
Canadian Paediatric Society

# 2009-2010 annual report




“There are two things we should give our children: One is roots and the other is wings.”

—Hodding Carter Jr., journalist and civil rights activist

# contents

# Local matters, national impact

Kenneth J. Henderson, MD, FRCPC

To paraphrase the former U.S. House Speaker Tip O'Neill: All paediatrics is local. Our success as a national organization depends on our ability to understand and reflect what's happening in the clinics, hospitals and communities across the country. As advocates for public policy that protects children and youth, we need to give voice to what paediatricians see and hear every day. As an organization mandated to support the professional needs of paediatricians, we need to be part of your world. And to do that, we have to be listening.

More than ever, running an effective member-based organization means engaging in conversation. We are doing our job if you, as members, feel you have a meaningful way to contribute to and influence the organization's priorities. The issues at the top of our agenda are there because of members—whether it's a clinical concern such as mental health, a professional need like online education, or an advocacy priority such as a federal Commissioner for Children and Youth.

Solutions to broad-based paediatric health problems also start locally. Long before childhood obesity became a "national epidemic" and headline news, paediatricians were managing the problem daily. Today, few decision-makers need convincing that physical activity and good nutrition for *all* children and youth must be supported by public policy and programming. Yet in the early days of the CPS healthy active living initiative, the paediatricians involved had to spend much of their time persuading people that there was a problem, before they could even start to talk about solutions.

With the recent creation of a new Mental Health Committee for the CPS—which evolved from an active task force—we hope

to be in a similar position several years from now. That is, we hope Canadians don't need to be convinced that action on mental health is urgently needed. Estimates are that 14% of children and youth under 20 years old—1.1 million young Canadians—suffer from mental health conditions that affect their daily lives. While clinicians know this is a critical paediatric issue, we have yet to see a corresponding public outcry over this impending crisis.

Kenneth J. Henderson

As with childhood obesity in the early days, public policy is lagging far behind: While the Mental Health Commission of Canada is developing a national mental health strategy with provisions for children and youth, the CPS has been calling on provinces and territories to act now. Many still do not have a mental health plan. In jurisdictions where a plan does exist, access to mental health services continues to be insufficient and, in some cases, is declining.

Healthy active living advocates often make their case by drawing the link between childhood obesity and chronic disease in adulthood—a powerful argument in the face of ever-rising health care costs. Similarly, about 70% of mental illnesses have their onset in childhood or adolescence, reinforcing the importance of early monitoring, prevention and treatment to reduce their potential lifelong impact.

We also know that action on the social determinants of health—particularly the living conditions of children's families—can have an impact on both mental health and obesity. That is why action on child poverty has become a top priority for the CPS, and was featured for the first time in our status report on Canadian public policy affecting children and youth, *Are We Doing Enough?*

Meeting the mental health needs of children and youth takes resources. These are complex problems that require skill, time, and care. Yet health care for children and youth is threatened by a significant shortage of paediatricians (among other specialists and subspecialists) and long wait lists for specialized services.

In 2009, the CPS released its *Model of Paediatrics*, developed to help health care planners determine how many paediatricians must be in place to serve a given population. It made clear what we have known for some time: Paediatricians are critical to the health of children and youth, they are in short supply, and the current shortage will become even more acute without immediate action. Many of you have been telling the health care planners in your region for years that there's a crisis in paediatrics. Now you have something to help them solve the problem.

Along with *Are We Doing Enough?,* the *Model of Paediatrics* is an advocacy tool that depends on local action. It comes to life when a paediatrician says to a decision-maker, "Let's work together and see what we can do for kids in our community."

As a national organization, we can describe the need for change, but you have the power to make the change happen.

Over the past year, I've had the privilege of seeing up close how CPS members are changing the lives of children and youth every day. I'm also grateful for the support of the Ottawa-based staff. It's been an honour and a pleasure to serve as president, and I'm looking forward to continuing this work in the years to come.

