

Senior Bulletin

AAP Section for Senior Members

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Volume 12 No. 3 – September 2003

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™



Chairman's Report

David Annunziato, MD, FAAP

Dear Senior Members,

I hope that all of you have had a relaxing yet productive summer. I pray for your good health.

This newsletter is the second under the editorship of Avrum Katcher and Joan Hodgman. I know that you agree it continues to be excellent. The transition from Bob Grayson has been smooth and relatively uneventful.

I have just completed the annual section report. It seems that all the members should be appraised of my comments. I have asked, therefore, that they be used as my chairman's report to you. Please send me any comments you may have.

Strengths and weaknesses

Our section has many strengths. We have a superb executive committee. All members are diligent in their duties, and complete their assigned tasks effectively and in a timely fashion. Our newsletter continues to be a highlight of our section. With each issue, numerous compliments are received. The programs developed by our program committee have been excellent. Cooperation amongst the executive committee members and by a number of section members has been great. Interest in our actions has been superb.

We have noted few weaknesses. We do have difficulty retaining membership for many under-

standable reasons, the greatest of which is age, retirement with loss of interest and of course the inevitable. We have attempted to address this problem with a survey, development of senior groups in each chapter and attempting to recognize and speak out on issues pertaining to seniors.

We have failed to recruit chapter webmaster in spite of an ongoing diligent search. We will continue to do so.

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Membership issues

We have addressed the recruitment problem in a number of ways. We discuss this problem at every executive committee meeting. The assessment of dues precipitating the loss of about forty members has been addressed with memos to the executive director and membership staff. We have at-

tempted to maintain interest with excellent programs, section member recognition and of course, with our excellent newsletter. We have not been able to prevent the inevitable.

Accomplishments & Impediments

We have introduced a senior advocacy award and we have had it funded. We have had a smooth and successful transition of the editorship of our senior newsletter. We have made small but improving gains in senior member licensure and coverage for their free service activities. We have continued to maintain excellent senior programs. We have had excellent communication among executive board members, and have addressed issues presented in a timely and successful manner.

Impediments to activities

Perhaps the greatest impediment to our recruitment and retention of members was the imposition of a dues assessment of senior emeritus members. Another impediment is notable in our inability to attract more attendees at our section meetings. We have noted stiff competition with other excellent section and general meetings which meet at the same time. We will address this, this year, by having a joint meeting and with greater advertising of our programs in order to gain more visibility and interest.

Efforts with chapters

We have attempted to create chapter activity surveys and letters to chapter leadership. This has been partially effec-

tive in that some chapters have indeed, appointed senior committees on groups. This effort is ongoing. New attempts will be developed this year.

A.A.P. support

We ask the executive board to rescind the dues initiative for emeritus members. We suggested that forty and fifty year members be recognized. Hopefully we can get better visibility for our section meetings. I would take this opportunity to thank the executive committee members, our excellent support staff and our members for their productive and innovative ideas and initiatives. I would also compliment and thank the past and new editors of our senior newsletter. You all know who you are. All have made the chairmanship job easier and happy.

Please note that our senior meeting will be on Monday, November 3rd in New Orleans. While you are enjoying this fun city, take the timeout to attend the meeting. We need your attendance, your support, your suggestions and your comments.

Cordially,
*David Anunziato, MD
Chairman, Senior Section*

P.S. We look forward to a note from Jim Reynolds with suggestions about restaurants, places to see and things to do in New Orleans.

Executive Committee

David Annunziato, MD Chair
East Meadow, NY

Avrum L. Katcher, MD
Flemington, NJ

Jacqueline Noonan, MD
Lexington, KY

James L. Reynolds, MD
New Orleans, LA

Donald W. Schiff, MD
Littleton, CO

Benjamin Silverman, MD
Seal Beach, CA

Herbert Winograd, MD
Past Chair, Scottsdale, AZ

Subcommittee Chairs

Program
Jacqueline Noonan, MD

Legislative Advocacy
Donald Schiff, MD

Financial Planning
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Membership/Budget
Avrum Katcher, MD

History Center/Archives
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LETTERS TO THE EDITOR

Exchange Transfusion:

I enjoyed Joan Hodgman's article on the changes wrought by the Southern California inauguration of exchange transfusions in management of Rh incompatibility, and the miraculous lessening of need for the procedure after the development of RhoGam. Joan and I are pretty contemporary, on opposite coasts. I graduated med school in '48 and after training in Baltimore and Boston, began practice in Princeton in '54. By then, exchanges had become a way of life, even for the practitioner.

The most fun I had with exchanges took place in Grenada some years later. When the Cubans went home after the invasion, Project Hope recruited volunteer physicians to fill the gap on the island. A group of us from the Children's Hospital of Philadelphia Emergency Department became the island's pediatricians for successive 2-month periods in 1983-84. A Grenadian native, Dr. Philip Finlay, who had just graduated St. George's Medical School on the island, served as interne. This wasn't truly Third World medicine, but more like 2 1/2 World. We had a somewhat satisfactory, poorly equipped hospital, with a lab that could do basic procedures including bili levels and type/match.

The biggest neonatal problem stemmed from the fact that the OB, also local, did not believe in, and possibly didn't have access to, RhoGam. Nor did we

have bili-lites. Rh negative mothers sat with and nursed their serologically incompatible babies on the maternity unit porch, in the perpetual Grenadian sunshine, hoping to soak up sufficient rays. Bilirubins rising high in the 30's were not uncommon, largely because transfusable blood was a scarce commodity. I did more high-risk blood exchanges at higher bili levels during my time there than in the rest of my years combined.

The first such exchange is very memorable, because I taught Philip the procedure. I have a wonderful photo (if I can find it) of my leaning over Philip's shoulder as he pushes and pulls blood. The nurse is lighting the field with a hand-held flashlight. Philip went on to a medical residency in the states (Miami), then to an Infectious Disease Fellowship there. He returned to the island where he is now chief of the AIDS program. He is also director of education at the local, refurbished, now modern Grenadian government hospital. He has developed a wonderful residency program, training mostly graduates of Caribbean and African schools. Beverly and I visit there almost annually and get great satisfaction from the progress we've seen.

Much progress is attributed to the work of a number of dedicated native physicians who, like Philip, returned home after completing residencies in the United States or the United Kingdom. In pediatrics, for

example, Dr. Beverly Nelson, whom I had met when she was a student at St. George's Medical School, and the daughter of a Grenadian native, returned to the island after a pediatric residency in New York and, starting from scratch, developed a top level pediatric and neonatology center and a very busy local pediatric practice. In a brief 20 year period, the process of improvement in the economic and health and educational and logistical life on the island has been a phenomenon that could be duplicated elsewhere.

*Benjamin Silverman,
MD, FAAP*

Letter to the Co-editors:

I congratulate Dr. Joan Hodgman on her well-written review of neonatal Rh hemolytic disease in *A True Medical Miracle* (Senior Bulletin, summer 2003). I, too, had the good fortune of introducing exchange transfusion at my staff hospital, Mercer Medical Center, Trenton, N. J., in 1955. The infant happened to have ABO hemolytic disease; the cord Hgb was down to 8 gm/dl. As we all know, ABO hemolytic disease is usually less severe, and today the treatment would be packed cell transfusion and phototherapy (unless newer advances have replaced phototherapy).

Mention should be made of the value of cord blood examination in Rh cases (what is left of them in the post-Rhogam era).

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Our obstetrical staff at Mercer, enamored with the ready availability of cord blood, insisted on continuing routine collection for both Rh and ABO infants. After reviewing a series of infants with ABO hemolytic disease (cord typing, Coombs test, CBC, bilirubin, and reticulocyte count) as well as doctor and nurse notes, I concluded that observation of the time of onset of clinical jaundice was sufficient to alert the physician. Cord blood testing is not only unnecessary in ABO cases, it is inappropriate and not covered by insurance. My findings were published in *Clinical Pediatrics*: 10:A27, No7 July 1971. "Should every newborn be given a Coombs test? The fate of Coombs-positive newborns."

*Sol Browdy, M.D.
Park City, Utah*

To the Editors:

**CUBA,
THAT'S THE WAY IT IS!**

I have a correction. There were several typos, probably mine, i.e. Cuba purchases BEEF not BEER from Australia and the Havana Psychiatric Hospital has 4100 beds, not 41.

It is pointless to respond to Dr. Reynolds, who condemns observations seen and heard on a visit to Cuba by a group from all parts of the United States. He has obviously not personally visited Cuba. I hope he favors the free medical and nutritional care of all children in the United States, as advocated by the AAP.

Those interested in this topic might read an article in *Smithsonian Magazine* for May 2003 on the conservation and ecology of untouched preserves, "The Nature of Cuba—The Caribbean's Unlikely Nature Preserve", by Eugene Linden with beautiful photographs by Lynda Richardson. Linden reports on a 1000 mile trip in Cuba's wildland's preserve. He was guided by Antonio Perera, an ecologist and former director of the Cuban government agency that oversees protected lands, who, with his colleagues, has won protection for swamps bursting with wildlife, rain forests, cloud forests, grasslands and lagoons. Perera notes that 22% of Cuban lands are under some form of protection, making its safeguarded environment among the highest of any nation. They are fighting to keep it that way against government and commercial development. The article is filled with descriptions of Linden's trip describing rare flora and fauna with beautiful illustration and photographs.

The 12 page article has a few interspersed columns covering history and government but notes less encroachment by Castro than previously. There

are also a few statements of other preservationists and their opinions, with paragraphs on general observations apart from *Ecology*. Linden notes "I am amazed at the cleanliness, orderliness and seeming functionality of these towns [in Cuba]....Luis Gomez-Echeverri, former director of the UN Development Program mission in Cuba, says the poorest Cubans have a better standard of living than poor people in any of the 82 countries he has visited." Linden continues, "Though Cubans have little economic freedom, the UN's annual Human Development Report ranks Cuba among the top five developing countries in terms of education and access to clean water, medicine and housing."

I am certainly opposed to the horrors of Castro and dictatorships. Along with the late President Eisenhower, I feel that more contact with people from different countries will help Cuba toward Democracy. Castro can't rule forever. Ignore the politics, whatever your opinions, and read the article for its nature study of Cuba's untouched preserves.

James Dick M.D. FAAP

Editors' Note: *We consider this correspondence closed. Without taking sides, we remind readers of two comments, one by a great 18th century playwright, one by the President of a distinguished university:*

"I disapprove of what you say, but I will defend to the death your right to say it." Voltaire "The idea that we should be open to all ideas, is very different from the supposition that all ideas are equally valid." Lawrence Summers, President, Harvard University.

WHAT IS THE AMERICAN ACADEMY OF PEDIATRICS FOR?

We all know—or think we do—what are the goals of the American Academy of Pediatrics. I've always felt that the organization existed to further the health and welfare (in the sense of overall goodness of life, not in the sense of financial support) of children up to the age of young adults. We have an even longer time-line, because recommendations and education we make may produce results many decades later. Yet recently when I checked what our records say, I found this:

Core Values

We believe in the inherent worth of all children. They are our most enduring and vulnerable legacy. Children deserve optimum health and require the highest quality health care. Pediatricians (primary care pediatricians, pediatric medical subspecialists, and pediatric surgical specialists) are the best qualified of all health professionals to provide child health care. A dynamic organization is necessary to advance these values. The American Academy of Pediatrics is that organization.

