



Speaking for Maryland's Kids

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President's Message Virginia Keane, MD

Dear Colleagues:

First, let me thank you for taking a breath and reading this. Everyone I know is working harder, and for longer hours, than they ever have in their life. This summer I heard that people were concerned that visits were down because of the economy. That's not the problem now. You, like I, probably had some plans for this fall. Maybe a trip, more family time, finally learning enough about emrs to start down the road of purchasing one, or maybe getting more involved in the health care reform movement.

I was going to work on Medical Home issues. We have a Catch Grant to work on improving medical homes outside of the Baltimore metropolitan area, a contract with Parents place to work on medical homes for special needs children, and The Maryland Health Care Cost commission is planning a medical home demonstration project, and the AAP has been invited to be involved in planning and implementation.

And then came the flu.

First there was having to get pedi-



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atric presence on the Governor's task force on H1N1 . Job done, and we are well represented by Ina Stephens, who keeps state leadership informed of the particular needs of the pediatric community.

Then, we heard the state was planning widespread seasonal flu vaccine campaigns in schools. We stepped up to make sure Pediatricians were involved in planning such efforts in the early stages, so we would not risk having left over vaccine.

Then there was planning for H1N1 vaccinations. Do you remember that initially the risk groups were pregnant women, health care workers and children up to age six? DHMH reached out to us, asking how they could get pediatricians to help them reach the preschool population. Plans were made. I made commitments on your behalf, because I know that you would eagerly join in the effort to protect young children.

And then, the CDC expanded the risk group to 24 years of age. The virus grew slowly and vaccine was in shortage. And somewhere along the line officials seem to have lost site of the fact that children under six and chronically ill children are the highest risk group. Health Depart-

ments got vaccine and gave it out first come first serve to anyone who had the ability to stand in line for four hours. We advised asthmatics to stand on line, but they got crowded out by healthy people. Pediatricians and hospitals did not get the vaccine they needed to vaccinate staff and high risk patients, but we witnessed school based campaigns on TV. Chapter leadership spoke up loudly to health officials, and they have heard us: we will see how the response is. 130,000 doses of H1N1 came in to the state this week, and they are being distributed, with strong messages that they should be given to health care workers and high risk people. I'm told that of the 2000 providers who signed up to give H1N1 278 were pediatric practices, and all have now received some vaccine, albeit not entire orders. I am told that reports of Maryland Pharmacies having vaccine are false: that no Maryland pharmacy has received H1N1. I am communicating daily in one form or another, that Maryland Pediatricians need more vaccine.

Then there was the fight to get the schools to stop asking for doctor's notes to go back to school. I personally think that winning this skirmish is responsible for some of the downturn in office visits we are now experiencing.

Like you, even with the slight recent downturn, I am seeing more patients than ever before. I'm in the office more, and can't seem to catch up on my charts. I know, whether you are in primary care or specialty care, inpatient or outpatient care, clinical work or policy/public health work, you are doing the same. And no one is taking the time to say thank you.

So I will. THANK YOU. Thank you for working hard, thinking hard, and doing your best for children. Thank you for signing up to give H1N1 when you had no idea if you would be paid. Thank you for working with your institutions and local health departments to do the best you can with the resources you have. Keep it up.

Working for you and Maryland's children -
Virginia Keane, MD, FAAP
President

WHY JOIN PROS?

During your very busy practice day, have you wondered whether your anticipatory guidance talks are having an effect? Do the parents remember, and more importantly, do they act on your advice?

Seeing the many kids rapidly increasing weight and BMI, have you questioned... "just what WOULD succeed in reversing this child's trend toward obesity?"

Has a parent ever asked when you thought their son would start puberty?

Walking into an exam room and trying not to cough at the acrid smell of tobacco smoke being exhaled by a parent, have you been frustrated because the patient continues to wheeze? And how can you convince the parents not only to place the child on maintenance inhaled corticosteroids, but also to keep a smoke free home or quit altogether?

Have you wondered what you can offer a family when the child is having behavioral or mood problems and they can't get access to a mental health professional?

