



American Academy of Pediatrics Section on Critical Care Medicine

SEPTEMBER 2005

A Note from the Chair

by Alice Ackerman, MD



Greetings to you all. I had anticipated this newsletter would be published toward the end of the summer, and wrote very upbeat words to help us transition into fall. However, with the end of summer has come the devastation that accompanied hurricane Katrina. I would like to extend my personal wishes to all those directly affected by the storm and the flooding for a rapid recovery, and my condolences to those of you who have lost loved ones. It is gratifying to see the outpouring of offers of help within the medical community. It will be needed for many months to come. As I write this, the Academy is still working on cataloging the needs of children after the storm. They anticipate a heavy need for mental health services in addition to ongoing "well" child issues as children are assimilated into new school districts, in new states, many of whom will have lost or missing medical records. Even though Katrina remains heavily on our minds, as we each find our own best way to help, I would like to update you on some of the activities of the Section since the last newsletter which you received last October.

The SOCC executive committee met most recently during the SCCM annual meeting in January of 2005. We focused on issues of section membership, among other items. One noteworthy development to present to you is the help we are receiving from the AAP in encouraging section membership,

by being able to offer a one-year trial membership to the section for those who may be interested but not certain. For current AAP members, a one-year section membership is available at no charge. Please encourage your colleagues and trainees to join our section so they can see for themselves the value of section membership.

Many of you were disappointed last year by the cancellation of the planned "Practice Management Course" that had been scheduled in conjunction with the Pediatric Critical Care Colloquium in NYC. I am pleased to inform you that this course will be presented, in slightly truncated form, at the upcoming NCE in October in Washington, DC. You all should have received the notice of the NCE in AAP News this spring, and I urge you to register and join us for the Section Program. In addition to the Practice Management Course, we will have the usual abstract (oral and poster) presentations (the titles are listed elsewhere in this newsletter), the presentation of the 2005 Section on Critical Care Distinguished Career Award, our lunchtime business meeting, and a half-day symposium on mechanical ventilation. The schedule of these events is listed inside. Washington, DC is lovely in October. Let's make this the best year ever for attendance by the SOCC. The very successful "Fellows Course" is being conducted this year again at the NCE. It is scheduled for October 7, and fellows and junior faculty from any subspecialty are welcome.

Regarding our program at the NCE.... I wanted to remind you that about 2 years of planning goes into the development of every program we propose and plan in conjunction with the AAP. At the helm of this planning process is the person who is the "program chair" for the section. I would like to take this opportunity to thank Jim Fortenberry who has been doing a superb job of bringing exciting section programs to fruition at each NCE. You should have received word through the SOCC email list notifying you that the Section is looking for a new "program co-chair" who can work with Jim for the next year and subsequently assume the role of chair to continue this tradition of stellar programming on behalf of our section. If you are interested in serving in this way, or you would like to recommend a colleague, please contact Sue Tellez.

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We have tended to focus our efforts at recruiting individuals into our specialty on the residents in our programs. That is wonderful and we should definitely continue to do that. However, I have found that many 4th year medical students already have an idea of which sub-specialty they may want to enter by the time they are applying for residencies. Because of that, and because many other subspecialties require residents to apply early in their residency for fellowship positions, I believe we may need to get our message to the medical students that pediatrics in general, and pediatric critical care, in particular is an exciting career path. To that end, I would like to point out that medical students can attend the NCE for FREE. They do need to join the AAP (\$15 per year) and they need to pre-register in order to attend, but there is no cost to them to attend. I plan to bring two students with me this year, who are both interested in a career in academic pediatrics, and I would encourage you to consider doing the same thing. The earlier we start, the better our chances of encouraging more of them to at least consider pediatric critical care as their subspecialty of choice.

The 2005 AAP elections were recently concluded. Our section responded well, with almost 36% of eligible members voting; of those one was via a paper ballot, the rest were completed on-line. I am pleased to inform you that Vicki Montgomery has been elected to the SOCC executive committee, and both Don Vernon and Barry Markovitz were elected to second terms. The terms are three years in length and *begin at the conclusion of the NCE*. Any individual may serve up to two consecutive terms. Congratulations to Vicki, Barry and Don—we look forward to three productive years!

Earlier this year we sent out an email request for *Chapter Liaisons* to/from our Section. Thus far we have received approximately 25 replies. Please review the list on pages 15-16 and feel free to volunteer if you feel you are able and you are in a state or region without a named liaison.

The middle of August brought the opportunity to attend the AAP's *Annual Leadership Forum*, in which your section chair met with leadership from other sections as well as chapters. The first such meeting was held last August, enabling these two groups of leaders, who tend to be fairly diverse, and which had always met separately in the past, to meet together to discuss mutual goals and develop strategies that work across the board to improve the health care of children. The meeting this year was exciting, and it was gratifying to see the work of the Academy "up close and personal." A large number of resolutions (brought by chapters) and recommendations (brought by the sections and the councils) were discussed. These statements are used by the AAP Board of Directors to help guide their strategic decisions. You can view some of the resolutions (the "top ten") and others on the AAP website, members only channel.

The ALF provided the opportunity to network with chairs of other sections, and to participate in chapter and district activi-

ties. I was impressed by how open an organization the AAP is, and how easy it is to be in touch with leadership, even though we are an organization of over 60,000 members. I wish you all a pleasant beginning of the fall, and am looking forward to seeing you all at the NCE in October. I am happy to receive your advice and comments on the work of the Section.

Please feel free to contact me by email at: ackerman@peds.umaryland.edu

Hurricane Katrina



If you would like to volunteer to help the victims of Hurricane Katrina go to:

<http://www.aap.org/moc/docs/volunteers.htm>

Please keep us informed by e-mail to oed.aap.org if you are contacted for deployment.

