SECTION ON CRITICAL CARE

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

October 2003

A Note from the Chair

by Michele Moss, MD

As a sure sign of fall, along with cooler temperatures, colorful leaves and carved out pumpkins, the 2003 AAP NCE is rapidly approaching. This will be a busy meeting for members of our section as we have not only a stimulating Section Scientific Meeting planned but also several events taught by Pediatric Intensivists for our general pediatric colleagues. Most exciting is the pre-course directed at all pediatric medical and surgical subspecialty in-training fellows, Preparing for Life in Academics. This course is sponsored by our section and the course director is Dr. Steve Schexnayder. Steve is an experienced pediatric intensivist with a very strong background in medical teaching and education. He has pulled together a panel of lecturers that are nationally recognized and experienced in teaching faculty development programs. This should prove to be a wonderful experience for the in-training fellows that hopefully will expose them to their AAP specialty sections. If you have any fellows in your program who have not signed up, there is still time!

Additionally the workshop, Critical Procedures, is again being held. This is a very popular hands-on interactive course at all the annual AAP meetings that our section has sponsored for several years. Pediatric intensivists living close to the site of the NCE put on this review of procedures such as airway management each year. The course is always well received, particularly by visitors to the NCE from outside the U.S. Our thanks this year go to Drs. Bonnie Desselle and Gary Dubon for pulling this course together in New Orleans.

While in New Orleans, do not miss the Joint Session with the Sections on Perinatal Pediatrics and Home Health on Saturday afternoon, November 1st. The session will review the current status of survivors of the neonatal ICUs who become medically complex children and frequent visitors into our ICUs. Our Section Scientific Program on Sunday, November 2nd is detailed further in this newsletter but here are some of the highlights. Dr. Jim Fortenberry, our section program chairperson, has developed a joint plenary session with the Section on Nephrology on Renal Replacement Therapy in the PICU. This should be a very interesting and useful session for all of us working in the PICU. Our 2002 New Investigator Research Award winner, Dr. Melissa Evans, will present her work on the use of protein synthesis inhibitors for metabolic down-regulation in shock. Scientific abstracts will be presented in the morning and the abstract award winners will be announced at that time. Our 2003 Distinguished Career Award will be presented before the Section Business Meeting.

Members of our Section gave the Pediatric Critical Care Coding Course in June in conjunction with the Third World Congress on Pediatric Critical Care in Boston. The course was again very well received with excellent reviews from the participants. Now in development is another course on Pediatric Critical Care Practice Management. This course should be useful to take the next step beyond coding to work more on developing an efficient practice with optimal reimbursement. The Coding Course will be given in the future but most likely every other year rather than yearly. Stay tuned for the time and location of the practice management course.

The NIH has been receiving grants from Pediatric Intensivists for the Pediatric Critical Care Scientist Development Program. The program will be centered at an academic institution and will provide a mechanism to distribute grants to young investigators in pediatric critical care. The Section on Critical Care has let Dr. Carol Nicholson of the NIH know that we are interested in helping in any way possible including serving on grant review committees. We are pleased that the NIH is beginning to recognize the need to fund research efforts in Pediatric Critical Care.

The Executive Committee had a conference call to begin working on the practice management course, review upcoming CME offerings, and review the status of several position statements and guidelines in development. The group will meet again at the NCE prior to the Section program on Saturday morning. If there are any issues or concerns you feel need the attention of the Executive Committee please let me know. We are always looking for your input.

Most importantly, please join me in welcoming Dr. Richard Salerno from Charlottesville, Virginia to the Executive Committee. He is an in-training pediatric critical care fellow. We all anticipate the addition of an in-training fellow with his perspective on where our specialty is and is going.

I hope to see you all in New Orleans!

Michele Moss, MD, FAAP

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PICU Course

In January 2002, the Resident Education Committee, a sub-committee of the Pediatric Section of the SCCM, launched a Web site designed specifically to meet the educational needs of medical students and residents rotating through the PICU. The site houses presentations on "core curriculum" topics authored by committee members. The site provides free access to these PowerPoint presentations that can be downloaded for local use. The presentations are designed to form a template for didactic sessions that attending physicians (or their designees) can provide to housestaff. This would permit tailoring of the presentations to suit the demographics and management philosophy specific to the institution. Since the launch of the site, medical professionals worldwide have accessed the site and downloaded presentations for educational use.

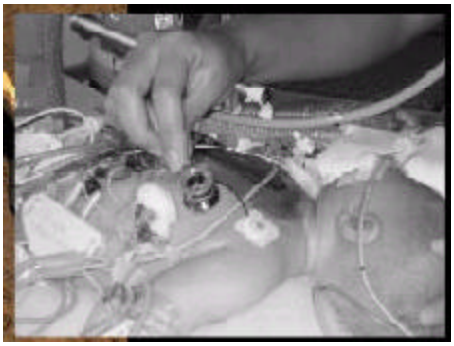
The second phase of the site was the development of an online end-of-rotation examination for residents to complete at the end of their PICU rotation. The examination has been available for testing since July 2002 and is being evaluated by several centers. The examination provides feedback to the examinee at the completion of the exam and will serve as a learning tool rather than one more test to take during residency. The "Outcome Project" of the ACGME is a new initiative that emphasizes the attainment of competency-based educational objectives for residents in training programs throughout the United States. A validated tool such as this online examination could conceivably be used as a "measurement tool for programs to use as part of an overall evaluation system" (as described in the Outcome Project).

The second online examination should be available for use by the end of June 2003. The Society and the Pediatric Section are discussing various options regarding funding including that of a fee-based service for the online examination and report generation. The scores on the online examination can be used for providing programs with annual reports of their residents' performance relative to their peer group both within the program and nationally. The Committee also intends to study the results from test scores to evaluate the curriculum content, advancement of knowledge base based on PGY level and other demographic parameters.

The Resident Education Committee is working with the Society to eventually transition the site over and make it part of the online educational offerings of the SCCM. The site has been a team effort of many individuals who have volunteered their time and effort in providing content, reviewed the presentations, and continue to be actively involved in the ongoing development of this Web site. Costs associated with site development were funded by a generous Grant from the John A. Wiebe, Jr. Children's Healthcare Fund of Omaha, Nebraska awarded to the Resident Education Committee.

The Resident Education Committee invites section members of the AAP to visit the site, peruse the educational content and provide feedback so the site can continue to evolve to meet the educational needs of our audience. Dr. Kenneth Tegtmeyer and Dr. Mary Lieh-Lai are the new co-chairs of this Committee. They begin their terms in January, 2003. Other current activities of the committee include the formulation of Goals and Objectives for a rotation in Pediatric Critical Care Medicine. These will be submitted for publication in a peer-reviewed journal. A working group has also been formed to evaluate the effect of the new resident work hour regulations on education of residents.

http://www.picucourse.org



2003 SOCC Distinguished Career Award

Ann E. Thompson, MD, FAAP, FCCM

Ann E. Thompson, MD, FAAP, FCCM is the winner of the 2003 SOCC Distinguished Career Award. This award will be presented to Dr. Thompson at the AAP National Conference & Exhibition during the SOCC program on Sunday, November 2, 2003 at 11:35am in Rooms 395-396 at the Ernest Morial Convention Center.

Dr. Thompson is director, Pediatric Critical Care Medicine, Children's Hospital of Pittsburgh, professor of critical care medicine and pediatrics, and vice chair, Department of Critical Care Medicine. She also is associate dean for faculty affairs at the University of Pittsburgh School of Medicine. She recently completed a master's degree in health care policy/management.

