In this issue............

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>WHO'S WHO</td>
<td>2</td>
</tr>
<tr>
<td>THE PRESIDENT'S PAGE</td>
<td>3</td>
</tr>
<tr>
<td>THE EDITORIAL PAGE</td>
<td>5</td>
</tr>
<tr>
<td>THE GRASS ROOTS</td>
<td>6</td>
</tr>
<tr>
<td>FROM THE DEPARTMENT CHAIRMEN</td>
<td>7</td>
</tr>
<tr>
<td>THE SCIENTIFIC PAGE</td>
<td>8</td>
</tr>
<tr>
<td>COMMITTEE REPORT</td>
<td></td>
</tr>
<tr>
<td>SCHOOL HEALTH</td>
<td>13</td>
</tr>
<tr>
<td>FROM THE RESIDENTS' SECTION</td>
<td>14</td>
</tr>
<tr>
<td>THE CATCH CORNER</td>
<td>14</td>
</tr>
<tr>
<td>MANAGED CARE</td>
<td>15</td>
</tr>
<tr>
<td>IN MEMORIAM</td>
<td>16</td>
</tr>
<tr>
<td>RISK MANAGEMENT</td>
<td>17</td>
</tr>
<tr>
<td>FROM THE AAP</td>
<td>18</td>
</tr>
<tr>
<td>SCHOOL HEALTH</td>
<td></td>
</tr>
<tr>
<td>COMMITTEE REPORT</td>
<td></td>
</tr>
<tr>
<td>FROM THE FCAAP</td>
<td>20</td>
</tr>
<tr>
<td>THE HISTORY CORNER</td>
<td>23</td>
</tr>
<tr>
<td>LEGISLATIVE REPORT</td>
<td>25</td>
</tr>
<tr>
<td>Add-a-Pearl</td>
<td>28</td>
</tr>
<tr>
<td>UPCOMING CME MEETINGS</td>
<td>32</td>
</tr>
</tbody>
</table>

Steve Edwards, President of AAP, addresses annual meeting
EXECUTIVE COMMITTEE Officers

Chapter President
Deborah Mulligan-Smith, M.D.
Coral Springs, FL
(e-mail: debmmsmi@aol.com)

Chapter President Elect
David Marcus, M.D.
Ft. Lauderdale, FL
(e-mail: starcode55@aol.com)

First Vice President
Patricia Blanco, MD
Sarasota, FL
(e-mail: pblanco@nemours.org)

Second Vice President
Jose DelToro-Silvestry, MD
Ft. Lauderdale, FL
(e-mail: jojorge_delcoro@pediatricx.com)

Immediate Past President
Richard L. Bucciarelli, M.D.
Gainesville, FL
(e-mail: buccirelli@peds.ufl.edu)

Regional Representatives
Region I
Thomas Truman, MD
Tallahassee, FL
Region II
James Waler, MD
Jacksonville, FL
Region III
Jyoti Budania, M.D.
Gainesville, FL
Region IV
Lloyd Werk, MD
Orlando, FL
Region V
Carol Lilly, MD
Tampa, FL
Region VI
John Donaldson, MD
Ft. Myers, FL
Region VII
Marshall Jershing, MD
Hollywood, FL
Region VIII
Kimberly Schwartz, MD
Miami, FL

Ex-Officio Members
U. Florida Pediatric Chairman
Terry Flotte, MD.
Gainesville, FL
U. of Miami Pediatric Chairman
R. Rodney Howell, M.D.
Miami, FL
U. - South Florida Pediatric Chairman
Robert D. Christensen, MD
Tampa, FL

Nov Southeastern U. Pediatric Chairman
Edward Packer, D.O.
Ft. Lauderdale, FL

EXECUTIVE OFFICE

Executive Vice President
Louis B. St. Petery, Jr., M.D.
1132 Lee Avenue
Tallahassee, FL 32303
(Ph)850/224-3939
(Fax)850/224-8802
(e-mail: lpetery@attglobal.net)
Membership Director
Edith J. Gibson-Lovingood
(Ph)850/562-0011
(e-mail: edelov@cso.com)
Legislative Liaison
Mrs. Nancy Moreau
(Ph)850/942-7203
(e-mail: nemo189@hotmail.com)

COMMITTEE STRUCTURE

Key Strategic Plan Chairmen
Advocacy Committee
Richard L. Bucciarelli, MD/Tom Benton, MD
Gainesville, FL
Communication Committee
Deborah Mulligan-Smith, MD
Coral Springs, FL
Practice Support Committee
Jerry Isaac, MD/Edward Zissman, MD
Altamonte Springs, FL
Member and Leader Development Committee
Patricia Blanco, MD
Tampa, FL

Liaison Representatives and Sub-Committees
Breast Feeding Coordinators
Arnold L. Tanis, MD
Hollywood, FL
Orlando, FL
Child Abuse and Neglect Committee
Jay Whitworth, MD
Jacksonville, FL
CATCH
Karen Tucker, MD
Jacksonville, MD
Deise Granado-Vila, MD
Coral Gables, FL
Child Health Financing and Pediatric Practice
Edward H. Zissman, MD
Altamonte Springs, FL
CHEC
Ramon Rodriguez-Torres, MD
Miami, FL
Collaborative Research/PROS Network Subcommittee
Lloyd Werk, MD
Orlando, FL
G7T4
Edward N. Zissman, MD
Altamonte Springs, FL
Environmental Health, Drugs, and Toxicology
Charles F. Weiss, M.D.
Siesta Key, FL
Home Health Care
F. Lance Francis, M.D.
Tampa, FL
FMA Board of Governors
Randall Bartlett, MD
Vero Beach, FL
Federal Access Legislation
Susan Grifis, MD
DeLand, FL
Healthy Kids Corporation
Louis B. St. Petery, Jr., M.D.
Tallahassee, FL
Pediatric Critical Care and Emergency Services
Phyllis Stenklyft MD
Jacksonville, FL
Jeffrey Sussmane, MD
Miami, FL
Residants Section
Sharon Dabrow, MD
Tampa FL
Lloyd Werk, MD
Orlando, FL
Schooli Health/Sports Medicine
Rani Gerene, M.D.
St. Petersburg, FL
Women’s Section
Shakira Junipe, MD
Apalachee, FL
Council of Past Presidents
Edward N. Zissman, M.D.
Edward T. Williams, III, M.D.
John B. Cuman, M.D.
David A. Cimino, M.D.
Robert F. Colyer, M.D.
Robert H. Threlkel, M.D.
Jerry Isaac, MD
Gary M. Bong, M.D.
Chairman of Pediatric Specialty Societies
Lawrence Friedman, MD
(Florida Regional Societyof Adolescent Medicine)
Michael Paul Pruitt, MD
(Florida Societyof Adolescent Psychiatry)
Andrew Kairalla, MD
(Florida Society of Pediatric Nephrologists)
Michael Paul Pruitt
(Florida Pediatric Critical Care)
Reginald A. Ford
(Florida Societyof Pediatric Critical Care)
Joel A. Handler
(Florida Societyof Pediatric Critical Care)
John F. Curran
(Florida Societyof Pediatric Critical Care)
Robert H. Threlkel
(Florida Societyof Pediatric Critical Care)
David E. Drucker, MD
(Florida Societyof Pediatric Critical Care)

E-Mail
Barrett, Douglas, M.D.
barred@peds.ufl.edu
Bauer, Charles, M.D.
bauer@peds.med.miami.edu
Benton, Thomas, M.D.
notrej@beesouth.net
Benget, Bruce, MD
bbdoffc@boll.com
Blavo, Cyril
blavo@hp.qacast.nova.edu
Budanna, Jyoti, MD
shalusa@jwu.net
Christensen, Robert, MD
rcrstate@hsc.usf.edu
Cimino, David A., MD
chmood@akids.org
Curray, John, MD
curran@hsc.usf.edu
Dabrow, Thomas, MD
sdbrow@hsc.usf.edu
Del Toro-Silvestry, Jorge, MD
Jorge_delcoro@pediatricx.com
Drucker, David, MD
vend@duckerma.com
Floke, Terence R, MD
ftrc@peds.ufl.edu
Friedman, Lawrence, MD
friedman@miamed.edu
France, F. Lane, MD
ffranc@mem.po.com
George, Donald E., MD
G@nemos.org
George, Rani S., MD
gegerei@akids.org
Girod, Jorge, MD
726 10.277@compasserve.com
Griffis, Susan, MD
sussangriff@yahoomail.com
Garama-Vila, Deise, MD
deise.granado-vila@mch.com
Howell, Rodney, M.D.
howell@peds.med.miami.edu
Isaac, Jerome, MD
jisaac@comcast.net
Junejo, Shakra, MD
Shakra, Junejo@fs.state.fl.us
Kainall, Andrew, MD
abka@aol.com
Katz, Lome, MD
lokatz@mem.po.com
Lilly, Carol, MD
cilly@hsc.usf.edu
Meek, Joan, MD
jmeek@nemos.org
Milov, David, MD
dmilov@nemos.org
Ohring, Marshall, MD
MOhring55@aol.com
Pomerance, Herbert, MD
hpomerman@hsc.usf.edu
Reese, Randall, MD
randall.reese@hotmail.com
Rodriquez-Torres, Ramon, MD
rrottopa@aol.com
Schwartz, Kimberly, MD
KSchwartz@med.miami.edu
Stenklyft, Phyllis, MD
Phyllis.stenklyft@jax.ufl.edu
Sussmane, Jeffrey, MD
Jeffrey.sussmane@mch.com
Truman, Thomas, MD
truman@tallynet.com
Waler, James, MD
jawaler@hotmail.com
Weiss, Charles, MD
cweiss@pol.net
Werk, Lloyd, MD
lewerk@nemos.org
Whitworth, Jay, MD
jwhitworth@busonet.net
Yee, Patrick, MD
Patey1@tampabay.rr.com
Wood, David, M.D.
david.wood@jwu.edu
Dear Colleagues:

I am truly honored to have been given the opportunity to serve you and this wonderful organization as your President. Before I begin to outline my agenda, I would like to give special recognition to Dr. Richard Bucciarelli and commend him for his excellent leadership and guidance of our chapter during the last two years. During his tenure, he kept the FCAAP at the forefront of children’s issues and advanced our collective agenda in both the state and the nation. Thank you, Dr. Bucciarelli for a job well done.

Like all of us, I am a product of valuable lessons learned from parents, family members, professors, mentors, colleagues, and, most importantly, those children and families that I have had the honor to serve. My teachers have been many and the knowledge gained from them invaluable. As I write this, two extraordinary and inspirational individuals immediately come to mind.

* * * * *

“...Thank you, Dr. Bucciarelli, for a job well done...”

* * * * *

Dr. Herbert Pomerance has been, and continues to be, an indefatigable and enthusiastic advocate for children. In his long and distinguished career, he has been a true innovator and originator of numerous improvements for pediatric healthcare. From his outstanding continuing contributions as a member of the Senior Section, to the advancement of medical knowledge and enhanced pediatric communication as editor of "The Florida Pediatrician", he has been a true inspiration to all of us and a perfect example of the vision and mission of the FCAAP. Dr. Charles “Chuck” Weiss is another selfless and dedicated champion of children’s issues. Throughout his career, he has shown his commitment to advancing pediatric healthcare in our state through multi-year contributions to "The Florida Pediatrician" and the Executive Committee of the Florida Chapter on topics related to environmental health and toxicology. The wonderful friends are each recipients of this year’s District X Special Achievement Awards.