Vision

The American Academy of Pediatrics exists to prepare its members with the tools, skills, and knowledge to be the best qualified health professionals: 1) to advocate for infants, children, adolescents, and young adults and provide for their care; 2) to collaborate with others to ensure child health; and 3) to ensure that decision making affecting the health and well-being of children and their families is based on the needs of those children and families. The American Academy of Pediatrics also exists to support members' professional satisfaction and personal growth.

In my own words, our organization exists to speak up for the benefit of these young people and to do what is possible to influence political and administrative systems, nationally, in each state and locally for those youngsters. The AAP bases its recommendations on the needs of young people and their families. Note that we recognize that the health of the young is rooted in the health of family function. The AAP also

collaborates with others as indicated.

Finally, the AAP also exists to support members' professional satisfaction and personal growth. That is, it is recognized that the essential tool, through which our vision, our goals are carried out, is the pediatrician, whether in practice, administration or academia. In order for that tool to work at highest efficiency and effectiveness, the AAP supports the best possible physical and mental health of its members.

It had been my impression that the AAP began (in my lifetime, but before I was even aware of what a pediatrician was) as an organization of pediatricians advocating for children as an independent pediatric forum. About 50 years later, one of the periodic swells of dissatisfaction with the pediatric life emerged as what was colloquially called, "the disgruntled pediatrician syndrome." One product of that era was the election of a President, Glenn Austin, who had not been a candidate selected by the National Nominating Committee. (Full disclosure: I served on that committee at that time.) Another product was recognition that education for the pediatrician on how to care for him and herself was also important.

At the recent meeting of the Senior Section Executive Committee, Don Schiff and Jackie Noonan spoke eloquently about the parallel tracks of the efforts of the AAP, for children and for the pediatrician. Not everyone agreed that the effort exerted in each area was proportional to need. But all agreed that both are justification for the efforts of each of us in the American Academy of Pediatrics, and in its Senior Section.

So much for the build-up. Now for the pitch:

What would you like the AAP and the Senior Section to do for you?

What can you do that will help the AAP and the Senior Section to work for children and for the pediatrician?

Please respond to the editors. In the next issue we will publish your comments.

EDITORS' ANNOUNCEMENTS

Advocacy Award will be made at the Senior Section Meeting at the National Conference and Exhibition (NCE) in New Orleans 3 November 2003.

How to Send Us Your Articles: Please send articles you are submitting for publication in the Bulletin of the Senior Section via U. S. Postal Service simultaneously to the co-editors:

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Arcadia, CA 91007
Flemington, NJ 08822

We have had great difficulty in opening and in preparing for publication material sent by e-mail. What seems to work best, if that is the only feasible route, is for the article to be prepared as a Word document, transmitted as an attachment, with a subscript of <.doc> at the end. Thus: <How I healed the sick children as a high school student all alone on Pitcairn Island.doc> However, if the document is difficult to open, or the format requires extensive renovation, it will be returned, and you will be asked to resubmit via USPS.

Errata: We apologize for the error in title of the brief item in the April issue containing a quote by George Bernard Shaw, the distinguished British playwright. The title should have been: From Candida, by George Bernard Shaw.

Health of the Pediatrician Meeting: The special interest group on the Health of the Pediatrician will have a meeting at the NCE in New Orleans. The meeting will be held in the same room as the Section on Administration and Practice Management, Saturday 1 November, 2003, from 3 to 4:30PM.

There are a number of Web sites available via the Internet for information on long distance telephone calling plans both wired and cell phones.

One is the Consumer Information Bureau of the FCC which offers all sorts of information via a Web Site: www.fcc.gov/cgb, or, if you prefer, voice telephone 1-888-225-5322, or TTY 1-888-835-5322.

Another provides all sorts of extensive and interesting information, including comparisons of costs of a variety of calling plans: www.abelltolls.com.

If you have questions, go to sources like these.

The late Senator Daniel Patrick Moynihan was widely respected as a scholar in addition to his political attainments. The following are prescient quotes from his writings:

- 1969: "The poverty and social isolation of minority groups in central cities is the single most serious problem of the American city today."
- 1988: "Not until we get [welfare] known as a program for people to find jobs can you maintain its cash benefits...If we accept the definition of welfare as a transition to employment, we will see the numbers of persons on welfare in New York City cut in half."

CHILDREN, OUR MOST PRECIOUS ASSET

By Donald W. Schiff, MD

How often we have heard or said ourselves that our nation's children are our most precious asset? We hear it from parents, teachers, nurses, pediatricians, social workers, politicians, everyone. But what do we really mean by that time-worn cliché? Do we mean that in a collective sense, or are we speaking only of our own family's children? Do we truly extend ourselves when our nation's children face a continued loss of health insurance as the private employer continues to cut back on employee benefits? As the Medicaid benefits are reduced and the SCHIP program is capped and states decide that competing demands for limited finances overwhelm their budgets, resulting in a loss of Medicaid funding? The federal government recently found billions of dollars to help increase the federal match and support the states' Medicaid and SCHIP programs, only to find that some states (Colorado) took the Medicaid money and used it to replace state dollars instead of enhancing the Medicaid program as it was intended.

The Congress is facing legislation designed to broaden our ability safely to prescribe medications for our patients by utilizing safety studies done on children in addition to adults. The previous pediatric rule which required pharmaceutical manufacturers to run these studies on children was eliminated by court order. Now we have the task of convincing Congress of the importance of safety and efficacy testing of all children's medicines.

The recent efforts of the federal government to enhance the role and responsibility of states in managing the Head Start Program is an additional example of a clear intention of block granting and diminishing a program which has demonstrated that helping children in the preschool period provides a superior school experience.

Finally, the recommended changes in the welfare program which will require mothers to work longer hours and to be away from their families appears to me to be a false economy and the antithesis of what we should be doing to help support the family.

As we reflect upon these changes, so stressful to family structure, we are compelled to answer the question, "What are we doing to resolve these critical questions?" The issues are not going away, as the philosophy which has produced these movements and the economy which excuses these reductions in government responsibility may very well accelerate if child advocates do not take on the challenge and reverse the trend toward undermining the family and children.

For further information, contact dschiffco@aol.com.

SENIOR SECTION ADVOCACY AWARD

By Donald Schiff, MD FAAP

The Senior Section of the Academy has been since its inception a strong foundation of advocacy for our nation's children. Although, as active practicing pediatricians, we support children and their families through our delivery of health care and educational advice on health issues, we can, as we have more time available, move on to other opportunities. Senior pediatricians have grasped the responsibility utilizing their experience, interests and contacts in their own communities and states. Some have served as mentors and instructors in academic programs. Others have become resources for the media, providing accurate information about the value and importance of childhood immunization programs and countering the myths and confusions promoted by the ill-informed opponents of this vital public health program. The promotion of educating children has attracted many senior pediatricians, who serve as teachers' aides helping children improve their reading skills or learn English as a second language.

Pediatricians will continue to be energetic in efforts to solve the major problems facing families and their children as we move through the next few years. Our mission has not changed, nor has the absence of health insurance, which remains the primary barrier to providing comprehensive quality health care to our nation's children. Whether we take a snapshot and see nine million uninsured, or we look at the year-long span and find double that number without insurance at some time during the year, the numbers are too high and demand remediation. How that is to be achieved, as an incremental advance or by a broad age-encompassing move, will be determined by the state of our economy and by the willingness of the nation to accept a comprehensive change.

During this interim, senior pediatricians can contribute by helping to educate the public on the problems children face without primary health care insurance. The Senior Section Advocacy Award will be presented at the Section meeting at the NCE in New Orleans to an outstanding pediatric advocate. Join us on November 3 at the meeting to honor him and share the festivities.

Editors' Note: *On the day Dr. Schiff's article arrived by e-mail, we received from the post office the latest edition of *The Future of Children: Health Insurance for Children*. Volume 13, Number 1, Spring 2003. This series is supported and distributed by the David and Lucile Packard Foundation, and edited by Richard Behrman. The latest volume is an in-depth review of every aspect of health insurance for children, including four articles on creative solutions which may be helpful. It is strongly recommended for all. Copies may be obtained by writing:*

*Circulation Department
The Future of Children
300 Second Street
Los Altos, CA 94022.*

*To sign up for the newsletter, go to their web site at
<http://www.futureofchildren.org>*

Editor's Note: *This summary of the present status of the Health of the Pediatrician initiative, serves to introduce three pertinent personal reminiscences. Dr. John Moyer tells us of his experience suffering an overwhelming, devastating personal loss. Dr. Theodore Kastner relates how he worked through a stressful professional situation to find a more satisfying work situation. Sol Browdy continues his series of personal encounters with adversities of aging. All have overcome adversity; a measure of their personal qualities is the openness with which they share intimate feelings. They deserve our congratulations.*

By the way, the distinguished health information site of the Mayo Clinic has an excellent summary of some of the newer risk factors implicated in cardiovascular disease, our old friend CRP=C Reactive Protein being one as well as a favorite of the newspapers. We all remember this one as a marker for inflammation, perhaps made redundant by the sed rate. There are others.

Check this out: www.MayoClinic.com

Then Mayo Clinic Health Information

Then Novel Risk Factors: Identifying New Culprits

For those interested in the Health of the Pediatrician, there will be a special program at the NCE in New Orleans, immediately following the meeting of the Section on Administration and Practice Management, in the same room (name of room not available at this time) from 3 till 4 PM.

HEALTH OF THE PEDIATRICIAN

Background: After the Chapter Chairpersons' Forum enthusiastically passed a resolution submitted by Bulletin acting co-editor Avrum L. Katcher, calling for more action on the part of the AAP in promoting the health of pediatricians, an informal subcommittee on Pediatrician Wellness was formed to enhance physician health and well-being. That initiative sparked considerable interest; in October 2002 at the National Conference and Exhibitions a special interest group (SIG) was formed under the sponsorship of the Section on Administration and Practice Management. The subcommittee and the special interest group are chaired by Hannah Sherman, MD, FAAP, of Lexington, Massachusetts. This report was prepared by Chairperson Sherman for AAP leadership. It is presented for the interest of Seniors, together with the results of a survey, and some comments by Dr. Sherman, at her presentation in New Jersey, May, 2003, about dealing with stress and burnout. An entire issue of the Western Journal of Medicine was devoted to Health of the Physician: January 2001, www.ewjm.com/content/vol174/issue1/

Current Membership: 125 members and actively growing

Summary of Mission: The goal of the Physician Wellness SIG is to support pediatricians to enhance their own physical, psychological and spiritual health and well-being with the intention of improving professional effectiveness, achievement and satisfaction.

Activities to Date:

1. Educational offerings
 - Successful educational programs at the 2002 NCE
 - Workshop on physician well-being and professionalism for the New Jersey chapter of the AAP, May 2003
 - Interactive seminar on professional and personal balance scheduled for 2003 NCE
 - Three physician wellness seminars proposed for 2004 NCE
2. Quarterly column on physician wellness in AAP News since April 2002 written by AAP Fellows and guest experts
Topics to date include:
 - A call for physician well-being and how the AAP is addressing the need
 - Meaning in medicine

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- Navigating transitions
 - Thriving in practice
 - Collegial support of the next generation
3. Physician wellness web page on AAP website is currently under redesign
4. Listserv for SIG members (122 of 125 current members have requested to participate.
- For posting of educational programs and well-being courses
 - For suggested readings of original journal articles and well-being books
 - For communication between steering committee and SIG members
 - For discussion among members

Summary: The Physician Wellness Special Interest Group addresses a significant need among members of the AAP to identify ways to support professional well-being and sustainable effectiveness.