# Root systems change flight patterns: The social determinants of health

Economic tough times only underscore what experts already know: Giving children what they need to thrive in their early years is critical to their health and well-being later in life. The leading social determinants of health could not be more basic: among them, income, education, housing, early childhood development. Indeed, living conditions can play a far greater role in the long-term health of children and youth than health services per se. Yet the need to meet such essential conditions—especially when families are struggling—is emerging as a unifying, urgent theme in CPS advocacy.

CPS efforts on behalf of children and youth health converged this year in the latest edition of *Are We Doing Enough?* Poverty is the driving theme. Several provinces/territories do not have child poverty legislation or strategies in place, and the CPS is calling for a national poverty strategy. Government investment in programs that affect children early and directly have huge social and economic benefits. What is more, these benefits are just as measurable as the terrible costs of *not* taking action, with populations that are already disadvantaged or marginalized paying the highest price for government neglect. *Are We Doing Enough?* calls on all levels of government to set specific targets and timetables to address disparities in income and opportunity.

The CPS believes that child and youth poverty rates should carry the same political import as rates of interest, inflation and employment.

While solutions for reducing child and youth poverty include income support, job training, and settlement programs for new Canadians, the need for accessible, quality child care and early childhood education are especially important for working parents. The CPS has advocated for a national child care strategy since 2008, but December's theme issue of *Paediatrics & Child Health* gave these efforts new impetus by putting Canada's record on public policy for our youngest citizens squarely in perspective. Child development programming falls short of what is needed, still shorter of what might be considered "good enough," and far short of what children deserve. In fact, Canada ranks last among economically advanced nations on the two most recent international rankings of commitment to the early childhood years.

Another driver of CPS advocacy is the need for access to mental health services for children and youth. This indicator was also measured in the 2007 status report. Two years later, despite the Mental Health Commission and allied efforts, there is still no national strategy to address the growing mental health needs of children and youth. Many provinces and territories do not have a mental health plan. Where plans exist, mental health services are lacking, and in some places have even declined since 2007. The CPS is now urging provinces and territories not to wait for a federal framework, but to act immediately by coordinating and implementing strategies to meet critical local needs.

There are other markers of child and youth health and well-being measured in *Are We Doing Enough?*, such as injury and disease prevention. Both have been CPS advocacy positions for some time, and both have strong causal links with poorer regions and populations. Research shows that children and youth who live in poverty still have higher rates of death due to unintentional injury than those who do not. The CPS continues to call for a national injury prevention strategy. Two indicators for disease prevention, publicly-funded immunization programs and measures to prevent and reduce adolescent smoking, yield better—though still telling—results. While disparities in vaccine access are undoubtedly narrowing, children and youth from low-income families are still far more likely to have incomplete immunization coverage than their peers from higher-income families. Similarly, although smoking among teens continues to drop in all provinces and territories, teens from low-income families are still bucking the national trend.

The CPS believes that child and youth poverty rates should carry the same political import as rates of interest, inflation and employment. The social determinants of health form a kind of root system for future generations, and must be nourished accordingly.

# On H1N1, a responsive and trusted source of information

In a year that saw a major public health scare, the CPS emerged as a responsive leader in providing reliable information. By mobilizing members and staff before H1N1 virus had become front page news, the CPS provided health care professionals and the public with the most credible, up-to-date information about the implications of H1N1 influenza virus and vaccination for children and youth.

Other health care organizations looked to the CPS to set policy and provide education around issues dealing with children and youth. The CPS worked alongside the Public Health Agency of Canada to get information to those who needed it.

What allowed CPS to be so responsive? The basics: partnership and preparation. Members of the Infectious Diseases and Immunization Committee took the lead in developing and updating resources, and also communicated through media such as *The Globe and Mail*, *National Post*, *Today's Parent*, *CBC News*, and *Canwest News Service*.