Both of these celebrated and distinguished pediatricians are superb examples of why our organization is a great one – just as Dr. Pomerance and Dr. Weiss have continued to learn and grow and serve those in need of their help, we as a Chapter continue to learn, grow, and collaborate – and never rest on our laurels. From our humble beginnings in 1920, when for every 1000 births, ten mothers died, 65 babies were stillborn, and over 100 infants died before their first birthday to now, when infant mortality has dropped to a record low and life expectancy has hit a record high – and deaths among children and young adults from unintentional injuries, cancer, and heart disease are down significantly, the Florida Pediatric Society/Florida Chapter of the American Academy of Pediatrics has grown and matured with each passing year. As always, as the economic, social, and scientific environments change, it is our duty to develop our skills and expertise, improve our knowledge, and collectively make sure children’s issues are given the attention and focus they so very much deserve.

(See President, page 29 *)
Yes, we are entering an interesting time. And as usual, when things are interesting, there is usually good news and bad news!

Good news first: As you know, and as you will read further in this issue of *The Florida Pediatrician*, we have a new president, who took office at the Annual Meeting of the society, in June. Debbie Mulligan-Smith is an active communicator among us, and has already given lots of her time on behalf of the society, during her ‘crawl’ up the ladder of society power. She has lots of ideas for the society during her tenure as president, and we will see these become obvious very soon.

There is another facet worth noting. Deb is the first woman to hold the presidency of this society, and does so coinciding with the election of Carol Berkowitz as President-Elect of the American Academy of Pediatrics. Being one of the early believers that, in a profession like ours, we need to be ‘sex-blind’, I applaud these events, knowing that both elections occurred because of the excellence of the candidates.

And now the bad news: I am writing in July, and at this time there is still no legislative action in an attempt to create a solution to the malpractice crisis. Our practicing physicians, pediatric or other, are still feeling the blade of the guillotine which threatens to behead their attempts to practice. And everyone has someone on whom to level the blame for lack of change.

Some blame us, the physicians. We should practice better medicine! Statistics suggest that a very small percentage of physicians are a part of most of the malpractice suits. Some blame the insurance companies, claiming their profit margins are high despite the insurance settlements. Yet, most of the companies have discontinued Florida business; would they if business were so good?

And of course, the rest blame the attorneys. They point our that, the bigger the settlement, the bigger the fee collected by the attorney, and that therefore the attorneys do not want to curtail the size of the settlements. I was told long ago, in a different context, that he who protests most loudly has the most to gain or lose. I do not know if this is true or not. I do know that relatively few attorneys practice malpractice law.

I do not know whose arguments are best or most true, and I do not believe that, at this point, it really makes much difference! We need some kind of plan to provide relief, and I understand that the Governor will push until he gets a reasonable relief.

Meanwhile, we are the ones who provide help to the children of our state, and we shall continue to do so, to the best of our ability.

The Editor
**Region IV reports:**

The recent quarter has been productive for the AAP and its mission through the efforts of our District members. Member activities have been recognized on a national, regional and local level.

Dr. Lloyd Werk M.D., FAAP, has been appointed representative to the national Membership Committee for the AAP and is among 8 FCAAP members serving on a national AAP committee. Joan Younger Meek, M.D., FAAP, editor of the AAP book New Mother's Guide to Breastfeeding, has been recently quoted by the Washington Post, New York Times, Newsweek and Parenting magazine on a variety of issues relating to breastfeeding. The Department of Health and Human Services, section of Maternal and Child Health will distribute a slide presentation to promote breastfeeding again edited by Dr. Meek.

Dr. Jan Howell has authored and published an interactive CD-ROM on the care of children with asthma. The work and has been distributed to all ABFP members. At the state level Ian Nathanson, MD, FAAP, president of the Orange County Medical Society, has led efforts from our area to impart to our political representatives the need for relief from malpractice increases, and no less important, assuring methods of access for all children. Our District membership stands at 289 with all but 16 members current with their membership dues.

Our region is very active at the level of young physicians and in the recruitment of pediatric residents. Our area has recently extended the highly successful After Hours Pediatrics concept with the operation modeled after the program from the Tampa Bay region. The Orlando effort is led by member Robert Cooper, MD, FAAP. The Central Florida Pediatric Society, presently presided over by Matthew Seibel MD, FAAP, holds quarterly dinner meetings which feature a speaker, CME , and an opportunity for central Florida's Pediatricians to network. On June 13, 2003, Daniel J. Friedland, MD discussed Evidence-based Medicine: A Framework for Clinical Practice.

The AAP super CME 2004 will be held in Orlando April 28-May 1, 2004.

David Milov, M.D.  
Orlando, FL  
Regional Representative

**Region VIII reports:**

District 8 currently has 368 members of the Florida Pediatric Society, 27 (7%) of whom are Emeritus. Fifty two (14%) new members were recruited in 2002-2003. The Greater Miami Pediatric Society (GMPS), under the leadership of Francisco A. Medina, the 2002-03 President, is the primary local organization for community and academic communication, holding quarterly meetings with guest lecture legs and social activities.

The University of Miami School of Medicine is in the final stages of recruiting a new Chairman for the Department of Pediatrics. Negotiations are currently underway with the anticipation that an announcement is imminent.

The American Academy of Pediatrics-Section on Neonatal Perinatal Medicine has announced the selection of Eduardo Bancalari, M.D. as the recipient of the 2003 Virginia Apgar Award. Dr. Bancalari is Professor and Director of the Division of Neonatology at the University of Miami-Jackson Memorial Medical Center. This is the highest honor in the field of Neonatology and Dr. Bancalari joins other outstanding neonatologists such as Mary Ellen Avery, William Oh, Mildred Stahslman, William Silverman, Avroy Fanaroff and others. The award will be presented on November 2nd during the annual AAP meeting in New Orleans.

The Department of Pediatrics has recently been awarded an Anne E. Dyson- 5 year Community Pediatrics Training Initiative. Currently ten (10) programs are funded throughout the United States with a goal toward the development of innovative residency training programs that emphasize a long-term commitment to community concerns. As part of this initiative, the Department of Pediatrics has developed a youth violence prevention project in Miami's inner city. The program is directed by Arturo Brito, M.D., and Lee M. Sanders, M.D., MPH, with the active involvement and collaboration of 14 pediatricians, including Kimberly Schwartz, the new District 8 representative.

The two Early Intervention Programs in Region 8, located at Miami Children’s Hospital and the Mailman Center for Child Development continue to provide services for an increasing number of children referred for assessment of potential developmental delays. This program serves the largest number of children in the state, with over 3500 clinic visits this past year, representing an 18% growth rate. There are currently 15 Early Intervention Programs in the State organized and administered by the Department of Health under the auspices of Children Medical Services.

Dr. Lee Sanders, an Assistant Professor in the University of Miami’s Department of Pediatrics has recently launched a Florida Campaign called the “Reach Out and Read Coalition", which seeks to address the major ingredient to personal and professional success- illiteracy. It involves

(See Region 8, page 30 •)
Graduation is always an exciting and gratifying time for me as a teacher. As I stand up on the podium, I watch with great pride and satisfaction as another class completes their studies and goes off for their postgraduate training. As one class graduates, I am well aware that it will not be long until our new students will be starting their education.

Medical education is evolving in both its scope and goals. As educators, it is becoming vital to train our students in modern molecular biology and to make them aware of the effects of the Human Genome Project on modern health care. Currently, I chair a committee that is developing methods of incorporating modern medical genetic issues into each of the clinical subjects presented to our students.

Various evaluations on the effectiveness of medical education have demonstrated that students educated using the traditional methods of lectures and textbooks often have difficulty applying their knowledge in real clinical settings. Our program is utilizing more Problem Based Learning forums to present new material. In these Problem Based Learning sessions, the students are presented with a written pediatric case that they attempt to diagnose and treat. The students work in small groups with a physician serving as a guide to focus the group and give specific learning objectives. The Problem Based Group leaves the session with specific items to research and then presents their findings to the group in the following session. Students working in the Problem Based Learning forum learn to research medical material, and learn medical techniques of problem solving.

One of the goals of modern medical education is to produce physicians that can perform a proper history and physical on a patient and reach an appropriate differential diagnosis. The Objective Structured Clinical Examination (“OSCE”) has recently been incorporated as part of the final examination in many of our courses. Nova Southeastern University has a specialized suite of examining rooms that are equipped with video cameras, and a team of “actor” patients that have scripted cases for student evaluations. The “OSCE” experience has proven to be a powerful tool for determining both the skills that our students have acquired, and how well we are teaching them to care for children.

Care of pediatric patients is often an important component of most primary care practices. For our students to succeed in primary care medicine, they must learn to properly care for children and integrate them into the routine of their office practice. I have worked to incorporate pediatric subjects into any of the courses our students take that could relate to child health subjects. In the past year, pediatrics has been added to the Preventative Medicine Course with subjects like infant nutrition. The Physical Diagnosis Course has added presentations on child abuse. The Medical Procedures Course has added presentations on care of the well and sick newborn. I will continue to find other courses where pediatric subjects can be added over the next academic year.

An ongoing challenge is to maintain didactic education for our students in the clinical years. Hospital rotations offer excellent opportunities for our students to experience patient care and to hear lectures from seasoned clinicians, but continuing the education in basic pediatric principles requires a different kind of presentation. Nova Southeastern University has an extensive network of two-way compressed video conferencing at all of our major hospital locations. With these video conferencing systems, we have been able to broadcast discussions on basic pediatric principles such as writing and calculating intravenous fluid orders for children.

The pediatrics department is currently developing a computer web-based site for all of our students to continue their education in basic pediatric...
SUMMARY

Cataracts in infants and children are due to different causes. Early diagnosis and treatment are key to the prevention of severe visual loss. The pediatrician plays a crucial role in the initial screening and diagnosis of newborn infants as well as children of all age groups affected with this condition. New surgical techniques including intraocular lens (IOL) implants as well as contact lens correction of aphakia have greatly improved the visual outcome in these patients, provided early diagnosis and treatment, including amblyopia treatment are administered before irreversible visual damage occurs.

WHAT IS A CATARACT?

Any opacity in the lens is called a cataract. It may be a small white dot opacity appearing in the center of the pupil, such as an anterior polar cataract. This type of cataract rarely causes a visual deficit and often remains stable (Figure 1). Or the opacity may be large and present in the visual axis leading to legal blindness. The prevalence of cataract is 1 to 6 cases per 10,000 infants. There are around 200,000 children worldwide that are blind from cataract. ¹

HOW AND WHEN DO WE DiAGNOSE A CATARACT?

All newborn babies should be screened for cataracts as part of their first neonatal physical examination given by the pediatrician in the nursery. They are further screened on their first office visit at 2 weeks of age and on each subsequent visit during the first 2 years of life. From then on this is followed by a yearly exam. The screening test used is the Bruckner Test or Red Eye test. The direct ophthalmoscope is set on the +10 green number; the pediatrician looks through the ophthalmoscope into the pupils of the newborn or infant at a distance of approximately 5 to 10 inches. Any opacity or dark spot obstructing the red reflex shining through the pupil may be a cataract (Figure 2). Direct examination of the infant’s eye with a penlight may reveal the opacity to be anterior, such as in the cornea, or further posterior, such as in the lens. Not all cataracts are visible to the naked eye, particularly if the opacity involves the posterior layers of the lens, e.g. posterior lenticous, or persistent hyperplastic primary vitreous. Leukocoria or white pupillary reflex may be caused by different pathologies (Table 1).

