV, by watching other moms in the family, and even at baby showers. What messages are young women getting about breastfeeding? Are their parents or other family members positive about breastfeeding? Are there any family role-models who breastfeed? Are their teachers discussing it in health classes? Are their family practice, OB/GYN, and Pediatric doctors, nurses and nutritionists promoting, teaching, and supporting breastfeeding? Do their employers recognize the importance of allowing a breastfeeding mom to stay home longer, then return to work on a flexible schedule with a decent place to pump her breasts? Do they have breastfeeding support in the home,

provided by family or community organizations or health care agencies? Could there be more positive breastfeeding images in the media?

There is a so much each one of you can do to make the answers to these questions YES in Florida. We all have a role to play in improving the health of America's women and babies through encouragement of breastfeeding.☐

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Managed Care

Medicaid Frustrations

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

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.☐

Medicaid continues to frustrate all of us. Dr Pomerance asked that I give you my view of the problems and potential solutions at this point in time. Here goes.

As you know, in spite of the State budget shortfall in the last session of the legislature, we were successful in keeping the 4% increase in Medicaid physician fees. That increase went into effect April 1, 2002, and was for all physician services provided to recipients ages 0-21 years. Particularly important is the precedent set by having a Medicaid increase apply across the board, for all procedures, but at the same time be limited to services for children. The concept of an increase limited to the 0-21 age group was hammered out with the FMA two years ago, recognizing the particular plight of physicians for children and the reality that children are far less expensive than adults, making such an increase more affordable in the current economic climate.

Long term, we are committed to working further with the FMA to assure that Medicaid payments for patients of all ages are similarly increased. We are hopeful that we can achieve a further increase in 2003, our ultimate goal being to bring Medicaid payments to a level that would at least meet costs, which would be at or above the current Medicare reimbursement level. Unfortunately, the financial picture for the state is bleak, and it is conceivable that we will be lucky just to maintain the current level of Medicaid payment. Stay tuned.

The recent article in Pediatrics, *Factors That Influence the Willingness of Private Primary Care Pediatricians to Accept More Medicaid Patients, Aug 2002, Vol 110, No. 2, pp 239-248,* pointed out that the 3 obstacles to pediatrician participation in the Medicaid program include not only Medicaid payment levels, but also the administrative and paperwork burden in dealing with Medicaid, and the reluctance of pediatricians to participate in capitated Medicaid programs.

In Florida, the administrative and paperwork issues that we have long had on our agenda include:

1. Florida Medicaid charges us to **verify eligibility**. No other 3rd party makes the provider pay to verify eligibility.

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2. There are inordinate **delays in processing claims** that include procedures requiring manual review (mostly specialty surgical procedures). At the present time Medicaid has only one person to do these manual reviews, and payment is often delayed months.
3. The fact that EPSDT, now called Child Health Check-Up, requires that you bill on a **special form**, and not the standard HCFA-1500, is unacceptable. All other 3rd parties are *required* to accept a standard HCFA-1500. Perhaps HIPAA will be more successful than we in resolving this problem. If that happens, it will inspire the first kind thought I have had about HIPAA.
4. The escalating problem of children being **reassigned by Medicaid** to another provider, without the parents' permission or knowledge, continues unabated. Current operating rules mandate such reassignment if a child goes off of Medicaid, and then is put back on after more than 90 days. Two months ago we had reached agreement with Medicaid to change that rule so that the child would go back to the previous provider for up to one year; now the decision to change has been mysteriously rescinded. I have

been unable to determine why.

5. Several years ago the FPS / FCAAP and other child advocates successfully lobbied for the Medicaid State Plan to include **continuous eligibility** for children ages 0-5 years. Under continuous eligibility, a child in that age range should receive uninterrupted coverage for one year, renewable yearly until the age of 5. In meetings with Department of Children and Families (DCF) officials we learned that the case workers, the ones who actually key in the child's Medicaid eligibility information, are often as frustrated as we are: the computer "system" won't actually allow them to put many children on for the requisite 12 months. Meetings are planned in the near future to see if this can be rectified. I never cease to be amazed at how we get issues encoded in statute or rule, only to find that the bureaucracy finds ways around our best efforts.
6. **Presumptive eligibility** has been on the books in Florida for several years, but never implemented, presumably because of gubenatorial policy and budgetary woes. We recently proposed a plan to implement presumptive eligibility for the 0-3 month old; this would solve our most difficult eligibility dilemma, the newborn. Our preliminary information is that this plan would most probably be budget neutral. We have been told by the Medicaid director that he could not consider such a plan

*(See **Managed**, page 29 ▸)*

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.]

The "AAP and You" talk has been given at residency programs for a noon conference to give residents (especially the new interns) an introduction to the AAP and its benefits. Residents learned how they could become involved on the local, state, or national level and how the AAP will be important in the "Life after Residency". USF's Talk was given by Laura Stadler, MD and included recent issues on the national level. Dr. Bauer spoke on August 27th in Miami. Dr Werk gave the presentation in Orlando on September 30th and Dr Genuardi plans to speak on October 14th at Jacksonville.

The national AAP Meeting is October 19-23rd in Boston. Friday October 18th from 7-8 there is a Resident and Medical Student Reception. The BIG day for residents is Saturday October 19th. Registration is at 7:30am and the day starts at 8am!

Speakers include Dr. James Stockman "The Pediatric Workforce: A Look to the Future" and Dr Judith Palfrey "Child Advocacy". Other sessions include "Fellowships", and "Practice Management". There is a special Med/Peds Section from 8:30-12:30 as well. On Monday, October 21, 2002, the Section on Administration and Practice management, the Resident Section, and the Provisional Section on Young Physicians is presenting "Entering Practice: The Early Years" from 9:30-11 and 1-3pm. The remainder of the conference offers many other good sessions - these were the things I found MOST important to the Residents.

Dr Lisa Cosgrove from Cocoa Beach FL introduced the Healthy Kids Challenge which was originally developed by Vicky James, a dietitian working with other dietitians and Cooking Light. Residents at the seven programs in the state should have received an email re: the PowerPoint Presentation that a team leader could use to introduce the program to the community/school. The website for this project is www.healthykidschallenge.com and each team leader may log on to the website and get more information, including a manual which further explains each person's role in increasing healthy choices. (including administrators, dietitians, teachers etc.). This project aims to affect children's cafeteria, classroom, and perhaps most importantly lifestyles. This sounds like a GREAT project for the residents to introduce to a school. Basically, the resident(s) would serve as the team leader to get it started and serve as a resource. We would like to do this STATEWIDE and I need to hear feedback re: this project. Please email me your thoughts and if you are interested in doing this.

We as a state would like to keep Obesity/Increasing Physical Activity as our advocacy goal for this next year. (We usually vote on an advocacy topic for the district at the fall national meeting) Especially if we implement the above program, we plan on "keeping the ball rolling".