The CPS was set apart by the timeliness with which it responded to an ever-changing landscape. Though misinformation and confusion were widespread in the early days of the flu season, from the outset the CPS aimed to ensure its information was helpful and consistent with what was coming from the Public Health Agency.

The team of CPS volunteers and influenza experts from across Canada made protecting children and youth a priority and were at the front-of-the-line in developing answers to the emerging questions. By early fall, the CPS was publishing regular information and updates to its website on topics such as the vaccine, antiviral drugs, strategies for protecting infants, infection control, and dispelling myths.

Using electronic and print communications, including trusted websites for medical professionals, parents and caregivers, *Paediatrics & Child Health,* electronic newsletters and social media, the CPS focused on reaching audiences quickly and in places where they gather information.

Finding reliable resources can be difficult. By providing a central, trusted source of information in a timely way, the CPS supported its members and front-line health care professionals when they needed it most, while at the same time responding to the information needs of parents and caregivers.

## Online health information seekers turn to CPS

From October 2009 to March 2010, information and resources on H1N1 were accessed:

- more than 27,000 times on www.cps.ca, and
- more than 13,000 times on www.caringforkids.cps.ca.

Information on fevers and temperature-taking was accessed almost 100,000 times over the same period.

# Connected with members

New technologies allow the Canadian Paediatric Society to be a more connected network than ever before, with opportunities to provide information and facilitate connections among members across the country. With these advances come new expectations about knowledge sharing. The CPS expects to provide members with current, up-to-date resources as quickly as possible. And members expect to receive critical information without delay, and without having to spend a lot of time looking for it or trying to make sense of it. In this information age, communications must be clearer and more convenient than every before.

But it's more than just communicating; it's about developing opportunities for members to have more meaningful connections with the Society and with each other.

EForums were launched in October 2009 to enable online discussion and information sharing among CPS sections and provide a platform to exchange ideas with colleagues across the country. EForum participants have engaged in lively online discussions on issues from H1N1 to systems of care and advocacy.

The CPS also recently launched a new Facebook community page. It's an opportunity for the CPS to provide members with regular updates and links to organizational news, publications, and upcoming professional learning opportunities. And this social media tool is also a step toward connecting paediatric health professionals in discussion and advocacy.

The CPS website continues to be a destination for timely, relevant resources. The online member centre received a facelift to make it more useful for members. It's now a centralized, easy-to-navigate portal where members can update their own profile, access media and advocacy tools, find contact information for CPS members or use services such as the national locum posting board and section eForums.

At the local level, the CPS now sends members electronic communication with region-specific information. Provincial/territorial member newsletters provide updates on issues discussed by the Board of Directors, both on a national and regional scale, and facilitate discussion and interaction between members and their board representatives.

The Society will continue to take advantage of new and innovative ways to connect with members, be responsive and engage in discussions to support member needs.

## Membership snapshot

| Member type | 2004 | 2009 |
|---|---|---|
| AAP members | 6 | 8 |
| Associate health care professionals | 61 | 110 |
| Associate medical students | 19 | 47 |
| Associate physicians, dentists and surgeons | 22 | 58 |
| Corresponding Fellows | 17 | 25 |
| Emeritus Fellows | 260 | 340 |
| Fellows | 1285 | 1528 |
| Honorary members | 2 | 5 |
| Life members | 10 | 20 |
| Residents | 506 | 690 |
| **Total** | **2308** | **2831** |

# Expanding newborn care: NRP takes off

Since becoming the Canadian home for the Neonatal Resuscitation Program (NRP) in 2006, the CPS has brought a new and distinctly national face to training in the acute care of newborns. Several initiatives have contributed to this transformation.

