

HEALTH families Canada adolescents public
children LEARNING youth SAFETY health
needs physicians child babies doctor kids
hospital community help education POLICY
growing medical NUTRITION active paediatric
support literacy vaccinating screening

outfront

ANNUAL REPORT 2007-2008



Canadian
Paediatric
Society

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PRESIDENT'S MESSAGE

A look back at the road ahead



Gary S. Pekeles, MD

No one in the country would argue that young Canadians don't have the right to the best health possible. They have this right regardless of where they live, their families' income, how many generations their families have lived here, their race.

Despite this consensus, nearly 20 years after Canada ratified the United Nations *Convention on the Rights of the Child* we are further than we should be from achieving these rights. *Canada's Child and Youth Health Charter*, which we affirmed with over 20 partners in October 2007, further specifies these rights as including:

- safe and secure physical and social environments.
- access to good nutrition and resources for development and learning.
- access to good health care services.

In a recent UNICEF report, Canada ranks 12th of 21 rich countries in overall child

well-being. We are 22nd among 29 OECD nations in preventable childhood injuries and deaths, and 27th in childhood obesity. Twenty years after a House of Commons vote to end child poverty by 2000, the rate has not changed. Vocal support is clearly insufficient.

In the face of competing demands, in health and elsewhere, the voice of children and youth and voices *for* children and youth are not well heard.

As part of our effort to raise and focus that voice, the CPS has called for the creation of a federal Commissioner for Children and Youth to bridge the gap between the rhetoric and the actions of our political leaders.

After six months, the federal government has finally released the report of its own Advisor on Healthy Children and Youth, Dr. Kellie Leitch. She calls for a National Injury



Prevention Strategy, action to reduce childhood obesity, improvements to mental health services, and a national Office of Child and Youth Health.

The good news is that this report could have been lifted from our own playbook. We met with her several times, and she heard us. The bad news is that the government's lack of enthusiasm for the report is palpable. Together with partners like the Canadian Association of Paediatric Health Centres and the Paediatric Chairs of Canada, we continue to work at this.

As paediatricians working in the community, in regional hospitals and in academic health centres, we know the threat to children's health care services posed by a shortage of appropriately trained health professionals. The prospect for the future is bleak.

The paediatric work force is aging. In 2005, 11 per cent of us planned to retire by 2010, and 30 per cent planned to reduce our work hours. The situation is most critical in smaller communities. We are not training our successors,

particularly in general paediatrics. Again, in the context of increasing access to a handful of procedures for middle-aged and older Canadians, our governments have lost sight of the health needs of children and youth.

The development of a "model of paediatrics" has been and will be extremely useful in our planning and thinking. It will describe specific roles of paediatricians within the larger health care team. However, we can't let differences about the role of primary care in paediatric practice prevent us from articulating together the need for more human resources in child and youth health. Projecting current numbers forward, we will fall short, even using more restrictive models of the role of paediatricians.

Our summary document on the model of paediatrics will be a central part of our strategy but, by itself, won't force provincial governments to define the need and train and recruit health professionals for this and the next generation of Canada's children and youth.

We still have work to do.

“More and more children are left without good access to primary care. This is worrisome because it can impact a child’s future health and development, and can lead to long-term problems—such as obesity—that could be avoided or better addressed.”

Dr. Pascale Gervais, CPS Board of Directors

From coast to coast to coast

The CPS continues to support members where they work and live by advocating for improvements to provincial and territorial public policy affecting children and youth, and by providing support and resources for members who want to advocate in their communities. Membership is on the rise in western, central and eastern Canada.

“Looming mental health issues and the impending shortage of paediatricians in Canada suggest that the wait-time crisis could be just beginning. Resources targeted toward adult wait-time initiatives should not come at the expense of services for children.”

Dr. Andrew Lynk, Chair, Action Committee for Children and Teens



ADVOCACY

Leading and collaborating: How to make a difference for children and youth

The Canadian Paediatric Society continues to be a leading force in shaping public policy on child and youth health.

In June 2007, the CPS released the second edition of *We Doing Enough*, a biennial report that assesses the extent to which governments are using their legislative powers to promote the health and safety of children and youth. In addition to rating provincial/territorial public policy in areas such as paediatric human resource planning, the report calls for federal strategies on injury prevention and mental health.