Dr. Thompson was president of the Society of Critical Care Medicine (2000-'01) and was former chair of the Pediatric Critical Care Medicine subboard, American Board of Pediatrics. She is a member of the Board of Directors of the World Federation of Pediatric Intensive and Critical Care Societies. She recently was appointed to the Residency Review Committee for Pediatrics of the American College of Graduate Medical Education.

AAP News, Oct 2003; 23: 178.

The SOCC program schedule can be found beginning on page 5 of this newsletter.

Drug Update - October 2003

Mary W. Lieh-Lai, MD, FAAP

I. Medication Errors

1. Chloral Hydrate: this drug is sometimes prescribed for administration to children at home to prepare them for an out-patient diagnostic procedure. When writing prescriptions for such use, be specific about the concentration. One child was given a concentration of 500 mg/5 mL instead of 250 mg/5mL. In another case, 120 mL of chloral hydrate was given instead of the prescribed 12 mL. Both children died.

2. Multi-channel IV pumps: these types are being used with increased frequency, especially in PICU's where children are on multiple inotropic agents. Occasionally, nurses mistakenly thread the IV tubing into a channel programmed to deliver a different medication at higher or lower volume infusion, resulting in over- or underdosing.

3. Tetanus toxoid (Td) and tuberculin purified protein derivative (PPD): Td was mistakenly used as PPD for TB skin tests. With the appearance of a "positive" reaction, patients were started on anti-tuberculous therapy.

4. Vincristine: there continue to be reports regarding vincristine being administered intrathecally by mistake causing slow painful deaths. Ascertain that all drugs are properly labeled and double-checked before administration.

5. Patients with morbid obesity: unfortunately, even pediatric practitioners are seeing an increasing number of children with morbid obesity. For most drugs, the lean body weight, and not the actual body weight should be used to calculate drug dosages. In one case, iron dextran was calculated based on the patient's actual body weight, and the patient exhibited muscle twitching, flushing and diaphoresis which resolved. For other drugs however, more severe toxicity is always possible.

II. Warnings

1. "Bolus" injections: be careful when writing IV "bolus"- this may result in too rapid administration of the drug. The "red-man" syndrome with vancomycin is certainly well known. Respiratory depression has been reported with rapid injection of midazolam. More recently, a physician wrote for labetalol IV bolus for a patient with hypertensive crisis. Following rapid injection of the drug, the patient arrested and could not be resuscitated.

2. Oral vancomycin is ineffective for systemic infections.

3. Heparin and enoxaparin: practitioners continue to make the mistake of prescribing both heparin and enoxaparin, or more commonly, forget to discontinue heparin when enoxaparin is started. In an attempt to prevent this error our pharmacists recently put together a "heparin-enoxaparin" alert (see attached) for placement in the front of patients' charts who are on heparin or enoxaparin.

4. Amiodarone is increasingly used for the treatment of arrhythmias in children. Frequently these children are on digoxin as well. Be aware that when amiodarone is started, the digoxin dose should be reduced by 25% to prevent digoxin toxicity. In addition, digoxin levels should be monitored.

5. Ephedrine and epinephrine: these are "sound-alike" drugs; both used for vasopressors/ vasoconstrictors and may also "look-alike" by similar packaging. A patient received a large overdose of epinephrine when a nurse misinterpreted an order for ephedrine. The patient developed tachycardia, severe hypertension and pulmonary edema.

6. Amphotericin B and liposomal amphotericin B: There are numerous preparations of both drugs: Abelcet, Amphotec, AmBisome, Amphocin, Fungizone intravenous. A nurse mistook amphotericin B for Abelcet giving the patient 350 mg of amphotericin B (maximum dose not to exceed 1.5 mg/kg/day) instead of 350 mg Abelcet, which is what had been ordered. The patient had a fatal cardiac arrest.

7. Metformin: an antihyperglycemic agent which can cause significant lactic acidosis when given to patients with renal insufficiency. Metformin use should be stopped temporarily when the patient is undergoing any study requiring IV iodinated contrast; and should be held for 48 hours after contrast administration, and only after adequate renal function is documented.

8. Aluminum content of TPN: there is a growing concern regarding the aluminum content in TPN, particularly in neonates and those with renal insufficiency. In January 2003, the FDA instituted strict requirements that the aluminum content in TPN solutions should not exceed 25 mcg/L.

III. Miscellaneous

1. Rule of six for continuous infusion calculation: The Harriet Lane recommends the following:

6 x weight (kg) = the amount of drug in mg that should added to 100 mL of solution.

The infusion volume in mL per hour will then equal the mcg/kg/minute dose desired.

Potential for errors:
a. If the "rule of 6" is not consistently used, those practitioners who use it routinely may assume that the solution is prepared according to the rule, and may recalculate the dose according to the rule of 6, resulting in potential for incorrect dosing.

b. Mistakes have been made where nurses confused mg with mL and added the drug by volume instead of by weight.

c. When using the rule of 6, the infusions are often prepared on-site in inpatient units rather than in the pharmacy. Many inotropic agents are available in different concentrations – this can lead to serious errors.

d. Solutions prepared using the rule of 6 can result in severe fluid overload in small infants when the dose is doubled.

e. The rule of 6 method leads to significant drug wastage: the amount required is usually only part of a vial, and the rest is discarded.

2. The American Academy of Pediatrics Policy Statement: Committee on Drugs and Committee on Hospital Care – Prevention of Medication Errors in the Pediatric Inpatient Setting, Pediatrics, Aug 2003; 112:431

The rates of medication errors are continuing to rise. This article provides a list of ways to decrease medication errors in children at all levels of hospital care.

3. Madenoglu H, Yildiz K, Dogru K and Boyaci A: Efficacy of different doses of lidocaine in the prevention of pain due to propofol injection: a randomized, open-label trial in 120 patients. Curr Ther Res Clin Exp, 2003; 64:310-316.

For those of you who use propofol for procedural sedation, you might find this interesting.