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Differential Diagnosis of Leukocoria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corneal opacity</td>
<td>Persistent hyperplastic primary vitreous</td>
</tr>
<tr>
<td>Cataract</td>
<td>Retinopathy of prematurity</td>
</tr>
<tr>
<td>Coat’s disease</td>
<td>Toxocara canis chorioretinitis</td>
</tr>
<tr>
<td>Retinal detachment</td>
<td>Chorioretinal coloboma</td>
</tr>
<tr>
<td>Retinoblastoma</td>
<td></td>
</tr>
</tbody>
</table>

WHAT CAUSES CATARACT IN CHILDREN?

Cataracts in children can be divided into 7 major groups.

I. CONGENITAL HEREDITARY CATARACT

These are frequently autosomal dominant with a positive family history where one parent is affected. They may be autosomal recessive. In such a case there is often a history of consanguinity. Rarely, hereditary cataracts may be recessive, X-linked.

II. CONGENITAL OR INFANTILE CATARACTS ASSOCIATED WITH SYSTEMIC SYNDROMES

Most cataracts associated with systemic syndromes are transmitted as autosomal recessive traits with the exception of Lowe’s syndrome, which is X linked recessive and Alport’s syndrome, which is autosomal dominant.

   - Lowe’s ocuculocerebrenoral syndrome
   - Alport’s syndrome: hemorrhagic nephritis, deafness and poor equilibrium
   - Zellweger’s cerebrohepato renal syndrome: hepateomegaly, polycystic kidneys, aminoaciduria and mental retardation

2. Congenital cataracts with Mental Retardation.
   - Morinesto-Sjorgen’s syndrome: spino cerebellar ataxia, mental retardation, and nystagmus
   - Cockayne’s syndrome: deafness, skeletal malformation, pigmentary retinopathy, progressive mental retardation and premature aging
   - Flynn-Aird syndrome: deafness, kyphoscoliosis, mental retardation, epilepsy, subluxated cataracts and high myopia
   - Norrie’s syndrome: mental retardation, CNS degenerative disease, and corneal opacities.

3. Cataracts with Musculoskeletal Anomalies
   - Conradi’s syndrome or stippled epiphysis syndrome
   - Myotonic dystrophy

4. Syndromes affecting the Facial and Cranial bones
   - Hallerman-Streiff syndrome
   - Albert’s syndrome
   - Crouzon’s syndrome
   - Oxycephaly
   - Smith-Lemli-Opitz syndrome

5. Cataracts associated with Dermatological Disorders
   - Bloch-Sulzberger syndrome (incontinentia pigmenti) X linked dominant
   - Congenital ectodermal anhydrotic dysplasia
   - Rothmund-Thomson syndrome (hypopigmentation and exudative dermatosis) AR
   - Congenital ichthyosis (hyperkeratosis and hyperhydrosis)

6. Chromosomal Anomalies and Cataract

There are numerous chromosomal anomalies associated with cataracts. The most frequent are:
   - Down’s syndrome (trisomy 21)
   - Patau’s syndrome (trisomy 13)
   - Edward’s syndrome (trisomy 16-18)
   - Turner’s syndrome (monosomy X0)

(Continued next page)
III. CATARACTS ASSOCIATED WITH PRENATAL AND PERINATAL FACTORS

Maternally transmitted intrauterine infections (TORCHS) may cause cataracts in the newborn. Rubella infection during the first trimester of pregnancy will result in congenital cataracts, microcephaly, hepatosplenomegaly, deafness and cardiac malformation. Vaccination against rubella has greatly diminished the incidence of congenital rubella syndrome, however it remains a major problem in developing countries. Other congenital infections include toxoplasmosis, cytomegalovirus, herpes simplex, and syphilis.

Drug ingestion, such as corticosteroids, by the pregnant mother may cause cataracts. Exposure of the fetus to irradiation, maternal malnutrition and intrauterine anoxia, are other factors that can cause cataracts. Maternal metabolic or endocrine disorders e.g. diabetes, hyp or hyperparathyroidism and diabetes, are also associated with infantile cataracts. Therefore a careful and detailed history of the mother’s physical condition during her pregnancy is important. Also a detailed history and physical examination of the newborn should be obtained. This includes APGAR, birth weight, as well as convulsions.

IV. CATARACTS ASSOCIATED WITH METABOLIC DISEASES

1- Deficiency of one of the 3 enzymes involved in galactose metabolism will cause cataracts. It is inherited as an autosomal recessive trait.
   a. Galactose 1-phosphate uridylyltransferase deficiency will cause galactosemia manifested by a sick baby with neonatal sepsis, vomiting, diarrhea, hepatomegaly, and jaundice. Cataracts first appear, as an increased density in the lens giving the appearance of an oil droplet, which progressively opacifies. If the condition is diagnosed and treated at the oil droplet stage the cataract will regress.
   b. Galactokinase deficiency has little systemic manifestation. Cataracts appear later in adolescence or early adulthood.
   c. Epimerase deficiency is not typically associated with cataracts and has little if any systemic manifestations.

2- Diabetes mellitus may cause cataracts and these have been reported as early as 11 months of age.3

3- Hypoglycemia occurs mainly in boys, small for dates and usually following a complicated pregnancy. The cataracts are lamellar in appearance.

4- Homocystinuria: autosomal recessive, associated with subluxed lens, high myopia, tendency to blood clotting and mental retardation.

5- Hypoparathyroidism and pseudohypoparathyroidism.

6- Wilson’s disease: autosomal recessive, hepatalenticular degeneration, is due to defective copper metabolism leading to copper deposits in different organs including the cornea giving the typical bluish and golden Kayser-Fleischer ring.

7- Fabry’s disease: X-linked recessive caused by deficiency of alpha-galactosidase enzyme. Symptoms appear around 10 years of age. Typical eye findings include cataract in the form of branching spoke opacities, whorl-like corneal opacities, tortuous conjunctival and retinal vessels, and edema of the optic disc and lids.

V. CATARACTS ASSOCIATED WITH CORTICOSTEROIDS:

Children receiving topical4 as well as systemic corticosteroids5 over a long period of time will develop posterior capsular opacification of the lens. However long term use of inhaled steroids does not seem to be associated with development of cataracts.

VI. CHRONIC INTRAOCULAR INFLAMATION:

Uveitis can cause cataracts. It can be associated with systemic disease such as rheumatoid arthritis, or can be restricted to the eye such as pars planitis.

VII. OCULAR TRAUMA:

This can be either a blunt or a perforating injury. A history of physical abuse should be considered.

MANAGEMENT OF CATARACTS IN CHILDREN

Once the diagnosis of bilateral cataracts is established, a thorough medical work-up should be conducted so as to determine the etiologic cause and to institute appropriate medical as well as surgical treatment. In spite of a complete medical workup 20% of infantile cataracts remain of undetermined etiology.6,7 Unilateral congenital or infantile cataracts are most often an isolated ocular malformation and do not need an extensive workup.

Not all cataracts require surgical intervention. If the cataract is small and is visually insignificant then careful observation as well as part-time occlusion of the good eye may be necessary to prevent and/or treat amblyopia. Only those opacities obscuring the visual axis and interfering with visual development (Figure 3), whether unilateral or bilateral, should be surgically removed as soon as possible, provided the general physical condition of the baby permits it.

The reason for early surgical intervention is based on solid physiologic and scientific evidence. It has been demonstrated by Weisel and Hubel10 in kittens, as well as by Von Noorden10 in primates, that unilateral lid occlusion during the critical period of visual development will lead to atrophy of the corresponding cells in the lateral geniculate body and occipital cortex, leading to irreversible organic amblyopia. In bilateral cataracts where there is lack of visual stimulation, the macula as well as the corresponding visual cell in the brain will not develop. A pendular nystagmus will appear at about 6 weeks to 3 months of age. Vision will be permanently compromised once nystagmus is established. The child will be legally blind even after successful cataract surgery. However if early surgery is instituted within the first few weeks of life and before the onset of nystagmus, only then is there an excellent chance of developing normal vision.11

Correction of aphakia is necessary following cataract surgery. In neonates contact lenses are the preferred method of optical correction, provided family conditions allow it. Contact lenses are well tolerated by the infant. The parents are taught how to insert and remove the contacts, as well as how to care for and disinfect them. However if family conditions are not adequate then optical correction can be provided with spectacles (Figure

(Continued on next page •)
4. They are not ideal as they are thick and difficult to fit on a baby. They will serve as temporary correction until they can be replaced by either contact lenses or a secondary intraocular lens (IOL) implant.

With newer and improved microsurgical techniques IOL (Figure 5) implants are now the preferred method of surgical treatment of cataracts in children 1 year of age and older. 12-14 IOL may be implanted as a primary correction during the initial surgery or as a secondary procedure following intolerance to contact lenses or spectacles. There still remains controversy as to the youngest age for IOL implants. This is due to the fact that there is very rapid growth of the axial length of the eye between birth and the first year of life. This growth is accompanied by a rapid change in optical power of the eye. Also an infant’s eye has an intense inflammatory reaction to surgical trauma, thus increasing the complication rate with IOL implants.

Complications following cataract surgery are infrequent. These include hyphema, vitreous attachment to the incision, retinal hemorrhage and detachment. Intraocular infection or endophthalmitis is rare occurring in 7 out of 10,000 cases.1 5 Like retinal detachment, aphakic glaucoma can occur in the immediate postoperative period up to several years following cataract surgery. The incidence of aphakic glaucoma varies between 5-15%. It can appear immediately following surgery, or several years later. Parents should be informed that amblyopia remains a major threat to the development of good vision, be it in unilateral or bilateral aphakia. They must be committed to the treatment of amblyopia with part-time occlusion of the better eye, as this is the key to a good visual outcome (Figure 6). It is therefore mandatory that all children operated for pediatric cataracts be followed by an ophthalmologist for the rest of their life.

**CONCLUSION:**

The pediatrician plays a crucial role in the early diagnosis of cataracts in children. An excellent visual outcome is possible provided the patient has early surgery and adequate optical correction of aphakia using either contact lenses or intraocular lens implants. Amblyopia treatment with part time occlusion of the unaffected eye in unilateral cases, or the better eye in bilateral cases, is crucial to the development of good vision.

References:


---

Fig. 1: Congenital anterior polar cataract, compatible with good vision

Fig. 2: Central posterior lens opacity partially obscuring red pupillary reflex

Fig. 3: Congenital posterior lenticous, a bulge in the posterior lens capsule associated with progressive opacification of the lens

Fig. 4: Spectacles for correction of aphakia

Fig. 5: Posterior chamber IOL implant well centered in capsular bag

Fig. 6: Amblyopia treatment in a child with IOL implant following a traumatic cataract.
Advertising page
Committee Reports
Committee on School Health and Sports Medicine

Rani Gereige, M.D.
Chairman

Childhood epidemics that emerged at the dawn of the millennium, e.g. Obesity, Type II Diabetes mellitus, high-risk behavior, violence/ safety, all made the priority list of the Healthy People 2010 initiative. As we know, these health issues are multifactorial and can only be addressed by using a team approach targeting the various factors. The pediatrician, however, is not just a team member but one of the key elements in that team. The partnership between the medical and educational systems is one of the first steps on the road to addressing these priorities. Because these issues are of public health magnitude, the best way to address them is through the public health model, which includes the triad of: Individual, Environment, and Agent. Schools are a key component of this triad and pediatricians are at a central position to interact and influence all three components of this triad.