If you would like to contribute to relief efforts, the AAP has established a relief fund through its Friends of Children Fund. All amounts contributed will go to organizations addressing the pediatric relief efforts in consultation with or through AAP Chapters in the overwhelmed areas. To donate online, go to:

<http://www.aap.org/sforms/fcform.htm>

Other links from the AAP:

<http://www.aap.org/new/disasterresources.htm>

<http://www.aap.org/moc/docs/0901katrina.cfm>



New AAP Policy Statements

Overcrowding Crisis in Our Nation's Emergency Departments: Is Our Safety Net Unraveling? (September 2004)
<http://aappolicy.aappublications.org/cgi/reprint/pediatrics;114/3/878.pdf>

Pediatric Care Recommendations for Freestanding Urgent Care Facilities (July 2005)
<http://aappolicy.aappublications.org/cgi/reprint/pediatrics;116/1/258.pdf>

Guidelines and Levels of Care for Pediatric Intensive Care Units (October 2004)
<http://aappolicy.aappublications.org/cgi/reprint/pediatrics;114/4/1114.pdf>

Admission and Discharge Guidelines for the Pediatric Patient Requiring Intermediate Care (May 2004)
<http://aappolicy.aappublications.org/cgi/reprint/pediatrics;113/5/1430.pdf>

Guidelines for Developing Admission and Discharge Policies for the Pediatric Intensive Care Unit (April 1999; reaffirmed January 2005)
<http://aappolicy.aappublications.org/cgi/reprint/pediatrics;103/4/840.pdf>

Death of a Child in the Emergency Department - Technical Report
PEDIATRICS, May 2005
<http://aappolicy.aappublications.org/cgi/reprint/pediatrics;115/5/1432.pdf>

Relief of Pain and Anxiety in Pediatric Patients in Emergency Medical Systems
<http://aappolicy.aappublications.org/cgi/reprint/114/5/1348>

Role of Pediatricians in Advocating Life Support Training Courses for Parents and the Public - Technical Report (December 2004)
<http://aappolicy.aappublications.org/cgi/content/full/114/6/1676%20>

AAP POLICY

American Academy
of Pediatrics



DEDICATED TO THE HEALTH OF ALL CHILDREN™

<http://aappolicy.aappublications.org/>

Have you heard.....?



The Section on Critical Care's web site has a new look!!!

Visit: www.aap.org/sections/critcare



AAP 75th Anniversary Celebration!

**Don't miss out on the chance
to commemorate
"75 Years of Caring"
at our special
Member Celebration Event on
Sunday October, 9 2005**

SECTION ON CRITICAL CARE MEDICINE PROGRAM SCHEDULE

Saturday, October 8, 2005

9:00 am – 4:00 pm **SOCC EXECUTIVE COMMITTEE MEETING**

Sunday, October 9, 2005

8:00 am – 4:45 pm **SOCC SCIENTIFIC and EDUCATION SESSION**

8:00 – 8:15 am **Introduction and Welcome**

James D. Fortenberry, MD, FAAP

8:15 - 9:30 am **Abstract Session I**

Moderators: *Alice Ackerman, MD, FAAP* and *Richard Salerno, MD, FAAP*

8:15 am **Rajasekaran S**, The use of Vapotherm™ in an oncologic pediatric intensive care unit (St. Jude Children's Research Hospital, Memphis, TN)

8:30 am **Tobias J**, Dexmedetomidine effectively controls opioid withdrawal in the pediatric PICU patient (University of Missouri, Columbia, MO)

8:45 am **Workie F**, A comparison of length of stay and hospital cost of neonatal ECMO patients to near miss ECMO patients treated with inhaled nitric oxide (Children's National Medical Center, Washington, DC)

9:00 am **Bembea M**, The impact of intracardiac catheters on morbidity after pediatric cardiothoracic surgery (The Children's Hospital, Cleveland Clinic, Cleveland, OH)

9:15 am **Schexnayder S**, Essentials of pediatric resuscitation: a primer on advanced life support for third year medical students during a pediatric rotation (Arkansas Children's Hospital, Little Rock, AR)

9:30 – 10:00 am **Coffee Break and Poster Review**

10:00 – 11:15 am **Abstract Session II**

Moderators: *Tom Bojko, MD, MS, FAAP* and *Barry Markovitz, MD, MPH, FAAP*

10:00 am **Jarvis J**, Parents on rounds: joint decision making in rounds in the PICU results in positive outcomes and increased satisfaction (Dartmouth Hitchcock Medical Center, Lebanon, NH)

10:15 am **Tobias J**, Noninvasive carbon dioxide monitoring in infants and children with congenital heart disease: transcutaneous versus end-tidal techniques (University of Missouri, Columbia, MO)

10:30 am **Nance M**, Pre-ECMO ventilation days and survival in the pediatric population (Children's Hospital of Philadelphia, Philadelphia, PA)

10:45 am **Miller M**, Elimination of catheter-related bloodstream infections in pediatric patients (Johns Hopkins University, Baltimore MD)

11:00 am **Hanson S**, Effect of volume resuscitation on perfusion in dehydrated patients by two-site near-infrared spectroscopy (Children's Hospital of Wisconsin, Milwaukee, WI)

11:15 – 11:30 am **Best Abstract/Physician-in-Training Awards Presentation**

11:30 am – 12:00 pm **Presentation of Distinguished Career Award**

Alice Ackerman, MD, FAAP

Recipient: *J. Michael Dean, MD, MBA, FAAP*

- 12:00 – 1:00 pm **Lunch & SOCC Business Meeting**
Alice Ackerman, MD, FAAP
- 1:00 - 4:45 pm **PICU PRACTICE MANAGEMENT: THE COURSE**
Moderator: *Alice Ackerman MD, FAAP*
- 1:00 – 1:05 pm **Overview: What is Practice Management?**
Alice Ackerman, MD, FAAP
- 1:05 – 1:35 pm **PICU and the Department/Hospital: An Administrator's View**
Peter Gilbert, MD
- 1:35 – 2:05 pm **Update on Billing and Coding**
Michele Moss MD, FAAP
- 2:05 – 2:35 pm **Intensivist and Advanced Practice Nursing Staffing Model**
Bruce Greenwald MD, FAAP
- 2:35 – 2:45 pm **Coffee Break**
- 2:45 – 3:15 pm **Recruiting and Retaining Intensivists**
Alice Ackerman, MD, FAAP
- 3:15 – 3:45 pm **Measuring Intensivist Productivity**
A. Marc Harrison, MD, FAAP
- 3:45 – 4:15 pm **Developing A Procedural Sedation Program: Lessons Learned**
Linda Snelling MD, FAAP
- 4:15 – 4:45 pm **Panel Discussion: Practical Issues in Practice Management**
Moderator: *Alice Ackerman, MD, FAAP*

Monday, October 10, 2005

- 8:00 – 11:00 am **MECHANICAL VENTILATION IN THE PICU: AN UPDATE**
Moderator: *James D. Fortenberry MD, FAAP*
- 8:00 – 8:45 am **Mechanical Ventilation: Breathing a la modes**
Mark Heulitt, MD, FAAP
- 8:45 – 9:30 am **High Frequency Oscillatory Ventilation: When And How To Use It in Children**
John Arnold, MD, FAAP
- 9:30 – 9:45 am Coffee Break
- 9:45 – 10:30 am **Adjunctive Therapies in the Ventilated Child with Lung Injury**
Douglas Willson, MD
- 10:30 – 11:00 am **Ventilation Dilemmas: Case Scenarios and Panel Discussion**
Drs Heulitt, Arnold, and Willson