First among these is the program's impressive web presence. Newly redesigned and upgraded, the NRP website (at www.cps.ca) is a user-friendly, interactive gateway to guidelines, resources, and learning components. An online database for instructors and coordinators became fully operational in 2009. Program coordinators and instructors across the country can now submit teaching rosters, generate course provider cards, monitor their instructor status, receive program updates, and communicate with one another, all online. By tracking regional data, the database also allows key program information to be retrieved—such as where teacher shortages are occurring. Through a new eForum, program participants can discuss issues and share information with colleagues or instructor trainers from right across Canada.

While the NRP's web profile has been hugely cohesive, the program's multidisciplinary approach and outreach best reflect its national character.

## NRP registration soars!

- Canada now has 1547 NRP instructors.
- In 2008, 90 new instructors registered; in 2009, 177: an almost 97% increase.
- 28,000 providers have been registered by Canadian instructors to date. Here's a snapshot: 51% are registered nurses, 18% are doctors, 12% are respiratory therapists, 2% are registered midwives, and 16% are in other health care professions (paramedics, nurse educators, etc.).

NRP management is led by a steering committee whose membership and activities underscore how many health professions may be involved in caring for newborns in their first minutes of life. NRP courses are provided to a wide range of licensed or regulated health professionals, including nurses and nurse practitioners, midwives, paramedics, respiratory therapists and, of course, medical residents and practitioners. There is ongoing provincial/territorial involvement in curriculum development and dissemination as well. Regional liaisons regularly report to the steering committee on changes in local treatment or management that might feed into a national protocol later on.

From its beginnings, the NRP's teaching model was based on a team approach and shared responsibilities. This paradigm has shaped participant outreach and collaborations nationwide, most recently finding expression in project funding. The NRP's first annual research grant was awarded to a study of how behaviours or attitudes contribute to successful resuscitation in an interprofessional team setting. The study's objective is to develop a tool to assess these skill sets in a group context.

What else makes NRP Canadian? There are unique, fully bilingual guidelines focused on the acute care of infants born on this side of the border. There have been Canadian adaptations and amendments to the NRP textbook and algorithms since 2006. As best practices evolve, clinicians, scientists and educators are defining approaches and recommendations for specific treatment modifications that reflect the Canadian context. Current examples include performance checklists and Megacode testing, a slide presentation kit and reference chart. New and innovative tools are also in development.

In keeping with other CPS continuing professional development initiatives, course formats are becoming more hands-on, interactive, and personalized—especially for evaluation and feedback—than ever before. New modalities, specifically simulation and debriefing, are being developed to "team teach" a new layer of competencies.

Now fully fledged and poised for flight, the NRP is sure to play a pivotal role in the evolving continuum of newborn care.

# Training wings: New courses piloted online

Over the last decade, a "typical" day in the life of a paediatrician has been transformed by communications technologies. What medical practitioners now value in their education—whether as trainers or lifelong learners—is changing too. The CPS has responded to the need for convenient, flexible ways to learn by offering education in new formats, to more participants, with a greater potential for instructor/learner interaction than ever before.

Web-based programming is the leading edge in medical education. Several online courses—from ADHD, to lysosomal storage disorders to invasive meningococcal disease—are now available through the CPS partnership with AdvancingIn Paediatric Health and mdBriefCase. One course developed in collaboration with the Public Health Agency of Canada, on H1N1 and seasonal influenza, is already online. Another, on immunization competencies, is in the works. Evidence-based and up-to-date, these offerings are more user-friendly than traditional formats. Learners can take a course when and where they want. They can interact with instructors in real time or with patients in "virtual practice" scenarios.

In effect, the learning experience itself is under transformation: Modules can be designed like a workshop, with a team-teaching approach, and practical hands-on features, including an expert's

critique and evaluation. These online courses are also designed to be more inclusive, both as to content and participation. Not only are the health needs of populations that may be under-represented in mainstream curricula better reflected, but these new learning opportunities are also open to a much broader range of licensed health professionals than ever before.