The Public Health Model

Earlier this year, at the beginning of my term as the Chair of this committee, I surveyed the FCAAP members on their interest to serve on or share their expertise with the committee. I would like to thank all of you who returned the survey. The response from interested members was overwhelming. I was very pleased to see the amount of interest in school health among Florida’s pediatricians. A large number expressed interest in serving on the committee or sharing expertise with the committee. Because of the limited number of members needed for the committee’s working group, I am pleased to present to you the following members of the FCAAP Committee on School Health and Sports Medicine:

1) Rani Gereige, M.D., MPH; Chairman, Clearwater, FL – gereiger@allkids.org
2) Karen Toker, M.D. (Ponte Verda Beach)
3) Christina Canody, M.D. (Tampa)
4) Maureen Novak, M.D. (Gainesville)
5) Sharon Leonard, M.D. (Pensacola)
6) Pedro Reimon, M.D. (Miami)
7) Lisa Cosgrove, M.D. (Cocoa Beach)
8) Kelly Crownin Komatz, M.D. (Jacksonville)
9) Antoinette Spoto-Cannons, M.D. (St. Petersburg)

I would like to extend an invitation to the Resident Section to nominate a member of the section who is interested in serving on our committee. Please e-mail me at: gereiger@allkids.org with a name of interested resident.

For those of you who expressed interest and returned the survey, I have kept your name and contact information and created a list for the committee to tap into your expertise as the need arises depending on the issues addressed. The committee will begin meeting periodically in few months via conference calls. Please feel free to contact me for any issues you would like the committee to address. I will periodically update the members on the work of the committee in the Florida Pediatrician. In addition, please e-mail me information on any school health projects you are conducting to feature in the Florida Pediatrician. It is through comprehensive school health approach, advocacy, and partnership that we can achieve healthier communities and healthier nation, physically and mentally.□

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 made distinguished contributions or rendered distinguished service to medicine.
Resident Member: A resident in an approved program of residency.
Medical Student: A student with an interest in child health advocacy.□
From the Resident Section

Cristina M. Estrada, MD
Resident Chairperson for FL
UF/Jax Program Representative

[In each issue, we will focus on one of the State’s Residency Programs and/or problems affecting all the programs]

[With this issue, we introduce a new Resident Chairperson for Florida, Cristina Estrada of Jacksonville, who represents the Jacksonville program and also the programs of Florida. She succeeds Laura Stadler, who served well, and we thank her!]

Spotlight on Jacksonville

Committed to providing residents with unique educational opportunities, the Pediatric training program at the Urban Campus of the University of Florida has many things to offer. The program is the product of the collaborative efforts of the University of Florida Health Science Center/Jacksonville, Wolfson Children’s Hospital, Nemours Children’s Clinic, and the Duval County Department of Health. The cooperation allows our fully accredited training program to provide strong pediatric fundamental experiences and a wide range of opportunities to explore specific interests. Our residents are thus able to provide complete primary, secondary, and tertiary care for the pediatric population of the northeast Florida and southeast Georgia region.

The Department of Pediatrics in Jacksonville is excited to be one of the recipients of an Anne E. Dyson Community Pediatrics Training Initiative grant. The program has partnered with the Duval County Health Department to provide residents with a better view of the complex issues impacting children and the interdisciplinary knowledge, skills and cultural competence required to understand and improve the health of children and families. This pediatric initiative is truly ground breaking in its integration of an academic medical center and a department of public health to form an academic public health pediatrics program.

The city of Jacksonville also provides our residents with several other community based experiences. During the first and second year, there are rotations specifically designed to expose the residents to the multiple resources available throughout the community for children and families. Senior residents also have enjoyed the Medical Economics elective, which provides significant exposure to the intricacies of healthcare finance as well as first hand experience at our state capital in its political processes. International medical interests have also been pursued to introduce residents to complementary and alternative medicine. In addition, several residents have worked with local Non-Governmental Organizations providing care to Caribbean islands and have participated in observerships to China and Southeast Asia. □
As the grant application cycle for CATCH 2003 closes, we would like to wish all Florida "Catchers", the best of luck for successful funding. Five applications were submitted for planning funds from our State. Proposals presented highly emphasize the CATCH mission to improve access to care, and to strengthen the medical home. Notifications will be sent prior to December 31, 2003. The number of CATCH applications received this year from Pediatricians and Residents continues to increase nationally. The first funding cycle for CATCH took place in 1993 when 20 out of the 23 applications submitted were approved for funding. Since, thanks to the tireless efforts of the Academy, our District and State Facilitators, and all who are firm believers in the value of community-based initiatives, in 2002 the CATCH program received 179 applications of which 59 were awarded. Kudos, to all of us for a job well done!

Residents will have an additional opportunity this winter to apply for CATCH funding. Check the CATCH website periodically at www.aap.org/catch/faqs.htm for more information.

The District X CATCH meeting will be held jointly with the Southeast Conference on Disabilities, November 13, 2003 in Atlanta, Georgia. This event will focus on Working Model of the Medical Home. The agenda includes presentations on medical home models from Florida to be addressed by Peter Gorski, David Wood and Karen Toker. If you are interested in attending this most informative meeting please contact Ms. Jina Lee, Program Manager Community Access to Child Health 800/433-9016 ext 4903 e-mail: Jlee@aap.org

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!
Managed Care

Athletic Screening of High School Students

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

As those of you who attended the FPS/FCAAP Annual Meeting last month in Orlando know, there are serious liability issues with the current law regarding pre-participation sports physicals for high school students. My purpose in writing is to summarize the problem, to suggest a short-term "solution", and to let you know what the Chapter is doing to achieve long-term resolution.

The Problem

The current statute (1006.20) requires the Florida High School Athletic Association (FHSAA) to publish a pre-participation physical evaluation form.

"...The preparticipation physical evaluation form shall advise students to complete a cardiovascular assessment and shall include information concerning alternative cardiovascular evaluation and diagnostic tests. Practitioners administering medical evaluations pursuant to this subsection must, at a minimum, solicit all information required by, and perform a physical assessment according to, the uniform preparticipation form referred to in this paragraph and must certify, based on the information provided and the physical assessment, that the student is physically capable of participating in interscholastic athletic competition. If the practitioner determines that there are any abnormal findings in the cardiovascular system, the student may not participate until a further cardiovascular assessment, which may include an EKG, is performed which indicates that the student is physically capable of participating in interscholastic athletic competition...."

The entire section is problematic, but the most problematic is the requirement that physicians "...certify...that the student is physically capable of participating..."

Short-term Solution

Several attorneys and a risk manager have been consulted regarding this problem. Their suggestion is the use of a disclaimer. Below are two versions, one for primary care physicians, and one for cardiologists. Although it is unlikely that the use of a disclaimer will protect you from a suit, it does help to educate the child's parents about the limitations of our ability to detect certain conditions. These documents can be printed from the Chapter web site, www.fcaap.org.

Long-term Solution

The Chapter has discussed this issue with representatives of the Governor, the legislature, and the FHSAA. All have agreed that the current law needs to be changed. As a result, the malpractice bills currently being discussed in the special session include an amendment to this statute. I have attached a copy of the amendment, which indicates our proposed additions and deletions. As you can see, all but the first sentence above is deleted. (The FHSAA insisted that the first sentence remain.) If and when a malpractice bill passes, and assuming that this language remains intact, the use of a disclaimer should no longer be needed.

Alternatively, if no agreement is reached on a malpractice bill, we will pursue this issue in any further special sessions this year, or in the 2004 regular session, next spring.

Please contact me if you have any questions about this issue. Copies of the forms are attached.

(See Managed, page 31 •)

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. □

FYI

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

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

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

Please consult your tax advisor for specific information. □
In Memoriam

Robert A. Good, M.D.

[adapted from “Focus on Health Sciences News, June 26, 2003, University of South Florida]

Dr. Robert A. Good, the father of modern immunology who translated his tremendous knowledge of cellular immunity into the first successful bone marrow transplantation, died June 13.

He was a consummate scientist, a caring pediatrician and an inspired teacher.

Many of more than 300 physicians and scientists he trained or mentored over the last 50 years hold leadership positions at such esteemed institutions as Harvard Medical School, the National Institutes of Health, Albert Einstein College of Medicine and others. Dr. Good discovered the role of the thymus in the development of human cellular immunity and laid out the connection between immune diseases and the two basic arms of the immune system known as T-cells and B-cells. The research resulted in the world’s first successful bone marrow transplant, which Dr. Good performed in 1968. His work was so groundbreaking that he appeared on the cover of the March 19, 1973 edition of Time magazine.

He joined All Children’s Hospital as Physician-in-Chief in 1985, and directed the hospital’s Division of Allergy and Clinical Immunology. He also developed the hospital’s first Bone Marrow Transplantation Unit. At the USF College of Medicine, Dr. Good was named professor of pediatrics, professor of microbiology and immunology, director of the training program in Pediatric Allergy and Clinical Immunology, and Distinguished University Professor. He also served as president of the St. Petersburg-based Children’s Research Institute.

At USF and All Children’s, where an endowed chair in pediatric immunology was created in his honor, Dr. Good’s research included the influence of nutrition on longevity, immunity, health span and diseases of aging, fundamental and practical aspects of bone marrow and stem cell transplantation, and other forms of cellular engineering.

He showed that bone marrow transplants in experimental animals can prevent and cure a wide variety of autoimmune diseases, immunological-based kidney diseases, and cardiovascular diseases, among others. He helped define the nature and isolation of stem cells, and contributed greatly to identifying and defining numerous primary and secondary immunological deficiency diseases and disorders.

Dr. Good received 13 honorary degrees from academic institutions across the world. He garnered more than 100 international and national awards throughout his scientific career.

Known for building the field of immunology in Japan, he was personally recognized by the Emperor of Japan for his research and educational achievements. He was elected to the National Academy of Sciences in 1970 - the only USF faculty member to have achieved that honor.

Dr. Good was the author or co-author of more than 2,200 scientific papers and wrote or edited 50 books.

“Robert Good was a friend and inspiration to me and to literally thousands of physicians and scientists who are trying to save children from complex diseases. He taught us to look further than we could see at the time, to reach for new horizons of ideas we hadn’t yet imagined.”

John Curran, MD
Vice Dean, USF College of Medicine
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]

What is Informed Consent?

Cliff Rapp, LHRM
Vice President of Risk Management, FPIC

Alleging a lack of informed consent is one of the easiest ways to reach the threshold in tort necessary to bring legal action against a physician. The mere execution of a consent form – which may be referred to as formal consent – does not necessarily constitute informed consent. Informed consent is a process of educating the patient about a proposed procedure’s risks, benefits, and alternatives. The physician is ultimately responsible for educating the patient about the proposed treatment or procedure and discussing the risks, benefits, and alternatives such that the patient’s decision, once made, constitutes an informed decision. The patient is responsible for weighing the information and making an informed decision. Ideally, the physician, and not a staff member, should obtain the patient’s signature on the consent form.

Informed consent is a process that encompasses the following four elements: discussion, consent form, documentation, and educational materials.

Discussion

The discussion is the most important element since informed consent is an extension of good communication techniques and helps establish doctor/patient rapport. Patients have a right to information and to participate in decisions affecting their health.