Lastly, resident work hours are being addressed at the programs in our state in order to be in compliance with new guidelines to take effect July 1, 2002. Orlando is developing a "Floating Continuity Clinic" to allow residents postcall to be in

compliance with the work hour regulations. Jacksonville is already in compliance, with most residents leaving postcall at noon. USF is attempting to lessen the number of residents who have a postcall continuity clinic. Pensacola is considering whether the small number of residents at their program will prevent them from being in compliance and is working on solutions to the dilemma.

Please mail any comments to lpstadler@hotmail.com

Spot light on Miami…

The Jackson Memorial Hospital residents are busy these days! The University of Miami Department of Pediatrics has been awarded the Anne E. Dyson Community Pediatrics Training Initiative over the next five years. All residents learn basic concepts in community pediatrics such as advocacy, bioethics, epidemiology, environmental medicine, and legal aspects of health care and immigration issues.

Many JMH residents are working with faculty to initiate a specific advocacy plan during a four week elective. Some residents have expanded their advocacy experience into developing research studies that benefit the community. Currently resident-driven projects include obesity in children, injury prevention, daycare outreach, breastfeeding and HIV prevention programs. Another exciting upcoming event is the yearly Masters in Pediatrics Conference at University of Miami. This CME conference combines local and national experts, exploring contemporary and future pediatrics, pediatric dermatology, pediatric pulmonology and allergy. We are looking forward to a fun and challenging year ahead of us!

Cheryl Aber, M.D.
Miami

Miami Children's Hospital is the largest freestanding pediatric children's hospital in the Southeast, containing over 280 bed, treating over 185,000 patients each year and a medical staff of over 650 professionals. The ER alone sees in excess of 75,000 patients each year. Miami Children's is the only licensed specialty hospital in South Florida exclusively for children and was this year ranked #1 in Florida and #2 in the Southeast in pediatrics by U.S. News and World Report as well as Child Magazine.

The residents, as a backbone to the institution, make up a group of nearly 60 pediatricians-in-training. The residents come from many different backgrounds and experiences, each bringing a unique approach to the treatment of children and the management of childhood illnesses.

Currently the residency program is working with the hospital to handle the increasing number of patients seen through the emergency room and inpatient wards. A night float system

*(See **Resident**, page 28▸)*

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]

Risk and Liability Issues Associated with Electronic Communications

Although written and verbal communications have traditionally been the primary method of communicating healthcare information, the Internet opens new avenues for providing such information and communicating with patients. In tandem with the potential benefits of electronic communications are sobering legal concerns and emerging increased liability exposure to the public through website capacity. To date, legal waters are largely untested. Consequently, it is important for those who communicate electronically to address the key risk management issues in developing office policies and procedures for Internet-based communication entailing patient privacy, confidentiality of patient information, security and encryption, informed consent, use of disclaimers, opportunities for patient education, and the implications of website linkage.

Recent data reveals that there is a growing demand by patients for specific healthcare information and directives. Along with that demand is an increasing expectation for online access and interactivity.

Electronic communication systems encountered in the healthcare delivery system include:

- Practice-based Internet web pages
- Electronic prescribing systems
- Wireless personal data
- Drug formularies, allergies, and potential conflicts
- Electronic/hard copy e-mail transmission
- Internal, intranet web pages

The advantages in communicating electronically with patients are numerous. Inherently, electronic transmission of information is faster than traditional modalities, and in some cases, instantaneous. Along with meeting growing expectations for quick and precise information exchange, electronic communications serve to inform and educate patients. This new form of communication can confirm delivery of communication/information exchange, and provides an automated follow-up system. Electronic communication also enhances informed consent and compliance process. Another advantage of this type of communication is that the process documents the sequence of communication.

There are, however, inherent risks in communicating electronically. The risks include online malpractice exposure. It is difficult to maintain the extension of the physician/patient relationship without face-to-face contact. At times a physician/patient relationship is inadvertently created where it would not have been through more traditional forms of communication. A major risk of electronic communication is the inappropriate disclosure of confidential patient information.

It is important to remember that seemingly intangible electronic communication becomes part of the patient's medical records, and as such could become evidence in a malpractice claim. Consider all forms of communication as potential evidence. In this context, will the communication support a defense or facilitate a claim? Such evidence could include:

- Notes you author
- Records made by others
- Correspondence
- Insurance & billing statements
- Staff notations and messages
- E-mail transmissions
- Answering service records

In today's technology-dependent society it is difficult to not have contact with patients via electronic communications. It is important to understand that this form of communication has many inherent risks and as such, care should be taken to minimize such risks.

[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.]☐

aventis ad

FROM THE A.A.P.

Academy Releases Influenza Vaccine Recommendations

The American Academy of Pediatrics has released its recommendations for the influenza vaccine for this (2002-2003) flu season. The statement will be published in the December 2002, issue of Pediatrics. Below are the recommendations from the statement:

A. Practitioners should increase their efforts through tracking and recall systems to ensure that children traditionally

considered at high risk of severe disease and complications from influenza infection receive annual immunization. High-risk children and adolescents who should receive priority for influenza immunization are those with the following:

- ♦ Asthma or other chronic pulmonary diseases, such as cystic fibrosis
- ♦ Hemodynamically significant cardiac disease
- ♦ Immunosuppressive disorders or therapy
- ♦ HIV infection
- ♦ Sickle cell anemia and other hemoglobinopathies
- ♦ Diseases requiring long-term aspirin therapy, such as rheumatoid arthritis or Kawasaki disease
- ♦ Chronic renal dysfunction
- ♦ Chronic metabolic disease, such as diabetes mellitus

Other individuals who should receive priority for influenza immunization include:

- ♦ Women who will be in their second or third trimester of pregnancy during influenza season
- ♦ Persons who are in close contact with high-risk children, including:
  - ✓ All health care personnel in contact with pediatric patients in hospital and outpatient settings
  - ✓ Household contacts, including siblings and primary caregivers, of high-risk children
  - ✓ Children who are members of households with high-risk adults, including those with symptomatic HIV infection
  - ✓ Home caregivers for children younger than 24 months and to adolescents in high-risk groups

B. Young, healthy children also are at high risk of hospitalization for influenza infection; therefore, the American Academy of Pediatrics encourages influenza immunization of healthy children between 6 and 24 months of age to the extent logistically and economically feasible. This applies to any child who will be 6 through 23 months of age at any time during influenza season, which extends from the beginning of October through March. Children should not be immunized before they reach 6 months of age. Influenza immunization of household contacts and out-of-home caregivers of children younger than 24 months also is encouraged when feasible. Immunization of close contacts of children younger than 6 months may be particularly important, because these infants will not be immunized.