The Immunization Competencies Education Program grew out of the recognition that an increasing number and wider range of health professionals are now involved in administering vaccines. Providing education that is multidisciplinary, yet firmly grounded in required knowledge and core practice, is essential. Video footage was taken at a live course in December 2009 to complement content being developed collaboratively by CPS faculty and other health professionals. A pilot program will be reviewed by all course participants and launched this coming December at the 9th Canadian Immunization Conference in Quebec City. The Immunization Competencies Education Program is designed not only to enhance knowledge, practice, and skills among vaccine providers, but to promote public confidence around vaccine effectiveness and delivery, and to foster relationships among health professionals unaccustomed to working together.

If anyone remained in doubt about the importance of inter-professional cooperation and exchange, this lesson was driven home by H1N1. The new influenza course was developed from clinical guidelines and other documents produced during the 2009-10 flu season. A team of infectious disease specialists, led by the CPS Infectious Diseases and Immunization Committee and collaborating closely with government health experts at the Public Health Agency, cooperated on information and messaging throughout the crisis. Their work laid the basis for a course designed for paediatricians, family physicians and public health professionals. Since children and youth are particularly vulnerable to H1N1, timely guidance for front-line health care providers could prove critical over the coming months.

## Who's taking online courses?

| Course title and participant totals | Nov. 2009 | Mar. 2010 |
|---|---|---|
| **Paediatric update** | **226** | **464** |
| Paediatricians | 37% | 30% |
| Family physicians | 18% | 18% |
| Other MD specialists (except paediatricians) | 19% | 11% |
| Allied health professionals | 26% | 41% |
| **ADHD: Measuring outcomes beyond the classroom** | **119** | **612** |
| Paediatricians | 24% | 22% |
| Family physicians | 22% | 26% |
| Other MD specialists (except paediatricians) | 23% | 20% |
| Allied health professionals | 31% | 32% |
| **Pneumococcal "virtual practice"** | **1075** | **1849** |
| Paediatricians | 29% | 32% |
| Family physicians | 18% | 21% |
| Other MD specialists (except paediatricians) | 6% | 6% |
| Allied health professionals | 47% | 41% |

For the Paediatric update course, total participants more than doubled in six months.

For the ADHD course, total participation increased more than five-fold in the same period: an almost 200% increase.

For the Pneumococcal "virtual practice," the first bilingual course offered by AdvancingIn *and* mdBriefCase, total participation rose by almost 60% in six months.

# 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

| | |
|---|---|
| Kenneth J. Henderson, MD | President |
| Robert I. Hilliard, MD | President-Elect |
| Jean-Yves Frappier, MD | Vice President |
| Joanne E. Embree, MD | Past President |
| Minoli N. Amit, MD | Representing the Board of Directors |
| Pascale Gervais, MD | Representing the Board of Directors |
| Robert Moriartey, MD | Representing the Board of Directors |
| Danielle Grenier, MD | Director of Medical Affairs |
| Marie Adèle Davis | Executive Director |

## Board Subcommittee Chairs

| | |
|---|---|
| Joanne E. Embree, MD | Membership |
| Marie Gauthier, MD | Communications |
| Susan E. Tallett, MD | Education |
| Kenneth J. Henderson, MD | Finance and Audit |
| Andrew Lynk, MD | Action Committee for Children and Teens |
| Glen Kielland Ward, MD | Public Education |

## Committee Chairs

| | |
|---|---|
| Angelo Mikrogianakis, MD | Acute Care |
| Jorge L. Pinzon, MD | Adolescent Health |
| Jeremy N. Friedman, MD | Annual Conference |
| Robert Bortolussi, 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 |
| Ann L. Jefferies, MD | Fetus and Newborn |
| Sam K. Wong, MD | First Nations, Inuit and Métis Health |
| Claire LeBlanc, MD | Healthy Active Living and Sports Medicine |
| Robert Bortolussi, MD | Infectious Diseases and Immunization |
| Natalie L. Yanchar, MD | Injury Prevention |
| Stacey A. Bélanger, MD | Mental Health |
| Denis Leduc, MD | Nominating |
| Khalid Aziz, MD | NRP Steering Committee |
| Valérie Marchand, MD | Nutrition and Gastroenterology |