SPECIAL INTEREST GROUP (SIG) ON WELLNESS-MEMBER INTERESTS SURVEY
March-April 2003

(All Respondents, N = 64; Return Rate = 57%; all percents have been rounded)

Of all respondents, just over half are female, and 45% are over age 45. Of the total, 69% engage in general pediatric practice; 31% are in subspecialties. Of 64 respondents, 19% are in the inner city, 23% in the city but not inner, 28% work in suburbs, and 6% in a rural area.

A wide diversity of preferred educational activities is noted, including retreats, local chapter programs, NCE seminars and workshops, the Super CME, a speakers bureau and special local conferences.

PARTICULAR INTERESTS IN PHYSICIAN WELLNESS INCLUDE:

Personal and Professional Balance	51	80.0
Restoring Meaning to Medicine	50	78.0
Physical Health and Well-being	49	77.0
-Exercise	51	80.0
-Nutrition	42	66.0
-Cardiovascular health	25	39.0
-Aging Issues	23	36.0
-Women's Health Issues	21	33.0
-Men's Health Issues	19	30.0
-Physical Challenges	14	22.0
-Chronic Illness	12	19.0
Organizational Changes	45	70.0
Recognizing Burnout	44	69.0
Mindfulness in Medicine	44	69.0
Nurturing Wholeness in Ourselves	41	64.0
Clinical Practice Redesign	37	58.0
Values Clarification	35	55.0
Effective Mentor and Role Model	34	53.0
Managing Mistakes	32	50.0
Building a Community of Support	30	47.0
Part-time Practice; interrupted career	26	41.0

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Spirituality of the Caregiver	23	36.0
Honoring Grief and Loss	21	33.0
Relationship-centered health care	20	31.0
Leading Well-being	20	31.0
Other	8	24.0

In response, Dr. Sherman prepared several comments, put forth at the seminar she gave at the Annual Meeting of the New Jersey Chapter.

Signs of Physician Stress and Burnout include among others:

- Unusual fatigue
- Irritability, anxiety and trouble concentrating
- Disinterest in work or personal life, Depression, and boredom
- Sleep disturbances
- Impaired relationships, social isolation and cynicism
- Poor health
- Alcoholism and substance abuse, poor job performance/quality of care

Signs of Well-Being, on the other hand, include among others:

- Attention to physical health such as regular medical and dental care exercise, and maintaining a healthful state of nutrition and body mass.
- Limiting and managing stress by identifying sources
- Responding specifically and thereby avoiding “spillover stress”
- Self-reflection with clarification of personal values, identity and integrity, meaning and purpose in life
- Self-acceptance and setting priorities based on values
- Developing meaningful relationships with family, friends, community and colleagues

Further help is achieved by:

- Balance and time management, creating time alone for personal growth and creativity, relaxation and reflection
- Time with family and friends for giving, receiving and enjoyment balanced with time at work, learning to feel valued and satisfied with work.
- Spiritual nourishment
- Recognizing needs and when appropriate seeking support and assistance

It is often helpful to explore questions like these:

- What would your workplace be like if it were a place that you looked forward to coming to each day?
- When has your work been most in alignment with what you value about who you are as a physician? What did you, other people, or the circumstances contribute to making it that way?
- If you could design the ideal balance between work and personal life, what would that look like?
- What steps would you need to take to bring your ideal life into reality? Who would you need to support you?
- What measures of success do you want your children to rely upon, or would suggest to young physicians, to use, for their lives? Are these what you use for yours?

ANDY'S LEGACY

By John P. Moyer, MD, FAAP

I am a retired pediatrician living about 45 minutes southwest of Denver. My wife and I have two sons, Andy and Matt. Andy died over ten years ago from a severe head injury he incurred while skiing. Matt and his wife live in nearby south Denver.

Andy was a senior at the University of Colorado in Boulder. He was a physics major and had aspirations to continue his education in either medicine or bio-engineering. He was the kind of person who would always take extra time to help them or listen to their problem. He was a giver and a nurturer.

Seeing him on life support was the worst experience I've ever had to deal with. I realized the finality of his dying when his critical care nurse told me his condition was very grave. His basic life functions of maintaining blood pressure and urine output were failing. The concept of brain death became clearer and clearer as I realized there was no longer any blood flow to his brain thereby causing brain death.

When we realized that Andy was brain dead, my wife, younger son and I decided to donate Andy's organs and tissues. His life had ebbed away from him. We knew that others would benefit from Andy's life saving and life enhancing gifts. We decided to give someone else life from Andy's vibrant life. Andy would never recover. He was gone. Leaving him on that Christmas Eve, looking so alive, was agonizing.

The grief pathway was terrible for the first 24 or so months. It was difficult not to try and be a superhuman, accomplishing the same tasks I had so easily

performed before the tragedy. It was so easy to avoid the pain and fill my life with activities. I soon learned to live each day moment by moment and every week day by day.

Even at the darkest point in the grieving period there was a glimmer of light. Our family created new memories every day and turned our focus outward. We were thankful for the many good things in our life, especially our younger son Matt.

Within six months we had heard from two of Andy's solid organ transplant recipient families. On a very memorable day about six months after his death, we met Dave, Andy's heart recipient, along with his wife. It was a scary thing to do. We had no idea what to expect! The two hours that we spent with Dave and Martha were remarkable. We were even able to listen to Andy's heart beating strongly and effectively in Dave's chest. Our two families have since developed a healthy and close bond. We meet four or so times per year and share in each other's lives. Dave spoke the eulogy at both of his parents' memorial services this year in separate events.

One of Andy's kidneys was transplanted into a man living in the Borough of Queens in New York City. Because the immunologic match was so perfect, the organ was flown all the way to the East Coast for the procedure. The recipient Joe has continued to thrive. Recently he was able to escort his oldest daughter down the aisle at her wedding. My wife and I traveled to New York and attended that joyous event. We were accepted as family.

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A MID-CAREER REALIGNMENT

By Theodore Kastner MD, MS

Twenty years ago, my career path included routine competition between my personal and professional goals. To paraphrase Heisenberg and his uncertainty principle, I imagined that personal and professional fulfillment could not be found in the same place at the same time. As I looked towards the end of my career, I believed that I would have to make a full-time commitment to continued work or retirement.

After fellowship training, I worked for twelve years at what I thought to be the perfect job. I directed a nationally recognized health care program for persons with developmental disabilities, participated in training residents through two universities, and made significant contributions to clinical research. It seemed the perfect balance of clinical work, teaching, research, and administration. I was well paid, had the respect of my colleagues, and thought I would eventually retire from the position.

But over time, my view of the horizon changed. While each patient was interesting, I wondered whether patterns to the types of patients I saw reflected systemic problems in the health care delivery system. My research interests also expanded to consider larger issues. I went from writing case reports, to case series, to retrospective chart reviews, and, finally, to prospective clinical trails. We eventually obtained databases from health insurers

and began studying patterns of health care utilization and cost. I began thinking about how changes in the health care system could improve healthcare for persons with developmental disabilities. I also wondered how my experience managing a single practice could be translated into running a statewide or national organization. How would I address issues related to how to starting a new organization, scalability across a large geographic area, or how capitation creates incentive and disincentives for health care providers in the health care system? These questions had never been asked about persons with developmental disabilities and I was excited by the challenge of answering them.

I realized that if I were to move in this direction, I would need to re-evaluate my feelings about management. Like most physicians, I viewed management with disdain and put management training on a par with obedience school. But while looking through brochures, I saw a picture of an old friend who had received a Masters degree in management and called him. He suggested I consider graduate training. The options included coursework (related or unrelated to a degree) in law, business or public health. I learned about the American College of Physician Executives and explored the graduate degree programs they offered in collaboration with several univer-

sities. While most offered an MBA, I chose an MS program at the University of Wisconsin School of Medicine because it included a focus on population health. The program was structured in an executive format involving 8 weeks on-site in Wisconsin combined with weekly assignments and conference calls over the 22-month program. I was accepted to the program and in July 1995, found myself surrounded by 24 physicians who, like me, had reached a self-perceived midpoint in their careers.

After my first week of classes I was convinced that graduate school would help me find a new way to practice medicine on behalf of persons with developmental disabilities. I filed incorporation papers, creating Developmental Disabilities Health Alliance, Inc. (DDHA), a company devoted to solving health care problems for persons with developmental disabilities. I didn't know what the company would do or how it would work. It just felt right. During the next two years, incorporation brought a focus to graduate school. When we studied managed care, for example, I considered how health care dollars could be better spent on health care services. I studied various business models in my class on 21st century delivery systems, developed pro forma budgets during my class in health care financing, developed a marketing plan in marketing, under-

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stood incentives in human resource management, and studied my competition in strategic planning. At various times, DDHA was briefly a preferred provider organization (PPO), a health management organization (HM), a group practice for persons with developmental disabilities or a disease management company. For my Capstone Project (our final exam), I presented a 100-page business plan for DDHA.

Upon graduating in June 1997, I knew that I had the skills to launch a new venture. Graduate school helped me depersonalize my experience as an employee and a manager and consider proposals based upon their merits. I went back to my old job full of new ideas about how we could develop services as the New Jersey Medicaid program began to enroll persons with developmental disabilities in managed care.

While I was matriculating, I had nearly 30 meetings with various hospital administrators to discuss my plans. I was frustrated because no one shared my passion for my patients or was willing to take a risk on a new venture. On the other hand the administration was preoccupied with larger issues. The hospital was merging with three others, creating a physician-hospital organization (PHO), underwriting a provider-sponsored HMO, and dealing with contracting revenues. Would the hospital consider placing DDHA in the PHO, the HMO, the new hospi-

tal structure or decline to develop the project? Would it be hospital owned, a joint-venture, or would I become an independent contractor? Finally, I was not sure if anyone could answer to these questions?

Fortunately, my wife was very supportive throughout this time in my career. She had confidence in my ability to find my way. She was also grateful that I had the benefit of input from my teachers and fellow students. They helped me maintain distance between my personal experience as an employee and my desire to do more during my career. Six months after graduation, I went to a holiday party to renew old friendships. The benign introductions seemed almost inquisitorial. When my friends asked, "How are you?", I stammered "O.K." When asked about my job, I passed and went to the buffet. Driving home that night, I realized that I loved my work but not my job. I woke my wife at 2:00 AM and told her I was quitting the next day. Rolling over, she fell back to sleep muttering, "That's nice."

It has been five years since I went out on my own. I lived the clichés of any start-up company. I worked out my home for 18 months, splitting time between child care and telephone conference calls. I hired two employees and held staff meetings at the International House of Pancakes, (Thank goodness

for air conditioning and bottomless cups of coffee!). I had endless nights of worry about finding enough work for my employees and repaying my brother for his loan of start-up funds. I struggled to remember that revenue is better invested in employee 401(k) contributions and tuition reimbursement than profits.