C. Antiviral drugs are an adjunct to, not a substitute for, the prevention of influenza with immunization. Amantadine and rimantadine are licensed for chemoprophylaxis of influenza A in children 1 year or older. Oseltamivir may be used for prevention of influenza A and B in persons 13 years and older. Chemoprophylaxis may be considered in the following situations:

- ♦ Protection of high-risk children during the 2 weeks after immunizations while an immune response is developing, if the children are immunized after circulation of influenza virus has been documented
- ♦ Protection of high-risk children for whom the vaccine is contraindicated (ie, those with a history of anaphylactic reaction to eggs)
- ♦ Protection of non-immunized close contacts of high-risk children
- ♦ Protection of immunocompromised children who may not respond to vaccine
- ♦ Control of influenza outbreaks in a closed setting, such as an institution with high-risk children
- ♦ Protection of immunized high-risk individuals if the vaccine strain poorly matches the circulating influenza strain(s).

To acquaint yourself with the implementation issues regarding the expanded use of this vaccine, visit the Members Only Channel (http://www.aap.org/moc) and click on the red "Immunization Hot Topics" button.☐

On Tuesday, October 1, 2002, First Lady Laura Bush, Governor Jeb Bush and First Lady Columba Bush atttended the "Ready to Read, Ready to Learn" early childhood cognitive development summit in Tampa.

The early reading initiative, "I'm A Reader" kit, was also launched on the same day. These kits, which contain tips and information on reading for parents of Florida newborns, are being distributed through hospitals statewide in three different languages. The "I'm A Reader" kit, made possible in part by a generous donation from Carnival Cruise Lines, will be delivered to nearly all of the 200,000 estimated newborns in Florida in the coming year.☐

Congratulations...

...to us, the Florida Chapter of the American Academy of Pediatrics, for winning the AAP Award for Excellence in Membership Recruitment. The award includes a small financial contribution and a handsome plaque.☐

Suicide Prevention Meeting

The Institute for Child Health Policy, a state-wide unit of the State University System of Florida with a direct working affiliation with Nova Southeast University, recently hosted a leadership meeting on suicide prevention. Jim McDonough, director of the Florida Office of Drug Control Policy, was the keynote speaker and discussed the Prototype Project strategic plan - based upon the Florida Commission on Mental Health Report and the Strategy Paper by the Florida Task Force on Youth on Suicide Prevention - to reduce the suicide rate.

The U.S. Substance Abuse and Mental Health Services Administration recently released a report that stated three million American teenagers have thought about suicide within just the past year, and, of those, more that a third attempted it.

Dr. Deborah Mullligan-Smith, our President-Elect, attended this meeting.☐

Childhood Pertussis Rate Climbs
When Parents in Boulder, CO
Spurn Immunization

The September 2002 issue of "The Atlantic Monthly" includes an excellent article about parents' refusing vaccinations for their children. By examining events in Boulder, Colorado, "Bucking the Herd" describes what happens when a community loses herd immunity. Boulder has the lowest school-wide vaccination rate in the state and has one of the highest rates of pertussis in the nation, with an average of 81 cases a year in Boulder County since 1993.

The author, Arthur Allen, has written an informative, readable, and thought-provoking article, which should be of interest to immunization providers and their patients. For this reason, the Immunization Action Coalition requested permission to reprint it.☐

Kudos...

...to Reed Bell, who received the AAP Section on Bioethics 2002 William G. Bartholome Award for Ethical Excellence☐

Kudos...

…to **Jeffrey Goldhagen**, awarded a Certificate of Appreciation for Outstanding Service. The Florida Medical Association made the presentation in recognition of his outstanding service t the association, medical profession, and the public. Dr. Goldhagen is chief of the Division of General Pediatrics at the U.F. Jacksonville and Clinical Associate Professor of Pediatrics at U.F.

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.☐

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 2001 because of the chapter's lobbying activity.

Please consult your tax advisor for specific information.☐

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!☐

More from the FCAAP

West Nile Virus

[Deb Mulligan Smith supplied this timely report, compiled from data from the meeting mentioned.]

The following summary is compiled from the transcript and news reports from the Sept 24th joint hearing of two subcommittees of the Senate: Committee on Health, Education, Labor and Pensions and the Governmental Affairs Committee about West Nile Virus.

Witnesses included: Julie Gerberding, Director of the Centers for Disease Control and Prevention in Atlanta; Anthony Fauci, Director of NIH's National Institute of Allergy and Infectious Diseases; Jesse Goodman, Deputy Director of FDA's Center for Biologics, Evaluation and Research; Fay W. Boozman, Director of the Arkansas Dept of Health; John R. Lumpkin, Director of the Illinois Dept of Public Health; Nickie Monica, Parish president, St. John the Baptist Parish, Louisiana; Sidney Andrew Houff, Professor and Chairman Department of Neurology, Director, Neuroscience and Aging Institute.

Summary: Witnesses indicated that while WNV has been established firmly in the mosquito and bird populations, they expect that WNV cases will drop sharply as more people gain immunity and communities quickly eradicate mosquito breeding grounds. As children and young adults become immune today, they will face reduced risks to WNV when they are older since the most vulnerable segments of the population are the elderly and the immune-deficient.

There are expectations that if WNV behaves like the other flaviviruses, such as St. Louis encephalitis virus, there will be cycles of little infection punctuated with outbreaks. One proposed theory is that most birds gain immunity from the previous year and hence the viral reservoir is exhausted for the following years. Therefore, John Lumpkin speculated that noticing falling immunity levels in bird flocks may provide us with warnings of the reemergence of WNV.

Since CDC believes that WNV can be transmitted through blood transfusions and organ donations, there is need to develop a blood test to screen blood banks. Most people who become infected never develop symptoms and may donate blood without knowing.

Jesse Goodman said that by next summer they hope to have adapted nucleic acid testing (NAT) that detects low levels of other viruses to test for WNV. Goodman said that though the risk to the blood supply was low since WNV only stays in the blood stream for a short time, there may be sufficient risk to warrant widespread use of this test voluntarily or experimentally. It may take years to fully evaluate an adequate method of screening WNV, but an experimental test may be employed as was done when the 1980s AIDS blood test was being developed.

Jay Epstein said that though an unlicensed test cannot be required, he expects that most blood centers would choose to use this test. Goodman also said that they are working on finding new techniques to inactivate pathogens in the blood.

John Lumpkin has also warned that people may be able to contract WNV from the blood of recently killed animals. Hunters are recommended to wear gloves when cutting and cleaning their game.

Anthony Fauci said that research for a WNV vaccine based on the existing yellow fever vaccine may be ready in three years. WNV genes have been spliced into the yellow fever vaccine to create a hybrid vaccine that has proven effective in animal studies. Acambis, a biotechnology company, is planning to conduct human testing in 2003. The NIH will also be testing for cross-protection in people vaccinated against yellow fever (e.g., travelers to parts of Africa and South America) since there seems to be a link between immunity to yellow fever, dengue fever and St Louis encephalitis and immunity to WNV.

Sources: Hearing called jointly by the Senate Committee on Health, Education, Labor and Pensions and the Governmental Affairs Committee. Washington DC. September 24, 2002.□

Kudos...

...to **Rick Bucciarelli**, our president, who has just been named Vice President for Governmental Relations at the University of Florida. Rick is also associate chairman of the Department of Pediatrics, Professor in the Department of Pediatrics, and Chair of the AAP Task Force on Health Insurance Coverage and Access to Care.