## Section Presidents

| | |
|---|---|
| Margo A. Lane, MD | Adolescent Health |
| Janet R. Roberts, MD | Allergy |
| Laurel A. Chauvin-Kimoff, MD | Child and Youth Maltreatment |
| Peter Nieman, MD | Community Paediatrics |
| Ana C. Hanlon-Dearman, MD | Developmental Paediatrics |
| Dawn S. Hartfield, MD | Hospital Paediatrics |
| Laura J. Sauvé, MD | International Child Health |
| Clare Gray, MD | Mental Health |
| Michael S. Dunn, MD | Neonatal-Perinatal Medicine |
| Adam Cheng, MD | Paediatric Emergency Medicine |
| C. Robin Walker, MD | Paediatric Environmental Health |
| Kelly J. Wright, DMD | Paediatric Oral Health |
| Laura K. Purcell, MD | Paediatric Sports and Exercise Medicine |
| Sarah E. Waterston, MD | Residents |
| Patrick Daigneault, MD | Respiratory Health |

## *Paediatrics & Child Health*

| | |
|---|---|
| Noni MacDonald, MD | Editor-in-chief |

## Healthy Generations Foundation

| | |
|---|---|
| Robert M. Issenman, MD | President |

## Immunization Monitoring Program, ACTive (IMPACT)

| | |
|---|---|
| Scott Halperin, MD, and Wendy L.A. Vaudry, MD | Co-principal Investigators |
| David Scheifele, MD | Data Centre Chief |

## Canadian Paediatric Surveillance Program

| | |
|---|---|
| Lonnie Zwaigenbaum, MD | Chair, Steering Committee |

# new publications

## Published since the 2008-2009 *Annual Report*

- *Are We Doing Enough? A status report on Canadian public policy and child and youth health* (3rd edition)
- Paediatric referral/transfer record

## Position statements and Practice points

**Adolescent Health Committee**
- Family-based treatment of children and adolescents with anorexia nervosa: Guidelines for the community physician
- Sexting: Keeping teens safe and responsible in a technologically savvy world

**Bioethics Committee**
- E-mail communication in paediatrics: Ethical and clinical considerations

**Community Paediatrics Committee**
- Extended-release medications for children and adolescents with attention-deficit hyperactivity disorder
- Guidelines for paediatric emergency equipment and supplies for a physician's office
- Preventive health care visits for children and adolescents ages 6 years to 17 years: The Greig Health Record
- Vegetarian diets in children and adolescents

**Healthy Active Living and Sports Medicine Committee**
- Physical activity recommendations for children with chronic health conditions: Juvenile idiopathic arthritis, hemophilia, asthma, cystic fibrosis

**Infectious Diseases and Immunization Committee**
- Management of acute otitis media
- A new meningococcal conjugate vaccine: What should physicians know and do?
- Prevention of respiratory syncytial virus infection

***Paediatric Infectious Disease Notes***
- Canada's eight-step vaccine safety program: Vaccine literacy
- Dispelling myths held by parents about the influenza vaccine
- Infective endocarditis: Updated guidelines
- Invasive group A streptococcal disease: Management and chemoprophylaxis
- Pandemic influenza (H1N1) 2009 and infection control controversies: Working with ongoing change
- Protecting young babies from influenza

**Nutrition and Gastroenterology Committee**
- Nutrition in neurologically impaired children
- Promoting optimal monitoring of child growth in Canada: Using the new WHO growth charts

**Psychosocial Paediatrics Committee**
- Cardiac risk assessment before the use of stimulant medications in children and youth: A joint position statement by the Canadian Paediatric Society, the Canadian Cardiovascular Society, and the Canadian Academy of Child and Adolescent Psychiatry

## Information for parents and caregivers

- Ear infections
- H1N1: Information for parents about the virus and the vaccine
- Respiratory syncytial virus (RSV)
- Vegetarian diets for children and teens

# 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, 2009 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, 2009 and the results of its operations and its cash flows for the year then ended in accordance with Canadian generally accepted accounting principles. As required by the Canada Corporations Act, we report that, in our opinion, these principles have been applied on a basis consistent with that of the preceding year.