IV. MedWatch

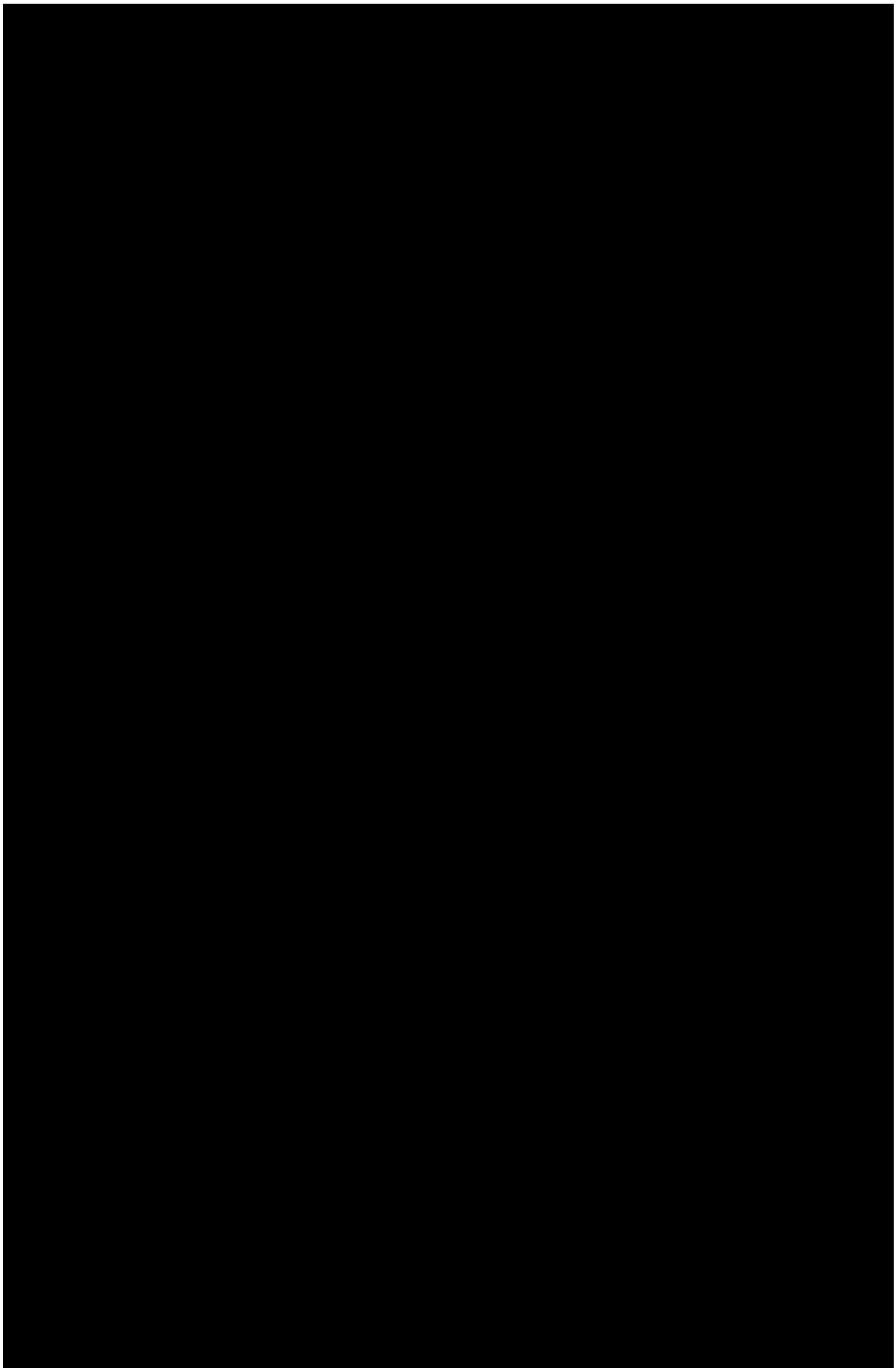
1. A recent warning from MedWatch: Reports of deaths resulting from liver toxicity from the use of both rifampin and pyrazinamide for the treatment of TB.

V. Drug Shortage

1. Methylprednisolone (Solu-Medrol®):
Our pharmacists at Children's Hospital of Michigan developed a corticosteroid conversion table to help us cope with this shortage **(see next page)**.

Note: Some of the above information was obtained from the ISMP bi-weekly newsletter.

SYSTEMIC CORTICOSTEROID COMPARISON CHART



AMERICAN ACADEMY OF PEDIATRICS
2003 National Conference and Exhibition
Section on Critical Care Program Schedule
November 1-2, 2003
New Orleans, LA

Saturday, November 1
7:30 am - 5:30 pm
Ernest Morial Convention Center, Rooms 265-266

7:30 am - 1:30 pm	**SOCC Executive Committee Meeting (by invitation only)**
2:00 pm - 5:30 pm	**Joint Session: Sections on Critical Care/Perinatal Pediatrics/Home Health** Chronic Illness in Survivors of Modern Neonatal Intensive Care
2:00 pm - 2:40 pm	**Case Studies: Who Are Today's Survivors? Perspectives from Pediatric Intensive Care Units and Home Health** (Stephanie Storgion, MD, FAAP and Judy Bernbaum, MD, FAAP)
2:40 pm - 2:50 pm	**Discussion**
2:50 pm - 3:20 pm	**New Technologies to Improve the Transition Home and Continuing Care of Medically Complex Infants** (Howard Panitch, MD, FAAP)
3:20 pm - 3:30 pm	**Discussion**
3:30 pm - 3:45 pm	**Break**
3:45 pm - 4:15 pm	**Neural Mechanisms of RSV Induced Airway Inflammation: Treatment Strategies** (Giovanni Piedimonte, MD)
4:15 pm - 4:25 pm	**Discussion**
4:25 pm - 5:00 pm	**Care on a Shoe-String: The Challenge of Providing, Financing and Coordinating Health Care Services for Medically Involved Infants** (John Lantos, MD, FAAP)
5:00 pm - 5:30 pm	**Interactive Panel Discussion: Stories from the Field**

Sunday, November 2
8:00 am - 5:00 pm
Ernest Morial Convention Center, Rooms 395-396

8:00 am - 8:15 am	**Continental Breakfast** **Introduction and Welcome** James Fortenberry, MD, FAAP
8:15 am - 9:45 am	**ABSTRACT SESSION I** Moderators: Alice Ackerman, MD, FAAP/Barry Markovitz, MD, FAAP

1. 8:15 am **Hebbar K,** Comparison of Temporal Artery Thermometry to Standard Temperature Measurements in PICU Patients (Emory University School of Medicine, Atlanta, GA)
2. 8:30 am **Lieh-Lai M,** In Vivo Release of Ibuprofen Attached to Dendrimers: Pharmacokinetics Following Intravenous Administration in Rats (Children's Hospital of Michigan, Detroit, MI)
3. 8:45 am **Zawistowski C,** Withdrawal of Life-Sustaining Treatment in Children: A Descriptive Study (University of Pittsburgh, Pittsburgh, PA)
4. 9:00 am **Halley M** Loss of Consciousness: When to CT? (Children's Hospital of San Diego, San Diego, CA)
5. 9:15 am **Foland J,** Earlier Use of Pediatric Hemofiltration Is Associated With Improved Survival (Emory University School of Medicine, Atlanta, GA)
6. 9:30 am **Fiore M,** Eosinophil Activation in the Cerebrospinal Fluid of Patients with Malfunctioning Ventriculoperitoneal Shunts (Wayne State University, Detroit, MI)

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Sunday, November 2
8:00 am - 5:00 pm
Ernest Morial Convention Center, Rooms 395-396
Continued

9:45 – 10:00 am **Coffee Break and Poster Review**

POSTER PRESENTATIONS:

P1) **Freishtat R**, Comparison of Mononuclear Cell Isolation Techniques for Small Blood Volumes (Children's National Medical Center, Washington, DC)

P2) **Lee A,** Prevalence of Pediatric Advanced Life Support (PALS) Certification in Practicing Primary Care Pediatricians (University of Maryland, Baltimore, MD)

P3) **O'Dowd L,** Reference Values for Hypothalamic-Pituitary-Adrenal Axis Function in Pediatric Patients Aged 5 Months to 5 Years (Astra Zeneca, Wilmington DE)

P4) **Mehta R,** The Use of Hypokalemia Treatment Protocol Is Effective in Intensive Care Unit Settings (Medical College of Georgia, Augusta, GA)

P5) **Pascucci R,** Communicating Bad News-A Program To Enhance Relational and Communication Skills (Children's Hospital, Boston, MA)

P6) **Jones M,** The Activity of Ceftriaxone and Comparators Against Pathogens Isolated from Pediatric Patients during 2000 to 2002 (Focus Tech, Herndon, VA)

P7) **Little D,** Patent Ductus Arteriosus in Micropremies and Full Term Infants: The Relative Merits of Surgical Ligation Vs. Indomethacin Treatment (Texas A&M, Temple, TX)

P8) **Wu H,** In-Vitro Study of pMDI-Delivered HFA Proventil from Two Valved Holding Chambers (University of Maryland, Baltimore, MD)

P9) **Zawistowski C,** Withdrawal of Life-Sustaining Treatment in Children: A Single Center Prespective (Children's Hospital of Pittsburgh, Pittsburgh, PA)

P10) **King W,** Enteral Nutrition During Vasopressor Infusion (Emory University School of Medicine, Atlanta, GA)