The discussion should cover the following topics

- Explain the patient’s medical condition and the treatment or procedure in lay language appropriate for the patient’s level of education or understanding.
- Disclose the risks.
  - Include severe risks, e.g., death, paralysis, loss of function.
  - Include frequent risks, e.g., infection, bleeding, possibility of additional procedures.
  - Include the incidence of risk (e.g., 1 in 10,000 experience this complication) to help the patient put risk in perspective.
- Provide information about common side effects, e.g., infection, bleeding, etc.
- Explain the benefits of the procedure.
- Don’t make any guarantees of 100 percent success.
- Provide information about potential outcomes if treatment is refused.
- Encourage the patient to ask questions.
- Acknowledge that the patient can withdraw consent.
- Make an offer for a second opinion.

Consent Form

The consent form, or formal consent, provides written information to help the patient remember the risks, benefits, and alternatives you have discussed. It is a good preventive measure to give the patient a copy of the consent and retain one copy in the chart. The consent form should include the same elements as the consent discussion and should be written in easily comprehensible lay language. Obtaining the patient’s signature should not be delegated to your assistant. A witness is not necessary.

Documentation

We recommend you write a brief note in the patient’s chart to document that a consent discussion occurred and the patient agreed to proceed with the treatment. If you gave the patient any handouts or instructions, document this action. Place the signed informed consent form in the patient’s chart.

Example: Advised patient of need for and benefits of arthroscopic surgery; discussed risks, benefits, and alternatives. Explained the risks and complications of foregoing surgery. Gave patient handout describing the procedure. Patient stated he understood and acknowledges he is at increased risk for infection due to his diabetes, signed consent, and agreed to proceed.

Educational Materials

Studies show that patients remember approximately 30 percent of verbal information. Educational pamphlets, written handouts, and pre-and post-instructions help the patient make an informed decision and later recall what was consented to if complications occur. Catalog and retain educational materials for at least ten years – an outdated informational pamphlet might very well be the evidence needed to defeat a claim or suit brought years after the care or treatment.

Patients are not required to submit to treatment. Several states have case law which mandates that doctors have the responsibility to disclose the possible outcome if treatment is refused. This is the Doctrine of Informed Refusal and it holds that the physician has the responsibility to inform the patients of potentially detrimental outcomes.

Although Florida statutes do not contain a Doctrine of Informed Refusal, it is wise from a claims prevention standpoint to incorporate this element into your informed consent discussion. If the patient refuses your recommendation, explain the possible adverse outcome. This conversation should be documented in the chart and, if possible, the patient should sign an informed refusal statement.

There are four general categories of circumstances in which consent of the patient is not required for treatment. With
From the AAP

Dr. BERKOWITZ ELECTED

The Academy has elected Carol D. Berkowitz, M.D., FAAP, of Torrance, California, as its new vice president. Dr. Berkowitz will take office as president-elect at the November 2003 AAP National Conference and Exhibition in New Orleans and will serve as the 2004-05 AAP president. She will be the Academy’s third female president.

Dr. Berkowitz currently serves on the AAP Committee on Pediatric Workforce, and its subcommittee, Women in Pediatrics. She spent six years on the Board of Directors of the American Board of Pediatrics.

A native of New York, Dr. Berkowitz attended Barnard College, Columbia University College of Physicians and Surgeons, and completed her pediatric training at Roosevelt Hospital. She is now professor and executive vice chair in the Department of Pediatrics at Harbor-UCLA Medical Center in Torrance.

She plans to focus on health care access and reimbursement issues.

Our Congratulations to Dr. Berkowitz

Kudos...

...to Audrey Schiebler, who has been appointed an Honorary Fellow of the American Academy of Pediatrics, announced at annual meeting.

Congratulations...

...to Herbert H. Pomerance on receipt of the AAP District X Special Achievement Award, for “outstanding continuing contributions, as a member of the Senior Section, to the advancement of medical knowledge and enhanced pediatric communication as editor of “The Florida Pediatrician”, the bulletin of the FCAAP”.

Congratulations...

...to Charles F. Weiss, on receipt of the District X Special Achievement Award, “for both career and outstanding multi-year contributions to ‘The Florida Pediatrician’ and the Executive Committee of the Florida Chapter on topics related to environmental health and toxicology”.

Note:
A summary of The Florida Pediatrician is on the website for the AAP. The URL is:
http://www.aap.org/profed/florida.htm
Study Fails to Show a Connection Between Thimerosal and Autism

The American Academy of Pediatrics provides the following information for clinicians who may be aware of recent press surrounding an article that claims to show a correlation between thimerosal and autism.1

This paper uses data from the Vaccine Adverse Event Reporting System (VAERS) inappropriately and contains numerous conceptual and scientific flaws, omissions of fact, inaccuracies, and misstatements.

The most important weakness of the article is the reliance on VAERS data to draw conclusions about adverse event associations or causality. VAERS is a passive surveillance system for reporting possible vaccine adverse events that depends on health care professionals, patients, and others to file reports. Health effects reported to VAERS as being associated with vaccines may represent true adverse events, coincidental occurrences, or mistakes in filing. Inherent limits of VAERS include incomplete reporting, lack of verification of diagnoses, and lack of data on people who were immunized and did not report problems. Data from VAERS are useful for hypothesis generation (raising questions) but should not be used for research aimed at determining whether vaccines cause certain health problems (hypothesis proving), as was done in the article by Geier and Geier. For example, VAERS worked well to quickly alert investigators to the possibility of intussusception after rotavirus immunization but could not prove the association. Proof required numerous controlled studies to document the nature and frequency of this association.

The original concern regarding thimerosal in vaccines was sparked not by any trends identified in the VAERS system after 70 years of experience with thimerosal use as a vaccine preservative but by theoretic concerns about total exposures infants might receive from all mercury sources in the environment, including vaccines. Research to date involving refined, controlled studies in large populations of patients has failed to demonstrate any association between vaccines that may have used thimerosal as a preservative and neurodevelopmental disorders including autism. The authors failed to acknowledge the inherent limitations of the VAERS database when drawing conclusions of adverse event associations contained in this report and their other publications. They are equally unclear as to how their data were generated, thus preventing accurate review of their methods and replication of their outcomes.

Other flaws in the article include the following:

- The law relating to VAERS reporting is misstated. Most VAERS-reported conditions fall into a category in which voluntary and passive, not mandatory or required, events after immunization are recorded. Only a specific set of more severe adverse events are specified as mandatory under the Vaccine Injury Table, and even then, reporting is inconsistent.
- Conclusions of the 2001 Institute of Medicine Immunization Safety Review Committee report2 as to what constitutes maximal permissible dose exposures to mercury are misinterpreted, and misleading statements are made concerning federal safety guidelines for mercury exposure levels that might be expected to cause harm.
- The authors fail to depict accurately the differences between pharmacokinetics of and exposure to methylmercury (found in contaminated food) and ethylmercury (found in thimerosal) and make unsubstantiated assumptions about the risks of the route of exposure (ingested versus injected).
- Adult heart disease is included as a possible thimerosal-related condition, although heart arrest reports in very young children are used in the analysis. Heart arrest in very young children (a common term used on pediatric death certificates and often unlinked to the actual cause of death) has nothing to do with adult coronary heart disease. The authors’ implication that thimerosal in vaccines is a cause of acute cardiotoxic events is unfounded in any scientific or clinical reports and represents a misuse of the terminology found in VAERS reports.
- The authors fail to reveal how thimerosal exposure was calculated—a critical omission, because much of the data required to estimate mercury exposure are not available in

VAERS reports. The authors’ stated estimates of exposure attributable to diphtheria, tetanus, and pertussis combination vaccines (DTaP or DTwP) do not add up. Some DTaP vaccines never contained thimerosal as a preservative, and any child may have received 1 or more DTaP doses, which would have resulted in no ethylmercury exposure.

- The authors claim to have analyzed data from biologic surveillance summaries by manufacturers, although data regarding specific manufacturers (some of which incorporated thimerosal as a preservative and some of which did not) and age and year of birth of vaccine recipients are not available in the publication cited. Data as to the number of patients receiving vaccines with thimerosal plus the number of doses of vaccine actually received by patients versus total doses of vaccine manufactured cannot be derived from biologic surveillance summaries, making the authors’ claims for baselines of actual vaccine use untenable.

Calculations for incidence rates and relative risk, which require information (age or year of birth) that is not available from biologic surveillance data, are not shown.

- An appropriate comparison is not made between thimerosal exposure and no thimerosal exposure, which is not possible using VAERS data, because one cannot be sure whether a child received a thimerosal-containing vaccine at any point before the event for which the VAERS report was created. Depending on the manufacturer, many of the children listed in VAERS reports could have received all vaccines that were free of thimerosal.

Statistical methodology for calculating the relative risk and correlation coefficients is not stated.

- The authors claim to have performed their own analysis of a Vaccine Safety Datalink (VSD) thimerosal screening study (reference 17 in Geier and Geier), although the raw data needed to perform an independent analysis are not available in the document cited. (Note: neither the original preliminary VSD study of thimerosal and neurodevelopmental disorders nor any of the follow-up expanded studies identified a “signal” indicating any association between thimerosal and autism.)

The authors claim that data for thimerosal exposure and autism risk follow an exponential distribution, although none of the thimerosal exposure categories had a significantly increased risk of autism. The figures used are confusing and not supported by an adequate explanation as to how they were constructed. Comparing the occurrence of late onset, chronic conditions like autism by using acute vaccine reactions like fever, pain, and vomiting (presumably attributable to other vaccine components) as controls makes no sense as a measure of relative adverse event rates.

When comparing early (1984-1985) to late (1990-1994) birth cohorts, the authors make arbitrary and unlikely assumptions of possible thimerosal exposure for both groups that are contrary to when thimerosal vaccines were introduced and what their expected pattern of use in the private and public sector was. The average level of thimerosal exposure claimed by the authors is not realistic.

The authors claim high correlation coefficients for thimerosal with certain neurologic disabilities without describing the statistical methods used, which makes the results highly unreliable.

The authors fail to note that a recently published review by Nelson and Bauman3 casts doubt on the biologic plausibility of symptom similarities between mercury poisoning and

(See AAP, page 31)
At the June meeting of the FPS/FCAAP, the biennial "changing of the guard" occurred. The presidency of the society was taken over by Deborah Mulligan-Smith, who will serve for the next two years. Leadership passed from Richard Bucciarelli, who served us well!

Kudos...

...to Edward Saltzman, awardee of the 2003 John Whitcomb Award, for his contributions to the state and its children. The award was made at the annual meeting of the FPS/FCAAP in Orlando.

Congratulations...

...to Jorge Del Toro-Silvestry, M.D., elected by the membership as 2nd Vice President, in the recent election.

Kudos...

...to our outgoing Regional Representatives, who have served well the past two years:
Region II: Donald E. George, M.D., Jacksonville
Region III: Thomas Benton, M.D., Gainesville
Region IV: David Milov, M.D., Orlando
Region VI: Bruce Berget, M.D., Ft. Myers
Region VIII: Charles Bauer, M.D., Miami

Congratulations...

...to the new Regional Representatives, progressing from Alternate:
Region II: James Waler (Jacksonville)
Region III: Jyoti Budania (Gainesville)
Region IV: Lloyd Werk (Orlando)
Region VI: John Donaldson (Ft Myers)
Region VIII: Kimberly Schwartz (Aventura)

Congratulations...