In the two years since the inaugural report, there has been some progress. Most provinces and territories are making commitments in healthy active living by integrating physical activity and nutrition programs into public schools. Almost all provinces have implemented smoking bans and many have enacted booster seat and ATV laws, though the strength of the legislation remains highly variable across the country.

Still, there is a patchwork of injury prevention policy that puts children and youth at risk. Not only is there a lack of harmonized legislation across the country, even within

provinces and territories there is no consistent approach to applying injury prevention policy.

The 2007 edition of the report also calls for the mandates of provincial/territorial Child and Youth Advocates to be expanded, and for the creation of a federal Commissioner for Children and Youth—powerful, independent voices who would ensure that governments are accountable to every child and youth they serve.

Recognizing that successful advocacy depends on the collective strength of voices, the CPS has been working with the Canadian Medical Association and the College of Family Physicians of Canada to urge the federal government to formally adopt a *Child and Youth Health Charter*. Launched in October 2007, the charter says all children and youth need a safe and secure environment, good health and development and access to a full range of health resources.

The CPS believes that governments must make a difference and is opening political ears and eyes to the challenges Canadian families face.

“Most mental health disorders affecting Canadians today begin in childhood and adolescence. Failure to recognize this fact leads us to dealing with a stage-four cancer, often with major secondary effects, instead of a stage-one or stage-two disease. Like obesity, mental health issues, if not addressed early in life, threaten to bankrupt our health care system.”

Dr. Diane Sacks, Past President, CPS

NATIONAL PROGRAMS

Easing minds and lives

How can one organization help to close the gap between need and delivery when it comes to mental health services for children and youth? Through collaboration, dialogue and the development of useful tools for frontline care providers, that's how.

The CPS Mental Health Task Force recently completed a project to review and rate upwards of 40 screening tools and rating scales for conditions such as anxiety and depression, attention deficit/hyperactivity disorder, autism and Asperger's syndrome, as well as learning and language disabilities. The tools were evaluated on criteria such as capacity for ongoing monitoring, opportunities for interaction, cost and access. The most useful tools are now available to members through the CPS website.

The CPS and McMaster Children's Hospital, with the Canadian Academy of Child and Adolescent Psychiatry (CACAP), developed a new list of recommended books about anxiety through the *Prescription for Information* program. All titles were reviewed by paediatricians and child psychiatrists, so that clinicians can feel confident recommending the resources to patients and families.

Another collaborative project, involving organizations in Canada and the U.S. and a range of experts—paediatricians, psychiatrists, psychologists, social workers and educators—was

endorsed by the CPS in 2007. *Guidelines for Adolescent Depression in Primary Care* (GLAD-PC) does more than take the first step in the continuum of care. Beyond diagnosis, it provides guidance on several treatment fronts: from assessing risk to involving families and schools, from setting individualized goals to knowing when to call in a specialist, from monitoring adverse reactions to medication and support planning. The guidelines and accompanying toolkit are available online at no cost.

The first issue of *Paediatrics & Child Health* in 2008 was dedicated to adolescent medicine in Canada. As guest editors Drs. Sheri Findlay and Jean-Yves Frappier observe, a running theme throughout the issue was “dialogue.” The need for clinicians to dialogue with teens and their families (rather than merely interviewing them), and for family members to talk to one another, is paramount in adolescent health. Active listening, motivational interviewing and pausing for feedback are strategies that help teens engage in their own assessment, and must be cultivated at every opportunity.

Finally, the CPS is bringing together representatives from CACAP, the Canadian Psychiatric Association, the Canadian Psychological Association, the College of Family Physicians of Canada, and the Canadian Association of Paediatric Health Centres to initiate a process to reduce wait times for child and youth mental health services.

“In any organization that is concerned with learning, it is important to understand the needs of your audience. It has to be relevant to their context and practice.”

Dr. Susan Tallett, Chair, CPS Education Subcommittee



PROFESSIONAL DEVELOPMENT

Learning more about learners

The Canadian Paediatric Society is committed to supporting the education of paediatricians, paediatric subspecialists and other child and youth health professionals. With new technologies influencing and changing the way doctors access educational opportunities, how the CPS delivers professional development is also evolving.

In 2007, CPS members confirmed that the Society is doing a good job of addressing the diverse learning needs of its members. A survey by the Continuing Professional Development Committee provided valuable information about how and what CPS members want to learn more about. The feedback has helped the Society identify a number of priority areas.