P11) **Mehta R,** Parents Think That Propofol IS Safe for Their Child When Used as Short Term Sedation (Medical College of Georgia, Augusta, GA)

P12) **Ponsky T,** The Use of Transcyte, A Bioactive Skin Substitute, In the Treatment of Toxic Epidermal Necrolysis (Children's National Medical Center, Washington, DC)

P13) **Haque A,** Alveolar Capillary Dysplasia Presenting As Failure To Thrive/Respiratory Failure in a 7 Week Old Infant (Vanderbilt University, Nashville, TN)

P14) **Sharma J,** Spontaneous Resolution of Marked Dilation of Cerebral Duro-Venous System in Newborn Presenting with Fetal Hydrops (The Children's Hospital, Brooklyn, NY)

P15) **Sharma J,** Serum Troponin: A Marker for Use of Intravenous Immunoglobulin in Viral Myocarditis in Infants (The Children's Hospital, Brooklyn, NY)

P16) **Muniz A,** Electrocardiographic Changes in an Adolescent with a Subarachnoid Hemorrhage (Virginia Commonwealth University, Richmond, VA)

P17) **Muniz A,** Infectious Mononucleosis Sepsis with Severe Thrombocytopenia and ARDS (Virginia Commonwealth University, Richmond, VA)

P18) **Jensen A**, Secondary Compartment Syndrome in Children: A Potentially Lethal Complication (Temple University School of Medicine, Philadelphia, PA)

P19) **Mehta S**, Does Oximetry Predict Length of Therapy in Children with Acute Asthma? (Hospital for Sick Children, Toronto, Ontario)

P20) **Cua C**, Correlation of Cerebral and Mixed Venous Saturations in Patients Undergoing Extracorporeal Life Support (Columbus Children's Hospital, Columbus, OH)

P21) **Tuggle D,** Hyperglycemia and Infections in Pediatric Trauma Patients (University of Oklahoma School of Medicine, Oklahoma City, OK)

P22) **Slesnick T**, Markedly Elevated Peak Serum Lactate: Is It a Reliable Predictor of Mortality in Critically Ill Pediatric Cardiac Patients? (Baylor College of Medicine, Houston TX)

P23) **Clark J**, Tissue Engineering of Large Caliber Arterial Structures Using A Chitosan Scaffold (Children's Hospital of Michigan, Detroit MI)

10:00 am - 11:15 am **ABSTRACT SESSION II**
Moderators: Thomas Bojko, MD, FAAP/Mary Lieh-Lai, MD, FAAP

7. 10:00 am **Haque A**, A Retrospective Cohort Study to Evaluate the Effect of Insulin Glargine (IG) on the Outcomes of Diabetic Ketoacidosis in Children (Vanderbilt University, Nashville, TN)

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Continued

8.	10:15 am	**Mehta R** , Activated Neutrophils Increase Tyrosine Nitration and Decrease Angiotensin Converting Enzyme Activitiy in Bovine Pulmonary Endothelial Cells (Medical College of Georgia, Augusta, GA)
9.	10:30 am	**dela Cruz R**, Unrecognized Imposed Resistive Work of Breathing Results in Inadequate Levels of Pressure Support Ventilation in Pediatric Patients with Respiratory Failure (University of Florida, Gainesville, FL)
10.	10:45 am	**Fiore M**, Pressure Control Aggravates Acute Lung Injury Compared to Volume Control Ventilation (Wayne State University, Detroit, MI)
11.	11:00 am	**Srinivasan V**, Are Timing, Duration, and Intensity of Hyperglycemia Associated with ICU Mortality in Children? (Children's Hospital of Philadelphia, Philadelphia, PA)

11:15 am - 11:35 am **New Investigator Research Award Study Results, 2002**
Use of Protein Synthesis Inhibitors for Metabollic Down-Regulation in Shock
(Melissa Campbell Evans, MD)

11:35 am - 12:00 pm **Presentation of SOCC Distinguished Career Award, 2003 to Ann E. Thompson, MD, FAAP**
M. Michele Moss, MD, FAAP

12:00 pm - 1:00 pm **Lunch & Section on Critical Care Business Meeting**
M. Michele Moss, MD, FAAP

1:00 pm - 4:30 pm **Joint Session: Sections on Critical Care/Nephrology**
Renal Support in the Pediatric Intensive Care Unit
(Steven Wassner, MD, FAAP, Timothy Bunchman, MD, James Fortenberry, MD, FAAP, Lawrence Greenbaum, MD, PhD, FAAP)

1:00 pm - 1:15 pm	**Welcome and Introduction** Moderators: Steven Wassner, MD, FAAP, James Fortenberry, MD, FAAP
1:15 pm - 2:00 pm	**Challenging Electrolyte Cases in the PICU** Lawrence Greenbaum, MD, PhD, FAAP
2:00 pm - 2:45 pm	**Renal Replacement Therapy in Critically Ill Children: Choices and Outcomes** Timothy Bunchman, MD
2:45 pm - 3:00 pm	**Discussion**
3:00 pm - 3:45 pm	**Advances in Pathogenesis and Management of HUS/TTP** Lawrence Greenbaum, MD, PhD, FAAP
3:45 pm - 4:30 pm	**Use of CRRT for Non-Renal Diseases: Indications and Controversies** Timothy Bunchman, MD
4:30 pm - 5:00 pm	**Best Abstract/Physician-in-Training Awards Presentation** James Fortenberry, MD, FAAP
5:00 pm	**Adjourn**

HEPARIN ALERT

Place this in your Patient's Chart while they remain on Heparin.

Below is important safety information regarding your patient's care while they are receiving Heparin.

Safety Guidelines for Using Low-Molecular Weight Heparin (Enoxaparin-Lovenox â) and Parenteral Heparin

1. Patients should NEVER be scheduled on both enoxaparin and heparin infusion due to potential adverse interaction between enoxaparin and heparin IV.

2. To convert from treatment doses of enoxaparin ⇒ IV heparin, determine the time of last enoxaparin injection.
   - ♦ If patient is on a Q 12 hours dosing regimen, start IV heparin 12 hours after last dose of enoxaparin.
   - ♦ If patient is on a Q 24 hours dosing regimen, start IV heparin 24 hours after last dose of enoxaparin.
   - ♦ No heparin bolus is recommended for both scenarios.

3. To convert from IV heparin ⇒ treatment doses of enoxaparin, consider:
   - ♦ Give first dose of enoxaparin injection, then discontinue heparin immediately thereafter.

4. If patient was on home enoxaparin, received a dose within < 12 hours, and admitted for a new venous or arterial thromboembolism:
   - ♦ Consider contacting hematology immediately for a recommendation.
   - ♦ If enoxaparin was given < 12 hours and heparin IV is deemed necessary, start IV heparin infusion WITHOUT a bolus dose.

5. Precautions for using enoxaparin in patients with epidural catheters.
   - ♦ No neuraxial interventions while on enoxaparin.
   - ♦ Wait to insert or discontinue epidural at least 12 hours after the last dose of enoxaparin.
   - ♦ Wait 2 hours after epidural removal to give next dose of enoxaparin.

Prepared by: Department of Pharmacy Services 11/12/2001; References: upon request; Approved by DMC P & T 10/12/2001

***Contact a pharmacist if you have any questions regarding this information.**

Note: This is not a permanent part of the patient chart.