American Academy of Pediatrics

NATIONAL CONFERENCE & EXHIBITION

Washington DC

OCTOBER 8-11, 2005

POSTER PRESENTATIONS

1. **Muñiz J**, Serum lactate levels in children with major trauma are not predictive of injury (Virginia Commonwealth University Medical Center, Richmond, VA)
2. **Tobias J**, Dexmedetomidine for procedural sedation during EEG analysis in children with neurobehavioral disorders (University of Missouri, Columbia, MO)
3. **Podurgiel R**, Extracorporeal membrane oxygenation for the resuscitation of cold weather-associated hypothermia (Indiana University School of Medicine, Indianapolis, IN)
4. **Abd-Allah S**, Esophageal foreign body removal in the pediatric intensive care unit (Loma Linda University Children's Hospital, Loma Linda, CA)
5. **Silverman A**, Characteristics of children admitted from the emergency department to the pediatric intensive care unit (Children's Hospital Los Angeles, Los Angeles, CA)
6. **Sharma J**, Management of intra-arterial catheter related thrombus in the PICU (The Children's Hospital at Downstate/SUNY, Brooklyn, NY)
7. **Wardrop R**, Fulminant sepsis associated with *Chromobacterium violaceum* in a patient with previously undiagnosed chronic granulomatous disease (University of North Carolina, Chapel Hill, NC)
8. **Davis R**, Lactic acidosis as presenting symptom of propofol infusion syndrome (Methodist Hospital, Indianapolis, IN)
9. **Hauk L**, An adolescent Jehovah's Witness with acute chest syndrome (UMDNJ-RWJ, New Brunswick, NJ)
10. **Bartley J**, Methicillin-resistant *Staphylococcus aureus* necrotizing fasciitis in a newborn (Medical College of Georgia, Augusta, GA)
11. **Dyamenahalli U**, Ductus arteriosus aneurysm with community-acquired ethicillin-resistant *Staphylococcus aureus* infection and spontaneous rupture (University of Arkansas Medical School, Arkansas Children's Hospital, Little Rock, AR)
12. **Alotaibi S**, Scimitar syndrome and pulmonary sequestration association in an infant presenting as recurrent right lower lobe pneumonia (Farwanyah Hospital, Kuwait)
13. **Quek BH**, Unusual cause of cyanosis in two young infants (KK Women's and Children's Hospital, Singapore)
14. **Cook A**, An infant with hypoplastic left heart syndrome and spinal muscular atrophy (Duke University Medical Center, Durham, NC)
15. **Davis R**, Pentobarbital vaso-paralysis presenting as multiple organ dysfunction syndrome (Methodist Hospital, Indianapolis, IN)
16. **Sharma J**, Recurrent chylothorax in infant with superior vena cava syndrome: surgical management and follow-up (The Children's Hospital at Downstate/SUNY, Brooklyn, NY)
17. **Hollenbeck L**, Septic shock due to parainfluenza virus and *Staphylococcus aureus* with purpura fulminans treated with extracorporeal membrane oxygenation (Riley Hospital for Children, Indiana University, Indianapolis, IN)
18. **Muñiz J**, Severe hyponatremia from inflicted traumatic brain injury (Virginia Com Center, Richmond, VA)

NATIONAL CONFERENCE & EXHIBITION

Washington D.C.

OCTOBER 8-11, 2005



PREPARING FOR LIFE IN ACADEMICS

Survival Skills for Fellows & Young Faculty

American Academy of Pediatrics
National Conference & Exhibition
October 7, 2005
Washington, DC

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.

Sponsored by the Section on Critical Care

Preparing for Life in Academics is a one 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 about career essentials such as effective negotiation, techniques to manage time effectively, and how to become involved at a national level. Opportunities to improve teaching skills will be offered through interactive sessions on feedback and delivering effective presentations.

Practices important to the business and organizational aspects of medicine will be addressed. Participants will also learn some of the more challenging areas that confront physicians: disclosing medical errors and preventing malpractice.

Friday, October 7

8:00-8:15am	Intro
8:15-9:15am	Academic Medicine 101: Becoming a Good Citizen
9:15-10:00am	Negotiation Skills
10:00-10:15am	Break
10:15-11:00am	Time Management
11:00-12:00noon	Teaching Skills Overview
12:00-1:15pm	Lunch
1:15-2:30pm	Disclosing Errors/Reducing Malpractice Risk
2:30-3:15pm	Performance Improvement Overview
3:15-3:30pm	Break
3:30-4:15pm	Tracks, Tenure, and Net- working: Three Essentials to your Career
4:15-5:00pm	Effective Presentations

Course Director

Stephen Schexnayder, MD, FAAP

Faculty

Debra Fiser, MD, FAAP
Gerald Hickson, MD, FAAP
Carole Lannon, MD, FAAP
Sanford Melzer, MD, FAAP
Michele Moss, MD, FAAP
Vinay Nadkarni, MD, FAAAP
Diana Wara, MD, FAAP

Registration Information



Please visit <http://s12.a2zinc.net/clients/aap2005/aap2005/public/enter.aspx> to register.

Note: Course is open to NCE registrants only. An additional fee of \$100 is also required. Breakfast, lunch and breaks are included.



Congratulations!

J Michael Dean, MD, MBA

**Section on Critical Care
2005 Distinguished Career
Award Winner**



Dr Dean is Professor and Vice Chairman of the Department of Pediatrics at the University of Utah School of Medicine. He attended Northwestern University Medical School (1977) and performed his pediatric residency and chief residency at Children's Hospital of Los Angeles. Dr Dean obtained critical care fellowship training at The Johns Hopkins Hospital in 1981, and remained

on faculty as an Assistant Professor until 1987, when he was recruited to Utah to assume the roles of Chief of the Division of Pediatric Critical Care at the University of Utah and Medical Director of the Pediatric Intensive Care Unit at Primary Children's Medical Center. From 1994 to 1996, Dr Dean served as the interim Chairman of the Department of Pediatrics and Medical Director of Primary Children's Medical Center. He subsequently received an MBA from The Wharton School at the University of Pennsylvania in 1999. From 1996 to 2005, he has served on the Board of the University of Utah Medical Group (UUMG) as well as the Executive Committee of the Board. He has served on the budget, contracting, and information technology committees for the UUMG.