DDHA is a little bit of all of the things it might have become. With 20 employees we provide health care to about 1400 persons with developmental disabilities across the state. We provide care management services to three HMOs with our partner the Robert Wood Johnson Health Network. We contract with the state to provide various clinical services and contract with Trinitas Hospital to provide clinical consultation to the state mental health system. We work with HMOs on issues related to premium management – pharmaceuticals, hospitalization, and day programs.

Looking back I realize that I should have quit my job well before I did. I tried too hard to make the hospital meet my needs rather than realizing that I had the responsibility to meet them myself. I now think that my desire for job security led me to unacceptable compromises about the kind of work I was doing. Whatever the cause, I outgrew my old job before I knew it. My graduate training taught me to consider my career like any other case

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study. The number of doors opening before me was limited only by my imagination. Catchy phrases I learned in marketing class like “think outside the box” and “go with the flow” actually took on a personal meaning.

As I consider my future retirement, I hope to apply this knowledge. Although I consider myself to be in mid-career, I spend time thinking about what it is that I really like to do. Each day affords me an opportunity to see every

task in a new light. What if this were the last time I reviewed a budget, saw a patient, or called the HMO? Would my life be enriched by that change? Or, even more difficult, would I rather free the time spent on these things to play with my family, restore a boat, or run a marathon? The options seem endless.

And that is what is so cool about living in the present. I don’t have a job for the future. I work in the present at things that I enjoy and my

work is continually changing to meet my personal and professional goals.

I used to think that I wanted to retire at a certain age and make a complete break with my old job – to do what I really wanted to do. My new perspective about work has changed that. I may leave my job but continue to work as long as I find it personally gratifying. In this respect, retirement is less a revolution than an evolution—an evolution that is already underway.

ANDY’S LEGACY Continued from Page 12

Andy’s liver and other kidney were transplanted into a great guy with oxalosis, living about 90 miles from us. Charlie has continued to live a healthy robust life and has seen nine grandchildren come along since the transplant in 1992.

My wife and I are active in helping and coming alongside other organ and tissue donor families. Investing in others after our time of grief, by providing support and encouragement to them, helped us heal. My wife has assembled a beautiful quilt with squares lovingly prepared by donor families throughout Colorado and Wyoming. These are tributes to the loved one who gave the gift of life. I spend significant

time volunteering with the National Kidney Foundation and the United Network for Organ Sharing, as well as regionally with our transplant organization. The volunteer hours with the NKF are reaching out to bereaved families who have lost children, spouses, or siblings.

At the time of Andy’s death a very special cousin of ours wrote these words. *“While a rose lasts for just a short time, it’s a very beautiful thing. And while some trees last for centuries, you cannot say the tree is more valuable because it lasted longer than the rose.”* For our family Andy’s life was like the rose; whatever it was meant to accomplish, it did.

DON'T OVERLOOK THE POWER OF PHYSICAL THERAPY

By Sol Browdy, MD, FAAP

Upon recovering from my crushing chest injury resulting from the totaling of my second Subaru in 21 days, my youngish but wise internist recommended an evaluation by an M.P.T. (master of physical therapy) and a course of recommended therapy, to begin at my home and to be followed up wherever necessary. The only physical therapy I previously received was following my acute M.I., post-op my 4-vessel CABG, and in connection with osteoarthritis of my right shoulder. (The arthritis immediately altered my not-so-robust serve and converted me into a lousy two-fisted backhander.)

The MPT methodically tested my lower extremities, uppers, spine, and balance. I had no idea that balance is included in this assessment. Let's face it: balance maintenance and falls are the bane of oldsters. Besides advanced age, diabetes and peripheral neuropathy are the other main causes of instability. Recent investigators recommend the "tandem stand" (put one foot behind the other and see how long you can stand.). If the subject cannot stand in this position for 30 seconds, he should be considered at risk for peripheral neuropathy and referred for balance training. Studies show that oldsters can still improve their balance and strength with short-term instruction.

Here are some of the simple exercises I performed inside my condo: sit/march in place; walk in hallway; wall squat; walk to second floor; heel/toe; walk to second floor twice ; ride broken-down bike; walk to outside dumpster and up stairs; and holding on to chair, try to maintain one-legged stance with eyes closed. For improving balance, he wrapped a flexible rope around me and I was instructed to step out in the four different directions and then back. To increase the available space, weather permitting, we did some of the exercises out in the street.

Ultimately we went to his nearby gym. He provided the to-and-fro transportation (remember I no longer drive) and added weights to the various apparatus of similar nature to the home exercises. Again we first focused on machines designed to exercise my lower extremities, e.g.,

bicycle, recumbent; ellipse; outer thighs; inner thighs; leg extension; lying leg curl; leg press; ball squats.

Next we turned to the upper extremities: side pulls; front pull; lateral raise; forward raise; seated row. Obviously some of the exercises involved both lower and upper extremities. Along the way we performed specific exercises designed to improve balance. Finally I have resumed workouts at my former fitness gym, incorporating the entire gamut of exercises in which I have been instructed.

So why do I sound as if I'm writing a commercial praising my M.P.T. (and collecting reimbursement on the side from the National Board of Physical Therapists?). I never sweated during or after any of my previous "workouts" utilizing only the treadmill. Now, even before the summer heat came along, I was starting to require a towel for my sweating during workouts. I honestly believe my former physical therapists were fearful of pushing me over the brink, not really sure of how far they could go. It seems as if a two-tiered approach is used by our health providers. Our cardiologists counsel that we should try to refrain from walking up stairs, etc. It's a different story when our physical therapists utilize walking up steps as a form of therapy to exercise our hearts. (Editor's Note: At our community hospital Cardiology maintains a rehabilitative PT program including emphasis on aerobic exercise. Perhaps they have different cardiologists.)

Finally, there is a sense of satisfaction and accomplishment along with a springier and straighter step than I've taken in several years, much of which I attribute to my most recent exercise training program.

I would be remiss if I did not strongly recommend two aids for anyone with cardiopulmonary problems. The first is a do-it-yourself sphygmomanometer for the taking of one's own blood pressure. The second is a small (but expensive) pulse oximeter for checking one's oxygen saturation and heart rate.

THE HOSPICE PROGRAM

By Robert Grayson, MD, FAAP

As pediatricians who practiced into the eighties, most of us had not been aware of the Hospice program, and had little need for the services which Hospice offered. Our very sick patients were usually hospitalized at the end of their terminal illnesses, and the hospital staffs provided necessary care, which often was care for the physical needs of the child and less for the emotional needs of the child and family. As we aged and our contemporaries developed malignancies or degenerative diseases (e.g. Alzheimer syndrome) we might have heard of the Hospice movement and the service they provided.

It was only when a problem struck home and my wife, Shirley, fought a brave and difficult battle against recurrent metastatic melanoma, that we were- put in touch with one of several local Hospice organizations by a surgeon who was familiar with terminal illness. We are eternally grateful for his advice. Before giving details of our personal experience, let me trace the history of the Hospice movement and their mission. Hospice is a most remarkable organization.

The word "hospice" stems from the Latin word "hospitium" meaning guest house. It was originally used to describe a place of shelter for weary and sick travelers returning from religious pilgrimages. During the 1960's Dame Cicely Saunders, a British physician, began the modern hospice movement by establishing St. Christopher's Hospice near London. St. Christopher's organized a team approach to professional care giving, and was the first program to use modern pain management techniques for compassionate care for the dying. The first hospice in United States is said to have been established in New Haven CT in 1974, although Cincinnati and Arlington, Virginia also claim that honor. In August of this year, Josefina Magno, an oncologist who survived cancer, died. Her obituary stated that she established pioneering programs in 1976 at Georgetown and in Virginia. She was the first Executive Director of the National Hospice Organization. By 1998 there were more than 3,100 hospice programs in the United States.

Hospice is not a place but a concept of care. Eighty percent of hospice care is provided in the patient's home, family member's home or in a nursing facility. Inpatient hospice care is sometimes available if necessary as a last resort.

For more on Dame Cicely Saunders see: "*Cicely Saunders-Founder of the Hospice Movement—Selected Letters 1959-1999*", by David Clark, Chair of Medical Sociology, University of Sheffield. Oxford University Press.

The above brief history and the following mission statement are taken from the web site of the Hospice Foundation of America. (<http://www.hospicefoundation.org>)

What is Hospice?

Hospice is a special concept of care designed to provide comfort and support to patients and their families when a life limiting illness no longer responds to care oriented treatments.

Hospice care neither prolongs life nor hastens death. Hospice staff and volunteers offer a specialized knowledge of medical care, including pain management.

The goal of **hospice** care is to improve the quality of a patient's last days by offering comfort and dignity.

Hospice care is provided by a team oriented group of specially trained professional, volunteers and family members.

Hospice addresses all symptoms of a disease, with special emphasis on controlling a patient's pain and discomfort.

Hospice deals with the emotional, social, and spiritual impact of the disease in the patient and the patient's family and friends.

Hospice offers a variety of bereavement and counseling services to families before and after a patient's death.

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The detailed chronology of the Hospice movement is described in the Hospice and Palliative

Care website. (<http://www.nho.org>), and is summarized here.

1964	St. Christopher's Hospice formed
1965-1968	Dane Cicely Saunders invited to Yale School of Nursing and Dean Wald of the Yale School of Nursing visited St Christopher's
1972	Dr Elizabeth Kubler-Ross book, " <i>On Death and Dying</i> " published. Dr. Kubler-Ross testified in Congress.
1976	Dr. Josefina Magno founds Hospice program at Georgetown and in Virginia.
1979	Health Care Financing Administration initiates demonstration programs in 26 Hospices around the country.
1982	Congress authorizes Medicare Hospice benefits.
1986	Hospice benefits now included in the Medicaid program.
1986 and 1989	Hospice Medicare benefits increased 30%.
1996	Large amounts of money from grant makers encourage research into quality of end of life investigations.
1999	Hospice is honored on commemorative postage stamp.
2000	Hospice payment rate increased by Congress.

So, briefly told, is the story of the hospice movement.

Now, let me tell of our personal experience, so that you may appreciate our enthusiasm. Shirley, my wife, came down with metastatic melanoma in 1999 after a six year hiatus following a primary scalp lesion which had been surgically removed with an excellent pathological prognosis. The metastatic lesion was surgically removed in early 2000, was followed with careful observation in the rest of 2000, and with various chemotherapeutic regimes in 2001 and 2002 with some delay of other metastases. After the last therapeutic trial in early 2003, the course was increasingly down hill. When we could no longer control pain with Percocet, we asked Douglas Garden Hospice here in Miami to enter

the picture. They took over her care and fulfilled their mission philosophy in every way. by providing all medications, equipment for home care, registered oncology nurses and nurse aides visits, social worker, massage therapy, grief counseling, and tender psychological support for the family and me. There was 24/7 telephone help for me, greatly appreciated. All of this was paid by Medicare. Shirl passed peacefully at home with the Hospice nurse present and holding our hands.

In the current medical environment of managed care and hurried and harassed doctors, the Hospice Organizations provide the missing ingredient to the art of holistic care when needed.