...to our newly elected Alternate Regional Representatives
Region II: Gary Josephson, M.D., Jacksonville
Region III: Mary Grooms, M.D., Gainesville
Region IV: Lisa Cosgrove, M.D., Merritt Island
Region VI: Benjamin Helgemo, M.D., Port Charlotte
Region VIII: Thresia B. Gambon, M.D., Miami Beach, FL

Kudos...

...to Jaime L. Frias, professor of Pediatrics and director of the USF Birth Defects Center, on his appointment to the newly established Pediatrics Subcommittee of the National Institute of Child Health and Human Development at the National Institutes of Health.

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.
Our Thanks to Our Supporting Vendors

The Florida Chapter AAP /Florida Pediatric Society
wishes to acknowledge the following organizations for their sponsorship of the
Annual Meeting

Alcon Laboratories
Aventis Pasteur
AstraZeneca
Dairy Council of Florida
FPIC
Fujisawa Healthcare
GlaxoSmithKline
Grayson Stadler
McNeil Pharmaceuticals
Mead Johnson Nutritionals
Medimmune, Inc.
Nestle
Ross Laboratories
Wyeth Consumer Healthcare
The past causes the present, and so the future.

Major Legislative Achievements of the FPS/Florida Chapter AAP

- Establishment of the Children's Medical Service (CMS) - A state agency that provides care for children with chronic or disabling conditions whose parents cannot afford treatment. CMS replaced the Florida Crippled Children's Commission which treated only orthopedic conditions.
- Disease specific programs established under CMS; e.g. Hematology/Oncology clinics, diabetes, kidney screening and treatment, rheumatic fever and rheumatic heart disease, cystic fibrosis, regional genetics program, cardiac disease program, pulmonary center program, cleft lip/palate, learning disabilities program and others.
- Regionalization of high risk newborn and obstetrical centers and transportation system. (Perinatal Intensive Care Program) State government funding for high risk newborn care. Step down care.
- Implementation of Title XIX.
- Mandatory use of seat belts in cars for children under five years. Later increased age requirements.
- Mandated insurance for newborns under family policies.
- Regulation of temperature settings for hot water heaters.
- Statewide program for the prevention of child abuse and neglect.
- School immunization law. Mandatory immunizations for all children before entering kindergarten.
- Metabolic screening program for newborns. Screening for maple sugar urine disease, galactosemia, hypothyroidism, and PKU
- Scoliosis screening program added by legislation to the infant screening law.
- Medicaid newborn funding for babies of Medicaid mothers for the first 60 days of life not withstanding the completion of an application.
- Robert Wood Johnson grant. Rural efforts to assist medically dependent children at home, in conjunction with medical staff from University of Florida Department of Pediatrics.
- 1986 was a banner year for the FPS/Chapter. After several years of legislative efforts, the Florida Child Health Assurance Act was passed. Nationally, the initiative was known by the acronym, CHIRP, Child Health Insurance Reform Program. This legislative victory is remembered as the Chapter at its best! We were the second Chapter (State) to enact this legislation which mandated that all family health insurance must cover children from birth. In 1986, under the watch of Drs. Bud Tanis and Marcus Moore another first was achieved. The Florida legislature and Board of Regents established the Institute for Child Health Policy, whose mission was to assist public and private agencies at the state, regional and national levels in the development of health policies and programs appropriate to needs of children and their families. Steve Freedman, PhD, was the first Director. The Institute is headquartered at the University of Florida in Gainesville, FL, with an office in St. Petersburg, FL and at office at Nova Southeastern University. Dr Freedman continues his role as Executive Director.
- Children (< 5yo) and Pick Up Trucks.
- Authorization of three poison control centers in the state, Tampa, Jacksonville, and Miami. By 1995 all centers were operating and meeting the standards of the American Association of Poison Control Centers.
- Personal Flotation Devices. Children < 6 years in a boat < 26 ft when underway and all ages on PWC.
- 1989, Firearm Safe Storage
- 1990, Healthy Kids Corporation
- 1993, Child Death Investigations; Possible SIDS < 1yo - autopsy
- 1992, State EMS Plan must include Pediatric Trauma referral centers.
- 1996, Bike Helmet Law

(Continued next page •)
History
(* continued from previous page)

- 1997, Create State Emergency Medical Services for Children (EMSC) committee of child health providers to advise on pediatric emergency room care, rehabilitation needs, etc.

“Back in 1990, Senator "Doc" Myers and Representative Fred Lippman (1996 Recipient of the Outstanding Legislator and Advocate for Children from the Florida Pediatric Society) joined a strong, bi-partisan effort to establish the Healthy Kids program. Governor Martinez and Treasurer Tom Gallagher were good stewards of this program.

Healthy Kids is one of the most successful prevention programs we have. It provides access to health care for uninsured children who would otherwise wind up in the emergency room.” Governor Lawton Chiles

- 1998, Florida Kid Care includes Healthy Kids and Medi-Kids
- 2000, Graduated License
- 2000, Universal Hearing Screening for Newborns.
- 2001, Graduated License and OUI

PAST FLORIDA PEDIATRIC SOCIETY PRESIDENTS

1936-37  Luther W. Holloway, MD
1937-38  William W. McKibben, MD
1938-39  Douglas O. Martin, MD
1939-42  Warren W. Quillian, MD
1942-46  Ludo Von Meysenburg, MD
1946-47  Councill C. Rudolph, MD
1947-48  James R. Boulware, MD
1948-49  Edgar W. Stephens, MD
1949-50  Hugh A. Carithers, MD
1950-51  Edgar Hitchcock, MD
1951-52  E. V. Anderson, MD
1952-53  Charlotte Maguire, MD
1953-54  C. Jennings Derrick, MD
1954-55  Lewis T. Corum, MD
1955-56  Wesley S. Nock, MD
1956-57  Joel V. McCall, MD
1957-58  Henry G. Morton, MD
1958-59  Burns A. Dobbins, MD
1959-60  Harry M. Edwards, MD
1960-61  Joseph K. David, MD
1961-62  Fred I. Dorman, MD
1962-63  John H. Cordes, MD
1963-64  George W. Griffin, MD
1964-65  Robert J. Grayson, MD
1965-66  Oliver F. Deen, MD
1966-67  James M. Weaver, MD
1967-68  Richard Skinner, MD
1968-69  Ray O. Edwards, MD
1969-70  Thomas M. Brill, MD
1970-71  John C. Moore, MD
1971-72  James M. Stem, MD
1972-73  Bernard F. O’Hara, MD
1973-74  David R. Gair, MD
1974-75  James M. San, MD
1975-76  W. Reed Bell, MD
1976-77  Andrews W. Townes, MD
1977-78  Michael Steiner, MD
1978-79  Thomas Grewe, MD
1979-80  Myrna B. Ginter, MD
1980-82  George A. Richard, MD
1982-84  Donald I. Macdonald, MD
1984-87  Marcus M. Moore, MD
1987-89  Gary M. Bong, MD
1989-91  George A. Dell, MD
1991-93  Robert F. Colyer, MD
1993-95  Kenneth H. Morse, MD

PAST STATE CHAPTER PRESIDENTS

1935-40  Warren Quillian, MD
1941-42  Gilbert Osincup, MD
1942-48  George Cook, MD
1949-51  James Boulware, MD
1952-57  Hugh Carithers, MD
1958-63  Wesley Nock, MD
1964-69  Henry Morton, MD
1970-75  Robert Grayson, MD
1976-78  F. Edwards Rushton, MD
1979-81  W. Reed Bell, MD
1982-84  Robert Threlkel, MD
1985-88  Arnold Tanis, MD
1989-92  John Whitcomb, MD
1992-95  David Cimino, MD

FLORIDA PEDIATRIC SOCIETY/FLORIDA CHAPTER PRESIDENTS*

1995-97  John Curran, MD
1997-99  Edward Williams, MD
1999-01  Edward Zissman, MD
2001-03  Richard Bucciarelli, MD

*In 1995, the Florida Pediatric Society and Florida State Chapter merged into one organization.

Where do we go from here?

“Challenges and New Directions in Delivering Care to Children”

My thanks to AAP staff, FPS/FCAAP Presidents, Executive Committee members, Executive Secretary of our Society, Dr. Louis St. Petery, Administrative Assistant, Ms. Edie Lovingood, The Florida Pediatrician Newsletter Editor, Dr. Pomerance and NSU Executive Vice-Chancellor and Provost Frederick Lippman for without their reports and contributions this document could not have been prepared. □
The 2003 Regular Legislative Session concluded with major issues unresolved, which has led to a succession of “special sessions” to address the State budget, medical malpractice reform and a number of other issues. At this writing the State budget has been passed, but a stalemate is ongoing on medical malpractice reform. It appears that we are in for a long contentious summer as the House, Senate and Governor dig in on malpractice reforms. The Governor and House leadership insist upon a “rigid” cap on non-economic damages, while the Senate has embraced a “floating” cap to address the severity of injuries in malpractice incidents. Neither house is close to compromise and the Governor believes that keeping the legislature in Tallahassee in a series of “special” sessions will bring about movement. Unfortunately he underestimates the resolve of each house and the resentment the Senate has over the bullying tactics he has used. Sadly, it appears that the focus on patient access to health care and the physician’s ability to sustain a viable practice has taken a back seat to a “Battle of the Giants”, trial attorneys and insurance companies, over money.

At the beginning of the 2003 Regular Legislative Session hope of greater cooperation between the Senate and House of Representatives was quickly dashed as the philosophies of the two houses took divergent paths. The passage of Constitutional amendments to lower class size, provide universal pre-kindergarten and ban smoking in all work places provided a challenge that was approached in uniquely different ways leading to gridlock during the Regular Legislative Session.

Supporters of the education initiatives wanted every available dollar dedicated to these initiatives while those in the social service and health areas knew that revenue shortfalls would devastate existing programs leaving many to literally fight for their lives. As has been widely reported, the Speaker of the House, Johnnie Byrd, dug in and refused to raise new revenue with a mantra to members to “live within our means.” Thus once again, Peter was robbed to pay Paul as trust funds were raided and recurring programs were funded with non-recurring dollars setting in motion an even bleaker situation for 2004.

Following is a listing of bills which may be of interest to the membership.

CS/SB 2084 — Prescriptions / Format (CH. 2003-41)

Written prescriptions for medicinal drugs issued by a health care practitioner are required by this legislation to be legibly printed or typed. Further, it is required that the prescription contain the name of the prescribing practitioner, the name and strength of the drug prescribed, the quantity in both textual and numerical formats and directions for use. Additionally, the prescription must be dated with the month written out in textual letters and signed by the practitioner on the day when issued.

Effective Date: July 1, 2003

CS/SB 2156 — Middle and High School Athletic Preparticipation Medical Examinations (CH. 2003-129)

This legislation amends the requirements for preparticipation physical assessments of the capabilities of a student to participate in interscholastic athletic competition. Practitioners who administer such assessments/examinations are required to follow a form approved by the Florida High School Athletic Association and certify when a student is deemed capable of participating in athletic competition. Additional cardiovascular assessments are required if abnormal cardiac findings are present in the initial examination. Students will not be eligible to participate in any competition, practice, tryout, workout, or other physical activity associated with the athletic team until the medical evaluation clears the student for participation. (An amendment is being offered by the FPS in the proposed Medical Malpractice legislation to negate some of these provisions.)

