

# SENIOR BULLETIN

AAP Section for Senior Members

**Editor:** Joan Hodgman, MD, FAAP  
**Associate Editor:** Arthur Maron, MD, MPA, FAAP  
**Advocacy for Children Editors:** Lucy Crain, MD, MPH, FAAP  
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## Message from the Chairperson

*Avrum L. Katcher, MD, FAAP*  
*Chairperson, Section for Senior Members*

Welcome to the good old summer time. The temperatures in many parts of the nation (not all, I am aware) rain, storms and flooding all demonstrate that global warming is upon us. Of course, the fact that this is mid June, with the longest day of the year upon us in less than a week, have nothing to do with it. Some of us may be old enough to remember mid-summers in the 1930s when the thermometer read in the 90s day after day, and movie houses, or other places of public assembly were shut because of fear of spreading polio—back in a time when the nature of polio and how it was spread were still unsolved mysteries.

Just a few weeks ago, in late May, your Executive Committee met with Dr. Ken Slaw, director of the AAP Department of Membership, our co-editor of the Bulletin, Joan Hodgman, our webmaster, Jerold Aronson, and our thoughtful Section Manager, Jackie Burke, to discuss the topic of “strategic planning” in order to help to define the future of our Section. This was one of the most productive meetings I have ever attended. It will be a pleasure to be able to lay out for you our recommendations for our Section to work on over in the next few years. Dr. Slaw led us through a most interesting and thoughtful process. We hope when you have a chance to inspect and cogitate about it, you will be as pleased as we were. At the same meeting, we were all saddened by Joan Hodgman’s announcement that she was resigning her position as Editor of the Senior Bulletin due to a progressively severe physical disability. At our meeting she was — as always — a great asset with her mental alacrity and wise insights, albeit physically handicapped. Joan has

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## Executive Committee

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### Membership

George Cohen, MD, FAAP

### History Center/Archives

David Annunziato, MD, FAAP

### Newsletter Editor

Joan Hodgman, MD, FAAP  
626/445-0178  
hodgman@usc.edu

### Associate Editor

Arthur Maron, MD, FAAP  
561/394-6114  
artmaron@aol.com

### Staff

Jackie Burke  
Sections Manager  
800/433-9016, ext. 4759  
jburke@aap.org

Tracey Coletta  
Sections Coordinator  
800/433-9016, ext. 4926  
tcoletta@aap.org

Mark A. Krajecki  
Pre-Press Production Specialist  
847/434-7866  
mkrajecki@aap.org

## Message from the Chairperson Continued from Page 1

done a wonderful job for some years, since I managed to weasel an agreement with her to take on this post. We had met for the first time at an AAP breakfast, and within an hour or two she agreed to give it a whirl. And what a whirl it has been! We are all grateful for what she, and then in conjunction with Arthur Maron, has accomplished. Arthur will be carrying the load until we have a new co-editor to work with him. If any of our readers might be interested in sharing this task, please write to Arthur and me, with a CV, some personal notes on your background and qualifications, and what you'd like to do. Also, if being a co-editor is not your primary interest, but assisting with special areas is, say so. All indications of interest will receive careful consideration.

Considering our communications, we hope that all of you have been following closely the postings on our Section web site selected by Jerold Aronson. He is also doing a splendid job, and if you have not had opportunity as yet to review what is available there, you owe it to yourself to do so now. Go directly to [www.aap.org/sections/seniormembers](http://www.aap.org/sections/seniormembers) and see the wealth of interesting information there for you. Tell your friends that Section membership is not a prerequisite to visit the Section pages. On the first page you'll see the picture of one of our very active members George Cohen, who is in charge of membership and also works with Lucy Crain on the wonderful programs we've sponsored at the NCE. This year our program is on grandparenting, and on the home page you'll see a link to further details.

Now I want to call your attention to the year 2007 National Healthcare Quality and Disparities Report, prepared by the staff of the Agency for Healthcare Research and Quality (AHRQ). Their web site is [www.ahrq.gov](http://www.ahrq.gov). The report is at [www.ahrq.gov/qual/qrd07.htm](http://www.ahrq.gov/qual/qrd07.htm). What you'll see is data that display the efficiency with which our health care system functions, and the success—or in some instances—lack of success with which it meets on an equal basis the health care needs of groups of different ethnic background. I provide two illustrative stats: "An important goal of improving health care quality is to reduce variation in care delivery across the country." This means that patients in all States would receive the same level of high quality, appropriate care. Since 2000, on average, variation has decreased across the measures for which the NHQR tracks State data, but this progress is not uniform. For example: The percentage of heart attack patients who were counseled to quit smoking has increased from 42.7% in 2000-2001 to 90.9% in 2005. Moreover, 48 States, Puerto Rico, and the District of Columbia all performed above 80% on this measure in 2005. Yet, in 2000, diabetic patients in the worst performing State versus the best performing State were admitted to the hospital 7.6 times more often with their diabetes out of control. By 2004, this difference had doubled to 14. If all States had reached the level of the top four best performing States, at least 39,000 fewer patients would have been admitted for uncontrolled diabetes in 2004, with a potential cost savings of \$216.7 million.

The same comprehensive report indicates that just under one woman in 5 of those who delivered a live infant, received prenatal care. Just about one child in 5 received all recommended immunizations. Not quite 50% of parents of overweight children heard a physician say so. About half of all children saw a dentist.

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For the revealing information about Health Literacy, go to: [www.ahrq.gov/qual/nhdr07/Chap2d.htm](http://www.ahrq.gov/qual/nhdr07/Chap2d.htm). This is the report from the same source, AHRQ. The definitions of health literacy, which shows how well different persons are able to perform the skills necessary for managing personal health and preventing disease indicate that 12% of our population possess these skills. 14% of persons listing themselves as White have them 2% of those listing themselves as Black, 4% of those listing themselves as Hispanic, 18% of those listing themselves as Asian or Pacific Islanders, and 7% of those listing themselves as American Indian or Native Alaskan. My reason for providing this information, and directing you to the source where you are able to learn more, is to indicate that while on the one hand we have done a great deal for children and by extension for at least some adults on the other hand we have a long way to go.