HELPING PHYSICIANS COPE WITH THEIR OWN CHRONIC ILLNESSES

By Mamta Gautam, MD and Rhona MacDonald²

Like many of their patients, physicians struggle to cope with chronic illness. While they have issues in common with other chronic disease patients, regardless of profession, physicians who are ill face an additional set of challenges. In this article, we address the following questions:

- How common is chronic illness among physicians?
- What are the additional challenges that physicians face in coping with chronic illnesses?
- How can physicians cope better with chronic disease?

METHODS

Few studies have specifically addressed chronic disease in physicians. Our advice is based on our experience working with chronically ill physicians in a private psychiatric practice (M G) in which the entire patient group comprises physicians and through a careers advice resource and an online support service for physicians with chronic disease (RM)³.

PREVALENCE OF CHRONIC DISEASE IN PHYSICIANS

Little information is available on the prevalence of chronic physical and mental illness in physicians either in North America or in the United Kingdom. Some US authors have suggested prevalence rates of 2.5% to 4%, but these rates apply only to physical disabilities and are only estimates without corroborating data.⁴ No prevalence study of chronic illness in physicians has been published, and most current information is anecdotal. The largest study of physical disability in physicians in the United States showed a wide range of different disabilities in this patient group, many of whom continued to practice medicine despite their limitations.⁵

A chart review of 248 physician-patients in a psychiatric practice (M G) showed that 203 (82%) have a chronic mental illness (unpublished data). Of these, 61 (30%) have concomitant chronic physical illness. Only 12 (5%) have ever taken time off work for reasons related to this illness. This finding supports assumptions that the true prevalence of chronic illness in this population may be underreported, and it suggests that physicians often just “accept, adapt, and carry on,” or as is often the case, carry on and adapt before accepting their illness.

CHALLENGES FACING PHYSICIANS WITH ILLNESS

Common personality traits of physicians have been described in a handbook published by the American Psychiatric Association⁶. Generally, physicians are perfectionists. They tend to have a strong sense of responsibility and a need for both control and approval. They often are plagued by self-doubts and tend to defer or delay gratification. All of these traits can affect the course of their chronic illness—the diagnosis, treatment, and ongoing management.

Physicians often delay getting help when they first notice symptoms of an illness. The reasons for such delay include not wanting to appear weak or as if they are overreacting. They may be concerned about being wrong in their self-diagnosis or may not want to “bother” colleagues. Some physicians may not think that self-care is a priority, perhaps assuming they will “get around to it later.”

The treatment of physician-patients may differ from that for other patients. Physician-patients often deny or minimize their symptoms, which may result in inadequate treatment. Physicians may find it difficult to care for a colleague or to explain adequately to them. Physician-patients may want to take control of their own medication schedules by self-medicating, changing medications or dosage, or discontinuing medications on their own.

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Accepting that they have a chronic illness is often difficult for physicians, most of whom hold idealistic views of their role in treating illness and fighting disease. The discovery that they have a chronic illness may lead to grief as they mourn the loss of their own perfect health. They may be anxious about the outcome of the illness and have fears of being disabled to the extent that they are unable to function as a physician—a huge part of their identity. Some physician-patients react with anger, frustration, and protest at being unable to prevent or fix their illness. Others may feel the injustice of contracting a disease that they think they do not deserve. Guilt can arise when they acknowledge the added burden their illness places on their families at home and their colleagues at work, especially when no contingency coverage is provided in their practice or the inflexibility of their work schedule makes it hard to take time on short notice.

TIPS ON AVOIDING STRESS AND COPING WITH ILLNESS

With the awareness of their new limitations and inabilities and the resulting loss of self-esteem, physicians with chronic illness are at risk of depression. They feel powerless, and because this feeling is the key cause of stress, their focus should be directed to what they can actually control in the 3 key domains of their lives—personally, at work, and at home.

We have developed checklists to help physician-patients take more control in each of these areas. These activities become easier with practice and time.

Taking more control in your personal life

- Find physicians that you trust, share your worries, and give them the responsibility for your care.
- Adhere as much as possible to the treatment regimen that is suggested.
- Try to accept the fact that you have a chronic illness.
- Enlist the help of a counselor, psychologist, or psychiatrist if you are having trouble accepting or coping with your illness.
- Get regular sleep—it is restorative, will help you cope, and increases energy levels.
- Exercise regularly.
- Admit when you are angry so that you can then manage your negative feelings.
- Be kind and gentle with yourself, much as you would treat a patient or colleague.
- Set aside time to worry and to look for solutions to problems. Then, let go of the worrying until the next scheduled “worry time.”
- Look for and enjoy humor daily.
- Learn a relaxation technique and practice it regularly. Meditation, for example, has been shown to benefit chronic pain⁷ and may benefit other symptoms of chronic illness⁸.
- Reach out to family and friends and allow them to help and support you.
- Address your spiritual and religious needs to provide purpose, meaning, and values in life.
- Prepare yourself for challenging situations.
- Join or start a support group.
- Help someone else.
- Treat yourself to a new book, a facial, or a fascinating course.
- Remind yourself of the things you can do and do them.
- Be patient.

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Taking more control at work

Inform and educate your colleagues about your illness. Remind them that you are not choosing this illness and any inconvenience caused them when you are unavailable is not on purpose.

Be prepared for questions from patients. Reassure them that you will be available to meet their needs and discuss backup arrangements that have been made in case you are ill.

Be assertive of your special needs, such as your need for a specialized wheelchair, software, robotics, or hearing/visual aids.

Modify your working hours and workload.

Ensure that a system of coverage of duties is established should you need to go to a medical appointment or into the hospital for care.

Consider specialties conducive to your abilities, such as psychiatry, rehabilitation medicine, or medical research. This choice depends on your particular disability and interests.

Take regular breaks and holidays.

Taking more control at home

- Reach out to family.
- Communicate your needs and how you are doing directly and clearly.
- Do not withdraw. Work on staying intimate-emotionally, physically, and sexually.

CONCLUSION

Chronic illness is difficult to live with and to manage, especially for physicians who are expected to be caregivers and not “caretakers.” It is not easy to learn to accept care. Although the symptoms of a chronic disease do not disappear,

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WHAT A DIFFERENCE VACCINES MAKE

By Julie M. Wershing, MD, FAAP

I have just received and read my copy of the Senior Bulletin and enjoyed your selection of articles. I thoroughly agree with your articles and Dr. Silverman's on the topic of vaccines and the diseases they prevent. I had considerable experience during my 29 years of practicing pediatrics in the Bahamas to witness the plethora of contagious diseases (especially the so-called "usual childhood illnesses" of old) and the results before and after the increase in vaccine usage.

When I arrived in the Bahamas in 1963, I found children with little or no history of immunizations. The public health department had started a program of immunization with DPT and Smallpox vaccines three years earlier. In 1964, an epidemic of polio involving primarily small children and infants was so extensive that a polio ward was created to care for the patients. Rubella epidemics occurred every three years, with predictable effects on the fetus of the infected pregnant women. Eventually a School for Retarded Children, a School for the Deaf, and a Heart Clinic were established. Thanks to a Rubella vaccination study in 1969, these epidemics almost ceased.

Those who have never witnessed an infant with Pertussis have been spared the heart-wrenching sight of an infant with conjunctival hemorrhages straining to cough, but exhausted by the prolonged staccato coughing paroxysms. To appreciate the effort involved, just take a deep breath and expel it in short coughs over the next 60 seconds without taking in any more air. You may then experience the extreme suffusion of blood in the head that occurs, as well as the exhaustion of the chest muscles! Culture Of H. Pertussis has always presented a difficult problem. I don't know if this is still true, but, if so, it becomes mandatory for physicians to be able to recognize the unique clinical picture. Also the degree of protection provided by the vaccines should be regularly challenged. There is a never-ending need constantly to re-evaluate potency, protective qualities and side-effects.

In addition to Babies with pertussis were little ones with Measles (with prolonged high fevers, pneumonia and encephalitis), Hemophilus

meningitis (with opisthotonus severe enough for the infant's head and feet to practically touch), and Mumps (with encephalitis, pancreatitis and occasionally subsequent unilateral or bilateral deafness). What a world of difference vaccines have made—when they are used!

Most of our younger compatriots are not familiar with the uncommon, but nevertheless severe problems associated with smallpox vaccine, particularly progressive vaccinia. Having trained with Dr. Henry Kemp, I was exposed to many cases of severe progressive vaccinia, which were only treatable with hyperimmune gamma globulin infusions. Now as smallpox vaccination has become non-existent we have lost the source of this counter-measure. (Dr. Kemp acquired his supply from donations of blood from recently vaccinated servicemen.) I don't know if our modern armamentarium includes other methods of treatment of this dangerous adverse reaction.

That brings me to my next comment. You asked for suggestions for topics to discuss. I would like to suggest the topic of hands-on clinical examinations. I note through my experiences lately that physicians appear to be poorly trained in the use of their senses in diagnosis. Examinations of the chest and heart are perfunctory. A stethoscope is placed on one or two locations only. A murmur is seldom heard, let alone identified by pitch or timing. Movement of the TM is rarely checked. The tonsils, if seen, are rarely observed enough to be described. Young physicians now rarely identify a "pyloric olive;" hernias seem to be picked up only if the parent complains of a mass.

I understand the trend towards teaching physical examination may be developing, but I hope it does before clinical diagnosis becomes a lost art! I was always amazed, during my years of teaching, at how little the med students knew of using their eyes, ears, hands and nose (yes nose) in examining a patient. I hope that those of us who learned the importance of these diagnostic tools can become advocates for students! If I remember the Hippocratic Oath well enough, I think we promised to pass on our knowledge,

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Editor's Note: *This excellent article describes an important subject—hunger of children—and a promising—and economical and simple—method to prevent it. Karen Olness, recent chair of the section on International Child Health, who has immense experience with the realities of child health in poor countries, says, “The Hunger Project is outstanding in terms of achieving desirable outcomes, efficiency, and local ownership. It puts to shame many highly funded programs/projects of UN agencies and large NGOs which prove unsustainable.” Senior Section members should consider this information which gives members a chance to be involved in something useful. There have been recent newspaper stories about other, somewhat similar projects, at least some of which have been for profit. The reader must judge.*

THE HUNGER PROJECT FOR PEDIATRICIANS

By Karl Hess, MD, FAAP

One of the frustrations of my practice in suburban Cleveland was that I wasn't able to deal with the causes of many of my patients' problems and illnesses. At the same time, the mission of the American Academy of Pediatrics was to help children all over the world; yet I found out that children were dying of hunger at the rate of 21,000 per day. Sounds hopeless, but it isn't. One of my patients introduced me to the Hunger Project <www.thp.org>, a private organization with a commitment to actually ending deaths from hunger. Now that is a commitment which gets you up in the morning. They know how to do it, too, because they have found a very effective and cheap way to deal with the basic cause. Intrigued?

It turns out that the root cause of hunger as a society-wide problem is the oppression of women, and the key indicator is the infant mortality rate. In societies where women are basically chattel the infant mortality rate (IMR is calculated as the number of babies per thousand births dying before their first birthday) is high, generally over 100, compared to maybe 10-15 in our inner cities. Sub-Saharan

Africa and south Asia is where this is where this situation persists. No countries in that area have an IMR below 90. In these societies women do most of the heavy labor and get the least to eat. Also, they receive the least schooling. The most powerful predictor of infant survival in a society is the female literacy rate.