Are there office or practice routines you think might be improved? And how do you get it done?

These are all topics that PROS practitioners and researchers have wondered about and are the subject of prior, current, or pending PROS research projects.

What research questions do you have?

Participating in PROS studies have been an honor and a privilege for me. During these very busy times and pressured paced environments, it may seem daunting to participate in any research project. Although the financial compensation is usually minimal, the personal and professional rewards are truly maximal.

The PROS practitioner does have an incredible central staff at the AAP main office in Elk Grove Village who will guide and assist through all phases of a PROS study from start to finish. If you need help with a local IRB (if you don't know what that is, then luckily you probably do NOT have a local IRB),

the PROS staff can help with the application and the renewal processes. All PROS studies have exceptional researchers who help design all aspects of the study and all are usually approved by both a University and the AAP IRB. The study protocols are usually simple and easily integrated into a busy

office practice...this is because the PROS coordinators, who are almost all full time busy clinicians, hammer/cut/paste/knead/modify and usually pilot test every PROS study prior to rolling it out to the general PROS practitioners.

The PROS practitioner does have to make a few commitments, including being certified in human subjects training, usually by NIH Web-based Training or by your local academic institution. The practitioner must agree to abide by the study protocol so the integrity of the study is maintained, and no biases are introduced...or as our patients would say... "no cheating"! That sounds obvious but during a very busy or stressful office day, you may be tempted to "just skip that one" and move onto the next patient.

Many PROS practices have an office manager or lead person in the office interested and willing to help with studies (keeping logs, getting consents, or organizing study paperwork). Often, the studies will have some honorarium that can be used to reward the staff or an ad hoc research assistant. Although the studies are designed to be able to be performed in an busy pediatric practice, all studies will take some time from the practitioner's day (full disclosure!), and help and buy in from the staff is always appreciated.

The personal and professional rewards, again, are what drives thousands of PROS practitioners from throughout the United States and Canada and Puerto Rico to continue in this research network. In 2003, PROS agreed to the following revised mission statement:

The mission of PROS is to improve the health of children and enhance primary care practice by conducting national collaborative practice-based research.

And we also agreed to five Guiding Principles, the first two being:

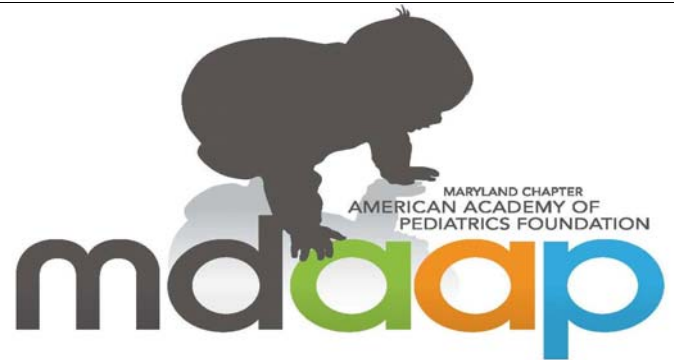
PROS believes that the pediatric practice, in reflecting the full diversity of clinical problems, patients, and prac-

tioners, is the appropriate laboratory for studying pediatric primary care issues. The pediatric practitioner, as a source and judge of relevant research questions and appropriate methods, is therefore an active participant in all phases of PROS projects.

PROS weds the wisdom of the practitioner to scientifically sound research methods.

If this mission and guiding principles resonate with you, then I encourage you to join PROS. There are several very exciting studies you can join now, and others coming up soon. Participation will reward you with a sense of contribution to the field of pediatrics that will compliment your satisfaction in helping individual patients and families.

Check out the PROS website at www.aap.org/pros. Click on JOIN PROS for the registration form, and read about current and upcoming studies. There is no fee and no commitment to specific studies upon joining. And all PROS and interested members are welcome and encouraged to come to the annual PROS meeting at the NCE. The Coordinator meeting is listed in the NCE schedule and is on the Friday and Saturday at the start of the NCE. It is free and no prior registration is needed. Hope to see you there!