Effective Date: June 10, 2003

HB 953 — Weight-Loss Pills / Minors (CH. 2003-24)

As of July 1, 2004 it will be unlawful to sell, deliver, barter, furnish, or give directly or indirectly, a weight-loss pill to a person under 18 years of age. Weight-loss pill is defined as a pill that is available without a prescription, which is marketed, advertised or packaged to indicate that its primary purpose is for facilitating or causing weight loss. This prohibition includes, but is not limited to, pills containing ephedra species, ephedra alkaloid containing dietary supplements or Sida cordifolia. Penalties for violations are provided.

Effective Date: July 1, 2004

CS/SB 1442 — Child Protective Investigations (CH. 2003-127)

The child protective investigation process is modified by this legislation. Of particular interest to physicians is the repeal of the requirement that complaints to the hotline by physicians, judges, etc. must be investigated. The process for accepting reports for investigation is to be determined by the Department of Children and Family Services. Other changes include: authorization for the central abuse hotline to determine the response time for institutional child abuse rather than the present requirement that the response be immediate; removal of the requirement that Temporary Assistance to Needy Families non-compliance cases be referred for protective intervention; clarification of the directive to proceed with an assessment for child-on-child sexual abuse reports; and, a prohibition from amending the DCF operating budget to shift funds or positions from protective investigations to other functions.

A study by the Office of Program Policy Analysis and Government Accountability is authorized to look at the impact that availability of services to families has on the turnover of protective investigators and on the families' re-entry into the child protective system. A Protective Investigative Retention Workgroup is established to address issues pertaining to the retention of protective investigators with a report to the Legislature.

Effective Date: June 10, 2003

(Continued next page •)
Legislative
(* continued from previous page)

CS/CS/SB 1318 — Rilya Wilson Act (CH. 2003- )

This legislation creates the Rilya Wilson Act which requires children, ages 3 years to school entry, who have been abused, neglected, or abandoned and who are enrolled in early education or child care programs as a result of being in the care of the State pursuant to court proceedings, to participate in such program 5 days a week. The eligibility for school readiness programs is modified to provide priority for these children. Reporting requirements are set forth to facilitate the quick identification of children who are missing. A study is required to examine the role of participation in licensed early education or child care programs on ensuring safety for these children.

Effective Date: May 30, 2003

CS/CS/SB 2404 — Substance Abuse and Mental Health Services (CH. 2003- )

This legislation creates the not-for-profit Florida Substance Abuse and Mental Health Corporation, Inc., to provide oversight and policy recommendations for the substance abuse and mental health systems. The corporation will have 12 members to be appointed by the Governor, the President of the Senate and the Speaker of the House of Representatives. The corporation is to work with agencies of state government to fully develop and integrate mental health and substance abuse systems. A memorandum of understanding is to be developed between the corporation and DCF requiring the department to consider and respond to the recommendations of the corporation.

The organizational structure for the Department of Children and Family Services’ substance abuse and mental program offices is modified to give these programs direct control of budgets and contracts including line authority over district program staff. Additional modifications include authorization for the department to adopt by rule new payment methodologies that include fee-for-service, prepaid case rate and prepaid capitation contract payment mechanisms for purchasing mental health and substance abuse services. The rule is prohibited from increasing local match requirements.

S. 409.912, F.S., is amended to require the Agency for Health Care Administration (AHCA) to seek federal approval to contract with a single entity to provide comprehensive behavioral health care services to all Medicaid recipients in an AHCA area. Each entity must offer a sufficient choice of providers and must include all public health hospitals. AHCA is further required to submit a plan for fully implementing capitated prepaid behavioral health care services throughout the state. Additionally, a plan must also be developed to implement new Medicaid procedure codes for emergency and crisis care, residential services and other services.

Effective Date: July 11, 2003

CS/CS/SB 2568 — Developmental Disabilities (CH. 2003- )

This legislation permits non-licensed direct care staff in day programs and intermediate care facilities for the developmentally disabled to administer prescription medications. Training of designated staff by either a registered nurse or physician is required, as are policies and procedures to ensure the safe handling, storage and administration of the medication.

The health care proxy statute is revised to provide for the appointment of a clinical social worker as a proxy in cases where the incapacitated person has not appointed a surrogate, does not have a guardian or a living will, and has no person as provided in statute to be a decision maker for him or her. The appointment of such a proxy must be made through the facility’s bioethics committee or in the absence of such committee, by the bioethics committee of another facility.

Effective Date: July 1, 2003

HB 195 — Emergency Medical Dispatch Act (CH. 2003-180)

The Emergency Medical Dispatch Act is created by this legislation which provides a statutory presumption of non-negligence for emergency medical dispatchers and agencies when the emergency medical dispatcher has been provided certain training and has followed protocols that are substantially similar to standards developed by the American Society for Testing and Materials or the National Highway Traffic Safety Administration. Participation in the Emergency Medical Services Grant Program is allowed for such dispatch services.

Effective Date: September 11, 2003

SB 2082 — Saboor Grieving Parents Act (CH. 2003-52)

This legislation requires physicians, nurses, midwives, birth centers, hospitals, ambulatory surgical centers, or mobile surgical facilities having custody of fetal remains following a spontaneous miscarriage after a gestation period of less than 20 weeks to notify the mother of her option to arrange for the burial or cremation of the fetal remains as well as the procedures provided by general law. The Department of Health must adopt rules for the development of forms to be used by the health care practitioner and the Agency for Health Care Administration must adopt rules for the use of facilities for the notifications and elections. Such forms must be provided to the mother by the entity having custody of the remains.

Effective Date: May 27, 2003

HB 457 — Indigent Care and Trauma Center Tax (CH. 2003- 77)

Authorization for qualifying counties to impose and collect an indigent care and trauma center surtax is continued by repealing the scheduled termination of this subsection of law. The clerk of the circuit court must prepare on a biennial basis an audit of the indigent care trust fund. Beginning February 1, 2004, the audit must be delivered to the governing body and to the chair of the legislative delegation of each participating county.

Effective Date: June 2, 2003

CS/CS/SB 250 — Rural Hospitals (CH. 2003-258)

The definition of “rural hospital” is changed to provide that a hospital that received funding under the Medicaid disproportionate share/financial assistance program for rural hospitals prior to July 1, 2002, will continue to be a rural hospital through June 30, 2012, as long as the hospital continues to meet certain criteria. An acute care hospital that has not previously been designated as a rural hospital and that meets the criteria may apply to the Agency for Health Care Administration for that designation.

The legislation exempts, provided certain conditions are met, rural hospitals from certificate of need requirements for new or replacement facilities.

The exemption from payment of an initial assessment for certain infants delivered in a hospital will continue to exclude infants born in a teaching hospital that have been deemed by the Florida Birth-Related Neurological Injury Compensation Association since fiscal year 1997 to fiscal year 2001.

Effective Date: July 1, 2003□
FROM WAR FRONT TO HOME FRONT - Better Band-Aids

Despite the advances of superior detection ion devices, precision bomb guidance systems and other hi-tech gear for the field of battle. Some of the biggest of advances may come in the field of medicine.

Half of all combat fatalities stem from bleeding to death on the battle field. However, new clotting products, bandages and wound dressings are being tested in hopes of reducing the number of deaths from that cause.

Past military medical breakthroughs include vaccines for malaria and anthrax and early testing or the penicillin and other antibiotics. This time the more important may be the innovations in bleeding control. Some of the items and spin-offs of the devices being used in Iraq may appear on your pharmacy/drugstore shelves.

QUICK CLOT
(A granulated powder of mineral zeolite)

HOW IT WORKS: Like a sponge and absorbs water and plasma, leaving behind the materials that can clot blood quickly. This salt-like substance was developed for military use in conjunction with the U.S. Navy’s Office of Naval Research, the U.S. Marine Corps Systems Command. Quick Clot was approved by the U.S. Food and Drug Administration last year for severe bleeding injuries. It was first used during the war in Afghanistan, and is now in Marine first-aid kits in Iraq.

CONSUMER versions of QuickClot should be on drugstore shelves by August 1 and be in 20,000 stores by the end of the year. . . . A small packet, which will contain more than one dose for minor injuries scrapes and cuts will cost about $10.00. It already has been distributed to emergency personnel.

HemCon Bandage

HOW IT WORKS: a four-inch square bandage is coated with a protein from shrimp shells that causes blood cells to clump and form clots. The bandage, developed with support from the Army was approved by the F.D. A. to control severe bleeding and is in battle field tests at present.

CONSUMER Outlook: Presently available by prescription for $139, and emergency personnel are next on the list as soon as military demand is met. Smaller, less costly bandages, intended for first aid kits, and a bandage for internal medicine is scheduled for later sale.

RED CROSS WOUND DRESSING

HOW IT WORKS: The four-inch-square wound dressing, coated with the plasma-clotting proteins fibrin and thrombin is still in early trial phase. Army and Special operations forces use the product in Iraq as part of clinical trials to treat severe injuries.

CONSUMER outlook: Although FDA approval is presently expected no predictions for civilian uses are available. When available, cost would likely be in the range of $1,000.

RDH BANDAGE

HOW IT WORKS: A four-inch square bandage, coated with a micro-algae polymer, attracts platelet and red blood cells to speed up clotting. The Rapid Deployment Hemostat, developed though a grant from the Office of Naval research is designed to withstand extreme temperatures and for easy portability. It is a battle field variation of the Syvek Patch, a dressing with the same clotting agent. It was approved by the FDA in 1997.

CONSUMER outlook - The ‘seaweed bandage’ costs about $100 and is used mostly in trauma situations at hospitals. By 2004, smaller and less-expensive variations may become available.

SONOSITE 180 AND 180 PLUS

HOW IT WORKS - Hand-held portable ultrasound devices allow surgeons to detect internal bleeding, basic heart motion and internal objects such as shrapnel. These devices, developed with assistance from the Defense Research Projects agency, or Darpa* and the Office of Naval Research, were approved by the FDA in 1997.

CONSUMER Outlook - The costs are not minuscule, $30,000, but they are in hospitals nationwide.

TERASON PROBE

HOW IT WORKS : An ultrasound device, when hooked up to a laptop or computer, acts as a portable probe that can view images and detect internal injuries, was developed with funding from Darpa*.

CONSUMER outlook - Has been used in hospitals nationwide to identify tumors, fetuses and hearts since early 2000. Cost $26,000.

LIFE SUPPORT FOR TRAUMA AND TRANSPORT

HOW IT WORKS: An entire intensive-care unit is miniaturized to fit in a five-inch platform underneath a stretcher. The units, which were developed with support from Darpa*, saw action in Kosovo and are in Iraq.

CONSUMER Outlook - Integrated Medica Systems expect the $165,000 units in the next several years to be used in trauma rooms when hospitals are over capacity and extra intensive care beds are needed. It also expects use in transferring patients between hospitals and in emergency-trauma situations such as highway accidents.

[This article was edited from the original in an attempt to avoid specific reference to any specific company or manufacturer. The purpose of editing was to also attempt to avoid endorsement of any product. The original entitled, "Medical Advances Follow a Path from War Front to Home Front" was originally published in the Wall Street Journal, April 22, 2003. It was reviewed as a continuing medical education effort in keeping with the purpose of the FPS/FCAAP Newsletter. The reviewer presents no personal views.]
As I begin my tenure as your President, I’m reminded of the words stated in the FCAAP mission: to promote the health and welfare of Florida’s children and support and promote the pediatrician as the best qualified provider of their healthcare. Though we as pediatricians have managed to forge paths to excellent healthcare for all American children, there is still much room for improvement. The following areas still pose significant challenges.