Good luck and good health to you all.

*Avrum L. Katcher, MD, FAAP  
Chairperson, Section for Senior Members  
American Academy of Pediatrics*

## EDITOR'S NOTE



Due to health problems I am resigning from my position as Editor of the Senior Bulletin. I have ALS and I don't have the energy or the muscles that I used to have. Dr. Arthur Maron as Associate Editor, has taken over with the excellent help of Tracey Coletta, of the AAP Staff, and will do the Summer and the Fall bulletins. After that, we will need a new Editor. If you have any recommendations either for yourself or others, please get in touch with our Chair, Avrum Katcher. I have enjoyed being Editor of the Senior Bulletin and very sorry to have to step down.

*Joan Hodgman MD FAAP, Editor.*

## 2008-2009 Senior Bulletin Schedule

Articles for consideration should be sent to the Editor at [artmaron@aol.com](mailto:artmaron@aol.com) with copies to the Academy headquarters [tcoletta@aap.org](mailto:tcoletta@aap.org).

### **Fall Bulletin**

August 25 articles due to Arthur Maron, MD, FAAP  
September 26 mailboxes

### **Winter Bulletin**

December 1 articles due to Arthur Maron, MD, FAAP  
January 9, 2009 mailboxes

### **Spring Bulletin - 2009**

March 17 articles due to Arthur Maron, MD, FAAP  
April 20 mailboxes

### **Summer Bulletin - 2009**

June 2 articles due to Arthur Maron, MD, FAAP  
July 1 mailboxes

# Section for Senior Members CME Program at the NCE in Boston

Monday, October 13, 2008  
Time: 1:30-5:30pm 3.5 CME hours

*by Lucy Crain MD, FAAP*

Our 2006 section survey revealed that the vast majority of our section members (as well as many other FAAPs) are or will be grandparents. While many of us enjoy the company of grandchildren, it is important to recognize that more than 600,000 children in the United States have grandparents serving as their parents, either in family or foster care. We invite you and your guests to attend this special program, featuring outstanding topics and speakers at the NCE this Fall.

## CRUCIAL CONSIDERATIONS FOR GRANDPARENTING:

- Tax Exempt College Education Investment Options for Grandchildren by Ms. Lorna Meyer from San Francisco, California. Ms. Meyer is Senior Vice President Private Banking and Investment Group, Merrill Lynch
- Foster Parenting and Grandparenting 101: Another Way to Stay Young by Dr. Errol and Mrs. Judy Alden of the AAP Office of the Executive Director Elk Grove Village, Illinois.
- Lessening Chronic Disease Risk for Future Generations: Impact of Diet and Lifestyle, Dr. Lisa Hark, Ph.D., R.D. Dr. Hark is the director of the Nutrition Education Program at the University of Pennsylvania School of Medicine

(Additionally, Dr. Av Katcher just sent a note on the AARP's website on Grandparenting. There's an abundance of good, useful information at [www.aarp.org/family/grandparenting/](http://www.aarp.org/family/grandparenting/) Check it out!)

- I'll hope to see you in Boston at our Section program this October.

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## No Guilt

*by Arthur Bolter, MD, FAAP*

Since I retired completely several years ago, I frequently am asked, usually by other doctors, whether I am doing any volunteer medical work. At first, I would answer, with some feelings of guilt, that I was not doing any medical work. After awhile as I reviewed my 50 plus years of Pediatric and Adolescent Medical Practice I did not need to feel guilty!

I never got into golf or tennis, as many of my doctor friends did because I spent my afternoons off donating my time! I developed two adolescent clinics before they were popular and because of my interest in Adolescents, I got into drug and alcohol abuse treatment. Since there was little education in that field, I spent a lot of time volunteering at the Haight-Ashbury Clinic (during the "Summer of Love") to get "on-the-job" training. Then I worked with school personnel to develop a very successful local community drug abuse treatment program. Naturally, I volunteered as Medical Consultant. I was involved with the development of the California Society of Addiction Medicine and was the first Pediatrician to take the certifying exam. Admittedly, a lot of time was also spent in meetings, but that also took up my "free" time.

So now when I am asked about volunteering as a docent in two museums which I find extremely interesting and I have become interested in opera and relearning bridge! I also enjoy going to the theater and the local symphony.

Although I admit that I miss some aspects of pediatric practice, I am enjoying life without doing any medical work.

## Historical Archives Advisory Committee

by Howard Allen Pearson, MD, FAAP

During the next year or so, the Historical Archives Advisory Committee of the AAP will present brief historical reviews of several important pediatric organizations in the United States.

*“Knowing where we have come from may give us insights into where we are going.”*



## THE AMERICAN PEDIATRIC SOCIETY (APS)

At the time of the founding of the APS in 1888 there was only one other national Pediatric society, the AMA Section on Diseases of Children. Despite its vigorous initiation by Drs. Abraham Jacobi and Samuel Busey in 1880, by 1885, the Section was floundering. No records of its meetings were published in the JAMA in 1886 and 1887. In 1889, an unsuccessful resolution calling for disestablishment of the Section was considered, but rejected, by the AMA House of Delegates.