MDAAP Foundation Fundraiser

Your Maryland Chapter is intent on shifting our funding away from grants from the pharmaceutical industry. A large piece of that effort is connecting with novel funders in the community and traditional connections with state agencies.

Our first-ever gala fundraiser will be **January 23, 2010** at the Hippodrome Theatre. The event will feature food provided by chef Randy Stahl of the Brass Elephant, a silent auction, and will be highlighted by a performance of "**Young Frankenstein**".

Ticket prices will include the cocktail hour, food and prime seating at the Hippodrome.

RESERVE THE DATE! More information will be coming in the following weeks.

MARYLAND INFANT AND TODDLERS PROGRAM

Part C of Public Law 108-446, the Individuals with Disabilities Education Act (IDEA) of 2004, legislates statewide, comprehensive systems of early intervention services to infants and toddlers with special needs. This law allows each state to determine eligibility criteria for children and families served; it also allows each state to determine family cost for participation. In Maryland, the early intervention program is called the Maryland Infants and Toddlers Program (MITP). In Maryland, children, ages birth to three years, are eligible to participate in the MITP if they exhibit a $\geq 25\%$ developmental delay, atypical development, or a diagnosed condition that has a high probability of resulting in delayed or atypical development. High probability conditions include, but are not limited to: a birth weight of $< 1,200$ grams, Grade III/IV IVH, PVL, CLD, severe congenital malformations, and neonatal abstinence syndrome. In 2008, the MITP provided early intervention services to more than 13,800 children through 24 local programs. The MITP provides early intervention services in the child's natural environment, at no direct cost to families.

Research and best practice demonstrate that infants and toddlers learn best through every day experiences and interactions with familiar people in familiar contexts. The MITP bases its early intervention practices on best available research and evidenced-based practice, while adhering to the laws and regulations of Part C of IDEA. Acknowledging the primary role of the family in the early intervention process, Maryland's early intervention system has evolved from a traditional child-centered "clinical model" to a family-centered developmental model where service providers work with the family in planning and providing services to help foster the development of their child. Services may include (but are not limited to) physical therapy, occupational therapy, speech/language therapy, and special instruction.

All potentially eligible infants should be referred to the MITP in a timely fashion. To learn more about the MITP, and to obtain a copy of the MITP referral form along with fax numbers, please refer to the MITP Physician's Guide. A complete copy of the

guide is available at http://www.marylandpublicschools.org/NR/rdonlyres/4BDA1AEE-2C71-4150-8180-A5AAEE4613E4/19550/MITP_Physician_Guide_March_2009.pdf or by calling the MITP at 1-800-535-0182.

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Breastfeeding Update

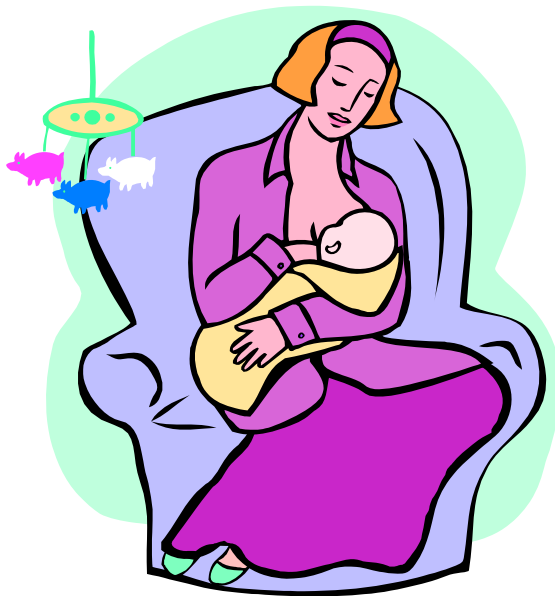
After almost a year-long break, the Maryland Breastfeeding Coalition was recently re-established. Its mission remains to improve Maryland's citizens' health by working collaboratively to protect, promote, and support breastfeeding. Several physicians, along with many other health professionals and those in the lay community are working to make breastfeeding as the norm for infant and child feeding throughout Maryland. Your Chapter Breastfeeding Coordinators have been elected to serve as President (Dana Silver) and Board Member (Edward Bartlett) in this up-and-coming Coalition. Anyone interested in becoming involved can contact us or visit the website at www.marylandbreastfeedingcoalition.org.

