SENIOR BULLETIN

AAP Section for Senior Members

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Message from the Chairperson

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

A happy autumnal equinox to all! Although I am writing in mid-August, during a classic northeastern United States triple H month (hazy, hot and humid, for the rest of you), this message will appear in the September issue of the *Bulletin.* We hope that you all continue to enjoy our *Bulletin* as much as I do. Joan Hodgman and Arthur Maron have been doing a splendid job as co-editors, along with their associate editors, who are responsible for specific areas.

Have you any comments on how we are doing? The Executive Committee, the *Bulletin* staff, our newly refurbished Web Site (more on that in a moment)? What can you suggest for topics, actions or projects to improve the effectiveness of the Section on Senior Members? Have any of you some thoughts about activities you would like to lead, for the Academy or for the Senior Section? We welcome your thoughts. By e-mail, to me (stellave@earthlink.net), or to Jackie Burke or Tracey Coletta, our splendid staff (jburke@aap.org or tcoletta@aap.org). Volunteer to make an improvement! At the October meeting, the NCE, in Washington DC, the Executive Committee will be preparing a list of three or four projects on which to concentrate during the following few months.

And, we all hope you will be attending the NCE, and will be at the Senior Section program! This will be on Sunday the 9th of October at 1:30PM. We look forward

Continued on Page 2

What's Inside?

Message from the Chairperson 1
Executive Committee/Subcommittee Chairs . . . 2
The Spirit Catches You and You Fall Down. . . . 3
Senior Program 2005 NCE. 3
Who Ever Said that it was Going to be Easy? . . 4
Senior Health On The Web 4
ICE Is Great For Cell Phones
No Joke: ICE - In Case of Emergency 5
HIPAA and Your Health Care
Power of Attorney/Medical Directive 5
Pediatric Resident Training Experience 6
Something for Nothing 7
More Ado About Nothing 8
Be Safe, Not Sorry On-Line (Part 1) 9
Book Review
Baseball Before We Knew It! 11
Gifting: Noble Gesture and Effective
Tax Strategy 12
Tribute to his mother 13
San Francisco's First 5 Commission 14
Chuckles 15
"DON'T!" 15
"On Medical Stories and Myths" 16
Seniors — Be Aware Neither Reputation
Nor Costs of Healthcare are Related
to Quality of Health Care 17
The AAP Historical Archives Committee
And the Oral History Project 18
Children 21
AAP Section for Senior Members
Strategic Planning — Member Survey 22-23

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Message from the Chairperson Continued from Page 1

to:

- The Senior Section Advocacy Award
- Donna Butts explaining about one of the great organizations for seniors, Generations United.
- Arlene Johnson telling us about a wonderful program for education for seniors who would like to earn university course credits in scholarly areas outside of medicine, the Donovan program.
- Our own Jane Schaller to discuss International Child Health, a topic in which her own achievements are distinguished.

Following these talks there will be a brief business meeting and a reception, closing in time to allow you to attend the President's Reception and the 75th Anniversary program.

Don't forget. Sunday the 9th October at 1:30PM.

It has become increasingly clear that much of the important work of the Senior Section should be performed at Chapter level, where the best knowledge is for what the Chapter needs, and what the Seniors need. We hope to see many Chapters open their own Senior groups in the near future. In order to further this, our principal project of the past few months has been to develop a Chapter Guide, with guidelines and encouragement for those Chapters ready to organize their own Senior Section. This is now in final draft version. We hope it will be available early this fall. If you have helpful experience or ideas in this area, do not hesitate to contact Jackie Burke or Tracey Coletta.

We have been delighted with the extraordinary job to improve our Web Site, carried out by Jerry Aronson and staffer Roxy Shannon. They have done wonders. Check out both the public web site, through the main AAP page at www.aap.org, and the Section web site, by providing your member number and password, and clicking through to the Section. Currently there have been some delays, due to the advent of Roxy's own personal pediatric project and her departure from AAP staff. We wish her the best while are awaiting word on her replacement.

Had a wonderful experience at the Chapter Forum/Leadership Gathering in Chicago last week. Too much to put in this message, but will report to the Executive Committee and all of you attending our business meeting at the NCE. Best wishes for the rest of your summer, and I look forward to seeing you in October.

You will see attached to our Bulletin a survey, developed by the hard work of Lucy Crain and George Cohen. It is an important source of information to help this Section function as effectively as possible, to do the most good for the most Fellows.