Right on, Rick!!□

Kudos...

...to **Deborah Mulligan-Smith**, our President Elect, given the FMA 2002 Physician Communicator Award. Deb was nominated by the Florida Chapter in recognition of Florida public education initiatives on first aid/CPR and injury prevention.□

Kudos...

...to the **Patels**, **Kiran** (cardiologist) and **Pallavi** (pediatrician) for their major contribution to Tampa and Florida culture, with a five million dollar gift for naming rights for the new arts school planned at the Tampa Bay Performing Arts Center. Dr. Kiran Patel made the contribution and the center will be called the **Dr. Pallavi Patel School for the Performing Arts.**

Patricia J. Blanco MD.
Sarasota FL
District X CATCH Facilitator

C.A.T.C.H.

"For all the excesses of the 1960s... and they were considerable..the one thing I admire about that era is that the people in it lived with a sense of the possible... Now at a time when technology reposes more power in the hands of the individual than ever before, we seem, paradoxically, to have lost faith in the power of one to move many."

Leonard Pitts Jr.,
Columnist for the Miami Herald

Although as a society many Americans may have lost faith in the ability of the individual to make a difference, many pediatricians across our nation are doing exactly that. Let me share one success story from the state of Rhode Island. In 1999, Dr. Ellen Gurney from the Providence Community Health Centers applied for and received a CATCH planning grant in the amount of $5000 for her program entitled "Six Years Old and Ready to Learn." Dr. Gurney's abstract described the fact that in Providence, RI, children were starting school with high rates of lead poisoning and poor social and emotional compctencies. The state government was also noting that monies placed into the urban school system lacked impact as many families young children were not finding the support necessary to provide their preschoolers with an environment optional for early childhood development. Consequently, the children in Providence, RI were experiencing overwhelming rates of school failure, school dropout youth incarceration, mental illness, violence, substance abuse and teen pregnancy. Dr. Gurney collaborated with the Providence school system, state and local government as well as nonprofit agencies to develop a plan for improving access, capacity and the quality of preventive health and family support services for the preschool children of Providence. This collaborative task force published its findings in a publication entitled "Ready to Learn: Investing in Providence's Youngest Children."

For two years, this community sought funding to implement the recommendations identified by the task force and recently were awarded $850,000 in federal funds through the US Department of Health and Human Services' Early Learning Opportunity Act (EEOA) program for the fiscal year 2002. This is but one of hundreds of examples in which pediatric leadership, seed money for planning and collaborative efforts have resulted in increasing resources for child health services.

I am writing this column while en route home from the District CATCH Facilitator meeting in Boston, Massachusetts. We have just completed once again reviewing the CATCH Planning Grants for the fiscal year 2002. When all is said and done we will have approved and financed greater than 100 projects nationwide that have the potential to significantly impact local child health issues. As always the AAP CATCH staff members are scurrying to augment the amount of monies needed to fund the projects we have approved. Despite generous donations from Wyeth-Lederle, Peds Care, Irving Harris, the Curry Foundation, the Maternal Child Health Bureau, and the Centers for Disease Control, additional funds must still be located to support the remaining approved grants. Florida has two pediatricians and two pediatric residents that secured grant monies for their projects during this CATCH Planning Grant cycle. Details of these grants will be forthcoming in future editions of the Florida Pediatrician. More news...

Fernando A. Guerra, MD, MPH, FAAP was awarded the Job Lewis Smith Award by the Section on Community Pediatrics for his outstanding leadership in community pediatrics at the Boston meeting on October 20, 2002.

Lastly. as I reflect upon how far we have come as a state in the area of community pediatrics, I have been incredibly impressed by the efforts of pediatricians across the state but most importantly in the Jacksonville and Miami-Dade regions. More CATCH Planning Grants, Healthy Day Care American funds and Healthy Tomorrow grants are being submitted and obtained from these areas of the state than from any others. I suspect

*(See **CATCH**, page 29 ▸)*

[The Senior members of our society are quite active (I am biased!), and have many accomplishments. The author of this article is a member of our society, and is the Editor of the AAP Senior Bulletin. The article which follows is a sterling example! -Ed.]

It's Never Too Late

Bob Grayson

Sixteen years ago I turned over our practice to my partner and said retirement here I come. Time to do the things that had been put aside during the busy practice years - travel, gardening, visiting, woodworking, photography, house maintenance, reading, grandchildren, and most of all, more spouse time. My plate was very full. Sixteen years later, I can look back and say that I sampled most of what was on the plate, with the exception of reading. Most other than reading, involved physical activity.

What was not expected in 19~6 was the computer. Apple had just introduced the Macintosh, and the experimenter in me could not resist the little Mac SE, with only floppies and no hard drive, and costing more than my current powerful G4. The computer will be another story sometime in the future.

Academy activities have taken a good share of time. We have traveled far and near, even with several Elder Hostel experiences. The garden has had its ups and downs, especially after the '92 hurricane Andrew. Thousands of travel slides are neatly stored in carousels but not looked at very often. Does that sound familiar? I tinker here and I tinker there, keeping the house running and learning new woodworking tricks. Even the stamp collection gets an occasional evening's activity. Only reading for pleasure has not received its full share, and that is what brings me to this story.

Finally. I got to the reading in earnest. What started it all was a little pullout ad in one of my hobby magazines offering a membership in the History Book Club with an introductory bargain of four books at $1.00 each. Bargain hunter that I am, I took the bait. A week later, McCullough's *John Adams*, Ellis' *Founding Brothers*, Bowen's *Miracle at Philadelphia*, and Morris' *Theodore Rex* hit the mail box. Never having been fond of fiction, science, mystery, or otherwise, I have found my literary niche.

The following are not intended to be book reviews, but are exhortations to my fellow seniors to explore, in particular, the beginnings of the American nation. Considering the instability of countries and governments everywhere. I am amazed that a group of individuals could have had the courage, the foresight, the energy, and the wisdom to have drafted the Declaration of Independence, the Constitution and the Bill of Rights. It was not an easy task. Travel was difficult within the 13 colonies, and even more so to Europe. All discussions of the gatherings had to be hand written, as well as all correspondence. There were strong differences of opinion between those who favored a strong Federal government, led by George Washington, John Adams and Alexander Hamilton, and those who favored a smaller Federal and powerful State governments, championed by the Virginia delegates. Jefferson, Madison, Lee and others of the Southern colonies. The issue of slavery was critical but a solution of this was put off to a much later time, culminating in the War between the States.

It was hoped that governing would be non-partisan, yet two very different parties were quickly formed the Republicans led by Jefferson, and the Federalist led by Adams, the second President, and Hamilton. The candidates did not run as party nominees, but ran as individuals, with the two who received the most electoral votes becoming President and Vice- President. A tie electoral delegate vote threw the election into the House of Representatives on two occasions in the first 30 years. It was paradoxical that when Adams was elected as President his Vice President was Jefferson. No common meeting of the minds here, and when Jefferson defeated Adams for reelection in 1802, by way of a very acrimonious and "dirty" campaign, their friendship was shattered for many years Reconciliation mediated by Dr. Benjamin Rush in 1812 lasted until their deaths, both dying on the same day, July 4, 1826.

