We would like to share with you our excitement about the Society’s 30th International Educational & Scientific Symposium. The Symposium will be held February 10-14, 2001, in San Francisco, CA, USA and is titled “Critical Care: Blending Science & Compassion”. This Symposium marks the Society’s first program for the new millennium, and commemorates 30 years of providing high-quality continuing education for the critical care community. We believe the program will be memorable for several reasons.

In addition to the important emphasis on basic science and state-of-the-art clinical presentations, a portion of the Symposium content will be devoted to the delivery of compassionate care in the intensive care setting. Providing compassionate care to critically ill patients at the end-of-life in the ICU is a fundamental skill for the critical care clinician. To acknowledge this vital aspect of our clinical life and to provide ongoing education in this challenging area, selected sessions will focus on ethics, end-of-life skills, and cross-cultural approaches to compassionate care in the ICU. A world-renowned, multidisciplinary faculty will be gathered to present concepts and data pertinent to high-quality end-of-life skills and compassionate care for the critically ill. Several of these sessions will be produced in collaboration with other medical societies, emphasizing the collaborative, multidisciplinary nature of critical care.

For the first time in the Symposium’s history, there is an international co-chair. In addition, the number of international faculty has been substantially increased. This program enhancement will serve to emphasize the global role of the intensivist and will improve the program.

The 2001 Symposium science component is very strong. There is a good mixture of basic science and clinical updates, which should appeal to a wide range of critical care clinicians and researchers. We hope you share in our enthusiasm for both the compassionate care and science elements of the Symposium.

continued on page 2
Six plenary addresses will be given at the Symposium during morning and afternoon sessions. Topics include “Managing Abnormal Blood Vessels and Damaged Heart Muscle in Circulatory Shock”; “Care of the Critically Ill Patient: Healthcare as Compassionate Care”; “Outcomes Research and the Politics of Healthcare: Where Have We Been and Where Are We Going?”; “Mechanical Ventilation in ICU Patients”; “Sepsis in the Critically Ill: Back to the Future”; and “Plagues of the Third Millennium: Can We Survive Microorganisms?”.

It is our intention this year to highlight the oral presentation of original scientific research at the 2001 Symposium. “Sandwich Sessions”, a format common in other programs, will consist of oral abstract presentations on a focused topic. These presentations are “sandwiched” by introductory and closing presentations given by expert faculty highly regarded in the topic area. We hope this will serve to further honor those investigators who choose to submit their original work to the Symposium, while further encouraging young investigators. In addition, the Society is introducing new abstract awards called “Research Citations”. These awards will be chosen, on-site, by a judging committee comprised of intensivist experts.

The committee will choose from a pool of pre-selected finalists and award the Research Citations to five winners at the Symposium. The Research Citations complement the already-established abstract awards.


Industry-supported Daybreak Panel Discussions and the Exhibit Hall provide you with numerous opportunities to interact with the latest cutting-edge technologies available to the critical care practitioner.

We hope that the combination of a strong international presence, an outstanding faculty, and stimulating presentations in fundamental science, as well as compassionate care, will give rise to a truly memorable Symposium. We look forward to seeing you in San Francisco!

Sincerely,

Jean M. Carlet, MD
Department of Critical Care
Foundation Hospital St. Joseph
Paris, France

Mitchell M. Levy, MD, FCCM
Director, MICU
Associate Professor of Medicine
Brown University School of Medicine
Providence, RI USA
Let me begin by saying I’m very grateful to the section and also to Roche Laboratories who sponsored the awards, for choosing me as the recipient of the 2000 Distinguished Career Award from the Section.

Good fortune, some ability, and support of individuals, some of whom are here today to share this moment with me, enabled me to have a career recognized by this award. Drew Costarino, who I considered Associate Director of the division when I directed the Division of Critical Care at the Children’s Hospital Philadelphia, helped me in many ways, but especially in the division’s training and research programs. He was a valued coworker and remains a good friend. We shared many humorous moments together. Jack Downes who lead the department for 24 years is a role model for me. Having won this award in 1996, I am especially pleased to be recognized for accomplishments similar to his. His influence brought me to the Children’s Hospital of Philadelphia for subspecialty training in pediatric anesthesiology and critical care. He suggested that critical care would be a satisfying career for me; his suggestion proved correct and his support, in no small measure, made it possible for me to obtain this award. Marianne, my wife, initiated her very valued counsel by encouraging me to go to medical school rather than dental school and has continued to provide welcomed, sound, loving advice throughout my career. She also, by the way, surprised me by arranging for my sons Chris and Jim, their wives, Julia and Cynthia and my sister and brother-in-law, Catherine and Tony Sirico to celebrate the receipt of this award. They are all seated here and I’m very grateful for them coming.