It also turns out that a very effective method exists for giving people the skills and perspective to turn their villages around. What the Hunger Project does is to begin work in a village. Actually that's the short description—considerable work at national and/or state level is required assure the village work will not be opposed. When a village decides to participate they receive training and a village bank capitalized by the Hunger Project. Training focuses on basic business literacy, handling money, and empowerment of women, who must make up at least half of all the members of committees. Since capital is extremely expensive in poor areas, the small loans—\$10-25—made by the village banking committee, get a payback rate of over 98% and make a spectacular difference in the well-being of the community. The villagers use their loans for

a wide variety of enterprises, all designed by themselves and responsive to local opportunities. Some are for agricultural projects such as raising sweet potatoes or building a village bakery in Uganda; renting use of a rice huller in Benin; building a fish pond in Benin where there is very little protein in their staple food—cassava. In our Malawi villages there was no starvation this year because of the village food stores.

Epicenters are buildings key to The Hunger Project's mobilization for the end of hunger in Africa. People in one centrally located village are mobilized to construct an “epicenter building” which houses a primary school, an adult training center, community demonstration farms, food processing facilities, a health clinic and rural bank. Virtually all the labor and materials are provided by local people Committees of villagers—equal numbers of women and men—take responsibility for managing every aspect of their centers. As our Africa Regional Director, Dr. Fitigu Tadesse has pointed out, the building of an epicenter interrupts a prevailing social condition in many parts of rural Africa whereby each family works only for itself. The

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OBESITY AND TYPE II DIABETES

By Eugene Wynsen, MD, FAAP

As you all know childhood obesity and Type II diabetes is a growing problem. Obesity leads to increased risk of diabetes II. Those of you who have had to deal with it in your practice know how frustrating it is to try to manage obesity. I think it was the most discouraging problem that I had to deal with. Diet instructions were generally not followed, and weight loss was minimal or non-existent most of the time. I tried referral to various weight clinics for children, but they were just as unsuccessful as I was. Part of the problem was that parents had to participate with the whole family, which was difficult to arrange and get compliance. Then payment was generally not obtainable, or severely limited or excluded in most insurance policies

I have been on our local Chapter's school committee for many years; we have tried to come to grips with obesity in schools. We have excellent rapport with the school dietitians, but it is still a problem, especially in the lower economic groups, and the inner city areas. A ban the sale of soda in the school areas is difficult to overcome; schools make too much money from it. Such a ban does not change the behavior that leads to obesity: too much TV, computer games, lack of exercise and activity, and eating too much of the wrong foods. Each could be explained in detail to show where problems are, but I will not do that here. So far no gene to explain obesity has been identified.

I tend to think a complex set of genetic factors will be identified, but this is no help now. It is apparent that "fat tissue" is a complex endocrine organ. Various programs have been proposed to alleviate obesity, and thus, Type II diabetes, but it is difficult to decide what program to use because there is little evidence that any specific program would work. I would be reluctant to recommend time, effort and resources for a program that does not have reasonable likelihood of success. One lecturer I heard recently said that we do not know how to manage obesity in children, citing examples of even intense efforts with hospitalization, diet education, and exercise training were unsuccessful.

We must start somewhere. Education with educational materials in the schools is the best place to start. My daughter, who is a teacher, tells me

that there is no time set aside for science, including nutrition education, in the curriculum. The emphasis is on reading, writing and arithmetic. I came across a game called Pyramid Bingo, but some parents protest using it, since they see it as a form of gambling. And even the pyramid concept is being challenged. And there is no time in the school schedule. National efforts to publicize nutritional materials and education would be helpful. Those of you still on school committees may be able to influence the schools to bring attention to the problem. National efforts to publicize nutritional materials would be helpful. It is a prime duty of the pediatricians to educate and supervise the dietary habits of the children under their care through the parents, making use of growth and development charts to help guide progress. We should not underestimate the influence that pediatricians may have on outcomes. Those of you still on school committees may be able to influence schools and bring attention to the problem. Needless to say, we have to look at ourselves as well. There is significant overweight in the adult population, including pediatricians. So we need to tune ourselves into being a role model and keep our weight in control as well as that of the children and the families of the children. Without cooperation in the family, weight control is doomed to failure.

Addendum: Since I prepared this article, *Pediatrics* for August, 2003, appeared with a policy statement on Prevention of Pediatric Overweight and Obesity, p424-430. Above, I refer to prevention for following the progress of patients at risk for overweight or obesity. The statement includes eight recommendations for health supervision and five for advocacy. My concern is that despite my efforts a significant group of children in my practice did not seem to be influenced by my efforts. I wonder what those of you who read this think of the problem and its solution?

Editors' Note: *Dr. Wynsen's* *plaint is heart-felt. What success have our readers had with overweight children and/or school programs?. Would you like to comment? Write to tell us. Elsewhere in this issue of the Bulletin we refer to the Pediatrician Wellness program, including concern about weight problem in the profession.*

JOINTLY OWNED PROPERTY

By Robert B. Haines, Esq.

Joint ownership of property, including bank accounts, securities, and real property, is very common and convenient. Holding property in joint ownership can avoid probate and can pass title to that property without a Will. These advantages may be particularly appealing for people who own properties in several states because it will avoid multiple probate proceedings on the death of first joint owner. However, despite those advantages, holding property in joint ownership can have serious disadvantages.

First, a brief description of the forms of joint ownership:

If you hold property with another person as “**joint tenants with right of survivorship**,” and the other person survives you, he or she becomes the sole owner. The property isn’t subject to the terms of your will: your ownership disappears the instant you die. Joint tenancy property doesn’t pass through probate when the first owner dies, because it isn’t controlled by his or her will. It will, however, be subject to probate when the surviving owner dies, because at that time it will be the survivor’s separate property. That’s why owning property as joint tenants is no substitute for a will. (In some states, real estate owned by married couples is held as “tenants by the entirety;” that’s just a fancier name for joint tenants with right of survivorship.)

The forms of joint ownership

known as “**tenants in common (without right of survivorship)**” or, if they live in a community property state (discussed next), as “**husband and wife, as community property**” is different - with those titles, each spouse in effect owns a separate one-half interest in the property, and each spouse’s will controls his or her one-half interest. This form of ownership does not have the advantage of avoiding probate when the first joint owner dies.

Disadvantage of joint ownership:

1. Loss of Estate Tax Exemption. If a couple owns most of their properties in joint ownership with survivorship, on the death of the first joint owner all of those assets will pass to the survivor and will then be included in the survivor’s estate. Each spouse in a marriage should have sufficient assets in his or her own name, including “tenants in common, without right of survivorship,” so that the first to die can fully fund a “Bypass” or “Credit Shelter” Trust for the survivor. With the Federal Estate Tax exemption now \$1,000,000 and scheduled to increase to \$1,500,000 next year and even higher thereafter, the forfeiture of that exemption when the first spouse dies can cost the family \$500,000 or more in additional estate taxes.
2. Conflict with your Will. If too many properties are held in

joint ownership with right of survivorship, an individual’s Will may not have control over enough assets to fulfill that individual’s estate plan. The individual may want to make gifts to children or charities which cannot be funded because most assets went to the surviving joint owner. Similarly, holding property in joint ownership with right of survivorship with a child may result in an unequal distribution among all children.

3. Loss of “step up” in cost basis. Most property owned at the time of death gets a new cost basis for calculating capital gain realized when the property is later sold. With one exception for certain joint property between spouses where the first spouse to die paid for all or most the property, only one-half of joint property gets an increase in cost basis.
4. Creditors of other joint owner. If the other joint owner gets into financial difficulty, his or her interest in joint property can be subject to levy by judgment creditors and trustees in bankruptcy; this could result in a forced sale of the jointly held property.
5. Taxable gift on creation. Creating joint property can be a taxable gift. If it is joint property owned by a married couple, it is still a gift but there is no tax. For other

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joint owners, however, the creation of joint property ownership will be taxable if the value exceeds \$11,000. If the individual who establishes the joint ownership has not exhausted his or her gift/estate tax exemption (currently \$1,000,000), there will be no gift tax due but a gift tax return must be filed and the individual's exemption available for other gifts or estate tax will be reduced.

6. Lack of control. Once joint ownership has been created, the co-owner's consent will be required to sell or borrow against the property and, if it is a liquid asset such as a bank account, the co-owner may withdraw the entire balance of the account without the knowledge or consent of the donor co-owner.

Options for Making Gifts to Minors:

A discussion of the annual giving exclusion: The Internal Revenue Code provides that each individual may annually give up to \$11,000 to any other individual without using up any of the donor's lifetime gift/estate tax exemption. To qualify for this annual exclusion the gift must be of a "present interest" – that is, the child/donee must have right to current use or enjoyment of the gift.

Methods of Giving

1. 529 Plans. These plans are named for the Internal Revenue Code Section which authorized them. 529 Plans are specifically

designed for education expenses of the beneficiary. Earnings (both capital gain and "ordinary" income) on amounts contributed to 529 Plans are tax-exempt. Distributions from 529 Plans are not taxable to the beneficiary if used for the beneficiary's education expenses. 529 Plans are an exception from the "present interest" requirement so that contributions do qualify for the \$11,000 annual exclusion and the statute permits a donor to front-load annual exclusion gifts by contributing up to five years of \$11,000 annual gifts in one year. Gifts in excess of the annual exclusion available in the year of the gift are treated as gifts in the next years—up to four years after the gift. For example, a \$30,000 contribution to a 529 Plan would be an annual exclusion gift for the year of the gift and would use up the donor's annual exclusion for that beneficiary for the next year and would then use up \$8,000 of the donor's annual exclusion for second year after the gift.

2. Trusts. 2503(c) Trusts (also named for the Internal Revenue Code section which authorizes them) must be distributed to the beneficiary when the beneficiary attains age 21; however, it is possible to write such a trust to provide that prior to age 21 (and after age 18) the child can elect to keep the funds in trust past age 21. These trusts must pay income tax each year on both capital gain and "ordi-

nary" income earned; to the extent the "ordinary" income is distributed to the child or used for child's benefit, that income will be taxed to the child. Any income taxed to the child will be taxed at the marginal tax rate of the child's parents until the child is over age 14.

"Crummy" Trusts. These trusts are named for the family that had to litigate with the IRS to win the issue of whether giving a donee the right to withdraw gifts to a trust is qualified for the annual exclusion. Crummy Trusts are frequently used to hold life insurance and to allow the funding of premiums to be covered by the donor's annual exclusion. The individual who has the right of withdrawal must be given notice of contributions to the trust and of his or her right to withdraw that contribution. Several individuals can be given such withdrawal rights so that fairly large insurance premiums can be covered by the annual exclusions. It is important that written records be kept of the notices to beneficiaries of withdrawal right because the IRS will frequently ask for them when they audit the estate tax return of the insured party.

Uniform Gifts to Minor Act ("UGMA"). A gift to a UGMA can be established at a bank or stock broker or just with a simple declaration that money or property is being transferred to a custodian for a minor. The

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WHAT A DIFFERENCE A VACCINE MAKES Continued from Page 22

and I hope, through means such as our Bulletin, we can fulfill that oath.

Editors' Note: *From: Final Report of Committee on Medicine and the Changing Order of the New York Academy of Medicine, 1947: The Committee*

report called for "major changes in medical education, including emphasis on careful medical histories and physical examinations before spending scarce funds on testing."