While most members still choose in-person courses and workshops over other forms of education, online learning is growing in popularity. In response, the CPS has started to

develop online paediatric education opportunities. Initial offerings will include electronic symposia (the online equivalent of a traditional conference, where delegates interact in real time—from the convenience of their own workplace—with expert speakers) from the 2008 Annual Conference and a virtual patient practice in immunization that allows participants to review patient visits online.

CPS members also said they want evidence-based continuing medical education on emerging clinical issues. As a result, subspecialty half-days at the CPS Annual Conference have grown exponentially, with eight programs to be delivered at the 2008 gathering in Victoria.

To further address this need, the Lifelong Learning in Paediatrics Courses will include even more diversity, starting in the fall of 2008.

“Poverty is the single most important determinant of poor health of children, but the solutions are not within the domain of our expertise.

It seems awkward not to address it head on. We need to pause and reflect to determine where the CPS can add value.”

Dr. Gary Pেকেles, CPS President

COLLABORATION

Child poverty: ‘The other inconvenient truth’

It’s widely recognized that social conditions have a profound influence on whether or not children grow up healthy. Provide secure and stable living conditions for families, and children and youth have a much better chance of good health.

Yet in Canada, one in six children lives in poverty, and the numbers are even higher in Aboriginal communities (one in four). Poverty is a risk factor for most negative health outcomes, including infant mortality, asthma, obesity, functional disabilities, poor literacy, poor school readiness, and behavioural and mental health difficulties.

Increasingly, the health care community is shifting its attention to how it can influence the so-called social determinants of health. Over the last year, the CPS took several significant steps toward getting the paediatric community actively involved in combating child poverty.

In October, its peer-reviewed journal, *Paediatrics & Child Health* was part of a global effort spearheaded by the Council of Science Editors to raise awareness, understanding and further research on poverty throughout the world. *Paediatrics & Child Health* was one of 235 peer-reviewed publications in 37 countries taking part in the event.

The theme issue of *Paediatrics & Child Health* provided a Canadian perspective on poverty, exploring issues such as

poverty during pregnancy, its relation to obesity and its impact on educational outcomes for children. The journal examined what paediatricians, family physicians and other child health professionals can do to break the cycle and improve health outcomes for disadvantaged children.

During the 2007 Annual Conference, a capacity crowd attended an innovative symposium on child poverty, featuring community leaders, a leading *Globe and Mail* journalist, and experts in social paediatrics. “Poverty is the great crippling disease of childhood, just like polio used to be,” said event co-chair Dr. Lee Ford-Jones. “It’s the other inconvenient truth.”

If paediatricians want to have a significant impact on child poverty, they don’t necessarily have to work more—but they will have to work differently. Speakers emphasized the need to work with colleagues and organizations outside of medicine to make lasting change, whether at the local, provincial/territorial or national level.

Canada is trailing behind other developed countries when it comes to reducing childhood poverty—it currently ranks 19th out of 26 OECD countries in terms of the percentage of children living in relative poverty. There is also significant variability, not only across provinces, but within certain communities, all pointing toward a need to intensify Canada’s efforts.

“The International Meeting on Indigenous Child Health represents a movement toward change and highlights the role physicians and health care workers can play in improving care for Aboriginal communities—in Canada, the U.S., and elsewhere.”

Dr. Kent Saylor, Chair, CPS First Nations, Inuit and Métis Health Committee



COLLABORATION

A movement for change

When more than 160 people met in Victoria, B.C. in 2005 and declared a commitment to improving the health of First Nations, Inuit and Métis children and youth, they knew it was just the first step in what would be a long-term movement for change.

Many Hands, One Dream is the name of an informal and growing network of organizations, communities and individuals—including the Canadian Paediatric Society—that want First Nations, Inuit and Métis children and youth to have the best chance at good health. Since that first historic gathering was held, the group has been taking a solutions-oriented approach to reaching their goal.

In 2007, the organizations involved in *Many Hands, One Dream* promoted a national advocacy campaign to encourage the federal and provincial/territorial governments to adopt a child-first principle to resolving jurisdictional disputes involving the care of First Nations children. In December 2007, members of Parliament voted unanimously in support of a private member’s bill to adopt “Jordan’s Principle,” which would ensure that children no longer face delays or disruptions in essential medical and

health services because of disputes over which government should pay the bills. Continued advocacy is needed to ensure that the federal government works with provinces and territories to put Jordan’s Principle into practice.