The mid-1880's were propitious times for the founding of national medical organizations, separate from the AMA. Some leaders of American medicine had become disenchanted by the AMA's positions on a code of medical ethics and on academic medicine and specialization. In addition, the by-laws of the AMA discouraged any independent action by its sections. The American Surgical Society was founded in 1880; the American Clinical and Climatological Society was established in 1860 for the study of the effects of climate on respiratory diseases; and in 1886 a group of laboratory-minded physicians founded the elite Association of American Physicians. As Dr. William Osler commented later,

*“Several societies had already been successful and the idea was in the air.”*

The major impetus for the formation of the APS came from Dr. Job Lewis Smith of New York City. Dr. Smith saw a need for a new national pediatric society independent of the AMA. He was the chairman of the Pediatric Section of the Ninth International Congress of Internal Medicine that was held in Washington D.C. in early September, 1887. The program included a number of presentations by pediatricians from the excellent centers in Europe, especially Germany and Austria. The scope and excellence of the presentations made Dr. Smith realize the neglect and comparatively primitive condition of pediatrics in the United States. Pediatric issues were certainly not being addressed by the AMA, whose general membership had not totally accepted the need to separate pediatrics from obstetrics and gynecology, a separation that was, in fact, opposed by their respective AMA sections.

After adjournment of the Congress, Smith invited a “few members” to discuss setting into motion activities to establish a new American pediatric society. Among those attending this meeting were: Drs. J. Lewis Smith, W.D. Booker of Baltimore, MD, I.N. Love of St. Louis, MO, S.C. Busey of Washington, D.C. and W.P. Watson of Jersey City, NJ. A motion was made by Dr. Booker and seconded by Dr. Love to organize a new pediatric society. A decision was made that the new society would be independent and avoid entangling alliances – especially with the AMA. Dr. Smith was elected temporary chairman and Dr. Booker, temporary secretary. The temporary officers were authorized to contact American and Canadian physicians “who had taken a special interest in the advancement of the study of diseases of children.” During the next 11 months, Drs. Smith and Booker wrote to physicians in the northeast and near Midwest describing the proposed APS, asking for their interest, and inviting their participation. The responses to these invitations “showed a general desire to organize the APS and a hearty cooperation was promised.” With such positive initial responses, Smith and Booker decided to leave all further actions and decisions for a formal organizational meeting so that all participants could have “an equal voice and responsibility in whatever measures were adopted.”

The organizational meeting was held in Washington, D.C. on September 18, 1888 and was attended by 14 physicians. Dr. Smith was absent because of a death in his family and so the meeting was called to order by Dr. Booker at 10:00 AM. Dr. Abraham Jacobi was appointed as chairman *pro tem* and Dr. Booker as secretary *pro tem*. Drs. Jacobi, and Booker were appointed as a committee to draft a constitution and report to the Society when it reassembled at 12:00 PM. A number of writers have marveled at the celerity with which the constitution was created. This was doubtless because Dr. Jacobi had available the constitution of the American Association of

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Physicians founded two years previously of which he was also a founding member. With the exception of a few name and term changes, the APS constitution was an almost verbatim copy of the constitution of the AAP.

Article I of the constitution outlined the objectives and name of the Society:

*“The Society has for its object the advancement of the physiology pathology and therapeutics of infancy and childhood. It shall be known as the American Pediatric Society, and shall hold an annual meeting.”*

After unanimous adoption of the constitution, permanent officers and a seven man council were elected. Dr. Abraham Jacobi was the first president. Dr. Jacobi's acceptance of the presidency was said to be characteristically graceful;

*“You take me by surprise and ought to give me a few hours to digest the strong dose you mean to administer.”*

Following these elections the Society adjourned until its first scientific meeting a year later.

The original APS members (Founders) numbered 43 men and consisted of individuals who had responded favorably to the original letters of Drs. Smith and Booker. The Founders were mostly young men – 65 % were less than 40 years of age. More than three quarters of the founders had medical school affiliations, although none were full time. Almost all of them also practiced general medicine, and only a few limited their practice to infants and children. Twenty five of the forty-three Founders practiced in the northeast; eleven were from middle-Atlantic states; seven came from the near mid-west; and two were Canadians.

Total membership, was originally limited to 100, the same as the Association of American Physicians. This was reduced to 60 in 1892, but as the numbers of pediatricians expanded, it was increased to 75 in 1912, and again to 100 in 1930. In 1938 numerical limitation of active membership was eliminated.

The presentations and discussions at the annual spring meetings of the APS as published in *Transactions of the American Pediatric Society*, were mostly clinical descriptions and case reports, but with passing time became increasingly scientific.

At the time of the founding of the APS, there were great social issues that affected the health and well being of children. However, in keeping with its constitutional mandate to advance “*the physiology, pathology, and therapeutics of infancy and childhood*,” the topics presented at the annual meetings were mostly concerned with disease processes and infant feeding; little attention was paid to social issues and non-medical aspects of children. Calls for an expansion of the scope of APS activity were made in several early presidential addresses. Dr. Abraham Jacobi in his presidential address in 1889 called for wider APS involvement in:

*“raising the standard of physical and mental health thereby contributing to the welfare and happiness of the people.”*

In 1909, Dr. Thomas Morgan Rotch of Boston presented a paper entitled “*The Position and Work of the American Pediatric Society toward Public Questions*.” Rotch's presentation evoked a long and sometime heated discussion that reflected the ambivalence of the membership concerning active involvement of the Society in developing and implementing social and public health measures for children. Many of the members supported such involvement; however, there were strong dissenters including Dr. I. Abt who said:

*“I should feel sorry to see a large part of the work of this Society devoted to subjects of this kind, which although of sociological interest, are not so much along the line of work of most of us. I believe we can do our best along the line of research. We have a duty to the public, but this should not be the most important side of our work.”*

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Concern was also expressed that the Society might be

*“smeared with the pitch of politics, however praiseworthy the objectives.”*

Dr. Rotch concluded the discussion, commenting prophetically:

*“I supposed that the Society would wish to lend its influence to broad questions of this time connected to pediatrics. If it does not so wish, these questions can be discussed elsewhere.”*

During the next two decades, APS presidents continued to challenge the APS to become socially and politically involved, but there was little or no response. In large part this was because the only function of the Society was to hold an annual scientific meeting and to honor pediatricians with the cachet of APS membership on the basis of their scientific and academic accomplishments. Many APS members participated actively in social, public health and educational activities involving children but they did so as individuals. This has continued to the present time. The need for a pediatric venue where social and educational issues that affected children could be addressed was a major impetus leading to the founding of the American Academy of Pediatrics in 1930.