Apparently no one listened 55 years ago, either.

THE HUNGER PROJECT FOR PEDIATRICIANS Continued from Page 23

epicenter fosters united community efforts - often for the first time.

With the women's input and their interest in schools, sanitation, and food, health also improves rapidly. The Hunger Project uses volunteers for most of the work, and locals for everything. So there are no people working for the Hunger Project in Senegal, for example,

except Senegalese. This makes the project more effective because the local people already know the language and culture. And since we give no money, the chance for corruption is minimized. In fact we got the award this year from Charity Navigator, the largest evaluator of charities, for the most efficient program. The work is all about partnership I'm in partnership with the

women working in the villages in India or wherever and I invite you to join as partners in investing in the end of hunger.

Check out the web site, give me a call, let me know if this opportunity means something to you. Karl Hess, M.D. F.A.A.P. 216-752-0768, khess@apk.net

JOINTLY OWNED PROPERTY Continued from Page 26

donor should not be the custodian to avoid having the transferred property included in the donor's estate. Earnings in UGMA accounts are taxable to the child beneficiary but will be taxable at the parents' marginal income tax rate until the child is over 14.

Gifts of Family Partnerships, LLCs and other Property. If the donor first places property in a Family Partnership or Limited Liability Company, the donor

can then make gifts of ownership interests in that entity. These gifts are subject to close scrutiny by the IRS because (1) they are used to get discounts of the value of the gift and (2) depending on the assets inside

the entity and provisions of the partnership agreement, the annual exclusion may be challenged. Gifts in this form do allow the donor to retain control of the property inside the partnership or LLC.

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RETIREMENT OPTIONS: DOCENT AT A MUSEUM

*By Joan Hodgman, MD, FAAP
Coeditor, Bulletin of the Senior Section*

Volunteering, before or after retirement, as a museum docent, provides an enjoyable activity with a number of advantages. Docents conduct museum tours, and may assist curators or other museum staff. Many of the tours, for children, are likely to be of interest to a pediatrician. With modest application one learns about museum holdings and areas of art, history or other fields in a pleasant non-stressful and hands-on way. Contact with other docents, most probably not physicians, offers social and educational opportunities in the fields of common interest. The time commitment is quite flexible, depending on the individual's time and inclination.

Becoming a docent is easy. Most museums are delighted with volunteer docents. Selection of an institution is easier in large cities with many choices, but even small towns have museums focusing on special interests of the area. In my area of Los Angeles and its suburbs, there are the usual large museums devoted to various periods of art and to natural history. But several smaller museums specialize in Native American culture, vintage automobiles or other subjects. Most suburbs feature smaller museums devoted to special niches. For example, Pasadena has a museum of Asian culture and little Monrovia has a historical museum devoted to the local Native Americans. Persons interested in horticulture should not overlook the arboretums and public gardens. These have tours designed to explain the plantings and provide a milieu for education in gardening. Larger museums have extensive collections and more facilities, but local museums have a smaller and more compact staff in which one docent can make a larger impact. The choice depends on the preference of the individual.

After selecting a preferred museum, one should call the museum and volunteer. All museums are listed in the local phone books and also in community centers such as the City Hall. Most will have an introductory day for new registrants. I suspect that it is possible to arrange a guided visit to any museum on an exploratory basis by making a request. Docents are given a course in the museum's collections, including their history and significance. This can take several weeks of weekly or biweekly visits and is one of the great advantages of volunteering. Learning does not end at the end of the indoctrination period, but continues with new acquisitions and special exhibitions.

Involvement in a museum can lead to a more active role in governance of the museum. It is always possible for an enthusiastic and committed person to become involved in the committees that advise the museum staff and eventually those that make policy for the museum.

Finally, all museums have social functions for their volunteer staff. There are also opportunities to visit other similar museums as part of an official tour. These can be very educational as well as pleasant outings. Involvement in a museum can take a minimum time with an interesting avocation or become a serious time commitment. The choice is yours.

Editors' Note: *We are grateful to Dr. Hurtado's daughter, Elisa, for transmitting this article to the Bulletin office. Interested readers who desire to learn more may communicate with him through his daughter's email address: EliKinder@cs.com. It might also be noted that research shows that gardening is an excellent method to reduce or even eliminate the noxious effects of stress.*

FROM CHILDREN TO PLANTS — NURTURING/CARING AS THEY GROW

By Felix P. Hurtado, MD

My decision to retire from the US PHS after 25 years of pediatric practice and administration came after many years of hard work in what I considered two phases of my career. The first phase was in Cuba, the second in the USA. God had taken care of my path and had provided an avenue to continue my practice in a free country. Upon retirement I decided it was time to give something back. I wanted to devote my free time to an activity closely related to the community where I had spent the last ten years prior to retirement. I was tired of traveling, meetings, committees and wanted something that would allow me to get closer to Mother Nature yet not have the demands of a full time job. I had no idea what that would be.

My interests veered towards a running column in our local newspaper devoted to "Gardening." The existing Master Gardener program needed volunteers. The description of the program appealed to me. It said you didn't have to be an expert to become a Master Gardener, just a desire to learn and help others become better gardeners. The program had different groups, one of them being "Youth Education," which included a summer school gar-

dening program for children in grades four through eight. My interest peaked.

At the office of the University of Arizona Pima County Cooperative Extension I learned the requisites to be accepted into the program, the courses that needed to be taken and the responsibilities involved in volunteering. That's when I decided to enroll in the program. I saw a close parallel between the plant kingdom and animal kingdom and approached it in a way that compared the anatomic and physiological features of each. The plants manufacture their own food (photosynthesis and chlorophyll); the animals depend on plants for food. Plants have unlimited growth; animals have a limited growth pattern. Plants are rigid and anchored to the soil; animals are mobile. Both are living things but have differences in their mode of nutrition, their scheme of growth and development, their cell wall composition and their locomotion. It was a good way to approach what I was about to undertake.

This opportunity to continue working with children and to apply to plants the anatomy and physiology that we learned in medical school was a good transition from medicine into this next phase of my life. I was

also asked to get involved in another project developing desert gardening educational material in Spanish. It was a great opportunity to use my bilingual capability to translate individual articles about fertilization, the ten steps towards desert gardening, roses and other articles. Then the opportunity arose to translate an entire book written by George Brookbank on Desert Gardening. We met with the University Press to discuss the possibility and publication of such a book and after agreeing to the plan, I set out to undertake the project. It wasn't easy as much of the English gardening terminology is not easily translated into Spanish but after a couple of years devoted to the project, the book was published and is now being sold.

The Master Gardener program consists of 12 weeks of training covering different parts of desert gardening, from preparation of the soil, nutrients, watering to plants that are appropriate for growing in the desert zone. Classroom lectures and practical experience are part of the instruction. The training also includes information on how to respond to questions from the public; many who live or move to the area call the center for seek help with their plant problems.

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Looking to the Future

By Sol Browdy, MD, FAAP

Self-Test for Seniors:

What do you think you will miss most around 70 to 80?

Select only one.

- 1. Spousal loss/companionship
- 2. Memory loss
- 3. Sex
- 4. Loss of driver's license
- 5. Enough money to live on

Let's face it. Those who checked #3 either are dreamers or fantasizers who have successfully experimented with viagra or other urologic devices at least once without suffering an acute M.I. Those who selected #4, loss of driver's license, are to be commended for their foresight and insight, because I happen to be in the same boat as you, and I commiserate with you.

From the landmark moment when you were issued your initial driver's license and acquired your first set of wheels as an adolescent, you were hell-bent on doing your own driving and you never thought twice about it. It was as effortless as breathing in and out, and if you drove defensively, avoided accidents, and incurred no traffic violations, it was as if your right to drive actually ranked high up with all the other bill of rights, although it never was expressed as such.

But along the way, if you had to surrender your license for various reasons, then it was as if suddenly your sense of independence was pulled out from under you and you found yourself on the ground perusing yellow and white pages as well. Among the options, my first choice would be key words such as transportation lines, city and county; senior citizen's services, city and county; and taxicabs. Last but not least I would look into private individuals seeking part-time employment, who usually charge by the hour. Park City's basic transportation services are free.

When I contacted Park City's transportation services, I was told that my address lay outside the regular bus routes by about one mile, but the staff was hopeful of extending their boundaries in the near future.

When I spoke to Summit County's transportation director, I was told that a bus recently was obtained — and my address would be eligible — once the program got under way. I decided to test the system, and made provisions for the driver to pick me up about 9:30 a.m. and drop me off at a local internist's office to have (fasting) blood drawn for studies.

The shiny new white mid-size bus arrived at 9:45 a.m. (I couldn't recall the last time I rode a bus, but was amazed that safety belts now are provided.) The ride worked out well, i.e. until the very end of the return trip to my condo, when in the process of stepping down, I lost my footing and, literally, squatted down, throwing my left arm outwards to protect myself. I lacerated my middle left finger, requiring five sutures for closure. The driver obviously was upset with my misfortune, and my hope is that this would be the last time she fails to get out of the bus to assist us a.k.'s in entering and leaving.

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Looking to the Future Continued from Page 30

It appears that once the county program really gets rolling, the bus will travel to and from Salt Lake City, which is about twenty miles from Park City.

When I called taxi companies, I was quoted hourly rates of \$18.00, and frequent users are entitled to a \$2.00 discount card per trip.

I know of no available listing of private individuals interested in chauffeuring non-driving seniors around, and it is more by word of mouth that word gets around. One young woman who was contacted charges \$18.00 per hours, the same amount she charges for house cleaning.

Finally, although all of us hate to impose on relatives and friends, inevitably the time will come when we must turn to them. One individual, a friend of my daughter's, who called to volunteer to pick me up and return me three times a week for gym workouts, refused reimbursement. He happens to love *diet-Coke*, and suggested that my buying him one at our favorite watering hole afterwards is sufficient.

P.S. One unplanned and totally unexpected dividend of totaling one's car within a couple weeks of purchase — provided you survive — is that when it comes to settling your auto insurance claim, you will receive not only the value of the car (little changed from what you paid) but in addition the registration and licensure fees. In essence, with the money you receive — assuming this is the second car you've totaled within twenty days and you've opted to give up driving — you could buy a used car in good condition and hire your own chauffeur!

FROM CHILDREN TO PLANTS — Continued from Page 29

At the end of the 12 weeks, a test is administered and each graduate receives a certificate.

All activities are on a volunteer basis. Since I started with the program in 1990 three-fourths of my time has been dedicated to the youth program, especially to the Summer School Program. I also help others improve their landscaping at their home concentrating on watering and what plants will survive in the Southern Arizona desert.

Note: For those readers who live in the southwest, Dr. Hurtado's Spanish translation

has been published and is available from the University Press. The county agricultural extension program has other materials written by him.

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3. Felix P. Hurtado *Jardinaria Desertica Mes Por Mes*, Spanish Language Edition, 2001, University of Arizona Press, ISBN 0-8165-2154-9,
4. Christine R. Szuter, Director, The University of Arizona Press 355 Euclid Ave., Suite 103 Tucson, AZ 85719. Fax (520)621-8899

Similar programs exist in almost every county in our country. Dr. Hurtado suggests the following references:

Babel Babble: What is the Doctor Saying? What is the Parent Hearing?