I have always regarded the AAP as an organization, though principally consisting of the members of the specialty of pediatrics, as one which welcomed and allowed other specialties committed to the care of children to participate in its affairs. The Academy supported me as an anesthesiologist in my effort to obtain consensus of interested sections and critical care providers as to whether critical care would be part of the existing Section on Anesthesiology as some at the time preferred, or, as I preferred, and many more advocated a separate section status.

When clarified, I was given the responsibility to form the section and was honored to serve as its first chairman. If my memory serves me correctly, Dan Levin chaired the first section’s scientific program and Murray Pollack the second during my 2 years of section leadership. I served initially as the liaison to the Committee on Hospital Care of the Academy. I campaigned for a voting position and successfully persuaded the committee to include a representative from the section to serve in that role. I certainly am proud to be a member of the section and humbly accept this award. I am cautioned, however, about exhibiting too much humility by the words of the great leader and states woman, Golda Meyer, “Don’t be so humble, you’re not that great.”

I have chosen to discuss 3 challenges that I foresee confronting critical care providers. The first is our contribution to ensuring patients’ and families’ confidence in our ability to provide safe care in an invasive, technology-laden environment where extended treatment occurs, numerous encounters create opportunities for error and margin of error because of profound illness remains very narrow. The Committee on Quality of Health Care in America of the Institute of Medicine, an entity established in 1970 within the National Academy of Sciences to secure the services of eminent members of appropriate professions in the examination of policy matters pertaining to the health of the public, issued the report, “To Err is Human: Building a Safer Health System” in March of this year. The IOM acts under the responsibility given to the National Academy of Sciences by its congressional charter to be an advisor to the federal government and upon its own initiative to identify issues of medical care, research, and education. The report received much attention from the media and President Clinton. The public which has been inundated with illustrations of the failure of the US medical system and the high cost of providing care to the US inhabitants once again had their confidence in our ability to care for them shaken. In the executive summary, the IOM states, “the combined goal of the recommendations contained in this report is for the external environment to create sufficient pressure to make error costly to health care organizations and providers so that they are compelled to take action to improve safety. Citing several anecdotal reports and 2 large studies, 1 conducted in Colorado and Utah, the other in New York, the committee projected from 44 to 98,000 US inhabitants die each year as a result of medical error. The committee defined error as a failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim.

To achieve a 50% reduction in errors over 5 years, a goal which the committee contends expecting anything less would be irresponsible, the IOM proposed a 4-tiered approach which: establishes a national focus to create leadership, research, tools, and protocols to enhance our knowledge about safety; identifies and learns from errors through immediate and strong mandatory reporting efforts, as well as encourage voluntary efforts, both with the aim of making sure the system continues to become safer for patients; raises standards and expectations for improvements in safety, through the actions of oversight entities, group purchasers and professional organizations, creates safety systems within healthcare organizations through the implementation of safe practices of delivery at the level which is the ultimate target of the recommendations proposed by the IOM.