Don't Throw in the Towel on Federal Medical Liability Reform

Backers of national medical liability reform are vowing to keep pressure on after the Senate failed to move forward on comprehensive medical liability reform legislation this July. Despite the setback, reform advocates say there are several reasons to be optimistic about the long-term prospects for the bill:

- President George W. Bush supports the legislation.
- The House of Representatives in March passed a bill (H.R. 5) that includes a $250,000 noneconomic damages cap, as well as several other critical reform provisions.
- A Gallup poll shows that 72% of Americans favor caps on noneconomic damages.
- The U.S. General Accounting Office (GAO) has issued a report on medical liability insurance which found that losses on medical malpractice claims—the largest part of insurers' costs—appear to be the primary driver of premium rate increases.

The GAO report "Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates" also states that caps on noneconomic losses may indirectly reduce malpractice insurance premiums. Insurers report that economic damages (generally medical costs and lost wages) are more predictable than noneconomic damages, which are generally meant to compensate for pain and suffering and thus are very difficult to quantify. Capping noneconomic damages reduces the uncertainty that can give rise to premium rate increases. The report explains that after the frequency and severity of malpractice losses have been reduced, insurers will decrease premium rates because they may be better able to predict what they will have to pay out in losses.

IN CONGRESS

The US House of Representatives passed comprehensive medical liability legislation known as the "Help Efficient Accessible, Low-cost, Timely Health Care" (HEALTH) Act (H.R. 5) in March by a vote of 229-196. The bill, which was reintroduced in the 108th Congress by Representatives Jim Greenwood (R-PA) and John Murtha (D-PA), would among other things:

- limit non-economic damages, such as pain and suffering awards, to no more than $250,000;
- limit punitive damages to the greater of two times the amount of economic damages or $250,000;
- establish new guidelines for joint and several liability so that providers could be held liable only in direct proportion to their percentage of responsibility; and
- allow providers to request periodic payments if an award for damages exceeds $50,000.
- The bill also would limit the number of years a plaintiff has to file a health care liability action; in cases involving care to minors under the age of 6, claims would have to be filed within 3 years or the minor's 8th birthday, whichever is later.

In July, the US Senate failed to agree on moving forward to consider similar legislation known as the "Patients First Act" (S. 11), which was introduced by Senator John Ensign (R-NV). However, Senate Majority Leader Bill Frist (R-TN) has indicated the measure is a priority and may return to the Senate calendar before the end of the 108th Congress. S. 11 is nearly identical to the House-passed HEALTH Act, with the addition of new language that requires expert witnesses in malpractice cases to be competent and experienced in the type of treatment under review.

These are solutions that the Academy and others in the health community have supported for over ten years. Moreover, they are not untested remedies. States such as California that have enacted and maintained these reforms have been shielded from the worst effects of the current crisis.

AT THE STATE LEVEL

Medical liability reform was a top legislative issue in many states in 2003. **Alabama**, **Arizona**, **Arkansas**, **Colorado**, **Connecticut**, **Delaware**, **Florida**, **Georgia**, **Hawaii**, **Idaho**, **Kentucky**, **Maine**, **Maryland**, **Minnesota**, **Mississippi**, **Missouri**, **Montana**, **Nevada**, **New Hampshire**, **New Jersey**, **North Carolina**, **North Dakota**, **Oklahoma**, **Pennsylvania**, **Tennessee**, **Texas**, **Utah**, **Virginia**, **West Virginia**, and **Wyoming** considered medical liability reform legislation. Of these states, **Oklahoma**, **Texas**, and **West Virginia** enacted legislation that places caps on non-economic damages. **Missouri** vetoed a cap on non-economic damages. **Delaware** enacted legislation that makes it more difficult to file medical malpractice lawsuits. **Florida** is poised to enact a medical liability reform package as well. The final details are still being worked out at the time of this writing. This issue will continue to be a contentious one in the 2004 legislative sessions.

NEXT STEPS

Through the Committee on Medical Liability and its leadership network of sections, committees and chapters, the Academy is monitoring the current malpractice crisis and its effect on pediatric care. Low reimbursement rates are already a major issue in many states, and the medical liability crisis places an added strain on the financial viability of pediatrician practices in these states. The Academy is very aware of these problems and is working aggressively to address them through public sector and private sector solutions. The AAP is very concerned that the combination of low reimbursement and dramatic increases in malpractice insurance costs may trigger problems with access to health care for children. These twin problems are likely to drive physicians away from particular states. These same states will likely have trouble attracting new pediatricians and pediatric medical and surgical specialists.

The problems of high liability premiums and low reimbursement rates are not confined to one section of the country. Arkansas, Illinois, Mississippi, Missouri, New Jersey, New York, Ohio, Pennsylvania, and Washington are all vulnerable states. These states are from different regions of the country, they have varying populations, and they occupy different points on the political spectrum. Already Pennsylvania and New York have reported concerns about the physician population in their states. The AAP recognizes that these two problems need to be addressed with a two-tier federal and state strategy, and the AAP is in the process of doing just that.

WHAT CAN YOU DO?

- Sign up for the AAP Federal Advocacy Action Network to receive action alerts on this important issue. Visit the site on the AAP Members Only Channel under Federal Affairs for the latest legislative news and action alerts.
- Stay abreast of the crisis by visiting the Medical Liability Crisis page on the AAP Members Only Channel.
- Watch for the latest information on the liability crisis in AAP News.
- Attend the session on "Navigating the Medical Liability Crisis" at the 2003 NCE in New Orleans.
- Contact your chapter to learn about its efforts to address this issue on the state level. You can also review the Issue Brief prepared by the AAP Division of State Government Affairs on medical liability reform. You can access it on the State Government Affairs page of the AAP Members Only Channel.
- Request copies of the Physician Action Kit includes everything you will need to educate and motivate your patients on this issue at http://www.ama-assn.org/ama/pub/category/10155.html

It's time to act. Without comprehensive medical liability reform today, many physicians may not be able to continue caring for children tomorrow.

For more information on the AAP response to the medical liability crisis, contact:

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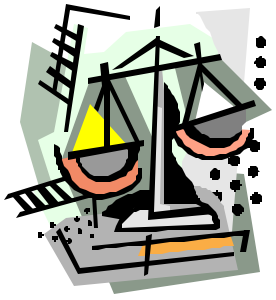

Maintenance of Certification for Pediatric Subspecialists (PMCP-S™)

*James A. Stockman III, MD, President * Paul V. Miles, MD, Vice President, Quality Improvement * Hazen P. Ham, PhD, Director of Recertification Programs*

Introduction

The American Board of Pediatrics (ABP) has initiated a new process of recertification called Maintenance of Certification. Maintenance of certification embraces a different philosophical premise than that of traditional recertification. The traditional recertification process focused on only one area of physician competence – knowledge of the subspecialty, and assessed that knowledge only periodically, eg, once every seven years. Maintenance of certification recognizes that there are several essential competencies[1] involved in delivering quality care that extend beyond medical knowledge, and these competencies should be developed throughout one's career. The new maintenance of certification process is designed to evaluate, on a *continual* basis, the general competencies deemed necessary for pediatric subspecialists to deliver quality care with an emphasis on continual *learning* and *practice improvement*.

The Maintenance of Certification Model

The American Board of Medical Specialties (ABMS; www.abms.org), the umbrella organization for the 24 medical subspecialty boards, is responsible for the shift from traditional recertification to maintenance of certification. A task force of the ABMS used the framework of general competencies to develop a four-part model of maintenance of certification. The ABMS member boards have endorsed and accepted this model, and have unanimously agreed to establish maintenance of certification programs in the near future. The four parts of the model are:

Part One:	Evidence of professional standing
Part Two:	Evidence of lifelong learning and periodic self-assessment
Part Three:	Evidence of cognitive expertise
Part Four:	Evidence of satisfactory performance in practice.