From the National Institute of Deafness and Communication Disorders, 2003

If Johnny's parent can't read, then his health is likely to suffer too, says Dean Schillinger, associate professor of medicine at San Francisco General Hospital, whose research is drawing a clearer connection between health literacy and the chances of beating, or at least successfully controlling, chronic illness. On Oct. 21, 2002, Schillinger, sponsored by the National Institute on Deafness and Other Communication Disorders, spoke on health literacy at the National Institutes of Health last October. His research was done with adult patients, but is highly likely to apply to pediatric patients via their parents.

Health-literacy is the ability to read and understand health information and to make decisions based on that information. One strong measure of health literacy is ability to read in general. Low literacy is a symptom of a number of underlying factors, and is not a lifelong constant. In addition to learning disabilities, vision problems, poverty, immigration and minority status and poor education all contribute to low literacy. Adults with fine reading, writing, and thinking skills may have difficulty as they age with reading and understanding information. Two-thirds of people ages 65 and older have poor literacy skills, while 25 percent of immigrants have poor literacy. The 1993 National Adult Literacy Survey showed 10 to 22 percent of Americans at the bottommost level of literacy, meaning that they are unable to read a medicine bottle or poison warning. Another 18 to 26 percent are functionally illiterate: they have trouble filling out forms for a job application. The reading level in the United States is between eighth and ninth grades; the average of Medicaid recipients is significantly lower at fifth grade level. 100 percent of health-related Web sites written in English, and 86 percent of Spanish health sites, were found to be written at the twelfth-grade reading level.

Low health literacy influences health care in three ways. First, health care costs are generally higher for patients with low literacy. A 1992 study at the University of Arizona, Tucson, found that health care costs for patients with low health

literacy skills enrolled in Medicare were more than four times as high as costs for patients with high literacy: roughly \$13,000 per year compared to \$3,000 per year. Although the relationship is robust, it is not clear whether it is causal, an association, or both. Second, a patient's own health assessment is usually gloomier if he or she is challenged by low literacy. In a study conducted in Atlanta, Ga., and Torrance, Calif., patients with low health literacy were more likely to report their health as poor than patients with adequate literacy. Third, patients with low health literacy tend to be less successful in managing chronic disease.

In a study on the effects of health literacy on blood-sugar control in Type II diabetics, Schillinger and his colleagues at San Francisco General Hospital found that patients with high literacy were more likely to have lower long-term blood-sugar concentrations; those with low literacy revealed poorer control. Complications associated with diabetes, such as retinopathy, increased as literacy decreased. Literacy also affects how well a patient grasps what a doctor is saying in a typical one-on-one conversation. One third of the same diabetes patients said that their doctor often uses words that they don't understand. These words are not necessarily medical jargon, but may be everyday words used in specialized ways or common words that are simply beyond the experience of the patients. More than one-fourth of patients said that their doctor gave them test results without providing an explanation.

People who do not have basic literacy skills usually have limited access to health information, their understanding about health-related matters is generally poor to begin with. They also may have trouble comprehending written health information that is given to them. In one nationwide study, researchers at Louisiana State University, Shreveport, found that the reading levels of materials given to patients were at levels five to seven years beyond the patients' ability to read them. Schillinger describes the

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MY PHILOSOPHY OF RETIREMENT

By Robert H. Anderson, MD

I opened my office for the solo practice of pediatrics in Old Town Alexandria in 1951. My practice was later taken over by Inova Primary Care Network with five pediatric offices and fifteen pediatricians. I have been retired about four years. I have worked for the Alexandria Health Department in the well baby clinic since 1954. When I retired I continued that working a half day twice a month. I have also worked at times for a Spanish speaking indigent clinic. I feel strongly that you must stay busy after retirement even if it is in volunteer work. We have a lot of retirees (especially military) in this area. Those that do nothing age very quickly. My malpractice is more than I make at the clinics.

I play tennis two or three times a week and play golf when the weather is good. Our golf course is being redone. I play in a jazz group (nine pieces.) I play tenor sax, clarinet, and flute. My son also plays in the group. It is called the Rotary Rooters. We play for the Alexandria Rotary Club once a month and often play for District Rotary Meetings. I am on the Salvation Army board and the Vestry of my church (St. Paul's.) I am on the Early Childhood Development Board for the city. We fund the day care centers. I try to do the crossword puzzle every day and am still doing PREP and Update. I read two or three books at a time (a little each day.) I am in several discussion groups (one at St. Elmo's Coffee House.) Another is Alexandria Agenda. I believe strongly in the old adage, "A used tool seldom rusts."

Editor's Note: *Dr. Anderson exemplifies a full life. Although the evidence is no more than suggestive, what there is seems to say that those who are happily active and busy are physically and mentally healthier.*

Babel Babble: What is the Doctor Saying? Continued from Page 32

current healthcare system as being designed to meet the needs of only the most literate. "In our society, while money may be power, literacy *really* is power...Literacy is the ability to advocate for oneself in a highly competitive healthcare system."

The relationship of these results to pediatric practice is self-evident. The literacy of the parent is the key to understanding and thence to adher-

ence to recommendations. Methods for improving parental understanding include asking parent, or older patient, to repeat a concept in his or her own words. If this is done correctly, the message is more likely to be remembered and acted upon. If not information should be reviewed and repeated. With understanding comes adherence. Other possible tactics weekly phone messages, designed by parents for parents, and group visits for discussion.

“Old Age is NO GAME for Sissies”

— attributed to the late **Millicent Fenwyk**,
sometime member, **US House of Representatives.**

ADVANCES IN SCIENCE

Kurt Semm, Founder of Laparoscopic Surgery, Dies at 76

From Dr. Semm’s obituary in NYTimes, 27 July, 2003: “When Dr. Semm presented his inventions at medical meetings, he was frequently derided as unethical by others who were shocked at how different his new techniques were.” On one occasion when he was making a presentation, “Suddenly the projector was unplugged with the explanation that such unethical surgery should not be presented...After Dr. Semm became the chairman of obstetrics and gynecology at the University of Kiel, his coworkers demanded that he undergo a brain scan because...’only a person with brain damage would perform laparoscopic surgery.’”

Editors’ Note: *And it may be true that only an original contribution to the body of scientific, medical, and even pediatric thinking would evoke such strong responses. A discovery that arouses no controversy probably does not add much to the framework of what we think we know.*

Herb Winograd sends us this:

An older couple killed in an auto accident were transported instantly to Heaven. As they were waiting at the desk for processing, they looked all around at their setting for eternity. The wife was amazed at the beauty, peace and contentment that she felt. She commented over and over about what a nice place Heaven was and how fortunate she felt to be there.

Her husband sneered, “ If it weren’t for you and your damned oat bran muffins and health foods, we’d have been here 15 years ago.”

A CIRCLE CLOSES

By Avrum L. Katcher, MD, FAAP

Somewhere in an earlier edition of the Bulletin I recounted an early learning experience in practice. The story went something like this: When I left the army in 1955, Philip and Bill Barba, father and son, offered to share their office space with me in Germantown, Pennsylvania. Phil, a truly fine pediatrician, and one of the most understanding people I have ever met, had been President of the Academy about 1953. One Sunday I was making a house call on a Barba patient, a child with an earache in a rather well-to-do home. When the child had been examined, and the problem discussed, the mother asked me to share a cup of coffee. Over coffee and a cookie, she praised Phil Barba to the skies. For my own education, I asked why she liked him. She replied: "Dr. Katcher, you know, I'm not too swift. I'm a bit of a ninny. But when I am talking to Dr. Barba, he always makes me feel like I'm the cleverest, the smartest, and the best mother in the world." What else is there to say?

If Phil were alive, he would be delighted with the follow-up to this story. Recently I was signing copies of a book of mine, just published, when a lady introduced herself. I had seen her son on referral from a school because of alleged "emotional problems" some twenty years ago. Although I did not remember the circumstances, she said what I told her was, approximately, "The thing to do is always listen first to what the mother tells you." And from there went on to diagnose a mismatch between the temperament of a child who withdrew from novelty, and was on the negative mood side of neutral, but who did not have a diagnosable condition, and who needed more understanding at school. Then she went on to say, "And you made me feel that I wasn't some stupid old crazy after all and I'll never forget you for what you did for me." Her son is getting along in life just fine now. And we hugged and kissed before the world.

Phil Barba, I always wanted to be like you, and sometimes could not quite manage, but at least once I hit it on the nose!

"A man may be counted a virtuous man, though hee haue made many slips in his life...also a comely man and louely, thought hee haue some warts upon his hand, yea, not onely freakles vpon his face, but also skarres".

— Miles Smith,
Bishop of Gloucester,
in his preface to the first edition of the then new King James Bible

A CONSULTANT CONSULTS ON A DIFFERENT PATIENT

By Avrum L. Katcher, MD FAAP

A few weekends ago we were visiting family. Our granddaughter, just turned seven, has been for some years now intensely concerned with clothing and dress—we know the one thing for a gift that always brings pleasure is some new garment. At one point during the weekend when her parents were not in the room, she said to me, “Please come up to my room I want to ask you something.”

I Could not imagine what ‘something’ might be, but followed to her room, where her grandmother’s alphabet quilt decorates the walls and her grandmother’s curtains dress the windows...you know what I mean. The young lady was to attend a birthday party the next day. Meanwhile, that morning is church. She showed me her “frock.” That stopped me. I did

not know that word is still in use. Thought it died 30 some years ago along with white gloves and a hat for going to a lady’s place of employment. She also had tights and more formal shoes for church in the morning. And regular pants for tonight’s outing with Daddy. She explained that the party is tomorrow afternoon, and the dress is dress casual, and now the real reason for the consultation: what is my impression of casual as opposed to dress casual? A subtle distinction indeed. Inspiration mingled with terror helped me out. I managed to make a few words of explanation—do not remember just what I said. The young lady looked comprehendingly at me. “Ah,” she said, “Casual is a white shirt with the sleeves folded up over the arms. Dress casual is the same shirt with the sleeves buttoned,

and boots with shiny buckles.” So much for style and manners in the first grade. Two additional comments should be included. First, this same young lady is enamored of form and color. She has done some excellent abstract watercolors, her clothes of course are obvious, and her drawing skills in general quite accomplished. The other comment is that when I related this consultation, which had been well received by the consultee, her mother, her mother’s two sisters and brother and sister-in-law broke up with laughter. The general sense was “You, consulting on clothes...that indeed is the end!” My lady bride, out of kindness, managed to keep a straight face. Armani, Carolyn Herrera, Pauline Trigere—you’ve nothing to worry about.

The AMA Voice for Senior Physicians, issue for Spring, 2003, has a worthwhile recommendation to think about. Senior pediatricians know that children who grow up with a sense of who they are and where they come from are more likely to feel good about themselves, to have a sense of personal quality and worth. One way to accomplish this goal is for each of us as we get older to set down our life story, who we are, where we came from, and what has happened to us in our lives. What formed us. What was most meaningful.

On a website: www.turningmemories.com, one will find many books and references to help accomplish this goal. One of them is a free list of questions to ponder and answer: <http://www.turningmemories.com/MLQEBK.pdf>. This article has 35 pages, with many questions to consider.