Deloitte & Touche LLP

Chartered Accountants
Licensed Public Accountants
March 11, 2010

## Statement of Operations

year ended December 31, 2009

| | 2009 ($) | 2008 ($) |
|---|---|---|
| **Revenue** | | |
| Advertising fees | **73,298** | 64,430 |
| Grants and sponsorships | **1,787,542** | 1,864,386 |
| Investment income (loss) | **85,023** | (215,396) |
| Meetings | **452,185** | 513,254 |
| Membership dues | **666,129** | 629,623 |
| Miscellaneous | **56,443** | 96,483 |
| Projects | **466,046** | 398,072 |
| Publication sales | **380,024** | 289,320 |
| | **3,966,690** | 3,640,172 |
| **Expenses** | | |
| Administrative services | **379,115** | 316,617 |
| Amortization of capital assets | **73,926** | 75,585 |
| Meetings | **891,639** | 662,414 |
| Printing and postage | **271,733** | 435,914 |
| Projects | **230,041** | 199,325 |
| Rent | **313,377** | 279,855 |
| Salaries and benefits | **1,490,027** | 1,494,232 |
| Technology services | **33,596** | 32,514 |
| Travel | **261,243** | 365,947 |
| | **3,944,697** | 3,862,403 |
| Excess (Deficiency) of Revenue over Expenses | **21,993** | (222,231) |

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

## Statement of Financial Position

as at December 31, 2009

| | 2009 ($) | 2008 ($) |
|---|---|---|
| **Current Assets** | | |
| Cash | **25,151** | 48,471 |
| Investments | **1,995,853** | 1,892,072 |
| Accounts receivable | **413,364** | 561,082 |
| Inventory | **238,419** | 288,165 |
| Prepaid expenses | **118,090** | 91,912 |
| | **2,790,877** | 2,881,702 |
| Other Asset | **53,369** | 108,000 |
| Capital Assets | **300,326** | 365,826 |
| | **3,144,572** | 3,355,528 |
| **Current Liabilities** | | |
| Accounts payable and accrued liabilities | **810,601** | 630,129 |
| Deferred revenue | **658,371** | 1,057,679 |
| Due to Healthy Generations | **151,418** | 165,531 |
| | **1,620,390** | 1,853,339 |
| **Commitment** | | |
| **Net Assets** | | |
| Special Projects fund | **122,901** | 122,901 |
| *Paediatrics & Child Health* fund | **71,905** | 67,382 |
| Section funds | **111,498** | 98,137 |
| Development fund | **80,000** | 80,000 |
| Net assets invested in capital assets | **300,326** | 365,826 |
| Operating fund | **837,552** | 767,943 |
| | **1,524,182** | 1,502,189 |
| | **3,144,572** | 3,355,528 |