PLEASE take a few moments, complete it, and mail it in!!
We need your input!!"

With best wishes,
Avrum L. Katcher, MD, FAAP

The Spirit Catches You and You Fall Down

by Eileen M. Ouellette, MD, JD, FAAP

In preparation for my coming year as president of the AAP, I have been reading and thinking a great deal about health equity and what the AAP can do to help achieve it. Health disparities occur from a variety of causes, among which are racial, ethnic and socioeconomic barriers to access to care. Cultural differences also play a significant role in preventing some children from having access to and benefit from the best of American medicine.

None of the articles I have read has had as much impact on me as Anne Fadiman's book, "The Spirit Catches You and You Fall Down", which is, in my opinion, one of the best ways for pediatricians, indeed all physicians, to learn about the importance not only of cultural sensitivity and cultural competence, but also the need to become culturally effective.

The book describes pediatricians and a Hmong family in Merced, California, who came to the U.S. from Laos after the Viet Nam war. Their 13th child, Lia, was born in the U.S. and had her first grand mal seizure at 3 months of age. Because there were no Hmong interpreters at the hospital, it required several visits to the emergency ward before the pediatricians actually witnessed a seizure and diagnosed epilepsy.

Over the next several years, her seizures continued to worsen in spite of numerous changes in anticonvulsant prescriptions. Her pediatricians were very dedicated and were committed to helping the girl, but it wasn't until a home visit was made that it was discovered that the family, who dearly loved the child, had not been giving the medications consistently and, instead, because of their animistic spiritual philosophy, were sacrificing chickens in their belief that her soul had left her body and the animal sacrifice would return it and cure her.

The state's child protective agency became involved, she was placed in foster care, and subsequently had an episode of status epilepticus with disastrous results. As a child neurologist, I had a very personal sense of identification with this story and appreciated the frustration and horror experienced both by the family and by the pediatricians.

What can we do to prevent this kind of tragedy? First, we must begin by educating our medical students and residents about the need to learn as much about our patients, their beliefs and cultures as possible. To that end, I recommend that this book be read by all pediatricians and those aspiring to this career. Second, I recommend that pediatric program directors use the book as a teaching aid and that it be discussed annually at grand rounds in pediatric training programs, as a springboard for more in depth discussion of cultural differences and their impact on the provision of quality health care.

This year the AAP is emphasizing health disparities in its CATCH grants. We should encourage pediatricians and residents to apply for and use these grants to educate and involve the community in which they practice, to support immigrants as they struggle to understand U.S. medical science and to educate American health care workers about the beliefs and mores that underlie the actions of parents of sick children from other parts of the world.

The AAP is making health equity a major priority in its strategic plan for the coming year. Our excellent staff are analyzing and coordinating all our present activities, performing a gap analysis and will present a plan to the board of directors for further action in October 2005. We hope to develop an action plan to move forward toward making health equity for children a reality.

Disclosure: I have no present or past connection with anyone involved in the writing or publishing of this book. I purchased my own copy and all those I have given as gifts with personal funds at my local bookstore.

Senior Program 2005 NCE

by Jackie Noonan, MD, FAAP

Planning for your "bonus" years is the theme of the 2005 Senior Program. Donna Butts, Executive Director of Generations United, will tell you about this national program which advocates for the mutual well-being of children, youth, and older adults. Find out how you, as older but wiser, can connect with the young and help unite communities. Arleen Johnson, Ph.D., Director of the Donovan Program at the University of Kentucky will discuss this program which includes free tuition to classes for those over 65 as well as 95 self enrichment programs in art, chorus, computers, dulcimers, etc. There is also a weekly forum of lectures and discussions open to the public. This program offers seniors the opportunity to broaden horizons, make friends and be of service through dynamic organized activities. There may be a similar program in your community. For the more adventurous senior, Dr. Jane Schaller will discuss opportunities to participate in international health activities. It promises to be an exciting program. Hope to see you there.

Who Ever Said that it was Going to be Easy?

by Donald W. Schiff, MD, FAAP

It is easy enough to find problems that affect children's lives and their future. Encouraging child development in families that are functional, loving and desirous of having children would seem to be a reasonable societal goal - reasonable but alarmingly difficult as the uncertainties of our times and culture multiply.