In the 1970's and 1980's a true revolution occurred in pediatrics and medical science at large. Dazzling new technologies to probe biologic mechanisms at cellular, sub-cellular and molecular levels became the glamour areas of research. The changes and an inexorable emphasis on subspecialty pediatrics were increasingly reflected in the content of the annual meeting of the APS. State of the Art Lectures and Symposia were organized to explain some of these complicated areas to the membership. The plenary and subspecialty became joint Sessions with the Society of Pediatric Research. The only unique APS functions that remain are the APS President's Address and the presentation of the Howland Award. The Howland Award was established in 1951 to honor

*“distinguished service to pediatrics as a whole.”*

Between 1952 and 2008 the Howland Award has been given to 58 eminent pediatricians and arguably is the most coveted award in all of pediatrics. Although the APS has become increasingly integrated with other national societies as the Pediatric Academic Society, it has retained its 75 year function of nominating three members to the Board of Directors of the American Board of Pediatrics.

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## Did You Know?

The Academy Travel Office is here to serve your travel needs Monday thru Friday from 8:00am till 4:30pm CST. Receive air discounts to AAP meetings and car discounts through Avis and Hertz.

We also offer reservations through RESX on line, for those who prefer to book their own travel. If taking a vacation is what you are looking for then contact Elizabeth Harrison for air, cruises or land packages.

Our toll free number is 888-227-1772.



# ADVOCACY IN ACTION

## ENVIRONMENTAL ADVOCACY

by Lucy Crain, MD, MPH, FAAP

Many pediatricians become involved with environmental advocacy at various times in their careers, and the need for such involvement is increasingly important in our globally oriented society. Whether it's lead in imported toys or candy or PCBs in various plastics, environmental toxins are a growing concern. A group of scientists and health policy makers at the Center for Occupational and Environmental Health at the University of California Berkeley (UCB) joined with like minded environmental advocates and researchers of the Collaborative on Health and the Environment (CHE) and met in 2006 at UCB to develop a GREEN CHEMISTRY POLICY document. Last fall, I was asked to review this report for the San Francisco Medical Society's delegation to the California Medical Association House of Delegates. The document is comprehensive and quite concerning in its implications, especially for the health of children. (I call your attention to the links at end of article.) The United States manufactures significant tonnage of chemicals for use in agriculture and households in our own country which are considered so toxic by standards of other countries, the European Union and others have implemented regulations banning importation and use. While the USA has peer reviewed chemical industry oversight for manufacture and distribution of such products, oversight is sorely lacking in funding, technologic support, and consistency, as well as federal/state authority. The following article excerpted from the May 2008 CMA Foundation Newsletter (with permission) summarizes the action to date by the CMA in bringing this issue to the attention of its membership and beyond.

- *More than 87,000 synthetic chemicals (and counting) are currently registered for use in the United States. Do you know what these chemicals are? Do you know that exposure to various chemical compounds can have profoundly negative effects on human health; or that the United States government currently has inadequate methods of protecting us from these effects?*
- *Members of the Collaborative on Health and the Environment (CHE) know, and they are taking great strides to see that these chemicals are appropriately tested for safety and efficacy before they are available for mainstream use. CHE was formed in 2002 with help of founding partner organization San Francisco Medical Society (SFMS) to convene those with an interest in environmental health particularly industrial chemical safety. CHE has more than 2,600 individual and 470 organizational partners worldwide that include practicing and research physicians, health care professionals, concerned citizens, children's environmental health organizations, government organizations and philanthropic organizations said Steve Heilig, MPH, Director of Public Health & Education for CHE and SFMS.*
- *At the 2007 CMA House of Delegates meeting, the policy "A Modern Chemicals Policy for California and Beyond", authored by Lucy Crain, MD, MPH and Robert Gould, MD and initiated by the SFMS delegation, was passed. The policy charges CMA with urging California and the U.S. government to develop and implement a state and national modern, comprehensive chemicals policy in line with current scientific knowledge on human health, and that requires a full evaluation of the health impacts of both newly developed and existing industrial chemicals now in use.*
- *According to CHE, the United States is so far behind Europe in industrial chemical policy, that many chemicals being manufactured and used here are banned in Europe. "We've now lagged so far behind, that even industry is pushing for chemical regulation, Heilig said. We are fighting for the development of a similar broad chemical policy that is based on known science. Taking the recently passed chemicals policy to the national level is very important.*
- *To learn more about industrial chemical policy or CHE, or for resources, facts and science information, visit [www.healthandenvironment.org](http://www.healthandenvironment.org) and [www.coeh.berkeley.edu](http://www.coeh.berkeley.edu).*

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**For more information or to join the section . . .**  
**visit our website at: [www.aap.org/sections/seniormembers/](http://www.aap.org/sections/seniormembers/)**

# Forced Retirement - (55 years and one month)

*by Hyman C. Tolmas, MD, FAAP*

After reading a number of articles relating to retirement over the last several years I felt compelled to submit this article to the Senior Bulletin. It may be interesting to some of my cohorts. The title of this will be "Forced Retirement - (55 years and one month)".

I was forced to retire following Hurricane Katrina in August 2005. Ironically, I have told the story several thousand times that August 1, 2005 was an anniversary date of sort in my professional life. It was the beginning of my 56<sup>th</sup> year in private practice in New Orleans, Louisiana. Then on August 29<sup>th</sup> after the levees broke following Hurricane Katrina, I was forced into retirement. On August 28<sup>th</sup>, we left New Orleans and headed to Houston, Texas with my daughter's three cats and our dog. After a seventeen hour trip (normally a five hour trip) we arrived in Houston. This being our 5<sup>th</sup> evacuation for hurricanes in the 54 years that we have lived in our home, we figured that within 2 – 3 days at the most, we would be back in New Orleans. It has now been 2 ½ years and it spells the end of my practice.