Dr Dean is an established national leader in pediatric critical care. He served on the Advisory Council, as Secretary, and Chairman of the pediatric section of the Society of Critical Care Medicine (1991 – 1993), and served in the Section on Critical Care in the American Academy of Pediatrics, including Section Chairman from 1989 – 1992. He hosted the 1992 Pediatric Critical Care Colloquium, the largest meeting of pediatric critical care physicians to that date. He served on the Council on Sections Management Committee for the American Academy of Pediatrics until 1996. Dr Dean was on the Subboard of Critical Care, American Board of Pediatrics (1996 – 2002) and is a member of the editorial board of *Pediatric Critical Care*.

Dr Dean's current research interests relate to outcomes after pediatric critical and emergency care. He remains the principal investigator on the Utah Crash Outcome Data Evaluation System (CODES), funded by the National Highway Traffic Safety Administration (NHTSA), and continues to play a consultative role in the formation of the National EMS Information System (NEMSIS). He is the principal investigator for the National EMSC Data Analysis Resource Center and the Central Data

Management and Coordinating Center for the Pediatric Emergency Care Applied Research Network (both funded by the National Institute for Child Health and Human Development). Finally, he currently serves as a research mentor or on the mentoring committee for five physician scientists.



Janet Rossi, MD

**Section on Critical Care
2005 Young
Investigator Award**

Congratulation to Janet Rossi, MD, from Children's Memorial Hospital and Northwestern University Feinberg School of Medicine, the 2005 SOCC Young Investigator of the Year Awardee. Her project is entitled: The Role of Myosin Light Chain Kinase in Acute Lung Injury and Sepsis. The award is for \$7500. Dr. Rossi will present findings from her research at the 2006 NCE.

Abstract

Capillary leak as a result of acute lung injury, ventilator associated lung injury and sepsis is a major complication in the pediatric intensive care unit. There currently are no safe and effective small molecule therapies for treatment of this complication. Cell based and in vitro studies implicate the endothelial cell myosin light chain kinase (EC MLCK) as the pivotal regulatory pathway in the development of capillary leak. This pathway has been targeted as a drug discovery pathway based upon the fact a genetically engineered MLCK210 knockout mouse does not develop capillary leak and acute lung injury in the face of endotoxin and aggressive ventilation. Supporting evidence to support this pathway is a small molecule inhibitor of MLCK can protect WT mice from the endotoxin and ventilator induced lung injury. Based on these observations, the experimental focus of this proposal is to use in vivo models, of ALI and VALI, in MLCK210 KO mice, together with wild type mice treated with a small molecule inhibitor of MLCK, to test the following hypotheses: 1) Inhibition of MLCK will attenuate capillary leak syndrome and improve functional outcomes in ALI and sepsis 2) Selective targeting of MLCK with pharmacologic inhibitors is effective therapy alone, or in combination with other drugs, in the proposal are:

Continued on page 9

1. Determine if inhibition of MLCK, administered in a chemotherapeutic mode, attenuates endotoxin induced capillary leak and improves lung function. We will demonstrate inhibition of MLCK will protect against ALI and VALI when administered after endotoxin through histological sections and survival curves.
2. Determine if inhibition of MLCK improves protection against endotoxin and ventilation induced lung injury in addition to current protective practices. We will show MLCK inhibition can add protection in addition to protective ventilation modes. Using low peak pressures and peep we will show MLCK inhibition can improve compliance and gas exchange above that provided with protective modes of ventilation.
3. Determine if inhibition of MLCK through small molecule therapy results in toxicological compromise or immunosuppression. We will show MLCK inhibition does not result in immunosuppression or toxicological effects through lymphocyte spleen preps and white blood cell chemotaxis.

Drug Update - Summer 2005

I. MEDICATION ERRORS

1. A cold storage solution (VIASPAN) used for cold flushing and storing of organs during procurement resembles a bag of IV solution;



The solution contains: 29 mEq/L of sodium, **125 mEq/L of potassium**, adenosine 1.34 g/L and allopurinol 0.136 g/L; with an osmolality of 320mOsm, and pH of 7.4.

2. A worker working on hospital elevators drained hydraulic fluid into detergent containers and replaced the caps. The containers, which still had their original labeling were returned to their original source, and used to wash thousands of surgical instruments. The FDA determined that the 4000 patients affected by this error had been endangered.
3. An order was written to not give a patient Coumadin (written as a zero with a slash mark across it) was misread as 4 mg of Coumadin. A better way to have written this order would have been: "No Coumadin tonight."

Coumadin & my po tonight

4. A patient undergoing surgery was given phenylephrine instead of metoclopramide – developed pulmonary edema and cardiac arrest. The phenylephrine had been mixed into a bin where metoclopramide was normally stored. The vials look similar, especially when the front panel is facing away.



II. WARNINGS

1. A table in the package insert for ACETADOTE (acetylcysteine) is incorrect and may lead to improper dosing (delay in maintenance dose initiation) in the treatment of patients with acetaminophen overdose. The dosing for ACETADOTE should start with a bolus dose followed immediately by the maintenance infusion. However, the package insert uses the words "in 4 hours" when referring to the maintenance dose. To avoid confusion, it should say run "over 4 hours".

Continued on page 10

2. Strangulation by IV tubing: A 10-month old hospitalized with leukemia was found pulseless, cyanotic and apneic with IV tubing tightly wrapped around the child's neck. Resuscitation attempts were unsuccessful. Risk of strangulation is associated with IV tubing, oxygen tubing and monitor leads.
3. On May 19, 2005 – the FDA issued a warning regarding the use of Natrecor (Nesiritide) for the treatment of acutely decompensated congestive heart failure. There are a number of published reports that raise the question of whether the product may have adverse effects on survival and kidney function compared to control agents such as nitroglycerin and diuretics. Check out: Sackner-Bernstein JD, Kowalski M, Fox M and Aaronson K: Short-term Risk of Death after Treatment with Nesiritide for Decompensated Heart Failure. A Pooled Analysis of Randomized Controlled Trials. JAMA 2005;293:1900-1905.
4. Baxter Colleague CV smart pumps will delete all hospital-specific data in the “drug library,” including concentrations and dosing limits, and revert back to factory settings if the main AND back-up lead acid batteries drain, and the maintenance lithium battery drains. If the lithium battery drains, caregivers will see “FC 199” on the screen and hear an alarm after the pump is plugged in. However, if the caregivers are not aware of what “FC 199” means – they may continue to assume that the pump is able to detect subtherapeutic and toxic doses as before. Despite the fact that users should not allow the batteries to drain completely, Institutions that use these pumps should have stickers on the pumps warning about this problem.
5. You are all aware by now that Eli Lilly discontinued enrollment in a study of drotrecogin alfa (activated) or Xigris in children with severe sepsis. The Data Monitoring Committee for the study determined from an interim data analysis that treatment with Xigris was highly unlikely to show improvement over placebo; and a numerical increase was noted in the rate of CNS bleeding in the Xigris versus the placebo group.