In the recent past, I have described the basic relationship between a child who is covered by health insurance and the probability that this child will receive quality health care, including the recommended physical and developmental evaluations and immunizations. As the economy weakens in parts of our nation, health care costs rise, and increasing numbers of employers drop health care coverage for dependents, the numbers of uninsured will jump and quality health care will become lost to them. The recent development and availability of important new and improved vaccines protecting children and adolescents against pertussis, meningococemia and human papillomavirus will increase the costs of health care both in the public and private areas. Whether these new costs will be covered remains to be seen.

But the increase in health care costs must be thought of as only one of the many societal facets that pediatricians face in helping families raise their children. A surge in concerns regarding the ability of our youth to acquire an excellent education and the motivation to move beyond the moment has led to multiple approaches to improve our educational system. These include charter schools, smaller high schools and an emphasis on the basics of education. There still remains the issue of finding sufficient funds to provide the smaller classes and adequate pay for teachers to enable children to receive the more individualized attention required by many.

As our nation continues to grow (now 293 million), particularly with the numbers of non-English speaking children multiplying rapidly, another opportunity presents itself as teachers of English as a second language.

Enumerating these problems serves to highlight the many ways that pediatricians, currently practicing, but those retired can continue as strong advocates for children.

Whether it is helping to educate ourselves and the public regarding children's needs and proper programs to help them, including proper use of tax funds, or working with the schools to tutor children, we can remain active participants in the lives of our nation's future. Please contact me with your thoughts and suggestions at donroschiff@comcast.net.

Senior Health On The Web

by Avrum Katcher, MD, FAAP

Considerable information is available at an NIH website for health of seniors. The link is http://nihseniorhealth.gov. When you first click on the link, you see a picture and in the right lower corner a click here message. At the top are choices to hear a spoken commentary, to increase contrast or to change the size of the print. After the first click, you see a list of topics to check out.

On exercise, for example, you are taken to multiple choices including strength, balance, endurance and stretching. On each page there are videos to watch, buttons to click for printer-friendly versions or links to MedlinePlus, etc. The videos come with sound but most duplicate the print.

ICE Is Great For Cell Phones
No Joke: ICE - In Case of Emergency

A campaign encouraging people to enter an emergency contact number in their mobile phone's memory under the heading "ICE" (i.e. In Case of Emergency), has rapidly spread throughout the world as a particular consequence of the terrorist attacks in London. Originally established as a nation-wide campaign in the UK, ICE allows paramedics or police to be able to contact a designated relative / next-of-kin in an emergency situation.

The idea is the brainchild of East Anglican Ambulance Service paramedic Bob Brotchie and was launched in May this year. Bob, 41, who has been a paramedic for 13 years, said: "I was reflecting on some of the calls I've attended at the roadside where I had to look through the mobile phone contacts struggling for information on a shocked or injured person. Almost everyone carries a mobile phone now, and with ICE we'd know immediately who to contact and what number to ring. The person may even know of their medical history."

By adopting the ICE advice, your mobile will help the rescue services quickly contact a friend or relative - which could be vital in a life or death situation. It only takes a few seconds to do, and it could easily help save your life. Why not put ICE in your phone now? Simply select a new contact in your phone book, enter the word ICE and the number of the person you wish to be contacted. For more than one contact name, enter ICE1, ICE2, ICE3 etc.

It's so simple that everyone can do it. Please do. Please email this to everybody in your address book. It won't take long before everybody will know about this. It really could save your life, or put a loved one's mind at rest.

In case you're concerned about the legitimacy of this idea, you can check the following:

http://www.eastanglianambulance.com/content/news/newsdetail.asp?newsID=64610

http://urbanlegends.about.com/library/bl_in_case_of_emergency.htm
http://www.snopes.com/crime/prevent/icephone.asp

HIPAA and Your Health Care
Power of Attorney/Medical Directive

by Avrum Katcher, MD, FAAP

Herold and Haines, a well-known legal firm, in Warren, NJ, specializing in estate and tax planning, among other areas, has issued a warning about the medical directive or health care power of attorney which is probably a part of your estate planning. These are the documents which enable your spouse, or other representative, to make health care decisions for you when you can not do so. The first step in this process is for a physician to write an opinion that you are unable to make your own decisions.