I started practice on August 1, 1950 and did general pediatrics primarily for the first 12 – 13 years and got very interested in adolescent medicine, which incidentally was in its infancy at that time. I became the first physician in the state of Louisiana and one of the first in the southeastern part of the country in helping to contribute to the development of this new sub-specialty. Over the next 46 years, the medical care of teenagers and young adults became the major portion of my practice; however, I still enjoy the other 25% of general pediatrics in treating infants from birth.

During the first 15 years of practice, beside a busy office based practice, the average day consisted of making 2 – 10 house calls, hospital rounds in 3 hospitals, attending caesarian sections, and teaching at both medical schools – Tulane University Medical School and LSU Health Science Center. As part of your obligation of being on the medical staff of the hospitals, you worked a free clinic once a week, gave 4 lectures a year to the students in the schools of nursing, rotated a month a year on call in the emergency room (before the days of emergency room physicians).

Community involvement was an integral part of our lives in the 50's and 60's. I served on the steering committee of the Orleans Parish Medical Society to develop a program for immunizing all of the children in greater New Orleans against Polio when the vaccine first came out, then several years later, against measles, when that vaccine came out. These programs were entitled K.O. Polio and K.O. Measles and were successful in immunizing several hundred thousand children.

In 1979, I organized a community program for parents through the auspices of my main hospital, East Jefferson General Hospital, to inform parents about changes, both psychological and developmental, in their youngsters going through adolescence. The naysayers doubted very seriously that we could get parents to come in and talk about their adolescent's drug use, sex lives and other high risk behavior. However, I arranged with a cohort, an adolescent psychiatrist, to have a seminar whereby he would speak for 30 minutes on the psychological changes in adolescence and I would follow that for 30 minutes on the developmental changes. Then we would have a period of 30 minutes during which the parents could ask questions. To make this program as non-threatening as possible, we titled it "Coping with Adolescence – the Challenging Years". Parents came in and were asked to sign so that we could develop a mailing list for future programs. Everyone was given several pieces of paper so that no one would be embarrassed asking a question, knowing that their neighbors were sitting in the same auditorium. The program started at 7:30 and was supposed to end at 9:00, but at 5 minutes to 11:00, two hours past the designated termination time. The auditorium was still full of over 300 parents. During the brief break after the specific talks, we collected about 350 pieces of paper with questions but after answering only about 20 of them, the audience spontaneously began to raise hands and "the ice was broken". After the program, the parents requested that we do this again so we did another session the next month and the following month as well at their request. Then they requested that we do this with their youngsters.

We developed a program of "rap sessions" for teenagers, with two of them for early adolescents 11 – 14, and two for middle and late adolescents 15 – 22. I developed a faculty that consisted of 2 psychiatrists, 2 psychiatric social workers, a juvenile court judge and a gynecologist interested in adolescent gynecology. I used three

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other speakers and myself for each one of these. No parents were allowed so that the youngsters coming were uninhibited in the questions that they asked. Following these sessions, there was a great request from the community for speakers and for the next 15 years the outreach program, went into every high school, middle school, grade school, churches, synagogues, other groups addressing various aspects of adolescence.

I also developed, as part of this continuing program, a talk on “The Forgotten Years” from 6 -12. I would go into schools and address the parent/teacher groups about expected behaviors and changes at each age going from 6 – 12, so that by the time the youngster got to adolescence, parents were pretty much informed about what to expect. This program was quite a success.

Another offshoot of this program was the development of a scientific exhibit to be presented at medical meetings. This was a multi-media exhibit with a video showing an ambulance driving up the ramp at the hospital unloading a youngster who had overdosed. There were three large Plexiglas panels – one showing the problems adolescents face – the middle panel showed how the community addressed them – the other panel showed how these problems were addressed by East Jefferson General Hospital. We also developed a brochure describing our program which contained samples of the posters and the fliers, the feedback instruments and other aspects of our program.

This scientific exhibit was presented at the annual meeting of the American Academy of Pediatrics in the early 80’s in New York, and a return showing was requested for the following year at the meeting in San Francisco. It was also shown at the American Academy of Family Physicians in Miami that same year. The brochure invites physicians to go back into their community and start up a program. This program was replicated in 11 cities in the 80’s. The need for programming of this sort today, since problems have escalated, is undoubtedly a worthwhile endeavor.

I wonder if the Senior Section of the AAP would be interested in sponsoring a rejuvenation of this much needed program throughout the country. I would be very happy to be part of this endeavor.

I enjoyed my 55 years and 1 month of practice and was not ready to “hang it up” yet. However, it’s too late for me to start back again, and I reminisce frequently about the many wonderful years that I enjoyed in the practice of pediatrics. One of the most gratifying rewards to me of having practiced so long was to think about the many relationships that I was able to enjoy. Now that I live in Dallas where my grandchildren are, I get about 3 – 5 phone calls a week from 2<sup>nd</sup> & 3<sup>rd</sup> generation patients wanting advice and checking on some of the care that their children are getting. It is very gratifying to me to have this ongoing contact with my former patients.

If anyone would be interested in getting one of these brochures, they can contact me at [hct.tolmas@nocomail.com](mailto:hct.tolmas@nocomail.com) or by phone at 972-386-0214.

## **Letter to the Editor**

by Ted Tapper, MD, FAAP

Many years ago, easily within the memory of all in the Seniors section, men outnumbered women in medical schools and in pediatric training programs. Efforts were made at that time to have “affirmative action” programs and recruit women to both medical schools and to pediatric training programs.

Times have changed but good. Women are at least equal to men nationally in medical schools and overwhelmingly dominate pediatric residency training programs. When will we see “affirmative action” programs trying to get more men into pediatrics? Does this type of “affirmative action” only apply when it’s “needed” for women but not for men?