continued on page 4
T Brennan, a senior author of one and a co-author of the other of the 2 reports used to estimate the prevalence of errors nationwide offers several impediments to achieving the IOM goal. In his comments appearing in the sounding board section of the 13th April 2000 issue of the New England Journal of Medicine, he cites cost, medical-legal action, the absence of actual nationwide instances of medical error, and the limitations of the epidemiologic science of error detection as obstacles to overcome if we are to meet the target proposed by the IOM. In addition, Brennan points out that the data cited in the IOM report indicate injury rate in fact due to medical care has declined. It was 4.6 in California in 1976, 3.7 in New York in 1984, and 2.9 in California and Utah in 1992. Projected across the nation Brennan contends that deaths from medical error declined from 92,000 in 1984 to 25,000 in 1992. While advocating caution in extrapolating from these locations where the studies were performed to the entire nation, evidence does suggest that doctors, nurses, allied health professionals, and health care institutions have improved the safety of medical care. Nevertheless, an effort by us to indicate our enhanced commitment to improve the safety defined by the IOM as freedom from accidental injury of the care of critically ill and injured children, has merit. The AAP has urged the Agency for Health Care Research to assign a high priority to 6 areas enumerated in a summary statement available through the Academy’s Department of Practice and Research. The Society of Critical Care Medicine has established the Foundation for Critical Care Medicine, the mission of which is to obtain funding for education and research to improve the safety of clinical care. Participation in these efforts should be our response to the IOM’s report, I contend, so that we can contribute to restoring public confidence in the safety of the US medical system.

A recent communication, which appeared on the PedsSCCM.org Web site, drew my attention to a second challenge confronting those who provide critical care to children, - the organ-specific intensivists and their integration into the existing groundwork of pediatric critical care. Honoring the principle of announcing one’s potential conflict of interest, among my 28 years at the Children’s Hospital, 10 were spent limiting my patient care activity to children and occasionally adults suffering from congenital and acquired heart disease. During that time, I directed the Division of Critical Care Medicine which included physicians who provided general intensive care and served as Medical Director of the Pediatric Intensive Care Unit where all the care of critically ill and injured children beyond the age of 30 days occurred. Changes in the leadership of the Divisions of Cardiac Surgery and Cardiology occurred, which resulted in the concept of a separate cardiac focused intensive care from the general intensive care, for which a prior cardiac surgery and cardiology leadership had campaigned, was implemented. I then divided my effort between the organ-specific ICU and a general ICU and in 1997, left CHOP to direct my attention to a unit which focuses entirely on the care of neonates, infants, children, and adolescents through 17 years of age suffering from congenital and acquired heart disease. Furthermore, I currently sit on a Board of Directors charged with establishing the Society of Pediatric Cardiac Intensive Care. I mention this history to establish some credentials and alert you to the experience which I contend enables me to comment on the evolution of organ- and system-specific pediatric intensive care providers and units.

The author of the communication to which I refer feels organ specific intensivists will have a negative impact on the care of critically ill children. Certainly at this time we have little or no information addressing the impact of the outcome from critical illness or injury resulting from the care provided in organ-specific critical care units. Indeed, we have limited, albeit increasing, data that critical care specialists have an impact on the outcome from critical illness or injury. Nevertheless, the subspecialty of critical care is now well established. In the absence of this information, we must refrain from taking the position which champions or condemns either general or organ-specific critical care, and develop information which enables us to conclude whether organ-specific critical care enhances or diminishes efficiency, survival, speed of recovery, magnitude of disability, analgesia, satisfaction of patients and families, or expense. You might remember or recognize those terms as what I contend are the features of quality of pediatric critical care. We must recognize vigorous advocates will exist for organ-specific critical care effort while this information is being obtained and be tolerant of their position until data clarifies its value.

A matter which I consider to have influenced organ-specific critical care is the following. As medical knowledge increases, demand for manual skill in performing invasive procedure escalates and clear judgment of with what and when to intervene is required to provide the optimal care for patients, individuals who will have to be geniuses, gifted in manual skill and practical, timely, and parsimonious with treatments that have burden as well as benefit. Intellectually gifted Michael Jordan’s of medicine who devote a majority of their waking hours to patient care effort are necessary if an individual is to possess these qualities. Alternatively, limiting the universe with which one has to contend by choosing to work in an organ-specific unit may enable us to succeed in providing optimal care. After all, hasn’t the specialty and subspecialty movement in medicine in general been a reaction to contending with the above qualities we must possess to provide optimal care?

To my knowledge, success in generating persuasive arguments for pediatric organ-specific critical care efforts has been limited to those individuals who focus on congenital and acquired diseases of the heart and great vessels. Tilford et al reported in the August 2000 issue of Pediatrics, an inverse relationship exists between patient volume, mortality risk, and length of stay. Since length of stay correlates with cost, an inverse relationship also exists between patient volume and expenses generated by providing critical care. A key factor continued on page 8
Dr. Donald Cook announced that the AAP is drafting a legal claim against the Health Care Financing Administration for “failing to provide appropriate services and treatment for children and adolescents, especially special needs children…We also contend that HCFA has failed to adequately reimburse pediatricians and pediatric subspecialists.”