Through the CPS, efforts are underway to ensure that health professionals are able to provide the best quality care to First Nations, Inuit and Métis children and youth. A group of paediatricians is developing a training module for paediatric residents that will eventually be shared with and adapted for other health professionals.

Plans are also underway for the 3rd International Meeting on Indigenous Child Health, to be held in March 2009 in Albuquerque, New Mexico. This cross-border meeting, held in collaboration with the American Academy of Pediatrics, is a chance for child health providers and researchers who work with American Indian, Alaska Native, First Nations, Inuit, and Métis children and families to come together and share solutions and strategies for promoting health in these communities. The 2007 gathering, held in Montreal, emphasized “Solutions, Not Problems.”

**“The D debate: How much of the vitamin to take?
The cancer and paediatric societies are calling for
much higher doses than Health Canada’s decade-
old standard”**

Headline from *The Globe and Mail*, September 10, 2007

COMMUNICATION

On the frontlines, in the headlines

There was a time you had to pick up a medical journal to find out what the Canadian Paediatric Society was saying about the latest child and youth health issue. Today, you’re just as likely to be reading about it in a major newspaper or online magazine. Increasingly, the CPS is helping to shape public debate about health issues that matter to Canadians. This year, the range of topics was broad and diverse—from vitamin D to cough and cold medications, from a new vaccine to trampoline safety.

The First Nations, Inuit and Métis Health Committee’s statement on vitamin D supplementation for babies and pregnant and lactating women was released as new studies promoting the health benefits of the “sunshine vitamin” made headlines. Several national health groups had recommended increased daily doses for adults, and public interest in the vitamin’s potential to prevent disease was growing. News of the CPS recommendations helped re-ignite the ongoing debate.

The CPS was also in the vanguard of debate over the safety and efficacy of over-the-counter cough and cold medications for young children. When the U.S. Food and Drug Administration advised last fall against giving the medication to any child under 2 years of age, CPS media spokespeople helped Canadians make sense of the recommendations. Despite voluntary product recalls by two major drug companies and a further FDA public health

advisory, this debate is far from over. Experts still need to decide whether OTCs are safe for young children over 2 years.

Human papillomavirus (HPV) immunization has also been a hot topic for the media. The good news is that both the CPS and the Society of Obstetricians and Gynaecologists of Canada have strongly endorsed a vaccine that is highly effective against the strains of HPV responsible for most cervical cancer cases. The bad news is that immunization is being resisted in some quarters. Dissent from some in the media and medical community is influencing parents, if the low compliance rate in Ontario is anything to go by. About half of parents surveyed did not want their daughters vaccinated against HPV. Fortunately, paediatricians are in an excellent position to influence families.

A joint statement on trampoline safety was the springboard for national news coverage on this potential risk to children and youth. The CPS collaborated with the Canadian Academy of Sport Medicine to recommend that trampolines not be used in backyards and playgrounds.

When CPS is in the news, parents, caregivers and policy makers know that the message is clear, evidence-based and—this year—well ahead of the curve.

“Jaundice can be hard to detect—especially at the time babies go home from hospital. But the severity of jaundice can be predicted through screening, which is now being recommended for all newborns in Canada.”

Dr. Keith Barrington, Chair, CPS Fetus and Newborn Committee



CLINICAL PRACTICE

From policy to practice to outcomes

At the heart of the CPS are its position statements, which aim to change clinical practice, patient behaviour and—increasingly—public policy. The recommendations issued by CPS committees over the past year promise to have dramatic implications on all these fronts, with benefits to children, youth and families across Canada.

In hospitals, recommendations from the CPS Fetus and Newborn Committee are changing the way babies are cared for in their first hours and days of life. Screening day-old newborns for hyperbilirubinemia, as the committee recommends, will help improve treatment for jaundice and could reduce the incidence of severe complications such as kernicterus. The committee also recommends that all expectant mothers be screened for group B *streptococcus*, which will help prevent the most common cause of neonatal sepsis.

In communities, many girls between the ages of 9 and 13 are being immunized against human papillomavirus, the most common sexually transmitted infection and a major cause of cervical cancer. The CPS Infectious Diseases and Immunization Committee recommends the vaccine, along with “catch-up” programs for older girls and programs to

improve sex education and teen participation in routine cancer screening. The First Nations, Inuit and Métis Health Committee has recommended that babies, especially those in northern communities, receive enough vitamin D supplementation to prevent diseases like rickets and promote healthy development. It adds that Canadian women should also take adequate vitamin D while they are pregnant.