III. INTERESTING DRUG TRIALS

Wheeler DS, Jacobs BR, Kenreigh CA, Bean JA, Hutson RK and Brill RJ: Theophylline versus Terbutaline in Treating Critically-ill Children with Status Asthmaticus – A prospective, randomized, controlled trial. *Pediatr Crit Care Med* 2005; 6:142-147



How does the EKG shown below help you make the diagnosis of hypospadias?



The answer is on page 13



Physicians urged to detail benefits of medication delivery system

Erin Stucky, MD

For many years, the “Rule of Six” (RO6) has been used effectively in pediatric and neonatal intensive care units for calculation of continuous drip medication infusions.

Rapid calculation of critical drips of dopamine, epinephrine and others by this method also has been the standard in emergency departments (EDs) and for first responders in the field.

The RO6 is a weight-based method: Six times the body weight (in kilograms) is the amount of medication in milligrams to be added to 100 milliliters of fluid, resulting in a concentration infusion of 1 microgram/kilogram/minute = 1 milliliter/hour.

The creation of this mathematical tool many years ago addressed concerns for errors in calculation. As is well-known, calculation errors are a significant source of concern in pediatrics given weight-based drug dosing. RO6 has been embedded in pediatric training and reference literature, including *The Harriet Lane Handbook*, Pediatric Advanced Life Support, *Neofax* and the *Pediatric Dosage Handbook*.

The use of the RO6 method of calculation most recently has come under heated review by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). The JCAHO’s Medication Safety Alert of Aug. 7, 2003, (Vol. 8, No. 16) started an animated discussion on the safety of RO6.

As part of the larger National Patient Safety Goals, #3b, “improve the safety of using medications,” mandates elimination of RO6 and conversion to standardized drip concentrations (SDC). This change, which was to take effect in January, has stirred significant controversy. Although some institutions changed to SDC, a survey performed by David Jaimovich, MD, FAAP, of 82 services of pediatric intensive care units, neonatal intensive care units, transport and EDs found that 67 used RO6, with five of the 15 using SDC having changed due to the anticipated JCAHO mandate.

A separate informal survey of Child Health Corporation of America pharmacists noted 10 of the 27 sites had changed to standardized drips, with change again due primarily to the JCAHO mandate.

An online survey by Gaffoor MI, et al. from the University of Maryland School of Medicine received 1,150 responses; more respondents recalled sentinel (adverse) events with SDC (67%) than with RO6 (51%) ($p < 0.001$).

Beginning January 2004, leaders in pediatric care, led by the Academy, challenged JCAHO’s position in a coordinated manner. Through e-mail, letters and conference calls, discussions with key JCAHO leaders resulted in a modification of the January 2005 standardized drip implementation date. In November 2004, JCAHO stated that institutions could petition for a waiver for up to three years, during which time RO6 may be used. A detailed medication safety plan must be submitted to and accepted by JCAHO.

Key issues raised throughout the months of discussion included:

- lack of data on error rate with RO6 use;
- decrease in medication error rate attributed to SDC actually included many system enhancements, such as smart pumps, pharmacist-only drip preparation and preprinted drip sheets for each patient at the bedside;
- significant fluid volumes for neonates with standardized drips; lack of standardization of drip concentration choices between institutions;
- inconsistently prepared drips within institutions serving adult and pediatric patients; and
- confusion of “mg” with “ml,” nurses rather than pharmacists preparing IV solutions, and accuracy of weight used for calculation argued as problems unique to RO6.

The next three years will afford pediatricians the chance to document benefits of their medication delivery system. Detailed outcomes from sites such as Albany and Duke medical centers, which have changed to SDC, will be of interest. Involvement in efforts like that of the University of Maryland’s will be needed to ensure unbiased evidence-based review of data.

Physicians are encouraged to submit comments to their local advocates and AAP representatives, as well as the AAP Committee on Hospital Care. Continuing collaborations with JCAHO are critical, as we partner to ensure excellence in pediatric patient safety.

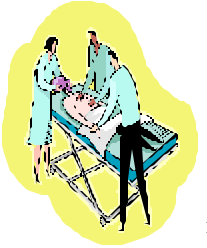
Dr Stucky is chair of the AAP Committee on Hospital Care and primary author of “Prevention of Medication Errors in the Pediatric Inpatient Setting,” Pediatrics.2003;112:431 - 436.

AAP News, February 2005

PCCM Fellowship Training Programs

Updates Related to the RRC

Mary Lieh-Lai, MD



For those who have PCCM Fellowship training programs and are way ahead of everyone, this update will not mean much to you, but for those who need periodic reminders, here goes...

1. Make sure that you have set up a Scholarship Oversight Committee (SOC) for your fellows. The American Board of Pediatrics has stated that each fellowship program needs a SOC – composed of some division members (but not the fellowship program director) and 1 faculty member who is not part of the division. The SOC oversees the research activities of the fellows, and should meet with them regularly. Minutes should be taken at the meetings and kept on file. A regular progress report and evaluation (quarterly) should be written by the SOC for each fellow and kept on file. The RRC will use these forms as an integral part of their evaluation of the research activities of the fellows in the program.

2. The 6 competencies:

Competency 1: Patient care.

Family-centered patient care that is developmentally and age appropriate, compassionate and effective for the treatment of disease and the promotion of health.

Competency 2: Medical Knowledge.

Fellows must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, and the application of this knowledge to patient care.

Competency 3: Practice-based learning and improvement.

Fellows must be able to use scientific methods and evidence to investigate, evaluate and improve their patient care practices.

Competency 4: Interpersonal and communication skills.

Fellows must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their families and professional associates.

Competency 5: Professionalism:

Fellows must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to diversity.

Competency 6: Systems based practice.

Fellows must practice quality health care and advocate for patients in the health care system.

Fellow evaluations, and goals and objectives, should be based on the 6 competencies.

Updates on PICUcourse.org

Mary Lieh-Lai, MD

As many of you know by now, picucourse.org has officially moved over to the Society of Critical Care Medicine Website. This has worked out very well. The SCCM IT personnel are very responsive to our needs and great to work with. There are a number of new developments, some of which have happened, some, about to happen.