First, we must facilitate better access to care for children and their families. Most people in our country believe that all Americans should be given access to a system of healthcare that is efficient, practical, and non-wasteful, but many of our citizens are being left behind and are unable to access a healthcare system they might desperately need. Although many Americans believe that society has the obligation to provide access to care for every citizen and that each citizen should compensate for those services in some way, be it through insurance or healthcare programs or other means, the unfortunate truth is that thousands of Americans are still uninsured and underinsured and not receiving appropriate and efficient healthcare.

Simply ensuring that every American is appropriately insured or enrolled in a healthcare program won’t completely solve the problem. To effectively hit the problem head-on, all necessary primary care and specialty services must be adequately distributed; community-based healthcare infrastructures must be designed and implemented to deliver, coordinate, and integrate services; and culturally aware and competent providers must be available to address the unique needs of their diverse populations.

Most importantly, we must listen to and involve those who know the most about accessing the healthcare system – the patients and families who use our services. Although it is very easy to discuss and debate policy and ultimately decide on a solution that we think is right for others, it is my opinion that communities should be involved from the start. I believe that to create a robust national vision, answers and solutions must be solicited from local communities first. Only then can we develop a clear and focused understanding of how best to tackle this issue.

Another challenge facing us today is re-thinking and improving the quality of care we are providing for our patients and their families. There is a startling lack of consistency. Various studies have shown that there is a considerable gap between the care we think we’re administering and the care actually received by our patients. According to NICHQ, children and families report that care they’re receiving is not “well-coordinated”, and most alarmingly, that “communication and support” are not meeting their definition and expectations of quality pediatric healthcare. Putting ourselves in the place of our patients and their families and looking at the healthcare system from their perspectives may help us listen to their needs better. We need to always remember that there are countless other things a child would rather do than see a doctor.

An ideal environment, as stated by NICHQ, would be evidence-based, responsive to the needs of children and families, and would result in excellent outcomes. As pediatricians, we have the responsibility to do our best to provide superlative care to the children and families in need of our help. And we have the responsibility to ensure that care is delivered in a consistent, reliable, and effective manner.

Our next challenge involves facilitating great changes in healthcare on a national scale. In conjunction with the Wye River Group Project, entitled “Communities Shaping a Vision for America’s 21st Century Health & Healthcare” and several other like-minded national organizations, the FCAAP will endeavor to improve health and healthcare in the United States by addressing deficiencies in our current system, protecting and preserving its advantages, and working toward constructive change. The Wye River Group project will not only involve public policy groups and national experts, but also the community, who will offer advice and opinions through a series of “listening sessions.” By targeting selected communities around the nation and meeting with local opinion leaders to gain a better understanding of each community’s unique cultural aspects and healthcare system dynamics, we hope to develop an agenda that goes far beyond politics and sector competition and fosters positive change in the American health and healthcare system.

Finally, another task we need to accomplish is to invite more pediatric subspecialists into our ranks. A recent NACHRI study found that “a shortage of pediatric subspecialists during the next decade may become the number-one strategic and operational issue facing children's hospitals” and a study in PEDIATRICS found that “pediatric subspecialists (report) levels of stress and burnout that raise significant concerns” for the future pediatric subspecialist workforce. Since 1986, the proportion of pediatric residents choosing advanced training has declined from 33 percent to 21 percent – mainly due to managed care's focus on primary care, which has guided reduced support for specialist fellowships and reduced reimbursement income for specialists. As a result, physicians within specific subspecialties are predicted to "age-out" within the next 15 years. Thus, it is extremely important to seek more pediatric subspecialist involvement in the FCAAP and welcome their views and opinions.

I consider it a privilege to serve you as President. There are great challenges to face in the next two years, and we will meet these challenges together. As leaders in pediatric healthcare, we have been given an extraordinary responsibility. We have been entrusted with the rare honor and gifts to advance and improve the health and well-being of children, in the state of Florida – and given our geographic location even the international community. Though each of us has gathered individual accolades and accomplishments, we should never lose sight of the fact that we work for the most vulnerable and the most wonderful members of our population – the infants, children, adolescents, and young adults who come to us seeking help, with hope in their hearts and faith in our abilities.

With sincerest regards,

Deborah Ann Mulligan-Smith, MD FAAP FACEP
encouraging young families to read to their infants and children by providing books, brochures, and other reading materials in doctor’s offices and other accessible areas. The program also provides appropriate books as gifts for children and their families, and recruits mentors to read to children. This is an exciting new program in Florida with potential, significant impact on the development of a very fragile population of infants and children.

This past fall, Dr. Charles R. Bauer gave a presentation to the Pediatric Residents in training at the University of Miami-Jackson Memorial Medical Center regarding the goals and advantages of membership in the Florida Pediatric Society and the Florida Chapter of the American Academy of Pediatrics.

Dr. Kimberly Schwartz welcomed Jonah, a healthy baby boy, into the family in July 2002. Mother and son are thriving, as is District 8.

Submitted by: Charles R. Bauer, M.D. District 8 Representative (retired)

Chairmen

Region 8

(• continued from page 6)

Chairmen

(• continued from page 7)

Chairmen

principles. Currently, our students have a written examination that must be passed after completing both the hospital and ambulatory pediatric rotations. In the future, this examination will be modified to incorporate the subjects presented in these web-based areas.

The most exciting event to occur this year is our approval to start a new pediatric residency at Palms West Hospital. The first residency class will begin training July 1, 2004. The new program at Palms West Hospital was established to provide training for new primary care pediatricians in both a general ambulatory pediatric practice and the care of hospitalized pediatric patients. The program was developed to meet the special criteria of a “Fast-Track” training program. A “Fast-Track” program meets the unique licensure requirements needed for osteopathic physicians in many states that require a physician to have completed a traditional internship prior to applying for a license to practice. After completion of the three-year pediatric residency, the resident will be considered to have completed both an internship and a pediatric residency in the three-year time span.

I look forward to the academic year that is about to begin. This time next year, I will be able to report on the events of the 2003 – 2004 academic year, and the beginning of our new postgraduate program.

Risk

(• continued from page 17)

regard to each, there is recognition that the patient’s right to know and choose may be outweighed by other considerations. These categories are emergency, therapeutic privilege, patient waiver, and governmental action.

Emergencies

It is generally recognized that emergencies may create situations where it is often impractical to obtain the consent of the patient or the patient’s legal representative. In situations where a patient is unable to provide consent and the representative cannot be reached in a timely fashion, the physician may proceed to administer medical therapy. The law recognizes an implied consent in these circumstances and it applies equally to both adults and children. However, some difficulty does arise in determining when an emergency exists.

Therapeutic Privilege

As noted in the landmark decision: “It is recognized that patients occasionally become so ill or emotionally distraught on disclosure as to foreclose a rational decision, or complicate or hinder the treatment, or perhaps even pose psychological damage to the patient” Where that is so, the cases can be interpreted to provide a physician with a privilege to keep information from the patient. However, a critical inquiry is whether the physician responded to sound medical judgment that communication of the risk information would present a threat to the patient’s well-being.

As explained in this case, the therapeutic privilege is thought of as being applicable where the patient’s condition is such that full disclosure of information would significantly worsen the condition. The cases that have discussed this issue are in disagreement as to whether the spouse or next of kin must be provided the full disclosure when it is withheld from the patient for therapeutic reasons. It would seem that the prudent course would be to give the spouse, next of kin, or patient’s representative the full disclosure that would have been presented to the patient.

One final caveat is in order with regard to this privilege. It should not be utilized if the physician is only concerned that the patient will not agree to the procedure if a full disclosure is provided. The patient has the right to choose and only in those circumstances where the condition would be significantly worsened should this exception be considered.

Waiver

A third recognized exception is a waiver by the patient. If an adult patient insists upon not being informed of the nature of the procedure or risks attendant to it, then the patient relieves the physician of the obligation to obtain an informed consent.

Obviously, if a patient has the right as a competent adult to demand information upon which to make a decision, the patient also has the right to forego receipt of that information. However, the exception is fraught with danger. One can easily envision a situation where a patient provides a waiver and later claims, upon the occurrence of a complication, that a waiver would never have been signed if the patient had known of that particular risk.

The physician, in most instances, is unprotected in this circumstance. As a result, it is recommended that the physician not rely upon a patient waiver and instead obtain the informed consent of the patient. The one exception might be where the therapeutic privilege is involved. If the physician realizes, after consulting with the patient, that a full disclosure would actually increase the risks of danger to the patient, the physician would be on firmer ground in accepting the patient’s waiver. In all such circumstances, the waiver should be completely documented and the form signed by the patient.

One practical concern in this regard is that the physician should not be the one to recommend a waiver of information. The physician is in a fiduciary relationship with the patient and, as such, the courts will impose upon the physician a duty to protect his/her charge. If the physician has been the one to suggest the waiver and the patient complains, a court or jury might hold that the physician’s suggestion was overreaching and in violation of their position of trust.

Governmental Action

Courts have recognized the rights of the state in some circumstances to have a medical act accomplished in spite of a lack of consent or even refusal by a patient. In these circumstances, public interest outweighs the right of the individual. Physicians most commonly experience this in civil or criminal cases where the court has ordered an examination of a patient. Even in this circumstance, however, the physician should endeavor to provide the appropriate information to the patient. If the patient refuses to consent, the court order is sufficient to allow the procedure. On the other hand, if the patient actively resists so that harm may result, the physician should refer the matter back to the court.

In addition to court orders, state statutes may authorize medical acts without patient consent. For this reason, seek risk management or legal guidance whenever uncertainty may arise.

[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.]
The authors claim falsely that children in the United States in 2003 may be exposed to higher levels of mercury from thimerosal contained in childhood immunizations than any time in the past, when in fact, all routinely recommended infant vaccines currently sold in the United States are free of thimerosal as a preservative and have been for more than 2 years (www.fda.gov/cber/vaccine/thimerosal.htm#1). No scientific data link thimerosal used as a preservative in vaccines with any pediatric neurologic disorder, including autism. Despite this, the Centers for Disease Control and Prevention, American Academy of Pediatrics, National Institutes of Health, and US Public Health Service have continued to investigate this issue to put theoretic concerns about this mercury-containing compound to rest. Thimerosal continues to be used widely as a vaccine preservative in many other parts of the world where economics and sanitation concerns mandate an effective means to safeguard vaccines from contamination when stored in bulk in multidose vials. Any scientific article that can prove a thimerosal link to significant adverse events in children must be published in respected and widely read journals because of the great general interest today in vaccine safety. These journals can be expected to apply the highest standards of critical peer review to the results of any research that purports the existence of these associations and claims of causality.

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: Practical Pediatrics  
Dates: August 29-31, 2003  
Place: Seattle, Washington  
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: October 10-12, 2003  
Place: Toronto, Ontario, Canada  
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: November 14-16, 2003  
Place: Tempe, Arizona  
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: Hematopoietic Growth Factors and Specific Antibacterial Antibody Preparations in Neonatology  
Dates: October 7-9, 2004  
Place: Coronado Springs Resort, Orlando, FL  
Credit: To be announced  
Sponsor: University of South Florida and All Children’s Hospital  
Inquiries: Continuing Professional Education, (813)974-4296 or 1-800-852-5362