On a similar note, we wish to invite you to join us and many other Maryland Pediatricians in the AAP Section on Breastfeeding (SOBr). Membership provides you with access to members-only breastfeeding resources on the AAP's Breastfeeding web pages, breastfeeding promotional materials, discussion boards, and much more. For more information, go to <http://www.aap.org/breastfeeding/sectionOnBreastfeeding.html#membershipInfo>, or contact your Chapter Breastfeeding Coordinators.

We look forward to assisting you with any breastfeeding matters. In addition, we would be happy to help arrange a speaker on breastfeeding-related topics for Grand Rounds or any other venues.

Dana Silver, M.D., F.A.A.P. and Edward Bartlett, M.D., F.A.A.P.

dsilver@lifebridgehealth.org



Upcoming Meetings

December 2, 2009
Legislative Session Meeting
6:00—9:00 p.m.
St. Agnes, Room 5A-B

December 11, 2009
CHAMP
8:00 AM
University of MD

December 15, 2009
6:00—9:00 p.m.
Developmental Screening
Training

Anne Arundel Hospital
Rotary Room, 2001 Clatanoff Pavilion

December 17, 2009
6:00—9:00 p.m.
Child Maltreatment Meeting
St. Agnes

January 6, 2010
6:00—9:00 p.m.
Executive Committee Meeting
Location TBA

Letter to the Editor...

Recent articles in the SUN, on whooping cough and primary care highlight the Sun Paper's attention to local and national health issues but fail to communicate the state of affairs where these two critical issues, vaccines and primary care, overlap.

We are at the precipice of a crisis when it comes to vaccines

Celebrities spread false accusations of vaccine danger, perpetuating the myth of a causal link between vaccines and autism. When science does not support their statements they accuse the pediatric physician community of being in the pocket of the vaccine companies, accepting large grants and small gifts in exchange for our continued support of vaccines. They falsely claim we make large profits in our practices from the sale of vaccines, and that this alone would cause us to turn our backs on all that is true, safe and ethical. They falsely claim that we would continue to give vaccines *even if we knew they were dangerous*. Suddenly we, the protectors of children, are accused of knowingly causing them harm!!

In some communities this false rhetoric has convinced large numbers of parents to refuse vaccines. When 15 percent of the population is unvaccinated there is loss herd immunity, protection of the group as a result of there being only a small number of susceptible individuals. In several western states there are large geographic areas where 20-35% of children are unvaccinated due to parental refusal! Some states, like our neighbor West Virginia, have solved this problem by passing "no exception" legislation, requiring every child to be vaccinated for public health reasons.

Fortunately, we are not yet seeing high refusal rates here in Maryland but the rates are climbing. Unvaccinated children get preventable diseases. This spring there was a mini outbreak of measles in Montgomery County, all in unvaccinated people. An article in the journal Pediatrics finds the risk of pertussis (whooping cough) is twenty three times higher in children who are unvaccinated compared to those who are vaccinated. The AAP and CDC agree that if vaccine refusals increase we will see thousands of cases of preventable diseases, and hundreds of deaths from preventable diseases.

Vaccine refusal is not the only threat to vaccine coverage.

A business model for vaccine compensation developed by the national American Academy of Pediatrics states that for financial sustainability physicians should be paid the cost of the vaccine plus 17-20% to cover overhead. Despite this some insurers continue to use the formula of paying the median community cost, with no compensation for overhead, which by definition means fifty percent of providers will be paid LESS THAN THE COST OF THE VACCINE, and all will be paid less than their total cost. This is supposed to incent physicians to find lower cost distributors, but what it really does is just drive down the median compensation. No shop owner could continue to sell an item for which he was compensated below cost. Some pediatricians are now saying they can no longer afford to provide vaccines. They are referring to the local health department. The local health departments do not have the infrastructure to provide vaccines to a large volume of patients. Thus, we face a crisis.