Thanks to the hard work of the SCCM Pediatric ICU Residents Education Committee, we now have a second set of post-test questions that will be posted on the Website soon. The plan is to have the first time rotators through the ICU take the first exam (original exam that you have been using for the past few years); and when the residents are coming through the ICU a second time – to have them take the “new” test. The IT group at SCCM is going to format the tests such that the residents will know which test to take. We still do not have the ability to have x-rays, EKG’s, etc to post with the questions, but hopefully this will happen in the near future.

There are (or will be) a number of new presentations on the Website (thank you to all the people who volunteered to write these):

- a. New revised version of status epilepticus
- c. Strokes in children
- d. Emergency preparedness
- e. Sickle cell emergencies

Once I receive the following presentations from the authors who volunteered to do them, these will be posted as well:

- a. Poisoning
- b. Metabolic acidosis
- c. Coma
- d. Guillain Barré and myasthenia
- e. Gravis
- f. Spinal cord injury
- g. Medication safety in the ICU
- h. Arrhythmias
- i. Cardiopulmonary interactions

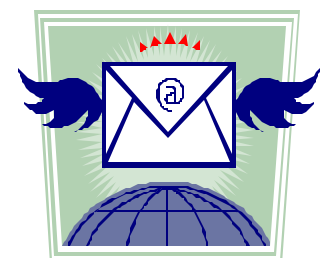
Last but not least, a critical care practitioner in Switzerland is translating all the picucourse presentations into German. Dr Heinrich Werner (Kentucky) and Dr Bonig (Seattle, via Teodor Butiu) have graciously agreed to check all the translations for accuracy. The translated presentations will be loaded into a Website that will eventually be linked to the picucourse.

If anyone has any interest in providing a presentation for the picucourse, please contact Ken Tegtmeier

tetmeye@ohsu.edu or me

mliehlai@med.wayne.edu. I hope all of you have found this Website beneficial for your residency training. If you have any other ideas to improve the picu course, please let us know. Thanks for all your support.

<http://www.sccm.org>



New Moderate Sedation CPT Codes

David Jaimovich, MD

As some of you may be aware, there has been a work group through the AMA RUC, with input from the various societies including the American Academy of Pediatrics addressing the issue of moderate sedation and the appropriate coding and billing.

Moderate sedation is the same service, which was previously described in CPT as conscious sedation. With evolution of medical practice of these services, moderate sedation is the most clinically relevant term used to describe the services provided. For this reason, the subhead and guidelines will be revised as part of CPT 2006 to reference conscious sedation as the secondary, less preferred term to describe moderate sedation services.

Instructions will be included in the guidelines for the moderate sedation codes to define the upper and lower levels of moderate sedation to distinguish these services from minimal sedation (anxiolysis) in the lower range of services from deep sedation and monitored anesthesia care in the upper range of services, and to assist in directing documentation regarding the services provided. Services which are included in moderate sedation, and therefore not separately reported, include:

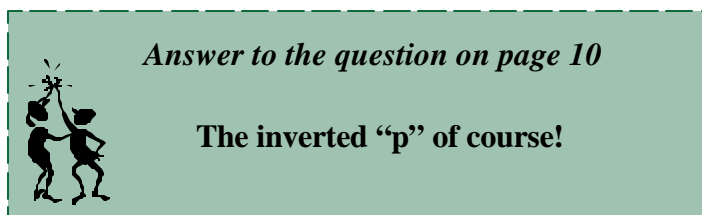
- Assessment of the patient (not included in intraservice time)
- Establishment of IV access and fluids to maintain patency, when performed
- Administration of agent(s)
- Maintenance of sedation
- Monitoring of oxygen saturation, heart rate and blood pressure
- Recovery (not included in intraservice time)

There will be a total of six codes reflecting moderate sedation services. Codes 99141 and 99142 which were previously used to describe moderate (conscious) sedation services will be deleted. While these codes were distinguished only by the route of administration, they have been replaced with two separate families of codes, distinguished by provision of sedation services by a single physician and a trained observer, or two physicians (other than an anesthesiologist). These families will consist of two separate time-based codes in each family, distinguished by patient age (under or over five years of age), with a single add-on code in each family to report additional time over the first 30 minutes of intraservice time. As the guidelines will indicate for these codes, the service time included in the descriptor will start at the time of the administration of the sedation agent. The new codes will continue to include all of the six possible routes of administration (intramuscular, intravenous, oral, rectal, intranasal, and inhalation).

These codes will be in effect January 1, 2006 and will be taking the place of all other sedation codes that are currently being used in the pediatric patient.

Respectfully submitted,

David Jaimovich, MD
Section Chief
Division of Pediatric Critical Care
Hope Children's Hospital
4440 W. 95th Street, Suite 3192H
Oak Lawn, IL 60453



Pediatric Critical Care Scientist Development Program (PCCSDP)

J Michael Dean, MD, MBA

- A.** The first retreat of the PCCSDP was held at the Lodges at Deer Valley in Utah on November 12-14, 2004.

A National Advisory Committee was established, with the following members:

1. Jeffrey Blumer, PhD, MD
2. Jeffrey Fineman, MD
3. Thomas Green, MD
4. Margaret Hostetter, MD
5. Patrick Kochanek, MD
6. George Lister, MD
7. M. Michele Mariscalco, MD
8. Jeffrey Burns, MD
9. Mary Lieh-Lai, MD

- B.** Applications: 23

C. Format: The proposals were each assigned to a primary, secondary and tertiary reviewer. During the first full day, the members of the Advisory Committee were grouped in two's or three's and all the candidates were interviewed by the Advisory Committee members for 20 minutes at a time. On the second day, the Advisory Committee reviewed and discussed all proposals, and also took into account the candidates' responses during their interview. The candidates were ranked.

- D.** PCCSDP Candidates Selected:

1. Brigham Willis, MD – UT Southwestern Medical Center, Dallas, Texas
Proposal: Epithelial-Mesenchymal Transition in Alveolar Epithelium
2. Sally H. Vitali, MD – Children's Hospital Corporation, Boston, Massachusetts
Proposal: Hypoxic Inflammation, Pulmonary Hypertension, and HO-1
3. Peter E. Oishi, MD – University of California, San Francisco, San Francisco, CA
Proposal: NO-ET-ROS Interactions in the Pulmonary Vasculature
4. Sujatha Kannan, MD – Wayne State University Detroit, Michigan
Proposal: PET Imaging and Targeted Therapy in Perinatal Brain Injury Associated with Chorioamnionitis

- E.** Support:

“The most important goal of the PCCSDP is to eventually fund 11 PCCSDP scholars, beginning with four in the first year, who will be in a 4-5 year training track. The training program will emphasize faculty career development and mentorship, successful research design and publication, and obtaining sustainable extra-

mural research funding. The program will be enhanced with an annual PCCSDP retreat, annual site visits by the Program Director or a member of the National Advisory Committee, and assignment of a personal advisory committee for each scholar to utilize throughout the five years of training.