AAP leadership believes a claim will result in faster action than a lawsuit. Some states have successfully pursued such claims. Members who have examples of Medicaid access and payment problems in their practice may email the AAP Department of Federal Affairs at kids1st@aap.org.

Updated information and the claim itself will be on the AAP Members Only Channel page, http://www.aap.org/moc/index.cfm.
AAP Call for Abstracts for the 2001 AAP National Conference and Exhibition
(formerly the AAP Annual Meeting)
October 19 - 24, 2001 San Francisco, California

Submission Deadlines:

Paper submissions: April 16, 2001
Electronic submissions: April 20, 2001

Section programs provide a forum for the discussion of clinical matters or research related to a particular subspecialty. Submissions by AAP members and nonmembers are welcome; participation is open to health professionals in any field. (However, the Section on Perinatal Pediatrics and the Section on Surgery require a sponsor for any papers whose authors do not include a member of the Section.)

The following Sections accept abstracts for presentation at the AAP National Conference and Exhibition. Abstracts are not accepted for general pediatrics or for other pediatric subspecialties not listed below.

Administration & Practice Infection and Poison Prevention Sports Medicine
Cardiology Orthopaedics Surgery
Computers/Other Technologies Otolaryngology Transport Medicine
Critical Care Perinatal Pediatrics Urology
Emergency Medicine School Health

Submit electronically from the AAP Web site http://www.aap.org under “Professional Education.”

Print versions can be obtained by calling the AAP Faxback Service at 847-758-0391. Ask for Document 1201 (Abstract Form & Instructions) or Document 1202 (Section on Surgery Abstract Form & Instructions).

Questions? Contact abstracts@aap.org, or Rebecca Marshall at 847-434-4079.

Pediatric Intensivist Workload and Compensation Project

Harold Amer, M.D. and Susan Jensen, M.P.H. have generated an in-depth survey of intensivist workload and compensation. Specifically, the survey asks

1) the number of hours of professional work an intensivist does yearly
2) how those hours are allocated among seven types of work
3) the monetary compensation an intensivist receives
4) how the compensation relates to the seven work types

The authors anticipate that unit or division directors will complete the survey. The survey is lengthy, and Dr’s Jensen and Amer and the Section Executive Committee have edited it carefully. The Executive Committee approved a version for trial use prior to dissemination to PICUs nationwide.

The Committee on Coding and Reimbursement has released the sixth edition of the Coding for Pediatrics manual. This version incorporates all relevant changes to the CPT manual and RBRVS made during 2000. The AAP continues to publish the Pediatric Coding Companion to supplement the coding manual.

For those who benefited from the 2000 RBRVS brochure from the Section on Perinatal Pediatrics, a 2001 issue is in press. The codes in the brochure are highly relevant to pediatric critical care. In addition to listing the RVUs for relevant codes, the new edition will list the Medicare Geographic Practice Cost Indices.

Stay tuned for a SOCC sponsored coding, reimbursement, and documentation workshop.
Forty-seven applications for section membership were recently approved, an increase compared with last year. While membership in the SOCC has declined from 594 to 572, this still represents an overall increase of 9% in the past five years. Some of the decrease is due to nonpayment of national AAP and/or section dues. Current membership criteria remain purposefully broad to be inclusive. In addition to full fellow, the section accepts the following additional fellows: specialty, post-residency training, candidate, honorary, emeritus, corresponding, and dual. The Section has corresponded with fellowship directors regarding the benefits of section membership, including an active forum for abstract presentation and the annual competition for the $10,000 New Investigator Research Award. The attraction of presenting research at the AAP Annual Meeting diminished after sponsors withdrew funding to publish accepted abstracts in a supplement to Pediatrics.

AAP chapters are the state organizations that perform much of the real work of the AAP. Chapters lobby legislatures to support health and safety measures. Many chapters have organized entire systems of care to benefit indigent or chronically ill children. Chapter dues and individual member involvement support these efforts, and the creativity of chapter members is remarkable. Naturally, the chapters are most effective when their memberships expand. Historically, few subspecialists (intensivists included) have belonged to the chapters.