Within this overall framework, individual ABMS boards will name their maintenance of certification programs to reflect their specific approach to the process. For pediatrics, the maintenance of certification program is known as the Program for Maintenance of Certification in Pediatrics™ (PMCP™). There are two variations of PMCP: 1) PMCP-G™ - the process that general pediatricians will use to renew certification and 2) PMCP-S™ - the process that pediatric subspecialists will use.

The Vision

The vision of the ABP is to ensure that pediatricians, "…possess the knowledge, skills, and experience requisite to the provision of high-quality care in pediatrics." The purpose of PMCP-S is directly in line with this vision – to create a process that enables diplomates to provide evidence to the public that the quality of their care is maintained over the course of their careers. This evidence is marshaled over the course of the certification cycle (ie, seven years) by completing activities that are related to each of the four parts of the maintenance of certification model. All of these activities are designed to lead to improved pediatric care and to enhance professional development throughout one's career.

The Focus on Improvement

PMCP-S will include quality improvement activities that were not a part of the ABP's prior recertification process. This emphasis on quality improvement represents a responsible shift on the part of the ABP from the traditional "inspection" model to an "improvement" model. Traditional recertification programs focused on setting a minimum standard below which a physician was considered inadequately prepared to deliver quality care. While PMCP-S will continue to set a standard for medical knowledge and professionalism, subspecialists will also be asked to demonstrate that they can assess and improve the quality of the care they deliver. They will not be scored on their performance on these activities nor will standards be set for individual clinical performance. The standard will be the active participation in a valid process of assessment and improvement of quality of care that should lead to improved patient outcomes.

Requirements for Maintenance of Certification in Pediatric Subspecialties

Following is a brief description of the activities required for the four parts of PMCP-S. A detailed description of these requirements is on the ABP's Web site (www.abp.org).

Part One: Evidence of Professional Standing. This part will require a valid, unrestricted license to practice medicine in all states in which a physician holds a license. This licensure requirement will be continuous, meaning that ABP certification may be withdrawn if the license is revoked or suspended at any time.

Part Two: Evidence of Lifelong Learning and Periodic Self-assessment. Participants will be required to complete a self-assessment that attests to their continued involvement in lifelong learning. Each of the ABP subboards will develop literature-based self-assessments that will address current advances in the subspecialty. These self-assessments will not necessarily assist one in preparing for the examination. We anticipate that other organizations, such as subspecialty societies, will develop self-assessment activities that will target examination preparation. Subspecialists may complete the assessment developed by their subboard or they may complete one developed by an external entity (eg, a society) that is more focused on examination preparation. Approved self-assessment programs will be posted on the ABP's Web site.

Part Three: Evidence of Cognitive Expertise. This activity will consist of a secure, closed-book examination administered in a half-day period at computer testing centers throughout the United States and abroad. The examination will be available six days each week for two months each year (mid-March through mid-April and mid-October through mid-November). The examination will focus on content related to the daily practice of the subspecialist and does not focus on issues that typically would require the use of reference materials.

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Part Four: Evidence of Satisfactory Performance in Practice. This part of the PMCP program is currently receiving a great deal of attention by subspecialty groups. We expect it to contain components similar to PMCP-G that will specifically address quality improvement issues for pediatric subspecialists.

There will be two components to Part Four:

> Component A: Peer and patient surveys will be used to solicit information about such competencies as interpersonal communications skills and professionalism. All peer and patient feedback will be anonymous. Feedback will be presented in an aggregate manner so as to offer diplomates the opportunity for self-reflection about how they compare on these competencies relative to other subspecialists and how they might improve their skills and behaviors in order to improve patient care. There will be no minimum standard for this activity.
>
> Component B: This portion of Part Four will contain activities designed to address quality improvement strategies that should ultimately result in improved care for children; activities will permit subspecialists to assess the quality of care being provided by themselves and/or the team in which they practice. For instance, one idea that is currently being considered is an Internet-based system that allows one to input anonymous information from actual patient charts, which will generate feedback on quality of care relative to current standards. This activity guides the physician through a full improvement cycle exercise including a follow-up assessment (eg, the AAP's eQIPP program [www.eqipp.org]).

The Board is working with various groups of subspecialists representing societies, sections of the American Academy of Pediatrics (AAP), and the ABP subboards, as well as quality improvement experts at the National Initiative for Children's Healthcare Quality, to develop a meaningful program that will be beneficial to subspecialists and their patients. It will be necessary for each subspecialty to have in place an activity for this part of the PMCP-S process within the next few years. The details of our progress on this portion of the PMCP-S process will be communicated to subspecialists as they become available.

Maintaining General Pediatrics and Subspecialty Certification

Subspecialists are NOT required to maintain their general pediatrics certificate in order to maintain their subspecialty certificate. However, if subspecialists wish to maintain both certificates, they may do so at a reduced cost; some reciprocity will be built into the two programs to alleviate redundancy across programs. The following table reflects how this reciprocity may work.

PMCP-G	*Reciprocity*	PMCP-S
Part 1: Professional Standing ▪ Medical license	←→	**Part 1: Professional Standing** ▪ Medical License
Part 2: Lifelong Learning and Self-assessment ▪ Knowledge Self-assessment ▪ Decision Skills Self-assessment	← **none**	**Part 2: Lifelong Learning and Self-assessment** ▪ Knowledge Self-assessment
Part 3: Cognitive Expertise ▪ PMCP-G Examination	**none**	**Part 3: Cognitive Expertise** ▪ PMCP-S Examination
Part 4: Performance in Practice ▪ Peer & Patient Surveys ▪ Performance in Practice Activity	←→ ←→	**Part 4: Performance in Practice** ▪ Peer & Patient Surveys ▪ Performance in Practice Activity

NOTE: The arrows indicate the direction of reciprocity. For example, when the ABP verifies a medical license for Part One in either program, the diplomate will receive credit for that activity in the other program. The same holds true for the Part Four activities. For instance, if a diplomate completes the Performance in Practice activity for PMCP-S, he/she will automatically receive credit for this requirement in PCMP-G. However, reciprocity works only in one direction for the Knowledge Self-assessment required in Part Two; diplomates will receive credit for this activity only for PMCP-G if they complete it for PMCP-S. There is no reciprocity for the examination because the ABP believes that evidence of maintaining the broad-based knowledge content of both fields must be provided at the time of testing in order to be certified in both fields.

Timing

The PMCP-S program became effective in early January 2003. There is a phase-in period that will permit the ABP and other entities that are working on this initiative adequate time to develop and implement all of the components. Therefore, during the phase-in period (2003 through 2009), only certain activities will be required; required activities are directly linked to the expiration date of an individual's certificate. Specifically, if a certificate is dated to expire **prior** to 2010, then only Parts One (medical license) and Three (examination) need be completed in order to renew the certificate. For those holding certificates dated to expire in 2010 or beyond, all four parts of the program must be completed prior to the expiration

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Maintenance of Certification for Pediatric Subspecialists (PMCP-S™)

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date of the certificate in order to successfully renew the certificate. The following table illustrates this phase-in process.

CERTIFICATE EXPIRATION DATE	ACTIVITIES REQUIRED TO RENEW A SUBSPECIALTY CERTIFICATE
2003 2004 2005 2006 2007 2008 2009	For certificates with expiration dates of **2003 thru 2009**, Part One (medical license) and Part Three (examination) activities must be completed before the certificate expire in order to renew certification.
2010 2011 2012 2013 2014 2015 and beyond…	For certificates with expiration dates of **2010 and beyond**, ALL PMCP activities must be completed in order to renew certification.

IMPORTANT: Beginning **January 1, 2010**, anyone seeking certificate renewal with the ABP is required to complete all PMCP activities.