Every page in all three books of the Revolutionary times was fascinating. I could not put the books down, even the 600+. page Adams. They read like novels. The scholarship and the language of the three was exciting. So much of the action in the stories is pertinent in the events of our world today. I strongly recommend these histories to all Americans, young and old. I suggest reading *Founding Brothers* first, the *Miracle at Philadelphia* next, and *Adams* last. A good book on Jefferson is yet to come.

I marvel that, for over 250 years. the work of these diverse Founding Brothers has held this country together and on course, through good times and tough times, through peace and war, through assassinations and the changes of the governing parties. Living as I do in a city of changing ethnicity and related to Latin America, I wonder why in even older civilizations than ours (South and Central America), there has not been the same stability of government and democratic institutions among our neighbors. What is the difference, and can it be changed? Perhaps it is a case of being able to put the good of country above the good of self.

In June 1826, Jefferson, having been invited to the fifty year anniversary of the Declaration of Independence celebration in the Nation's Capital, was not able to go because of his declining health. He sent the following message to be read at the celebration, in reference to the Declaration:

"May it be to the world, what 1 believe it will be (to some parts sooner, to others later, but finally to all) the signal of

*(See **Senior**, page 29 ▸)*

skb ad

(◂ continued from page 9)

expected, and when child abuse may certainly occur. Table IV lists some of the inborn errors of metabolism which may be found.

Table IV
Metabolic Diseases as Causes of Sudden Death

Lactic acidemias
Aminoacidopathies
Glycogen storage diseases
Hyperglycinemia
Urea cycle defects
Membrane-bound enzymes
Carnitine uptake deficiency
Translocase deficiency
Carnitine palmitoyltransferase II deficiency
Very-long-chain acyl-CoA dehydrogenase deficiency
Trifunctional protein deficiency
Mitochondrial matrix enzymes
Individual acyl-CoA dehydrogenase defects
Long-chain acyl-CoA dehydrogenase deficiency
Medium-chain acyl-CoA dehydrogenase deficiency
Short-chain acyl-CoA dehydrogenase deficiency
Short-chain 3-hydroxy acyl-CoA dehydrogenase deficiency
Multiple acyl-CoA dehydrogenase deficiency
ETF subunit α deficiency
ETF subunit β deficiency
ETF - ubiquinone oxidoreductase deficiency

CoA=coenzyme A; ETF=electron transfer flavor protein
From:Valdes-Dapena M, Gilbert-Barness E. Sudden and unexpected death in infants. Gilbert-Barness E (ed): Potter's Pathology of the Fetus and Infant. St. Louis, Mosby, 1997, p438

Differentiating between SIDS and child abuse may be a problem. An autopsy examination cannot distinguish between suffocation and SIDS. Physical abuse that produces subdural hematomas or massive hemorrhage into the abdominal organs is evident. Suffocation with a soft object (e.g., a pillow or the cupped hand of an adult) is virtually impossible to prove during an autopsy. Shaken infant syndrome usually can be identified by the presence of subdural and retinal hemorrhages. In Munchausen syndrome by proxy, a mother or caretaker repeatedly almost suffocates an infant, then comes to an emergency department claiming that the infant suffered an apneic episode. Finally, death from suffocation occurs.

Accidental infant deaths have several recognizable patterns, again not SIDS. Table V is a listing of some of these.

Pathogenetic Mechanisms of SIDS

Many pathogenetic mechanisms have been suggested; however, chronic hypoxemia may be the initiating cause in many cases. Pathologic changes in the brainstem in the centers for cardiorespiratory control have been identified. Hypoxemia is reflected in subtle changes in the

Table V
Accidental Infant Death: Findings in 36 Autopsy Cases

Type of Accident	Number of Deaths
Unsafe sleeping environment	8
Overlying	6
Drowning	4
Scald burn	3
Plastic bag suffocation	3
House fire	3
Motor vehicle collision	3
Foreign body asphyxia	2
Hypothermia	2
Fall from height	1
Alcohol toxicity	1

From: Corey TS, McCloud LC, Nicholls GR II, Buchino JJ. Infant Death due to unintentional injury - 11 year autopsy review. Am J Dis Child 146: 969, 1992

organs and increased levels of fetal hemoglobin in victims of SIDS. In infants who are so compromised, the prone sleeping position may aggravate and augment the risk for SIDS.

Mechanisms for hypoxemia in susceptible infants implicated in the prone sleeping position include:

- Respiratory obstruction owing to backward displacement of the mandible
- High cephalic position of cervical structures in a young infant, with apposition of the soft palate and back of the tongue.
- Nasal obstruction owing to compression of the nose (most infants up to 4 months of age are obligate nasal breathers)

The BACK TO SLEEP campaign has reduced the incidence by greater than 50% in the United States and in some statistics by 70%.

NOTE: It is important however to remember that premature infants may aerate better in the prone position in the neonatal period.

Prevention of Sudden Infant Death

- The infant should sleep in a supine position until at least 6 months of age.
- The room in which the infant sleeps should be warm but not hot. If space heaters are used, ventilation must be adequate. Heavy blankets restrict movements and should be avoided.

(Continued next page ▸)

Scientific

(◂ continued from previous page)

- Preferably the infant should not sleep in the same bed as an adult. If it is necessary for others to be in the same bed, protective devices to shield the infant should be recommended.
- Cribs must meet federal safety standards. New cribs have a label. "Hand-me-down" cribs should have bars too close together for the infant's head to get caught (2 3/8 inches). The mattress should fit snugly against the crib sides; more than a two-finger space should be filled (e.g., with a rolled-up blanket). Crib bumpers should be avoided because an infant's head can become wedged between the bumper and the mattress. The crib should not be filled with stuffed animals. Bedding should be firm, with no comforters, pillows, beanbag cushions, or sheepskins. Adult waterbeds should not be used.
- Breast feeding should be maintained as long as possible.
- The mother should avoid alcohol, tobacco, and other drugs during pregnancy and breast feeding.
- Smoking should be prohibited in the house.

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President

(◂ continued from page 3)

services is important to all providers including hospitals, clinics and Pediatricians.

We will also be ready to advocate for good legislation that will improve the safety of our children and the environments in which they live. However, we must remain ever vigilant and be prepared to fight against bad legislation which undoubtedly will be introduced, and though well intended, have very serious consequences to families, children and the practice of Pediatrics.

Last year's legislative successes occurred because our membership could be mobilized at the appropriate time to advocate for issues important to us. Readiness and the willingness to help will be essential if we are going to achieve our goals as the number-one advocacy organization for children in Florida.

Finally, as we approach the end of 2002, I want to, on behalf of the officers, wish each of you a very happy holiday season and I look [redacted] session.