In emergency rooms, guidelines from the Child and Youth Maltreatment Section are helping to raise awareness about the hidden symptoms of abusive head trauma, so that doctors and nurses will be more likely to examine a child closely even if there is no outward sign of injury. The guidelines will help child protection workers and the police develop their own local protocols for identifying and dealing with child maltreatment, and enable those working with families to assess risk and need, coordinate support and share information more effectively.

In physicians’ offices across Canada, position statements from CPS committees help clinicians deliver evidence-based care and advice to parents and families—from how to choose and use an appropriate car seat to the risks of recreational trampoline use.

COMMITTEES AND SECTIONS

Members of committees and sections devote hundreds of hours each year to developing position papers, providing expert advice on issues related to their area of expertise, advocating on child and youth health issues, working on CPS projects and continuing professional development, serving as media spokespeople, and much more.

Executive Committee

Gary S. Pekeles, MD	President
Joanne E. Embree, MD	President-Elect
Kenneth J. Henderson, MD	Vice President
Robert M. Issenman, MD	Past President
Marie Gauthier, MD	Representing the Board of Directors
Theodore A. Prince, MD	Representing the Board of Directors
Glen Kielland Ward, MD	Representing the Board of Directors
Danielle Grenier, MD	Medical Affairs Officer
Marie Adèle Davis	Executive Director

Board Subcommittee Chairs

Joanne E. Embree, MD	Membership
Robert M. Issenman, MD	Communications
Susan E. Tallett, MD	Education
Glen Kielland Ward, MD	Finance and Audit
Andrew Lynk, MD	Action Committee for Children and Teens
Robert M. Issenman, MD	Public Education

Committee Chairs

Angelo Mikrogianakis, MD	Acute Care
Jorge L. Pinzon, MD	Adolescent Health
Paul N. Thiessen, MD	Annual Conference
Charlene M.T. Robertson, MD	Awards
Ellen Tsai, MD	Bioethics
Mark E. Feldman, MD	Community Paediatrics
Susan E. Tallett, MD	Continuing Professional Development
Michael J. Rieder, MD	Drug Therapy and Hazardous Substances
Keith J. Barrington, MD	Fetus and Newborn
Kent D. Saylor, MD	First Nations, Inuit and Métis Health
Claire LeBlanc, MD	Healthy Active Living and Sports Medicine

Robert Bortolussi, MD	Infectious Diseases and Immunization
Lynne J. Warda, MD	Injury Prevention
T. Emmett Francoeur, MD	Nominating
Valérie Marchand, MD	Nutrition and Gastroenterology
Ian M. Wilson, MD	Physician Resource Planning
John C. LeBlanc, MD	Psychosocial Paediatrics

Section Presidents

Johanne Harvey, MD	Adolescent Health
Zave H. Chad, MD	Allergy
Laurel A. Chauvin-Kimoff, MD	Child and Youth Maltreatment
David T. Wong, MD	Community Paediatrics
Jill Suzanne Houbé, MD	Developmental Paediatrics
Suzette R. Cooke, MD	Hospital Paediatrics
Douglas D. McMillan, MD	International Child Health
Clare Gray, MD	Mental Health
Francine Lefebvre, MD	Neonatal-Perinatal Medicine
C. Robin Walker, MD	Paediatric Environmental Health
Angelo Mikrogianakis, MD	Paediatric Emergency Medicine
Ross Anderson, DDS	Paediatric Oral Health
Bianca A. Lang, MD	Paediatric Rheumatology
Laura K. Purcell, MD	Paediatric Sports and Exercise Medicine
Ereny Bassilious, MD	Residents
David Wensley, MD	Respiratory Medicine

Paediatrics & Child Health

Noni MacDonald, MD, and
Elizabeth (Lee) Ford-Jones, MD Editors-in-chief

Immunization Monitoring Program, ACTIVE (IMPACT)

Scott Halperin, MD, and	Principal Investigators
David Scheifele, MD	(until December 2007)
Wendy Vaudry, MD	Principal Investigator
	(as of January 2008)

Canadian Paediatric Surveillance Program

Gilles Delage, MD	Chairman, Steering Committee
	(until December 2007)
Lonnice Zwaigenbaum, MD	Chairman, Steering Committee
	(as of January 2008)



A home for specialty interests

Nearly half of all members belong to one or more of the Canadian Paediatric Society's 15 specialty sections. The sections—which include neonatal-perinatal medicine, hospital paediatrics and mental health—allow members with a special interest to share ideas, network and develop education.