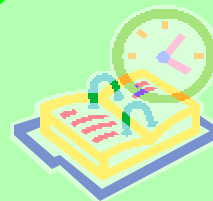
With this support, the goal is to increase the number of highly trained, successfully funded, and sustainable pediatric critical care physician scientists who will perform translational research to enhance the scientific understanding, clinical management and rehabilitation of critical illness in children, leading to better long term outcome.”.....JM Dean (PCCSDP Proposal, 2004).



I am pleased to announce that there are two to three positions available beginning January 2006 for Scholars in the (PCCSDP). Please let your young faculty and colleagues know about this opportunity. Some recipients of this email are not critical care physicians, but have extensive contacts that might help disseminate this information.

There is now a web site with information at www.pccsd.org and it includes detailed instructions. The deadline is October 1, 2005.

Please let me know if you have any questions or comments.



Save the Date
**2006 Course on
Neonatal & Pediatric
Critical Care Medicine**

October 2006

Section on Critical Care Chapter Liaisons

State	Dist	Liaison	City	Phone	E-Mail
AK	VIII				
AL	X				
AR	VII				
AZ	VIII	David Rosenberg	Chandler		dirflyfish@aol.com
CA	IX - 1				
CA	IX - 2	Harold Amer	Los Angeles	310/423-8080	hamer@mailgate.csmc.edu
CA	IX - 3				
CA	IX - 4	Nick Anas	Orange	714/532-8620	nanas@choc.org
CO	VIII				
CT	I	Jacob Hen	Bridgeport	203/384-3711	pjhen@bpthosp.org
DE	III				
DC	III				
FL	X	J. Del Toro-Sylvestry	Ft Lauderdale	954/468-8000	jorge_deltoro@pediatrix.com
GA	X	Robert Pettignano	Atlanta	404/778-432	t_pettignano@oz.ped.emory.edu
GA	X	Lyle (Gene) Fisher	Augusta	706/721-4402	lfisher@mail.mcg.edu
GA	X	James Fortenberry	Atlanta	404/325-6397	james.fortenberry@choa.org
GA	X	Tony Pearson-Shaver	Augusta	706/721-4402	tpearson@mail.mcg.edu
HI	VIII				
IA	VI				
ID	VIII				
IL	VI	Kathleen Webster	Maywood	708/216-5841	kwebste@lumc.edu
IL	VI	David Jaimovich	Oak Lawn	708/346-5685	david.jaimovich@advocatehealth.com
IN	V				
KS	VI				
KY	IV				
LA	VII	Stephen Levine	New Orleans	504/896-9438	slevinemd@aol.com
MA	I				
MD	III	John Straumanis	Baltimore	410/328-6957	jstrauma@peds.umaryland.edu
ME	I				
MI	V				
MN	VI				
MO	VI				
MS	VII				
MT	VIII				
NC	IV	Otwell Timmons	Charlotte	704/355-7815	otwell.timmons@carolinashealthcare.org
ND	VI				
NE	VI	Mohan Mysore	Omaha	402/955-4226	mmysore@chsomaha.org
NH	I				
INJ	III	Timothy Yeh	Newark	973/926-3886	timyeh@sbhcs.com
NM	VIII				
NV	VIII				
NY	II-1	Kathleen Donnelly	Albany	518/262-5127	donnelk@mail.amc.edu
NY	II-2				
NY	II-3	Edward Conway	Hartsdale	212/870-9692	econway@bethisraelny.org
NY	II-3	Charles Schleien	New York	212/305-8458	cs600@columbia.edu

Continued on page 16

Section on Critical Care Chapter Liaisons

State	Dist	Liaison	City	Phone	E-Mail
OH	V	Kathryn Weise	Cleveland	216/445-1404	weisek@ccf.org
OK	VII				
OR	VIII				
PA	VII				
RI	I				
SC	IV	Melinda Lucas	Maryville	865/544-9402	mlucas@utk.edu
SD	VI				
TN	IV				
TX	VII	Don Vernon	Salt Lake City	801/588-3281	donVernon@hsc.utah.edu
UT	VIII				
VA	IV				
VT	I				
WA	VIII				
WI	VI	Tom Brazelton	Madison	608/263-8901	brazeltoniii@wisc.edu
WV	III				
WY	VIII				
PR	X				

Canada

Providence	Dist	Liaison	City	Phone	E-Mail
Alberta	VIII				
British Columbia	VIII				
Manitoba	VI				
New Brunswick	I				
Newfoundland	I				
Nova Scotia	I				
Ontario	V				
Prince Edward Island	I				

If you are interested in serving as a liaison to a Chapter that is currently not represented, please contact Sue Tellez at stellez@aap.org

Articles Authored by SOCC Members AAP Grand Rounds

July 2004 - July 2005

Susan L. Bratton, MD

Telemedicine and Critical Care

AAP Grand Rounds, July 2004; 12: 9-10

Monika Gupta, MD

Saline or Albumin in the ICU

AAP Grand Rounds, August 2004; 12: 16-17

Kenneth A. Schenkman, MD

Pulse Oximetry May Unnecessarily Prolong Hospital Stay for Bronchiolitis

AAP Grand Rounds, September 2004; 12: 27

Stephanie Burns Wechsler, MD

Outcome of Hypoplastic Left Heart Syndrome

AAP Grand Rounds, November 2004; 12: 59-60

Susan L Bratton, MD

Traumatic Brain Injury in Children

AAP News, December 2004; 12: 71

Susan L Bratton, MD

Talking About Death with Children Who Have Cancer

AAP Grand Rounds, December 2004; 12: 67-68

Susan L Bratton, MD

Preservation of Organs from Brain Dead Patients

AAP Grand Rounds, February 2005; 13: 21-22

Susan L Bratton, MD

Effectiveness of Helmets in Skiers and Snowboarders

AAP Grand Rounds, March 2005; 13:30-31

Susan L. Bratton, MD

Factor VII for Acute Intracerebral Hemorrhage

AAP Grand Rounds, March 2005; 13:66-67



<http://www.pedsccm.org/>

CALENDAR OF EVENTS

AAP National Conference & Exhibition (NCE)