# Part-Time Pediatrics: A Growing Practice

by Jennifer Shu, MD, FAAP

At some point in your career, you may decide that a 40-plus hour workweek is not for you. You have people to see and places to go, and these do not necessarily involve seeing patients in your office. Fortunately, you are not alone. Others before you in the American Academy of Pediatrics and American Medical Association have extensively researched this issue and compiled all the information you need to make a successful transition to part-time practice.

A full-time partnership on part-time practice. The AAP Division of Graduate Medical Education and Pediatric Workforce has partnered with the American Medical Association (AMA) and the Women Physicians Congress (WPC) to provide physicians with web-based tools to assess work/practice options. The joint web site, Explorations in Work/Practice Options ([www.ama-assn.org/go/workpracticeoptions](http://www.ama-assn.org/go/workpracticeoptions)), includes online and downloadable self-assessment questionnaires; information and insights from physicians who are working part time, have worked part time or work in other non-traditional ways; a tailored bibliography; data sources; and links to additional online information.

The formation of this partnership was due in part to findings from AAP surveys, AMA surveys, and AAP/AMA joint surveys on part-time work issues. Here are some of the highlights of their findings:

Everybody's doing it. Male and female; solo and large group physicians; academic and private practice; and early-, middle- and late-career pediatricians are all increasingly choosing to work part time. More than any other specialty, pediatricians work part time or intend to work part time at some point in their careers. Reduced hours may be appealing to physicians with young families, those caring for sick or elderly relatives, individuals gearing toward retirement, and basically anyone pursuing other personal or professional interests during a typical work day. Not only can part-time practice give you the flexibility to travel the world, you can become a leader in organized medicine, businessperson, lawyer, politician, writer, consultant, locum tenens doc, volunteer physician and more yet not have to ditch your day job (and the accompanying personal satisfaction or income) completely.

There's strength in numbers. According to a 2006 report of the Association of American Medical Colleges, 21% of physicians older than 50 worked part time and another 46% were considering it. In one example of part-time work, locum tenens (traveling/fill-in/"substitute" physicians) positions are often filled by physicians over 50 (over 1/3 of the employees of one locums company are older than 50, and this proportion continues to grow). Transitioning to part-time practice can ease the retirement process as well as retain physicians in the workforce—all potentially good things, both personally and for patients affected by physician shortages.

Help is just a click away. You don't need to reinvent the part-time wheel when it comes to considerations such as contracts, scheduling, liability insurance, finances, benefits, job-sharing options, continuity of care, and partnership issues. Resources to help achieve a peaceful coexistence with your full-time colleagues can be found on the following AAP and AMA websites:

Joint AAP/AMA Explorations in Work/Practice Options web site: [www.ama-assn.org/go/workpracticeoptions](http://www.ama-assn.org/go/workpracticeoptions)

AAP Practice Management Online web site: <http://practice.aap.org/>

AAP Women in Pediatrics web site: <http://www.aap.org/womenpeds/>

AMA Women Physicians Congress web site: <http://www.ama-assn.org/go/wpc>

*Jennifer Shu, MD, FAAP, is a general pediatrician in Atlanta and former chairperson of the AAP and AMA national sections on young physicians. She is a habitual part-time physician, speaker, writer, and full-time mom.*

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## Have an Issue?

Join the Section for Senior Members Listserv by contacting [tcoletta@aap.org](mailto:tcoletta@aap.org)

For more information or to join the section . . . visit our website at: [www.aap.org/sections/seniormembers/](http://www.aap.org/sections/seniormembers/)

# Internet Search Engines – How can they work for you?

*by Jerold M. Aronson, MD, FAAP (SFSM Webmaster)*

Searching for anything on the Web carries uncertainty. You may know exactly what you're looking for, but you don't know where to find it or who to ask. And when you do ask, you can't be sure you'll get the right answer. In 1994 when the World Wide Web first took off, your choices for searching the Net were pretty limited: Yahoo and Yahoo.

Today, the Web is crawling with thousands of search sites vying to show you the way. Sites include pure search engines, general- and special-interest directories, and metasearchers (which query multiple search sites at once). When you need to know about a particular subject, how do you know which pages to read? Internet search engines can help.

Internet search engines are special sites on the Web designed to help people find information stored on other sites in the hundreds of millions of pages available. Popular internet search engines include: Google, Yahoo, Microsoft Live Search, AOL, and Ask. While various search engines work differently, they all perform three basic tasks:

- They search the Internet — or select pieces of the Internet — based on important words.
- They keep an index of the words they find, and where they find them.
- They allow users to look for words or combinations of words (query) found in that index.

Search engines display results from many different sources. Most search engines use software robots called spiders guided by algorithms that “crawl” the web, e.g. Google, Yahoo, Ask/Teoma, Microsoft Live Search (previously MSN Search) to build lists of the words found on web sites to collect and index the full text of pages that they find.

Once the spiders have completed the task of finding information on Web pages the search engine must store the information in a way that makes it useful. There are two key components involved in making the gathered data accessible to users:

- The **information stored with the data**
- The **method by which the information is indexed**

The proprietary storage and indexing strategies employed by different search engines are key to enable the most useful pages to appear at the top of the list of search results very quickly.

When you search via Google, Yahoo, etc., you build a query that searches through an index. The query can be quite simple, a single word at minimum or more complex requiring the use of **Boolean operators** that allow you to refine and extend the terms of the search (Think PubMed Medline searching). Common Boolean operators are “and”, “or”, “not”, “followed by”, “near”, “quotation marks”. A Boolean search is called a literal search. (For more on Boolean operators, view [www.aap.org/seniors](http://www.aap.org/seniors).)

Popular search engines then combine spider web crawl results with results from directories that rely on human editors to sift through pages, winnowing out inappropriate ones and categorizing sites by subject. Since directories are crafted by hand, they are far less comprehensive than search engines, hence the need to combine search techniques. While Google claims to have indexed more than a billion pages, the largest directory, called the **Open Directory Project**, (aka ODP or DMOZ, [www.dmoz.org](http://www.dmoz.org)) a volunteer-built guide to the web, is tiny in comparison with a current index of only about 2 million sites.