Some physicians are worried about HIPAA because of requirements under the act regarding privacy and unauthorized release of a patient's "protected health information." There are heavy penalties involved. Worried physicians may not be willing to provide medical information to your spouse or other representatives. In such an instance, it may be necessary to go to court, resulting in stress, expenses, and loss of time.

The remedy is to act now, by updating your estate documents, so that your medical directive or health care power of attorney expressly authorize your representative to receive your protected health information in accordance with HIPAA.

Pediatric Resident Training Experience

by Avrum Katcher, MD, FAAP

Just the other day, while discarding material from old files, a copy of a letter sent over eight years ago came to light. Had long ago forgotten about it. The letter was addressed to Mary Ruth Back, of the Future of Pediatric Education II Project of the AAP. The following excerpts and discussion are presented for the interest of old-timers, and, of course, to promote discussion and identify different points of view. Perhaps firm rules and legislation have, to an extent, settled the issue described, but it might yet be worth consideration.

"Education for the resident should relate to the work the resident will be doing—not so much how but what. Accepting some degree of uncertainty, we can predict the type of problems to be seen much better than how to handle them. We can train a resident to be a lifelong student…Therefore the programs should be able to show the range of normal child and family function as well as the many types of dysfunction. All too often residency training is involved with the sickest members of those families who have the greatest numbers of grave problems. Typical ambulant care settings can be overwhelming and induce a sense of hopelessness and cynicism in the most energetic and idealistic young physician. Residents need some protection from this. Residents should see middle class children from effective families as well. Really, they should be exposed to a wide range of children, families, environments and cultures as well as a wide range of illnesses and problems and degrees of health.

"…emphasize outcomes in training—creating a structure such that a resident takes notes on patients seen and is expected to investigate later what has happened to them. Not weeks later but six months or a year later. [My other point] may just be a result of my era [training 1948-1952]. But to this day, three years after my retirement [when letter was written], and [57] years after I began my residency, I respect what I learned from 8 P M to 8 AM as much or more than what I learned in the other twelve hours of the day. Yes, I worked too hard, and so did everyone else. But there is something about exposure to the face of worry, disease, disaster, conundrums, under conditions in which decisions must flow under circumstances of uncertainty, that teaches one the appearance and reality of sickness to an extent that can not be learned in any other way."

To this, I would add these comments:

Today pediatricians in primary care practice are able to take advantage of hospitalists' and neonatologists' help in caring for patients. The question of a resident, fatigued, sleep-deprived, and perhaps not as knowledgeable as should be, is less significant. And, proficiency in care of the seriously sick child is less important. When I completed my training, I was a good sick kid's doctor. But I knew almost nothing about well children. That I learned on the job, and from my bride, when she became a mother. And ever since. Is it possible to combine in residency experience the time allocation to the sick vs. that to the well in a manner which relates to the challenges subsequently to be faced? And to "well" children and families of ethnic, religious, social and economic qualities reflecting a broad range of backgrounds?

It would be wonderful if I knew the answers. Of course I do not. However, the reader might care to consider this, and perhaps write to the Editors of the *Bulletin* in agreement, disagreement or moderation about these issues.

Something for Nothing

by Eugene Wynsen, MD, FAAP

I would like for you to perform a simple experiment. Take two regular beans and plant them. Plant them in exactly the same kind of containers and with the same nutrients and water. Put them out in the yard and cover one with a large black pot of some sort. Then watch. You will be surprised to find that the covered bean grows taller than the one in the sun. Why? I have tried to present this to many people, including some with a good deal of scientific training, and my peers in medicine. But I have been greeted with a lot of different interpretations, and complete rejection of my explanation along with a lot of suggestions of my lack of intelligence.

One would generally expect that you cannot get a stimulus response from "nothing". The absence of light is "nothing". You do not expect that "nothing" would act as a stimulus. But the commonest answer given is that the darkness stimulated the plant to grow taller. That is, the absence of light (nothing) acted as a stimulus for the plant to grow. A stimulus has to be something. If I push on a rock, the force causes it to move. If I pinch you, the excess pressure causes it to hurt. They are stimuli that are easy to understand. Another explanation that has been given is that the difference in the dark and light is the cause.

I am sure you have all heard that the lack of oxygen stimulates respiration. The lack of nutrients causes a person to die. The lack of light stimulates the plant to grow. These are incorrect statements. Our language is full of such misleading statements. The dirt was sucked up by the vacuum (lack of pressure). Evacuated (lack of pressure) hollow steel hemi-spheres are said to be held together by the vacuum inside. We talk about how people become depressed in the perpetual darkness (lack of light) of the artic regions indicating that darkness causes depression. Lack of food caused me to be hungry. ("nothing" made me hungry). The lack of anything cannot cause something.