All of this is happening as we approach the most vaccine intensive fall we have ever had. This is the first year that universal influenza vaccination of children birth to eighteen is recommended by the CDC. Physicians who provide childhood immunizations are struggling with how much vaccine to order so they have enough but do not

have any left over, and how they are going to get every patient into the office for a vaccine in a six week period, while carrying on their practices.

There is also a very good chance that we will be giving two waves of flu vaccine: one for the new H1N1, and the other for the seasonal strains. A double dilemma.

Primary care physicians are the vaccine distribution system.

If we can't do the job, or can't afford to do the job, there is no substitute system

It's time for policy makers, legislators and the public to recognize that the vaccine distribution system is at risk and take steps to assure that primary care physicians can continue to vaccinate Maryland's citizens.

Vaccines are safe and vaccines save lives.

Let's make sure primary care physicians can give them and you can get them.

Virginia Keane, MD

President

Maryland Chapter, American Academy of Pediatrics

MDAAP Planning Meeting/ Leffler Lecture & Awards Dinner

The MDAAP held it's annual Planning Meeting in conjunction with the Leffler Lecture/Awards Dinner on September 17, 2009 at the BWI Marriott. Kenneth Roberts, MD, FAAP was the keynote speaker for this event, which was well received. This was the first year that both award nominees and recipients were recognized at this event. There were 14 nominees and 5 award winners total.

Pediatrician of the Year Award

Nominees: Allen Walker, MD; Howard Dubowitz, MD; Joseph Wiley, MD

Award Recipient: Virginia Keane, MD

Child Advocate Award

Nominees: Brenda Donald, Secretary; Harry Goodman, MPH, DMD; Joan Patterson, MSW

Award Recipient: Coalition to End Childhood Lead Poisoning

Leadership Award

Nominees: Wendy Lane, MD, MPH; Maura Rossman, MD; Brian Corden, MD

Award Recipient: Diana Fertsch, MD

Special Achievement Award

Nominees: Paul Lipkin, MD; Tina Cheng, MD; Carol Carraccio, MD

Award Recipient: George Dover, MD

Lifetime Achievement Award

Nominees: Susan Panny, MD; Prasanna Nair, MD; George Lentz, MD

Award Recipient: Misbah Khan, MD

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Toxic Topics: Mercury in the Environment

By Michael Ichniowski, MD, FAAP

(This is the first article on topics in Environmental Health for the Maryland AAP Newsletter)

Mercury was named *Hydrargyrum* (liquid silver) by the ancient Romans, hence the elemental symbol, Hg. It can occur in the elemental form, inorganic salts or organic compounds, each with its own potentially toxic effects.

Elemental mercury, a liquid at room temperature, is poorly absorbed from the GI tract if ingested, and poses no significant health risks in this form. The bitten thermometer of years past was more dangerous from the broken glass than the mercury contained inside. The danger from elemental mercury occurs when it is vaporized, either by heating it or vacuuming it following a spill. Vaporization of mercury also occurs from the burning of fossil fuels, especially coal, and from incineration of waste that may have mercury-containing devices (e.g. thermometers, thermostats, button batteries, fluorescent bulbs, and dental amalgam). Mercury vapor is extremely toxic. At high concentrations, it can cause necrotizing pneumonitis, which may be fatal. Mercury vapor absorbed through the lungs into the circulation passes readily into red blood cells and the central nervous system, where the primary toxic effects occur. These symptoms may include tremor, impaired memory, emotional lability, insomnia and speech impairment, mimicking dementia or a psychiatric disorder. Circulating mercury also accumulates in the kidneys, leading to glomerular damage with resultant proteinuria and nephropathy.