As always, I appreciate you allowing me to be your President.

Richard L. Bucciarelli, M.D.
President□

Chairmen

(◂ continued from page 7)

The largest growth in faculty members this year occurred in the Division of Neonatology, which increased to 21 neonatolgists, six fellows, and 180 NICU beds. This was accomplished by merging All Children's Hospital neonatology group (West Coast Neonatology) and the University group, with Dr. Roberto Sosa as the Division Chief and Dr. Darlene Calhoun as the Program Director. Dr. Robert Nelson, Neonatology Division Chief from 1991 through 2002, became Vice Chairman of the Department.

This fall, with the addition of many new research-intensive faculty, the USF/ACH Children's Research Institute Building on the All Children's Hospital Campus will be completely occupied. Thus, our attention now turns to the next phase of growth at USF, which involves construction of another research building, renovation of inpatient and outpatient space for our new Pediatric Clinical Research Center, and a major expansion project of the All Children's Hospital inpatient facility.

Accompanying the new grants acquisitions, the faculty recruitment, and the new building programs, the Department developed an amalgamated five-year vision and strategic plan and devised a new faculty bonus plan. These were written, approved, and put into place this year, and we maintain that these will set the

course toward continued growth and improvement of the USF Department of Pediatrics over the coming decade.□

Legislative

(◂ continued from page 10)

ordinance, an additional three dollar surcharge on civil traffic penalties to fund traffic education in public and non public schools.

Section 322.056, F.S. relating to the mandatory revocation or suspension of a driver's license for persons under age 18 found guilty of certain alcohol, drug, or tobacco offenses, has been amended to provide discretion to a court to direct the department to issue a license for restricted driving privileges for business or employment purposes only.

CS/CS/HB 1057 - Driving and Boating Under the Influence

(Chapter No. 2002-263) Effective Date: July 1, 2002

Beginning July, 2003, courts will be required to order the placement of an interlock device on all vehicles either individually or jointly leased or owned and routinely operated by a person who is convicted of a second or third DUI, or who is convicted of DUI with a blood alcohol level of .20 or higher or while accompanied by a child under the age of 18. Penalties for a third DUI or BUI offense that occurs within 10 years after a prior third degree felony conviction for DUI or BUI are increased. The law will now require rather than permit a law enforcement officer to order blood testing of all drivers or boat operators involved in accidents causing death or serious bodily injury where there is probably cause to believe that the driver or boat operator is under the influence. Various provisions relating to boating under the influence have been revised to be the same as those for driving under the influence.

HB 3E - Governmental Reorganization

(Chapter No. 2002-404) Effective Date: January 7, 2003 (reorganization) and June 6, 2002 (other provisions)

In response to an amendment to the State Constitution approved in 1998 to merge two Cabinet positions into one Chief Financial Officer (CFO) a new organizational structure is delineated in this legislation.

The Department of Financial Services headed by the Chief Financial Officer is created consisting of the following divisions: Accounting and Auditing, Administration, Consumer Services, Information Systems, Insurance Agents and Agencies Services, **Insurance Consumer Advocate**, Insurance Fraud, Legal Services, Risk Management, State Fire Marshal, Treasury and Workers' Compensation.

An independent agency housed within the Department of Financial Services, the Financial Services Commission, is created and consists of the Governor and Cabinet. Any Commission action will require three votes. Two offices are created: the Office of Insurance and the Office of Financial Institutions and Securities Regulation.

- The Office of Insurance Regulation is responsible for regulation of insurance companies and other risk bearing entities, including licensing, rates, policy forms, solvency, claims adjusters, market conduct, viatical settlements and premium financing and administrative supervision of insurers as provided in the Insurance Code or Chapter 636.
- The Office of Financial Institutions and Securities Regulation is responsible for banks, credit unions, other financial institutions, finance companies, and the securities industry.

HB 67E - State Universities / Liability in Tort Actions

(Chapter No. 2002-401) Effective Date: June 7, 2002

This legislation defines the scope and limit of liability in tort actions involving state universities and particularly the scope and limit of liability in specified medical malpractice actions.

- Establishes the doctrine of comparative fault rather than joint and several liability as applicable to the individual university board of trustees in medical malpractice actions accruing after January 7, 2003.
- Defines a university board of trustees as a state agency or subdivision for purposes of applying the sovereign immunity provisions in tort actions arising after January 7, 2003.
- Defines a physician's scope of supervision over a medical resident as the supervision standards established by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association for purposes of liability coverage under the Neurological Injury Compensation Act (NICA).
- In a NICA action, permits a family to recover expenses for the personal provision of professional residential or custodial care of a severely brain injured child.

SB 968 - Florida Healthy Kids Corporation / Operating Fund

(Chapter No. 2002-220) Effective Date: July 1, 2002

Limits the Florida Healthy Kids Corporation operating fund to no more than 25 percent of annualized operating expenses. Upon dissolution of the Corporation, any remaining cash balances of state funds shall be returned to the state General Revenue Fund or other state funds consistent with appropriated funding as provided by law.

HB 615 - Federally Qualified Health Centers

(Chapter No. 2002-289) Effective Date: July 1, 2002

A program is created to provide financial assistance to federally qualified health centers that apply and demonstrate a need for such assistance in order to sustain or expand their provision of primary and preventative health care to low-income Floridians.

The Department of Health is authorized to contract with the Florida Association of Community Health Centers, Inc., to administer the program and to provide technical assistance to health centers selected to receive assistance.

HB 1405 - Health Care Practitioner Student Loans and Service Obligations

(Chapter No. 2002-254) Effective Date: May 13, 2002

Failing to repay a student loan issued or guaranteed by the state or the federal government or failing to comply with service obligations will be considered a failure to perform a statutory or legal obligation and subject to disciplinary action as stated in this legislation. The Department of Health is required, upon receipt of information that any Florida licensed health care practitioner has defaulted on a student loan issued by the state or the federal government, to notify the practitioner by certified mail that he or she is subject to immediate license suspension unless, within 45 days after the date of mailing, the licensee provides proof that new payment terms have been agreed upon by all parties to the loan. The Department of Health must issue an emergency order suspending the license of the practitioner if proof of an agreement for payment has not been provided.

The minimum disciplinary action imposed must be a suspension of the license until new payment terms are agreed upon or the scholarship obligation is resumed, followed by probation for the duration of the student loan or remaining scholarship obligation period, and a fine equal to ten percent of the defaulted loan amount.

SB 612 - Controlled Substances / Carisoprodol

(Chapter No. 2002-78) Effective Date: July 1, 2002

Carisoprodol, a prescription muscle relaxant, is placed in Schedule IV of Florida's controlled substance schedules. The effect of

this change is to limit the number of allowable prescription refills within specified periods, makes various drug offenses applicable to this drug

(Continued next page ▸)

Legislative

(◂ continued from previous page)

and makes it a third degree felony to possess carisoprodol without a prescrption.