October 8-11, 2005

Washington, DC

<http://s12.a2zinc.net/clients/aap2005/aap2005/public/enter.aspx>

5th Annual Optimizing Mechanical Ventilation for Infants and Children Conference

October 19 - 21, 2005

Durham, NC

<http://www.pcics.com/DesktopDefault.aspx?tabindex=2&tabid=13>

Pediatric Cardiac Intensive Care Symposium (PCICS 2005)

December 7 - 10, 2005

Miami, FL

<http://www.pcics.com/DesktopDefault.aspx?tabindex=2&tabid=13>

16th Annual Pediatric Critical Care Colloquium

February 21 - 24, 2006

Snowbird, UT

<http://pedsccm.wustl.edu/organizations.html#pccc98>

Annual Critical Care Congress

January 21 - 25, 2006

New Orleans, LA

http://www.sccm.org/education/annual_congress/index.asp

4th International Conference on Pediatric Continuous Renal Replacement Therapy (PCCRT)

February 24-26, 2006

Zurich, Switzerland

<http://www.pccrt.com/>

Pediatric Critical Care Medicine 2006: A Review for Board Preparation and Comprehensive Update

March 25-28, 2006

McLean, Virginia

<http://www.cbcbiomed.com/>



Section on Critical Care Membership

Background:

The Section on Critical Care (SOCC) was founded in 1984 and enables members who are primarily interested in pediatric critical care to meet for the purpose of discussing and developing ideas and generating programs and projects which will improve the care of infants, children and adolescents. Membership in the SOCC is open to Fellows, Post-Residency Training Fellows, Candidate Fellows, Honorary Fellows, Emeritus Fellows, Life Fellows, Dual Fellows, and Resident Fellows of the American Academy of Pediatrics. Section members should be actively involved in some aspect of the study of life-threatening single or multiple organ system failure caused by disease or injury. Section members may vote on issues related to SOCC business and may be elected to serve on the SOCC Executive Committee. The Section currently has over 600 members.

Mission:

Section 1. To improve the care of infants, children, and adolescents by:

- A. Providing an educational forum for the discussion of problems and treatments relating to pediatric critical care medicine.
- B. Stimulating research in, and the teaching of, pediatric critical care medicine;
- C. Disseminating knowledge of pediatric critical care medicine through Academy channels to the medical profession at large.

Section 2. To serve in a consulting capacity to the Board of Directors of the Academy and to make recommendations for programs, policy statements, and other actions on matters relating to pediatric critical care medicine.

Benefits:

- √ Advocacy
- √ Educational Programs
- √ Networking
- √ Leadership opportunities
- √ Awards / New Investigator Research Grant (for SOCC members only)
- √ Abstract Submission
- √ Biannual Newsletter
- √ Eligible for election to the SOCC Executive Committee
- √ Access to SOCC website (<http://www.aap.org/sections/critcare>) and Listserv

How to Join?

It's easy! Go to <http://www.aap.org/moc/memberservices/sectionform.cfm> (AAP Members Only Channel, Member Services) to complete a fast-track online application or call AAP Membership at 800/433-9016. Annual dues are \$35 for AAP Fellows; \$10 for Residents.

Continued on page 19

Advocacy & Networking

The AAP serves as the nation's primary advocate for the health needs of children, and the SOCC is the primary voice within the AAP for critically ill infants and children. The Section provides input to the Academy on issues such as reimbursement, standardized drug dosing, and workforce issues. In addition, the AAP has a dedicated Department of Federal Affairs in Washington that advocates for the health of all children. The AAP is viewed as the "white hat," and has considerable influence on advocacy related issues because it focuses on the child. Access to health care for all children, immunizations, injury prevention, and Medicaid are a few of the topics on the AAP agenda. The AAP advocates for children and adolescents with chronic diseases more than any other medical organization. The SOCC collaborates with many other committees and sections of the AAP as well as outside organizations including the Society of Critical Care Medicine. The SOCC also advocates for pediatric intensivists within the AAP and works closely on related issues with others. For example, the SOCC was instrumental in working with the AAP to gain AMA approval for establishment of two new global CPT codes for pediatric critical care. Each SOCC member that becomes involved in the AAP will benefit from these collaborations as well as the opportunity to network with other pediatric subspecialists

Policy

The SOCC serves as an expert resource to the AAP by providing review of official AAP policy and by developing policy guidelines on pediatric critical care. The SOCC has collaborated with the Pediatric Section of the Society of Critical Care Medicine where possible. Current SOCC policy statements (*joint with SCCM) include: "Guidelines & Levels of Care for PICUs" (10/04)*; "Admission & Discharge Guidelines for Pediatric Patients Requiring Intermediate Care" (5/04); and "Guidelines for Developing Admission & Discharge Policies for the PICU" (5/99)*.

Education & Leadership

The SOCC sponsors scientific abstract presentations, a business meeting, and educational programming each year at the AAP National Conference & Exhibition. The Section also sponsors an annual call for abstracts, presented at this meeting and published in *Pediatric Critical Care Medicine*. In addition, SOCC has sponsored two Pediatric Critical Care Coding CME courses - October 2002 during the Colloquium and June 2003 with the World Congress - as well as a course on Preparing for Life in Academics in October 2003 that will be repeated in October 2005 along with a course on PICU Practice Management. Members of the AAP and SOCC receive discounts on and access to the AAP educational resources such as *Pediatrics*, *AAP News*, *PediaLink*, and manuals for health professionals (ie, Red Book). Leadership training and lobbying workshops are available to SOCC members through the AAP and members are eligible for election to the SOCC Executive Committee. This year the SOCC will begin working with AAP to develop an online subspecialty self-assessment program to help intensivists meet ABP requirements for lifelong learning and recertification.

Awards

The SOCC sponsors an annual \$1000 Distinguished Career Award, a \$7500-10,000 New Investigator Research Award (if funding is available), and several annual abstract awards.

SOCC Executive Committee (2004-2005):

Chairperson: Alice Ackerman, MD
Tom Bojko, MD, MS
Dave Jaimovich, MD
Barry Markovitz, MD, MPH
Richard Salerno, MD
Don Vernon, MD
Tim Timmons, MD
Ex-Officio: Michele Moss, MD

Newsletter Editor: Mary Lieh-Lai, MD
Program Chair: Jim Fortenberry, MD
Web Site Editor: Barry Markovitz, MD, MPH
SCCM Liaison: Stephanie Storgion, MD
ACCM Board Liaison: Tim Yeh, MD
Section on Transport Medicine Liaison:
Tony Pearson-Shaver, MD
AAP Staff: Sue Tellez