## Statement of Changes in Net Assets

year ended December 31, 2009

| | 2009 ($) | 2008 ($) |
|---|---|---|
| **Special Projects fund** | | |
| Balance, beginning of year | **122,901** | 122,901 |
| Balance, end of year | **122,901** | 122,901 |
| ***Paediatrics & Child Health* fund** | | |
| Balance, beginning of year | **67,382** | 59,215 |
| Transfer from operating fund | **4,523** | 8,167 |
| Balance, end of year | **71,905** | 67,382 |
| **Section funds** | | |
| Balance, beginning of year | **98,137** | 86,613 |
| Transfer from operating fund | **13,361** | 11,524 |
| Balance, end of year | **111,498** | 98,137 |
| **Development fund** | | |
| Balance, beginning of year | **80,000** | 80,000 |
| Balance, end of year | **80,000** | 80,000 |
| **Net Assets Invested in Capital Assets** | | |
| Balance, beginning of year | **365,826** | 439,292 |
| Transfer from operating fund | **(65,500)** | (73,466) |
| Balance, end of year | **300,326** | 365,826 |
| **Operating fund** | | |
| Balance, beginning of year | **767,943** | 936,399 |
| Excess (deficiency) of revenues over expenses | **21,993** | (222,231) |
| Transfer to *Paediatrics & Child Health* fund | **(4,523)** | (8,167) |
| Transfer to Section funds | **(13,361)** | (11,524) |
| Transfer from Net Assets Invested in Capital Assets | **65,500** | 73,466 |
| Balance, end of year | **837,552** | 767,943 |

# board of directors



**President**
Kenneth J. Henderson, MD

**President-Elect**
Robert I. Hilliard, MD

**Vice President**
Jean-Yves Frappier, MD

**Past President**
Joanne E. Embree, MD

William H. Abelson, MD
British Columbia and
Yukon Territory

Minoli N. Amit, MD
Nova Scotia

Anthony Ford-Jones, MD
Ontario

Marie Gauthier, MD
Quebec

Pascale Gervais, MD
Quebec

Ramaiyer Krishnaswamy, MD
New Brunswick and
Prince Edward Island

Stan Lipnowski, MD
Manitoba and Nunavut

Susanna Martin, MD
Saskatchewan

Robert Moriartey, MD
Alberta and
Northwest Territories

Élisabeth Rousseau-
Harsany, MD
Quebec

Susan E. Tallett, MD
Ontario

Christina G. Templeton, MD
Newfoundland
and Labrador

Robin C. Williams, MD
Ontario

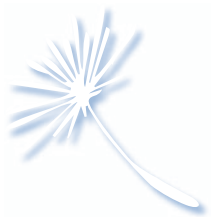
Noni E. MacDonald, MD
Editor-in-chief
*Paediatrics & Child Health*

Robert M. Issenman, MD
President
Healthy Generations
Foundation

Sarah E.Waterston, MD
President
Residents Section

Marie Adèle Davis
Executive Director

Danielle Grenier, MD
Director of Medical Affairs

# 2009 supporters

Abbott Laboratories, Ltd.
Abbott Nutrition
Air Canada Kids' Horizons
BC Children's Hospital Foundation
Children's and Women's Health Centre of British Columbia
CIHR - Institute of Human Development, Child and Youth Health
Citizenship and Immigration Canada
Danone Inc.
First Nations and Inuit Health Branch, Health Canada
General Mills Canada Corporation
Genzyme Canada
GlaxoSmithKline
Ikaria Canada Inc.
Janssen-Ortho Inc.
Johnson & Johnson
Mead Johnson Nutrition (Canada) Co.
Merck Frosst Canada Ltd.
National Collaborating Centre for Aboriginal Health
Nycomed
Procter & Gamble
Public Health Agency of Canada
Purdue Pharma
Sainte-Justine UHC Foundation
Sanofi Pasteur Limited
Royal College of Physicians and Surgeons of Canada
Shire Canada Inc.
University of Montreal, Faculty of Medicine, Department of Pediatrics
Wyeth Pharmaceuticals

## Mission

The Canadian Paediatric Society is the national association of paediatricians, committed to working together and with others to advance the health of children and youth by promoting excellence in health care, advocacy, education, research and support of its membership.

Canadian Paediatric Society

2305 St. Laurent Blvd.
Ottawa, Ontario K1G 4J8
Tel.: 613-526-9397 • Fax: 613-526-3332
www.cps.ca • www.caringforkids.cps.ca