Some search engines gather their own listings for the main results they display, e.g. Google. Other search engines use third-party search providers for their results. For instance, the main search results at AOL come from Google's crawler-based listings, rather than from work inside AOL. However, AOL search adds a search of AOL sites to Google results. Any other search site can license Open Directory and use its database for their search results,

One area of search engine research is **concept-based** searching. This research involves using statistical analysis on pages containing the words or phrases you search for, in order to find other pages you might be interested in. Another area of research is called **natural-language queries**. The idea behind natural-language

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queries is that you can type a question in the same way you would ask it to a human sitting beside you — no need to keep track of Boolean operators or complex query structures. The search engine “parses” the query for keywords and applies them to the index of sites that it has built.

Do you want a broader search? Metasearch engines ([www.metacrawler.com](http://www.metacrawler.com), [www.dogpile.com](http://www.dogpile.com), [www.search.com](http://www.search.com)) call on other engines and directories each time you issue a query. Most metasearchers combine results, weed out duplicates, and present you with more links than you’d get if you confined your search to a single engine. However, metasearchers may fail to match the relevance of Google because it’s so tough to mesh links from disparate sites coherently. And note, the more engines a metasearcher queries, the longer your search can take.

Finally, there are specialty search engines. Are you interested in a home brew club in Portland, Oregon? Then check [Beersite](http://www.beersite.com) ([www.beersite.com](http://www.beersite.com)). Single topic search sites cover just about every subject imaginable. There are search sites for astronomy, politics, and fishing. Within their specialty, the best are authoritative in ways that general-purpose engines rarely are. Since these sites are so focused, the results are highly relevant. How do you find out if there’s a search site devoted to, say, springer spaniels? Simple: Consult a guide to topic-specific searchers, e.g. Search Engine Guide ([www.searchengineguide.com](http://www.searchengineguide.com)). Note -Look for a “Last updated” banner on the home page—and move on if the site seems to be in limbo since many are the creation of obsessed individuals.

Logically you’d expect the search engine that indexes the most pages to have the best chance of finding what you need. Organization of sites is key to the user experience. Google is usually rated as providing the most consistently pertinent results. The site uses “page rank” technology to track the number of pages that link to a site. If a lot of pages link to a particular site on a specific topic, the reasoning goes, that site must be relevant to that subject. Consequently, Google gives it higher placement in the results. Another Google plus: Below each link it finds, Google provides a snippet of text with the word or words you searched for highlighted in bold. That helps you eyeball the results and gauge the relevance of each link quickly. (Most engines simply display the first line or two of text from each linked page, whether the text contains your search terms or not.)

In summary, don’t depend on one site, or even two. Bookmark a bunch of them, get to know their strengths and limitations, and use them all. Even then, they won’t always know the shortest route to the knowledge you seek: The Web is rife with detours and dead ends. But with the right sites to guide you, you’ll spend less time driving aimlessly on the information highway.

For more information on web searching, including a Table of Web Search Engine features, check our Section website at [www.aap.org/seniors](http://www.aap.org/seniors), Click on the Living Well Section in the right pane and scroll down to Technology for Seniors.

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## Update your Personal Profile

An important service is available on the AAP Member Center. A Personal Profile has been added to provide you with an opportunity to view and update your contact information, demographic, and subspecialty information. Simply enter the changes into the form and our database will be updated the following day.

The online Member Directory should be your primary resource to locate colleagues. Physician Referral Service (PRS) should be used for patient referrals. These resources have the most accurate, up-to-the-minute contact information available.

With these new changes and enhancements, we believe we can further improve service to members and the public. However, it is also an important time for our members to check their address and demographic information for accuracy. Please take the time to visit the Member Center and click on “Update Contact Information”. If you prefer to contact us by phone or e-mail, you can call 866/THE-AAP1, or send an e-mail to [membership@aap.org](mailto:membership@aap.org).

# THE HIGH TEA GENE

*by Joseph A.C. Girone, MD, FAAP*

It went unnoticed by the media and so not many people are aware of a recent genetic discovery. Scientists have identified the “high tea” gene. This gene is located on the X chromosome, close to the “ask for directions” gene. This means women have 2 of these genes and men have only one.

Essentially, this results in a different appreciation and perspective of high tea for women and men. What do you see in the Tea Room as a result of this genetic phenomenon?

As a woman enters the tea room, her face is aglow, smiling, bright-eyed, anticipating a wonderful experience. After being seated, she adjusts her wide-brimmed red hat and removes her ruffled mesh gloves. She slides the flowered cotton napkin from the napkin holder, places it on her lap and picks up the menu. She selects the high tea and then discusses with her friends whether to have the soup or savory. She chooses a fragrant tea from a long list of unique teas.

The tea pot arrives. It is poured into the china, hand painted cup and the tea cozy is placed over the pot. Next the cup of soup is served in a decorated, petite cup. The conversation is fascinating with many interesting discussions including gossip, fashion, and health.

The three-tiered server is placed in the center of the table. The wait staff describes the content, beginning with the lower tier of tiny tea sandwiches, the middle level of scones with spreads and the top tier of miniature desserts. The superb experience continues with more conversation and pouring of more tea from the pot. At last, delicate desserts are consumed to complete the experience.

A man has only half a dose of the high tea gene, so his perspective and experience has to be very different.

As a man enters the tea room, he is confused and startled by the wide-brimmed red hats and intensity of the conversations. He has had bizarre dreams that made more sense. It is obvious he is the only male in the room. His past experiences with this much intensity in conversation and social energy has always involved beer and darts. He is asked to pick his tea. Lipton, of course. They don't have it. He recognizes “Earl Grey” from a response on Jeopardy, so that's his choice. Soup or savory? What in heaven's name is a savory? He picks soup.

His pot of tea is served with the cozy. He's not sure if the cozy is part of ritualistic head gear worn by men when drinking tea in place of a red hat but he is quickly advised it covers the pot. The soup arrives in a cup that resembles a thimble on steroids. Not a he-man portion. It is devoured in less than a minute.