Support this vital branch of the AAP with your membership!
therefore in the justification for organ-specific units would be a sufficient number of patients so that length of stay and outcome are optimal. Since approximately 1% of neonates born in the US have some form of heart disease, an organ-specific unit for their care and focused professionals may meet the standard advocated by Tilford et al.

The third challenge I see for critical care providers is to maintain interactions between members treating critically ill or injured patients as some of them compete for payment of the services rendered. I refer specifically to the advanced practice nurses who seek and have found a role in the critical care team. I currently provide care in an environment where APNs and PAs have prominent roles. Furthermore, I chair the Task Force of the American College of Critical Care Medicine which is charged with developing guidelines for the role of APNs and PAs on the critical care team.

Most physicians view the acute care advanced practice nurse (ACAPN), a clinical nurse specialist (CNS), as substitutes for physicians in post graduate training or professionals who perform tasks medical doctors assign a lesser priority within their work day. I prefer ACAPN to nurse practitioner since the individual who provides “conventional” nursing care at the bedside is in fact a nurse practitioner, so rather than call them a nurse practitioner.

However, a conversation I have had with one acute care advanced practice nurse and a member of the faculty of a university program for pediatric critical care advanced practice nursing leads me to conclude they disagree with the physician perspective of their contribution to the care of critically ill or injured patients. Acute care advanced practice nurses describe physicians as focused on the science of medicine. They contend ACAPN emphasize the art and caring portions of medicine. I vigorously disagree with that ACAPN assessment of physicians and contend we both have equal interests in the science and caring of medicine.

Cost containment of medical care in the US continues to emphasize reducing payment for hospital and professional services, improving efficiency in providing medical care and reducing the variability in medical practice. This focus will continue until evidence surfaces which indicates medical care of the US citizen has suffered or economists conclude no additional savings can be obtained from these measures. Only then will the unpopular limitation of services available to US citizens become an additional component of controlling costs of medical care.

Competition remains an important dimension for obtaining high-quality service at low cost in the free enterprise system which, to date, has dominated the US medical care delivery system. Increasing government manipulation of the system with an escalating rule as a payor for medical services continues as the US public encounters obstacles to receiving medical care they desire under the free enterprise system. An example of government involvement in the system and an illustration of competition lie in US Public Law 10533 which occupies a part of the Balanced Budget Act of 1997. This provision now enables ACAPN and CNS to receive direct payment for Medicare Part B services they provide to beneficiaries of that federal government entitlement program. Previously enacted legislation - the Omnibus Budget Reconciliation Acts of 1989 and 1990 - restricted direct payment to APNs to those who provided services in skilled nursing facilities and in locations designated as rural. Under the newer law, ACAPN and CNS may receive payment for services ordinarily covered when provided by a physician according to the health care financing administration’s interpretation of the law published in the final rule contained to November 1990 issue of the Federal Register. The services must meet the medically reasonable necessary and other Medicare requirement standards and exist in the scope of services, the ACAPN and CNSs have been authorized to perform by their state licensure boards. In states where no law governs the MD, advanced practice nurse clinical specialists’ collaborative relationship, the ACAPN must record their scope of practice and indicate their relationship they possess with the physician to contend with issues outside of their scope of practice. The payment to the acute care advanced practice nurse and clinical specialist equals 80% of the lessor of either the actual charge or 85% of the medicare physician schedule payment for the service. The services for which the ACNP/CNS receive payment include all the current procedural terminology, evaluation, management, and procedure codes. Other payors I contend that medicare will likely adopt similar positions if their subscribers envision obtaining care which satisfies them and reduces their premium.