NEW PUBLICATIONS

Published since the 2006-2007 Annual Report

Brochures

- Bedwetting
- Colic and crying
- Common infections and your child
- Getting your shots: HPV vaccine
- Guiding your child with positive discipline
- Healthy bowel habits for children
- Healthy sleep for your baby and child
- Healthy teeth for children
- Playground safety
- Toilet learning
- Vaccination and your child
- When your child misbehaves: Tips for positive discipline
- You and your child's doctor

Position statements and Practice Points

Adolescent Health Committee

- Harm reduction: An approach to reducing risky health behaviours in adolescents
- Issues of care for hospitalized youth
- Transition to adult care for youth with special health care needs

Bioethics Committee

- Guidelines for genetic testing of healthy children (addendum)
A joint statement with the Canadian College of Medical Geneticists

Children and Youth Maltreatment Section

- Multidisciplinary guidelines on the identification, investigation and

management of suspected abusive head trauma (*with eight co-signatories*)

Community Paediatrics Committee

- Special considerations for the health supervision of children and youth in foster care

Fetus and Newborn Committee

- Management of the infant at increased risk for sepsis

First Nations, Inuit and Métis Health Committee

- Vitamin D supplementation: Recommendations for Canadian mothers and infants

Healthy Active Living and Sports Medicine Committee

- Trampoline use in homes and playgrounds
A joint statement with the Injury Prevention Committee and the Canadian Academy of Sport Medicine

Infectious Diseases and Immunization Committee

- Antifungal agents for common paediatric infections
- Human papillomavirus vaccine for children and adolescents
A joint statement with the Adolescent Health Committee
- Infection control in paediatric office settings
- Needle stick injuries in the community
- Prevention of congenital rubella syndrome
- Testing for HIV infection in pregnancy

- Therapy of suspected bacterial meningitis in Canadian children six weeks of age and older
- West Nile virus: In the context of climate change

Injury Prevention Committee

- Transportation of infants and children in motor vehicles

Paediatric Emergency Medicine Section

- Paediatric basic and advanced life support guidelines: An update

Paediatric Environmental Health Section

- Paediatricians and the environment: Bringing our expertise to the support of Canadian children's health

Paediatric Sports and Exercise Medicine Section

- Exercise and febrile illnesses

Information for parents and caregivers

- Are home trampolines safe?
- Biting in child care: What are the risks?
- Car seat safety
- Growing up: Information for boys about puberty
- Growing up: Information for girls about puberty
- Needle stick injuries
- A parent's guide to immunization on the Internet
- Rubella (German measles) in pregnancy
- Teens and sleep: Why you need it and how to get enough
- Testing for HIV during pregnancy
- Vaccine safety



NOTE FROM THE FINANCE AND AUDIT COMMITTEE

Over the years, the Canadian Paediatric Society has evolved into a complex organization with many sources of revenue and numerous projects. As a non-profit and mission driven organization, our financial goals are inextricably tied to what we can accomplish for Canadian children and youth, and for our membership. Our aim is to end each fiscal year in a break-even position.

The financial statements on pages 16 and 17 show a loss of over \$50,000 for 2007, representing approximately 1 per cent of total revenue. In large part, this is due to a change in accounting standards set out by the Canadian Institute of Chartered Accountants (CICA). The CICA requires organizations like the CPS to record investments at market value, as opposed to the cost value which was the previous practice, making us more vulnerable to fluctuating market forces. On the positive side, this resulted in a one-time increase of approximately \$186,000 to the net assets. We do not expect these changes or losses to be repeated in future years.

The CPS remains in a very solid financial position, with almost \$2 million in investments and gross assets of over \$3.6 million.

Glen K. Ward, MD, FRCPC
Chair, Finance and Audit Committee

FINANCIAL STATEMENTS

Auditors' Report

To the Members of the **Canadian Paediatric Society**

We have audited the statement of financial position of the **Canadian Paediatric Society** as at **December 31, 2007** and the statements of operations, changes in net assets and cash flows for the year then ended. These financial statements are the responsibility of the Society's management. Our responsibility is to express an opinion on these financial statements based on our audit.