CS/CS/SB 1412 - Prescription Drug Claim Identification Cards
(Chapter No. 2002-245) Effective Date: October 1, 2002

Health insurers, health maintenance organization and all state and local government entities that provide prescription drug coverage will be required to issue a drug benefits identification card containing certain specified information. Specified information is not required if the card provides information on access by electronic means. Temporary stickers containing the required information that policyholders can affix to the existing card will meet the requirements of the law.

SB 2054 - Tallahassee Children's Medical Services Building
(Chapter No. 2002-305) Effective Date: May 13, 2002

The new Children's Medical Services building in Tallahassee is designated the "Elaine Gordon Children's Medical Services Building". Elaine Gordon, who recently passed away, was a former member of the House of Representatives and recipient of the Florida Pediatric Society's Samuel P. Bell Award.

HB 27E - General Appropriation Act / Fiscal Year 2002-2003
(Chapter No. 2002-394) Effective Date: July 1, 2002

There were no substantial changes to appropriations to fund health services for children. However, several opportunities to enhance services and reimbursement have been provided in proviso language.

Proviso:

- **Kidcare** -
  The Florida Healthy Kids Corporation is authorized to use up to $15 million of reserves to replace local match previously required for Title XXI eligible children. Voluntary local contributions are authorized to expand participation.
- A minimum of $7 million in local match is required to be used to fund children not eligible for Title XXI coverage.
- The Florida Healthy Kids Corporation is authorized to use funds for eligibility system enhancements.

Agency for Health Care Administration -

Authorization is provided to expand existing programs utilizing increased federal reimbursement programs to include a physician upper payment limit program to increase Medicaid fees for health professionals; finance physician related projects to increase Medicaid beneficiary access to primary and specialty care or to test additional care management programs.

Authorization is provided to seek federal waivers or a state plan amendment to create a special Medicaid payment to increase reimbursement to Medicaid participating organ transplant facilities or implement global fees for transplant services.

Authorization is provided to develop a plan for implementation of a Diagnosis Related Group (DRG) reimbursement methodology for Medicaid providers.

A study authorized to evaluate mandated health benefits (insurance and HMO) was vetoed.

Children's Medical Services -

A study group appointed by the Secretary is directed to conduct a study of standards contained in s. 383.19, F.S. relating to the number of Regional Perinatal Intensive Care Centers and the cost effectiveness of expanding the number of such centers. The report is due by March 1, 2003.□

Resident

(◂ continued from page 13)

was instituted in an attempt to lesson the work demands of the interns on-call. The second year residents are currently creating an ER guidelines text based on the AAP recommendations for managing the most common pediatric illnesses. The residents are also working to implement the PRIDE program (Pediatricians Recognizing Individuals Displaying Excellence) in the Miami area. MCH has recently added an adolescent medicine specialist to the staff at MCH, and the adolescent educational program for residents is developing into one of the more rewarding aspects of the residency requirements.

In addition to the new, the tradition of great education continues to prevail at the hospital. The residents continue to host case report based educational topics every week, as well as daily lectures on pediatric disease directed by many of our staff physicians. Our weekly radiology conference is a draw for many community pediatricians. The Friday Grand Rounds are an exceptional showcase for visiting physicians and topics of current debate and investigation.

Dr. Jennifer Horn
drjdrj1975@hotmail.com

Add-a-Pearl...from Chuck Weiss

Poisonous Chilean spiders found in Central Florida

WINTER HAVEN -- The state established a new Web site about venomous spiders after one of the world's most toxic species was discovered at a Central Florida home recently.

Sixteen Chilean recluse spiders were removed from the Winter Haven home in July, prompting the state Department of Agriculture and Consumer Services to put up the Web site with photos and information about them and other poisonous spiders found in Florida.

The Chilean recluse is native to South America but has shown up recently in California, Kansas and Massachusetts. This was the first time it was detected in Florida. The house where they were found was treated, and inspections of nearby houses turned up no more of the half-dollar-size spiders, whose color ranges from pale yellow to reddish brown.

Most recluse spiders are nocturnal and generally not aggressive toward people, the agriculture department said. They are most often found in dark, undisturbed places inside buildings.

They are believed to have been brought into the state in luggage and cargo, the agriculture department said. Anyone who suspects they've found a venomous spider can contact the department's Division of Plant Industry at (352) 372-3505.
(from the Sarasota Herald Tribune, Sept 21, 2002

Managed

(◂ continued from page 12)

if it costs "one dollar more". A meeting is expected soon to review cost estimates for this plan.

Regarding the finding that pediatricians are less likely to participate in a capitated than a fee-for-service Medicaid program, that certainly has been the experience in Florida. The vast majority of capitated Medicaid programs in Florida are Medicaid HMOs, which don't receive high marks from Florida pediatricians. Indeed, Governor Bush tried to totally eliminate Medipass, which would have made Medicaid HMOs the only option. Fortunately, we and others were able to convince the legislature to keep the Medipass program. One of our arguments came from data gotten from the Medicaid director's office: for children aged 1-5 years, it was actually cheaper for the state to have them cared for in Medipass. The per member, per month figures were $79.41 for children in Medicaid HMOs, and $69.95 for children in Medipass. I suspect Medicaid HMOs are not happy with us. As a result of my personal involvement by testifying at a legislative committee hearing, I received, by certified mail, a legal threat to "Cease and Desist...recent statements...may constitute defamatory comments and/or anti-trust violations against _____ HMO"(!) Other issues with the Medicaid HMOs include:

- The **hassle factor** in dealing with authorizations and prior approval.
- Provider **panel limitations** are a real problem for both patients and physicians.
- **Payment delays**. Medipass, with electronic billing of clean claims, and provided no manual review is required, pays claims as fast as, if not faster than, any third party; usually 10-14 days. Medicaid HMOs take considerably longer.
- If a mother is on a Medicaid HMO, her newborn will **automatically** be on that HMO for at least 3 months, even if the mother does not want the infant on the HMO and her other children already see another provider. It usually takes from 1-3 months to get the infant off of the HMO and onto Medipass. What happened to **patient choice**?
- The State does not adequately **police Medicaid HMOs**. Our complaints that a local HMO had no pediatric providers in Leon County, and that our former patients were being assigned, without their knowledge, to providers 2 ½ hours away (Jacksionville), have never been thoroughly addressed. On February 29, 2002, I filed a formal complaint that the Medicaid HMO collected a capitation from the state, while they had no pediatric providers, in violation of their contract. I recently saw one of the investigators, who stated that case is still "under investigation".

We will continue to pursue these issues, because our goal is to promote access to quality care for indigent children. About 52% of live births in Florida are now Medicaid eligible, so few of us have the luxury of not dealing with Medicaid. National data shows that the majority of US children receive preventive care from private primary care pediatricians or family physicians. In 1988, >80% of ambulatory pediatric care was in private offices. National studies have shown that having a private practicing physician as the usual source of care results in a 1/3 decrease in total Medicaid expenses.