The Development Process

The development process for PMCP-S is well underway and will continue over the next few years. The ABP is seeking input from the AAP, subspecialty societies, and various other subspecialty groups to create the details of PMCP-S. This collaborative approach will ensure that PMCP-S does not evolve into more "hoops" to jump through, but rather becomes a meaningful part of a subspecialist's practice, one that ultimately improves the quality of care for children.

Several types of activities will be available to participants in order to satisfy the four parts of PMCP-S. With the exception of Part Three (the examination), it is expected that all activities may be completed at any time during a seven-year cycle. The examination may only be completed in the last two years of the certification cycle, ie, year six or seven. PMCP-S will involve only one fee, which will be collected at the time of application for the examination.

Summary

The implementation of PMCP-S will be gradually phased in over a period of several years. The ABP anticipates that all required activities would be available by 2007 or 2008 so that those who are required to complete all parts of the process will have adequate time to do so prior to 2010. As the details are finalized, information regarding the logistics will be provided on the ABP web site and in various publications. The design of PMCP-S will be as straightforward as possible and will be congruent with PMCP-G. The intent of PMCP-S is to allow subspecialists to determine strengths and opportunities for improvement, assess the quality of the care they deliver, and demonstrate improvement in a manner that is not overly time-consuming, burdensome, or redundant.

Questions or comments about the PMCP-S program may be addressed to James A. Stockman III, MD, President, at pmcp@abpeds.org.

[1]The ACGME and the ABMS have endorsed six general competencies, knowledge of the subspecialty being one of them. Following is a paraphrase of the competencies that will be evaluated as part of the maintenance of certification process.

The physician should:

1. Demonstrate skill with procedures and processes of care
2. Communicate effectively with patients and peers
3. Act in a professional manner
4. Incorporate the best available evidence for decision making
5. Demonstrate systematic continuous learning
6. Demonstrate their ability to systematically assess and improve quality of care

For a complete description of the six general competencies see the ACGME Web site (www.acgme.org).

CALENDAR OF EVENTS

http://www.pedsccm.org/

Meeting Title	Meeting Dates	Location	Contact
AAP Preparing for Life in Academics Course	10/30/03 - 10/31/03	New Orleans, LA	http://www.aap.org/sections/critcare
AAP National Conference and Exhibition	11/1/03 - 11/5/03	New Orleans, LA	http://www.aap.org
First International Conference on Heart Failure in Children and Young Adults	12/3/03 - 12/6/03	Houston, TX	www.heartfailureinchildren.org
SCCM 33rd Critical Care Congress	2/20/04 - 2/25/04	Orlando, FL	Information is at http://www.sccm.org/
The Canadian Critical Care Conference	2/25/04 - 2/29/04	Whistler, BC, Canada	Contact Zena Davidson at zdavidso@vanhosp.bc.ca
Pediatric Critical Care Nursing	9/9/04 - 9/12/04	Las Vegas, NV	For information, call 800/377-7707, email: info@cforums.com or Web site: www.iapsurat.com/ncpcc/
15th ESPNIC Medical and Nursing Annual Congress "Paediatric and Neonatal Critical Care - Art or Science?"	9/16/04 - 9/18/04	London, United Kingdom	Contact Mirella Kester, Project Manager at mkester@rose-international.com

Benefits of Being a Section on Critical Care (SOCC) member!

- **Section on Critical Care Web site**
  Visit http://www.aap.org/sections/critcare for important information about upcoming events and Section related activities.

- **Section on Critical Care E-mail List**
  The E-mail list allows the AAP Staff and SOCC Executive Committee to communicate with members through periodic e-mail messages.

  If you would like to join the E-mail list, simply: e-mail Carolyn Mensching at cmensching@aap.org with "SOCC LISTSERV" in the subject line.
  ****Be sure to include your name and contact information.**

Steering Committee on Clinical Information Technology Computer Lab 2003

The 2003 SCOT Computer Lab is a potpourri of computer and medical information technology. We have a broad variety of topics, a great selection of speakers, and always someone who can give you a hand learning something new about technology you can use in your practice.

We open this year with a discussion that anyone who uses or is thinking about using a computerized medical record will want to attend, and then take off to the internet, practice management and patient record software, PDAs and many points between. The Computer Lab is presented by the AAP Section on Computers and Other Technology. It is located in Information Alley in the Exhibit Hall. Discussion topics are informal, fun, and interactive. Computers and PDAs are available to practice and learn on, and a sampling of AAP and other software is available for demonstration.

************************************ALL EVENTS ARE LOCATED IN THE EXHIBIT HALL.************************************

Saturday, November 1, 2003

3:00 PM **Secret Features of Windows and Web Browsers; *Joseph H. Schneider, M.D.*** - Learn "secret" features that can speed your use of Windows-based computers. Selected keyboard shortcuts and special toolbars will be covered. At this session you'll learn tricks that are guaranteed to save you time !!

4:00 PM **So You Want to be a Hacker?; *Lewis C. Wasserman, M.D.*** - Ever wonder what you could find out about your neighbor? How to get information out of your competitor's computer? Would you like to know what secrets your kids have been keeping? Are you curious what people can find out about you? Come get a glimpse at the hacker's art, and perhaps find a few pearls for protecting yourself.

5:00 PM **Introduction to Database-Driven, Dynamic Web Sites; *Stuart T. Weinberg, M.D.*** - Would you like your website to update itself automatically, removing notices of events after they occur, posting news items during specified time periods, without using web publishing software? See demonstrations of web sites where content is stored in databases and manipulated using "scripts". The concepts of scripts and web-based databases will be introduced, using PHP and MySQL, and some simple examples will be illustrated.

6:00 PM **DermAtlas; *Christoph U. Lehmann, M.D.***

Sunday, November 2, 2003

10:00 AM **NLM and PubMed; *Michelle Malizia***

11:00 AM **Preparing for your EMR; *Roy Schutzengel, M.D.***

12:00 PM **Using Your Data for Performance Improvement; *Donald E. Lighter, M.D.*** - With all the data we collect in the office or the hospital, it sure seems like we should be able to do something good with it. During the hour presentation, we will discuss sources and uses of data in office and hospital settings, as well as methods of analyzing and reporting information using tools that most people already have on their computers - spreadsheets, presentation programs, etc. Some useful, inexpensive add-ins for Excel will be presented that can make data analysis faster and more accurate.

1:00 PM **TBA; *Michelle Malizia***

2:00 PM **Beyond the EMR: Changes in the Way We Practice Medicine; *Roy Schutzengel, M.D.*** - The EMR is simply a tool that allows individual physicians and physican groups to enhance the way they practic medicine. Facilitating medical documentation and improving its quality is only the first step. Physicians can spend less time doing redundant paperwork and chart reviews and more time face to face with patients in the office. In addition to improving care to patients individually, EMR technology allows for the creation of a national databank of patient care information, which in turn can be incorporated in standards for "best Care Practices"

3:00 PM **Newer Methods of Patient-Physician Communication; *Donald E. Lighter, M.D.*** - Many pediatricians have started using modalities like email for communicating with patients, but there are a number of newer methods on the horizon. Using demonstrations of secure messaging modalities and live online web conferencing, this presentation will provide some insight into the newer methods that are becoming increasingly available to physicians. Some of these technologies will also be available in the Computer Lab for participants to sample.

Monday, November 3, 2003

10:00 AM **Best of the Pediatric Web; *Joseph H. Schneider, M.D.*** - Catch up on the classic pediatric websites and learn about new ones!! See them demonstrated and learn how they can help your practice. Audience contributions are strongly encouraged. Bring your best sites and share them with others !!