He isn't sure why a napkin needs to be placed in a ring and then removed. His thought is interrupted by the arrival of the three tiered server. Because of the confused look on his face, he is instructed to start at the lower tier and go up. The lower tier has miniature sandwiches, with the crust cut off. The entire sandwich can be held by the thumb and index finger. It can be, and is, consumed in one bite. What do they do with the crust? Why cut it off?

Another new word is scone. Since he is starving, he eats it. It's dry, so he loads it up with some kind of jam. He recognizes some of the desserts on the top tier, but they have been shrunk down somehow. All of the food is miniaturized as though 3 year-olds are going to eat it. I guess the process to make the food so small is expensive and that is why the HighTea costs so much. Another minute and the desserts are history.

At this point, it's only a matter of deciding how long to wait before going to a bar for a roast beef sandwich and a cold beer!

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# THE MAN WHO MADE LISTS

## Love, Death, Madness and the Creation of Roget's Thesaurus

by Joshua Kendall

Published by G. P. Putnam's Sons, New York, 2008

Review by Avrum L. Katcher, MD, FAAP

Almost everyone who reads knows what a thesaurus is, and almost everyone knows how to use it. The Random House dictionary explains to us:

1. a dictionary of synonyms and antonyms
2. any dictionary, encyclopedia, or other comprehensive reference book
3. a storehouse, repository, or treasury
4. computers
  - a. an index to information stored in a computer, consisting of a comprehensive list of subjects concerning which information may be retrieved by using the proper key terms
  - b. a dictionary of synonyms and antonyms stored in memory for use in word processing

[Origin: 1730:40; < L thisaurus < Gk thisaurss treasure, treasury]

Dictionary.com Unabridged (v 1.1)

Based on the Random House Unabridged Dictionary, Random House, Inc. 2006

As we see, and as is so often true, words ending with -us, or -os are derived from Greek, and the meaning is a treasure or treasury. And for us, the treasure is one of words, their meaning, lists of other words which have either similar or opposite meanings. It is hard to imagine a library which contains books of reference without a thesaurus. In 1852, a man named Peter Mark Roget, published in England the first thesaurus aspiring to a comprehensive listing of words by the similarity to each other—or lack of it. There had been similar prior efforts, but they were smaller and much less effective.

This fascinating biography is an effort to describe the man who created the first real thesaurus, and what in his life led to this effort. If you enjoy words and language, this will hold your attention, and enlarge your comprehension. Roget was born in 1778, and died in 1869, at almost 91 years of age. This is the first of many ways in which he was different from many of his countrymen: most of them, and many of his family, did not survive to anywhere near that age in those times. By eight years of age, he was already showing signs of the obsessive/compulsive behaviors accompanied by intermittent depressions, which remained with him throughout his life. He began then to make lists of words grouped under assorted categories. He grew up with this kind of activity. As an adolescent he was entered into medical school in Scotland—at that time one of the leading foci of medical scholarly learning—and demonstrated a talent in befriending and being befriended by men who were widely known in medicine. Like John Hunter, the pioneering anatomist/physician, who preceded him by about 30 years, Roget was happy when puzzled. In Hunter's words: "I know I am going to learn something." Roget was one of about 5% of his class who graduated first time around. Despite what is noted above, his thesis, in Latin of course, was on The Laws of Chemical Affinity. But it was really about the abstract principles of the language which enabled the explanation of chemical observations and laws—in other words, it was about classification. After graduation, at age 20, he set about befriending the great men in medicine of his time, with considerable success. He joined a society, the Lunar Society of Birmingham, so named because they met monthly, usually when the moon was full, from which, they were known as 'lunatics'. In addition to chemistry, Roget studied tuberculosis, in particular treatment, he experimented with gases, including nitrous oxide, the preservation of foods by placing them underground with chunks of ice, learned the practical aspects of international politics when he was trapped in France, with two nephews whom he was leading on a tour, at a time that Napoleon resumed the chronic warfare with Britain, and all along studied insects, animals, growing plants, and any other feature of nature he found of interest. And, at the same time, wrote down thousands of words he had heard, how they fit together, what their similarities and differences were. An ideal project of an obsessive-compulsive personality. He did not just note them, he learned about language and meanings. Thus, at one point during the wars mentioned, he said of a foreigner visiting France "the despotism which prevails, and the vexations and trifling regulations of the police are all carried on in the name of liberty and equality." Sound familiar?

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Roget's research on sanitation was performed in Manchester, England, where he opened an infirmary—a clinic for the poor with fevers. By strenuous sanitary measures, the census of the ward dropped steadily and he was able to show that this type of care, and the encouragement of the population to do the same in their pitiful homes, resulted in an increase in survival. At the same era, he worked along side of Dr. John Ferriar, head of the Board of Health in Manchester. It was Ferriar who was the first physician to take note of the effect upon heart troubles of dried leaves from a plant known as *Digitalis purpurea*. At about this time Roget began to put together his book, his thesaurus, to prepare it for publication. At a similar time in his life, he also did something in a totally different field: a slide rule, based on logarithms, which would show the powers and the roots of numbers. He also, by careful study of the spokes of a wheel as seen through vertical apertures, developed the underpinnings of what would some day be the motion pictures.

This book is a wonderful read. In particular, attend to the mixture of what he did, his difficult personality, and his fascination with the world of the lexicographer.

## **SECTION ELECTION RESULTS**

We are pleased to announce new leadership for our Section as a result of the recent election. Dr. Lucy Crain will be assuming the role of Section Chairperson and Dr. Alan (Buz) Harlor will be joining the Executive Committee at the NCE in November. Dr. Avrum Katcher, after six years as Chairperson, will remain on the Executive Committee as Immediate Past Chairperson. Congratulations and Best wishes to our new leadership team! Our Section will continue in capable and competent hands.