Most of what I know about Medicaid comes from my 28 years in the trenches in Tallahassee, embellished by the tales of similar woes from y'all around the state. Please continue to provide me your input regarding the problems you are experiencing with Medicaid so the bureaucrats in Tallahassee won't say "you're the only one who ever complains, Dr. St. Petery". ☐

C.A.T.C.H.

(◂ continued from page 22)

the fact that Dr. F. Edward Rushton is retiring to Amelia Island may have had some influence in stirring up the pot in his area of the state. It goes without saying that wherever Dr. Rushton goes. he leaves in his wake a legacy of improved health care systems for children For those of you who may not know, Dr. Rushton is essentially the "Father of CATCH." We are fortunate as a state to have him in our midst. In closing, recall that CATCH is not simply a grant program, nor just a department in the AAP Section an Community Pediatrics. It is a philosophy; a networking mechanism for pediatricians of like mind, and in my humble opinion, it is organized child health advocacy for access and services at its finest.☐

Senior

(◂ continued from page 23)

arousing men to burst the chains under which monkish ignorance and superstition had persuaded them to bind themselves, and to assume the blessings and security of self-government... All eyes are opened or opening to the rights of man. The general spread of the light of science has already laid open to every view the palpable truth, that the mass of mankind has not been born with saddles on their backs, nor a favored few, booted and spurred, ready to ride them legitimately by the grace of God. These are the grounds of

hope for others; for ourselves, let the annual return to this day forever refresh our recollections of these rights, and an undiminished devotion to them."

How meaningful in today's troubled world! It is never too late to start reading our country's history. Ask me.☐

Table II
Biochemical Parameters before and after Removal of Hemangiopericytoma of Left Iliac Wing

Time after surgery	Phosphorus (mg/dL)	Calcium (mg/dL)	Alkaline phos. (U/L)	25 vitamin D (ng/mL)	1,25 vitamin D (pg/mL)	PTH (pg/mL)	FGF-23 *(RU/mL)
Pre-operative	1.5	10.3	1044	14	28	69	**1875**
10 hrs	2.1	8.9					
24 hrs	2.1	9.1	729				161
48 hrs	2.6	9.0	755		49		43
8 days	3.1	9.6	801	13	104	161	
1 mo	4.7	8.6	723	10	162	103	
6 mos	5.2	9.6	452	22	131	52	

*RU = Reference units. Normal values in 30 adult control patients were 67.9±7.9 RU/mL

Correction

In the article Tumor-Induced Osteomalacia, which appeared in the August 2002 issue of *The Florida Pediatrician*, one number was missing in Table II. The table is repeated here, with the re-instated number in bold type:

White Coat

(◂ continued from page 8)

are: integrity, respect, and compassion". The Arnold P Gold Foundation, the sponsor of the Humanism in Medicine Award, defines Humanism as "the link between compassion and scientific competence". My definition of Humanism is quite simple. To me, you display humanistic behavior any time you selflessly get out of bed to treat a child, reassure an anxious parent, a patient, or a family member, any time you listen to your patient with warmth and compassion, any time you respect your patient's individuality, culture, environment, trust and confidentiality, any time you teach and learn from your patients and colleagues. Basically humanism is present anytime you do your job as a physician, and do it well, giving it all that you've gotten from knowledge to compassion. To me, Medicine is more than an art and a science. It is a noble mission that dates back to the stone ages, and no matter how times change it, its humanistic essence remains untouched.

Members of the class of 2006, as you receive your white coat now, wear it with humility and pride. Because you have worked hard for this goal, let it project the humanism and the values it symbolizes, and remember: Do no harm., and, as Dr. Gold nicely said: "Do not only take care of patients but care for them".

Letters to the Editor

Let me be the first to congratulate you and welcome you to the family of the medical profession. We are glad you are here, enjoy your wonderful journey, it is a privilege you earn, take it seriously. BUT REMEMBER, have fun with it!!!!

Thank you!!!!☐

Classified Advertising

To the Editor:

Your reference to "flash in the pan" [Editorial, August 2002] set off a trickle of

neuronal flashes in my RAM. It seemed to me that the reference was to the misfiring of flintlock muskets. Thanks to Google I was able to locate the attached confirmation. I don't claim to be older than you, but the phrase predates flash photography. And this proves that people do read the editorials. From: http:phrases.shu.ac.uk/meanings/138450.html: "Flash in the pan in its strictest usage means ineffective or nopnproductive. It derives from the early days of firearms - specifically flintlock muskets. These guns used a piece of flint to strike sparks on a steel plate called a frizen. These sparks fell into a small pan of fine gunpowder that was quickly ignited and enough fire was supposed to pass through a small touchhole at the base of the gunbarrel to ignite the main charge. If the touchhole was clogged, only the powder in the pan would ignite, giving a bright flash and lost of smoke - but nothing else."

Sam H. Moorer, M.D.
Tallahassee

[Editor: I stand corrected. I heard my explanation a long time ago, and certainly cannot document it as Dr. Moorer has done his. Since his documentation precedes my explanation, it is more likely to be the right one. Isn't nice to be able to have this kind of diversity of thought?]□

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: Neonatal Hematology and Immunology
Dates: November 14 - 16, 2002
Place: Coronado Springs Resort, Lake Buena Vista FL
Credit: Up to 15 hours for Category 1 for AMA Physician Recognition Award
Sponsor: University of South Florida and All Children's Hospital
Inquiries: Office of Continuing Professional Education (813)974-4296 or (800) 852-5362 or hmoretti@hsc.usf.edu

Program: Practical Pediatrics
Dates: December 13 - 15, 2002
Place: Williamsburg Lodge, Williamsburg, Virginia
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: Masters of Pediatrics
Dates: January 15-20, 2003
Place: Sheraton Bal Harbour Beach Resort, Florida
Credit: Hour for hour (up to 34.5 hours) for Category 1 for AMA Physician Recognition Award
Sponsor: University of Miami School of Medicine
Inquiries: Bonnie Shinkle, (305-243-3992/3994/800-622-4453

Program: Practical Pediatrics
Dates: January 16-19, 2003
Place: Steamboat Springs, Colorado
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: Management of the Tiny Baby
Dates: January 23-25, 2003
Place: Lake Buena Vista, Florida
Credit: Up to 14 hours for Category 1 for AMA Physician Recognition Award
Sponsor: Orlando Regional Healthcare and Shands Children's Hospital
Inquiries: Patty Devlin (800) 648-0450

Program: 38th Annual Pediatric Postgraduate Course
Dates: January 24-30, 2003
Place: Sheraton Bal Harbour Resort, Miami Beach, FL

Credit: Up to 52 hours for Category 1 for AMA Physician Recognition Reward
Sponsor: Miami Children's Hospital
Inquiries: 38th Annual Miami Children's Hospital Postgraduate Course, (800) 445-9340 or (305) 669-5858

Program: Practical Pediatrics
Dates: March 13-15, 2003
Place: Hilton In 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: 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

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