11:00 AM **Prescription Writer; *Mark M. Simonian, M.D.*** Pediatric practices are looking for methods to create and distribute their prescriptions in a legible format that can also be shared with patients and pharmacies. There will be a discussion of a custom database creation and a vendor product that marries practice management data and faxes the prescription wirelessly through the Internet to the pharmacy.

12:00 PM **Introduction to Database-Driven, Dynamic Web Sites; *Stuart T. Weinberg, M.D.*** - Would you like your website to update itself automatically, removing notices of events after they occur, posting news items during specified time periods, without using web publishing software? See demonstrations of web sites where content is stored in databases and manipulated using "scripts". The concepts of scripts and web-based databases will be introduced, using PHP and MySQL, and some simple examples will be illustrated.

1:00 PM **Office 2003 - What's New, What's Cool.; *Donald E. Lighter, M.D.***

2:00 PM **Using a PDA in Pediatrics; *Mark M. Simonian, M.D.*** Pocket PC and Palm devices are gaining popularity as a useful tool and alternate entry device for the practicing pediatrician. Practical examples of programs and applications will be demonstrated as well how to pick the PDA that will work best for you.

3:00 PM **TBA; *Christoph U. Lehmann, M.D.***

RESPONSE REQUESTED BY DECEMBER 1, 2003

CALL FOR NOMINATIONS
AAP SECTION EXECUTIVE COMMITTEES

The American Academy of Pediatrics seeks nominees to run for election to the Executive Committees of 45 Sections, including 30 sections who are seeking candidates for Chairperson or Chairperson-elect. (A list of vacancies follows.)

Terms vary from section to section, but in most cases the successful Chairperson candidate will serve as a two-year term and the successful Executive Committee Member candidate will serve a three-year term, to begin immediately following the 2004 AAP National Conference and Exhibition in San Francisco.

Summaries of responsibilities for the AAP Section Chairpersons and Executive Committee Members can be found on the AAP Members Only Channel (www.aap.org). Go to the Member Services Area and select Orientation Materials for New National Committee and Section Executive Committee Members. *Each Section will appoint a nominations committee to review the nominees and select the candidates for the ballot. Submission of this form does not guarantee inclusion on the ballot.*

If you would like to be considered for candidacy by a section nominations committee, or if you would like to nominate a colleague, please:

1. **Complete this form;**
2. **Attach a brief biographical sketch (no more 250 words) which will be used on the ballot, *if you are nominated;* and**
3. **Fax it to 847/434-8000, ATTN: Beki Marshall, *no later than December 1, 2003*.**

Name: (Please Print) _____

Address: (Please Print) _____

Telephone: _____

Fax: _____

Email: _____

Current Position: _____

Fax **(847/434-8000)** to Beki Marshall **on or before December 1, 2003.**

Thank you!

SECTION EXECUTIVE COMMITTEE VACANCIES FOR 2004-2005

The following sections have **chairperson** vacancies following the 2004 National Conference and Exhibition:

Administration and Practice Management
Adoption & Foster Care
Anesthesiology & Pain Medicine (Chairperson-elect)
Breastfeeding
Child Abuse & Neglect
Children With Disabilities
Community Pediatrics
Critical Care
Dermatology
Emergency Medicine (Chairperson-elect)
Epidemiology
Hematology/Oncology
Hospital Care

The following sections have **executive committee member** vacancies following the 2004 National Conference and Exhibition:

2 Administration and Practice Management
2 Adolescent Health
1 Adoption & Foster Care
2 Allergy & Immunology
2 Anesthesiology & Pain Medicine
1 Bioethics
1 Breastfeeding
1 Children With Disabilities
4 Clinical Information Technology (Steering Committee)
2 Clinical Pharmacology & Therapeutics
1 Critical Care
3 Dermatology
1 Emergency Medicine
2 Endocrinology
2 Epidemiology
2 Gastroenterology & Nutrition
2 Hematology/Oncology
2 Hospital Care
1 Infectious Diseases

Nominations will be accepted through December 1, 2003.

All nominations will be forwarded to the section nominations committees. The nominations committees will review the nominations and selected the candidates to appear on the election ballot.

The section elections will be held in Spring 2004.

Preparing for Life in Academics

American Academy of Pediatrics
National Conference & Exhibition
October 30-31, 2003
New Orleans, Louisiana

Sponsored by:
AAP Council on Sections
AAP Section on Critical Care

Target audience:

Fellows at all levels of training in any subspecialty or post-residency training program expecting to enter academics

Academic faculty in their first few years of appointment

Opening Remarks by: E. Stephen Edwards, MD - AAP President

Preparing for Life in Academics is a one and a half day seminar developed specifically for those preparing to enter academic medicine or just starting their academic career. The course brings together academic leaders from a number of medical disciplines to discuss many of the issues not covered during traditional fellowship training. In this course, participants will learn techniques to manage time effectively, develop a curriculum vitae, negotiate effectively, run efficient meetings, and become involved at a national level. Opportunities to improve teaching skills will be offered through interactive sessions on feedback and delivering effective slide presentations.

Practices important to the business and organizational aspects of medicine will be addressed through sessions on coding and compliance, managing grant budgets, and performance improvement. Participants will also learn some of the more challenging areas that confront physicians: disclosing medical errors, preventing malpractice, and coping with malpractice litigation.

Thursday, October 30

7:30am	- 8:00am	Continental Breakfast
8:00am	- 8:15am	Welcome
8:15am	- 9:00am	Developing your CV
9:00am	- 9:45am	Negotiation Skills
9:45am	- 10:00am	Break
10:00am	- 10:30am	Teaching Skills Overview
10:30am	- 11:00am	Feedback Breakouts
11:00am	- 11:45am	Performance Improvement (CQI)
11:45am	- 1:15pm	Lunch Break
1:15pm	- 2:00pm	Running an Effective Meeting
2:00pm	- 2:45pm	Avoiding Malpractice
2:45pm	- 3:00pm	Break
3:00pm	- 3:45pm	Coping with Malpractice
3:45pm	- 4:30pm	Becoming Involved Nationally
4:30pm	- 6:00pm	Reception

Friday, October 31

7:30am	- 8:00am	Continental Breakfast
8:00am	- 8:45am	Time Management
8:45am	- 9:30am	Disclosing Medical Errors
9:30am	- 9:45am	Break
9:45am	- 10:30am	Grant Budget Management
10:30am	- 11:15am	Billing, Coding, and Compliance
11:15am	- 12:00pm	Effective Slide Presentations
12:00pm		Adjourn

Faculty

Stephen Schexnayder, MD, FAAP – Course Director
A. Wesley Burks, MD, FAAP
Debra Fiser, MD, MBA, FAAP
Gerald Hickson, MD, FAAP
Uma Kotagal, MD, FAAP
Gary Noel McAbee, DO, JD, FAAP
Sanford Melzer, MD, FAAP
Michele Moss, MD, FCCM, FAAP
Vinay Nadkarni, MD, FAAP
Robert H. Squires, Jr., MD, FAAP
Diana Wara, MD, FAAP

Registration Information

Registration is now only available on-site in New Orleans.

Please visit http://www.aap.org/nce for more information about the AAP National Conference & Exhibition.

NOTE: Course is open to NCE registrants only. An additional fee of $26 is also required.

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2002-2003

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MEMBERSHIP DIRECTORY ON-LINE!

The AAP has added a link to the section membership roster on the Section's home page on the Members Only Channel. The roster will first appear as an alphabetical listing, and each member's name links to more detailed information about that person.

Be sure to contact the Membership Department at membership@aap.org should any of your information change, such as name, address, phone, fax or e-mail address.

You may also make the changes on-line on the Members Only Channel. Just follow the link on the Section's home page!