Inorganic mercury may be associated with many of the same toxic effects. It has greater absorption in the GI tract than elemental mercury, ranging from 10-40%. Many mercurial salts, which were once used in a variety of medicinal products (including infant teething products), are no longer in use. The syndrome of acrodynia, manifested as painful red digits, generalized rash, peripheral neuropathy, hypertension and renal dysfunction, was the result of childhood exposure to inorganic mercury in such medications--the cure was indeed much worse than the disease. One previously common industrial use of inorganic mercury involved steaming animal fur in mercuric nitrate in the production of felt for hat making. Chronic exposure to the vaporized inorganic mercury produced the same symptoms described above for elemental mercury vapor. The symptoms of dementia led to the phrase "mad as a hatter" in Victorian England, and the "Danbury shakes" were tremors common among hat factory workers in Danbury, Connecticut. To this day, mercuric waste continues to be a significant contaminant in the soil and local rivers in Danbury, decades after the elimination of mercury use in hat making and the subsequent closure of the factory there.

Another well-known example of severe mercury toxicity involved the industrial use of inorganic mercury, and its subsequent conversion to organic methylmercury by aquatic microorganisms. In 1955-56, a disastrous outbreak of severe neuro-developmental disorders occurred in the area around Minamata Bay in Japan, with the majority of cases occurring in newborns and children. A large plastic manufacturing plant that used mercuric oxide as a catalyst discharged mercury-containing waste directly into Minamata Bay. This inorganic mercury was methylated by aquatic bacteria, producing a highly absorbable, highly toxic form of organic mercury, which was increasingly bio-concentrated as it progressed up the aquatic food chain. The larger fish were a significant food source for the residents around the bay. The methylmercury ingested by pregnant women and mothers of newborns passed readily across the placenta and into breast milk, and from there into the CNS of the fetuses and children, leading to the severe neuro-developmental disabilities. The adults were relatively unaffected, but their more vulnerable children suffered devastating consequences.

This incident illustrates the process by which fish currently become contaminated by methylmercury. The primary source today is airborne mercury vapor released in the burning of coal by power plants and from the incineration of mercury-containing wastes. Rainfall washes the mercury onto the land, and into streams and rivers where methylation by soil and aquatic bacteria takes place. This is a substantial problem in the Chesapeake Bay watershed, where fish consumption advisories have been issued for *all* lakes and rivers in Maryland and Pennsylvania, and many in Virginia. The advisory applies to rockfish (striped bass) caught in the Chesapeake Bay as well. Fish beyond the Chesapeake area with dangerously high levels of methylmercury include larger predatory fish, such as shark, swordfish, king mackerel, tilefish and orange roughy. Other fish that may be high in mercury include tuna, bluefish, marlin and Spanish mackerel. Useful guides to mercury in fish are available at: www.epa.gov/OST/fish and www.sierraclub.org/communities/mercury/fishguide.pdf.

These food advisories are particularly applicable to pregnant women and women of childbearing age, nursing mothers and young children.

Another organic mercury compound of current interest is ethylmercury, found in thimerosal, an antibacterial preservative previously used in many vaccines, but now limited to multi-dose vials of influenza and tetanus-diphtheria vaccines. No scientific evidence has linked the thimerosal in vaccines to autism or other developmental disorders, and the incidence of autism has not declined following the removal of thimerosal from vaccines. Ethylmercury has a much shorter half-life than methylmercury (10-20 days vs. 70 days) which also lessens its potential for toxicity. Concerns about ethyl mercury arise from toxicity observed with much larger doses of this compound in older pharmaceuticals no longer in use, or inappropriate use of products containing ethyl mercury. These toxic effects have included acrodynia, renal failure, shock and CNS depression.

Treatment of mercury poisoning begins with prevention. Elimination of sources of mercury exposure is of the greatest importance. There is no currently FDA approved chelation therapy for treatment of acute mercury poisoning, though chelators, such as dimercaprol (BAL), d-penicillamine, and succimer (DMSA) have been used in experimental studies for inorganic mercury, and N-acetylcysteine for methylmercury poisoning.

A regional resource, the Mid-Atlantic Center for Children's Health and the Environment (MACCHE) based at the Children's National Medical Center in Washington, DC, is available for consultations and referrals. They can be contacted toll-free at 1-866-622-2431 (1-866-MACCHE1) or at their website www.health-e-kids.org.

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