The American Academy of Pediatrics states its position on the role of the nurse practitioner (or advanced practice nurse) and physician intensivist in the care of hospitalized children published in the May 1999 issue of Pediatrics. In that issue, the comment sited studies which suggest the ACNP and CNS who went through Medicare payment receive less money for the same services that physicians provide, however, the overall costs would be the same since ACANPs and CNSs spend more time during each encounter and a limit to the number of hours they can work per week compared to physicians would demand more of them to provide the service. Anesthesiologists perhaps have the greatest experience with advanced practice nurses providing services similar to that which an anesthesiologist provide. Although, I think maybe obstetricians and midwives have a rather long interaction. Having been in the system meeting the demands for anesthesia care to inhabitants in the US for many years, the Clinical Registered Nurse Anesthetist contribution is necessary to provide anesthetic care to all people who must have it in the US. Payment for the CRNA services by government and other payors has improved but remains below that the anesthesiologists receive. Persuaded that the quality of
anesthetic care provided by CRNAs does not differ from that provided by anesthesiologists, payors accept service from CRNAs as a cost containment measure. CRNAs actively campaign for independent practice without anesthesiologists’ direction.

Competition between the 2 disciplines has resulted in a harmonious interaction becoming a strained one. Indeed, what was formally a long history of cooperation has deteriorated into an acrimonious relationship at least on the part of the national professional organizations, the American Society of Anesthesiologists, and the American Association of Nurse Anesthetists representing these providers of anesthetic care.

Another issue related to our responsibility includes offering the public an explanation of why we encourage and accept the movement of individuals from a role of critical care registered nurse for which a projected shortage will exist, into a role which duplicates in many instances the function of a physician of which, some contend, there is an over supply.

As one accomplished ACANP stated, “We should not limit choices individuals have for career options if the ACAPN role appeals to appropriately prepared nurses. The liberty to serve in that capacity should indeed exist.” Theresa S. Raymond and others, in the paper titled “Reimbursement for Acute Care Nurse Practitioner Services” published in the January 2000 issue of the American Journal of Critical Care, state… “the Balanced Budget Act of 1997 provides an opportunity for advanced practice nurses to take advantage of the financial opportunities in all settings and geographic locations. Indeed, these individuals should be rewarded fairly for the services they provide. Satisfaction on which in no small measure compensation for work performed has an impact will attract and retain the most accomplished individuals. Physicians have welcomed the pioneers in the career of advanced practice nurses who have performed admirably rewarded only recently by their accomplishments and expectations that their value would be recognized in the future. Their efforts have persuaded us of the importance of their contribution to the critical care team. Our challenge is to ensure that the competition encouraged by cost containment effort does not decrease the quality of critical care we provide to infants and children.

In conclusion, let me thank you very much for your attention, and this distinguished career award.

Russell C. Raphaely, MD, FAAP

AAP Section on Critical Care: New Investigator Award

APPLICATION DEADLINE: MAY 1, 2001

This is the 6th year that the American Academy of Pediatrics’ Section on Critical Care will fund a New Investigator Research Award. The 2001 award will be for $10,000 and is available to section members during their pediatric critical care fellowship, or within 2 years of completing an accredited critical care fellowship. The award, which is competitive, will provide support to an individual who has demonstrated aptitude for clinical or basic science research and who presents a sound plan of investigation. Section on Critical Care membership is required.

The award will be judged on scientific merit, clarity of presentation, likelihood of productivity by the investigator, sponsor’s evidence of appropriate academic environment, and relevance to critical care.

The New Investigator Award Grant Application 2001 (Microsoft Word document, 120K) is available as a direct download at:

http://PedsCCM.wustl.edu/ORG-MEET/AAP/

AAP_Crit_Care_grant.html.