We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we plan and perform an audit to obtain reasonable assurance whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation.

In our opinion, these financial statements present fairly, in all material respects, the financial position of the Society as at **December 31, 2007** and the results of its operations and cash flows for the year then ended in accordance with Canadian generally accepted accounting principles.

Ottawa, Canada
March 14, 2008



Chartered Accountants
Licensed Public Accountants

Statement of Financial Position

December 31

	2007 (\$)	2006 (\$)
Assets		
Current Assets		
Cash	197,071	39,074
Investments	1,919,619	1,826,803
Accounts receivable	755,427	868,829
Inventory	139,288	271,694
Prepaid expenses	71,717	73,943
	3,083,122	3,080,343
Other Asset	108,000	108,000
Capital Assets	439,292	494,567
	3,630,414	3,682,910
Liabilities		
Current Liabilities		
Accounts payable and accrued liabilities	738,753	812,418
Deferred revenue	1,113,560	1,236,684
Due to Healthy Generations	53,681	36,093
	1,905,994	2,085,195
Net Assets		
Special Projects Fund	122,901	122,901
Paediatrics & Child Health Fund	59,215	46,345
Section Funds	86,613	82,121
Development Fund	80,000	80,000
Net Assets Invested in Capital Assets	439,292	494,567
Operating Fund	936,399	771,781
	1,724,420	1,597,715
	3,630,414	3,682,910

FINANCIAL STATEMENTS

Statement of Operations

Year ended December 31

	2007 (\$)	2006 (\$)
Revenue		
Grants and sponsorships	1,755,285	1,751,938
Membership dues	590,731	607,779
Projects	631,786	472,752
Meetings	457,033	467,986
Publication sales	625,012	444,550
Investment income	85,202	97,227
Advertising fees	49,973	46,853
Miscellaneous	14,650	14,609
	4,209,672	3,903,694
Expenditures		
Salaries and benefits	1,345,618	1,245,611
Meetings	768,184	885,659
Printing and postage	395,871	451,679
Travel	375,097	328,132
Administrative services	493,685	342,690
Projects	426,597	134,372
Rent	285,847	280,120
Technology services	86,400	78,179
Amortization	91,750	106,030
	4,269,049	3,852,472
Excess of (Expenditures over Revenue)		
Revenue over Expenditures	(59,377)	51,222

A complete set of audited financial statements
is available on the CPS website at
www.cps.ca

Statement of Changes in Net Assets

Year ended December 31

	2007 (\$)	2006 (\$)
Special Projects Fund		
Balance at beginning of year	122,901	122,901
Balance at end of year	122,901	122,901
Paediatrics & Child Health Fund		
Balance at beginning of year	46,345	40,695
Transfer from Operating Fund	12,870	5,650
Balance at end of year	59,215	46,345
Section Funds		
Balance at beginning of year	82,121	79,864
Transfer from Operating Fund	4,492	2,257
Balance at end of year	86,613	82,121
Development Fund		
Balance at beginning of year	80,000	80,000
Balance at end of year	80,000	80,000
Net Assets Invested in Capital Assets		
Balance at beginning of year	494,567	586,976
Transfer to Operating Fund	(55,275)	(92,409)
Balance at end of year	439,292	494,567
Operating Fund		
Balance at beginning of year, as previously reported	771,781	636,057
Adjustment on implementation of financial instruments standards	186,082	—
As restated	957,863	636,057
Excess of (expenditures over revenue) revenue over expenditures	(59,377)	51,222
Transfer to Paediatrics & Child Health Fund	(12,870)	(5,650)
Transfer to Section Funds	(4,492)	(2,257)
Transfer from Net Assets invested in Capital Assets	55,275	92,409
Balance at end of year	936,399	771,781

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The future voice of child and youth health

Did you know that every paediatric resident in Canada is a member of the Canadian Paediatric Society? As the future voice of child and youth health in Canada, paediatric residents play a critical role in shaping the CPS. And thanks to continued support from paediatric training programs, many residents are able to participate without financial barriers.

Widening the circle

In just 10 years, membership in the CPS has increased 30 per cent, with more than 2,600 members in 2007-2008. Not only does the CPS have a broader range of membership options, including categories for non-paediatrician physicians and other health care professionals, but the quality and scope of programs and services continues to attract new members and keep longtime members involved.

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