Please contact Sue Tellez at 800/433-9016 (x7395) or e-mail her at stellez@aap.org for further information.
<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Address</th>
<th>Phone</th>
<th>FAX</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>M. Michele Moss, MD</td>
<td>Chairperson</td>
<td>Arkansas Children's Hospital, 800 Marshall St</td>
<td>501/320-1479</td>
<td>501/320-3667</td>
<td><a href="mailto:mossmichele@exchange.uams.edu">mossmichele@exchange.uams.edu</a></td>
</tr>
<tr>
<td>Alice Ackerman, MD</td>
<td>Dir, Div Pediatric Critical Care</td>
<td>Univ of Maryland Medical System, 22 S Greene St</td>
<td>410/328-6957</td>
<td>410/328-0680</td>
<td><a href="mailto:aackerma@peds.umaryland.edu">aackerma@peds.umaryland.edu</a></td>
</tr>
<tr>
<td>Thomas Bojko, MD</td>
<td>Infants and Children’s Hospital of Brooklyn</td>
<td>Division of Pediatric Critical Care, 4802 10th Ave</td>
<td>718/283-8841</td>
<td>718/635-6331</td>
<td><a href="mailto:tbojko@maimonidesmed.org">tbojko@maimonidesmed.org</a></td>
</tr>
<tr>
<td>Brahml Goldstein, MD</td>
<td>Div Pediatric Critical Care</td>
<td>Doernbecher Children’s Hospital, 3181 SW Sam Jackson Park Rd</td>
<td>503/494-4308</td>
<td>503/494-4953</td>
<td><a href="mailto:goldsteb@ohsu.edu">goldsteb@ohsu.edu</a></td>
</tr>
<tr>
<td>Stephanie A. Storgion, MD</td>
<td>Dept of Critical Care</td>
<td>University of Tennessee, 50 N Dunlap, 4th Floor</td>
<td>901/572-3132</td>
<td>901/572-5198</td>
<td><a href="mailto:storgjon@utmem1.utmem.edu">storgjon@utmem1.utmem.edu</a></td>
</tr>
<tr>
<td>Otwell Timmons, MD</td>
<td>Carolina Medical Center</td>
<td>1000 Blythe Blvd, Charlotte, NC 28232</td>
<td>704/355-7815</td>
<td>704/355-1221</td>
<td><a href="mailto:otimmons@carolinas.org">otimmons@carolinas.org</a></td>
</tr>
<tr>
<td>Tim Yeh, MD</td>
<td>Past Chairperson</td>
<td>Children’s Hospital of Oakland, 747 52nd St</td>
<td>510/428-3714</td>
<td>510/450-5885 (office)</td>
<td><a href="mailto:timbobyeh@aol.com">timbobyeh@aol.com</a></td>
</tr>
<tr>
<td>Niranjan (Tex) Kissoon, MD</td>
<td>Program Chairperson</td>
<td>Wolfson Children’s Hospital, 820 Prudential Dr</td>
<td>904/202-8758</td>
<td>904/391-8662</td>
<td><a href="mailto:niranjan.kissoon@jax.ufl.edu">niranjan.kissoon@jax.ufl.edu</a></td>
</tr>
<tr>
<td>Timothy S. Yeh, MD</td>
<td>Nominations Chairperson</td>
<td></td>
<td>904/406-9884</td>
<td></td>
<td></td>
</tr>
<tr>
<td>otwelltimmons.md</td>
<td>Newsletter Editor</td>
<td></td>
<td>706/721-4402</td>
<td>706/721-7872</td>
<td><a href="mailto:tpearson@mail.mcg.edu">tpearson@mail.mcg.edu</a></td>
</tr>
<tr>
<td>Brahml Goldstein, MD</td>
<td>Awards Chairperson</td>
<td></td>
<td>317/274-9981/8222</td>
<td>317/274-0282</td>
<td><a href="mailto:lmeans@iupui.edu">lmeans@iupui.edu</a></td>
</tr>
<tr>
<td>Harol N. Amer, MD</td>
<td>Workforce Subcommittee Chairperson</td>
<td></td>
<td>706/721-4402</td>
<td>706/721-7872</td>
<td><a href="mailto:tpearson@mail.mcg.edu">tpearson@mail.mcg.edu</a></td>
</tr>
<tr>
<td>Sue Tellez, Manager</td>
<td>AAP Staff</td>
<td></td>
<td>800/433-9016, ext 7395</td>
<td>847/434-8000</td>
<td><a href="mailto:stellez@aap.org">stellez@aap.org</a></td>
</tr>
<tr>
<td>Robert J. Brilli, MD</td>
<td>LIAISONS: Society of Critical Care Medicine</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Richard J. Brilli, MD</td>
<td>AAP Liaisons</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lynda J. Means, MD</td>
<td>AAP Liaisons (AMPG)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stephanie A. Storgion, MD</td>
<td>AAP Liaisons (COPEM)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lynda J. Means, MD</td>
<td>AAP Liaisons (SOA)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lynda J. Means, MD</td>
<td>AAP Liaisons (SOTM)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anthony L. Pearson-Shaver, MD</td>
<td>AAP Liaisons (Section on Transport Medicine)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>