In a nutshell, the plant grows taller because sunlight inhibits the growth. If you look up the physiology in the botany books you will find that auxin production at the tip of the plant is inhibited by the sun. Auxin is a plant growth hormone. It is the auxin that makes the plant grow at the tip, and sunlight inhibits the auxin. In another case, the branches of trees grow toward the sun, leading one to think they are searching for the sun. But it really results from another mechanism, poorly understood, but different from the one above. Nevertheless, in this case it is the sun acting as a stimulus that causes the side facing the sun to grow slower. You might think that it is the sun inhibiting the trunk of the plant on the side of the sun resulting in slower growth, and this causes the branch to bend toward the light. But I believe it has to do with the hormone auxin being somehow stimulated to act on the far side resulting in more rapid growth on the far side rather than inhibiting the side facing the sun, and resulting in tilt in the direction of the sun. So although it would seem to be similar, it is a difference process.

Inhibition may become a mechanism whereby we see what looks like a stimulus acting. The plant growth at the tip is inhibited. It is not the darkness (lack of light, or nothing) that simulates the growth. Therefore, there must be an inherent factor that makes the plant grow in the first place. I do not pretend to know all that plant physiology, but there are multiple factors involved in growth including calcium, water, gravity, etc., and auxin is just one of them.

Chemorecptors of the body are not stimulated by the lack of oxygen. Rather it is the build up of CO2 that stimulates respiration. Filter out the excess CO2 and respiration is not stimulated. The lack of oxygen does not stimulate respiration. In fact, oxygen inhibits respiration in a complex fashion. I believe inhibition happens in many ways in physiology, and are important to keep in mind. In a cascade of reactions, inhibition of one of them may result in measurable effects.

Lastly, a reaction is not stimulated to stop by withdrawing the source of energy. If you take away the oxygen, the fire will go out. Taking away the energy simple does not allow the reaction to continue since there is no more energy. Physiologic processes stop and can not continue when energy is not supplied, and the process stops…the organism dies. The lack of energy (nothing) does not cause this. It may seem a semantic problem, but I think it is an important point of view. If a needed substance is not supplied or available, the process cannot continue. Also, if there is some-

Continued on Page 8

thing that interferes (inhibits) with a process, there may be an observable effect. For example if two objects are on a collision course, they will eventually collide. We could stop the objects by adding a force of energy in the opposite direction, thus inhibiting the movement. But if we don't provide that inhibiting energy the objects will collide as expected. But we do not say that "nothing" (lack of energy to stop them) caused the collision. The effect may be critical or beneficial or at least observable in whatever system it is operating.

In metabolic diseases it is stated that the abscence of an enzyme is said to cause the disease process. But in reality, the absence of the enzyme (nothing) cannot do anything. It is the substance or substances that build up or stop as a result of the altered chain of chemical reactions that result in the disease process. These processes can be complex. I have often wondered if retinopathy of prematurity is not at some point involved in this kind of process. Oxygen at a low level in the neonate retina may occur at some point. Oxygen may be an inhibitor of some innate process of neovascularization that then allows that innate process to proceed somewhat akin to the plant growth in the dark. It is likely a complex process like the plant growth. The absence of oxygen frees the system to proceed to neo-vascularization. On the other hand, too much oxygen may also stimulate neo-vascularization to occur through toxic mechanism(s) of oxygen, but perhaps of a different nature. This might include inhibition of substances that in turn inhibit neo-vascularization. This is conjecture, of course, and I do not wish to be attacked by the neonatalogists for my lack of intelligence, but just a thought. Comments are welcome.

Editors' Note: The mechanisms causing Retinopathy of Prematurity are not well understood. Oxygen, both too little and too much , clearly has a great effect on the immature retina. Current thinking is that early hypoxia (lack of oxygen or nothing) causes death of retinal cells and that later oxygen levels that would be normal for a mature infant but excessive for the immature over stimulate neovascularization. Early cell death may be due to biochemical changes but these are caused by lack of energy (nothing). Perhaps Dr. Wynsen would like to comment further in our next issue.

More Ado About Nothing

by Eugene Wynsen, MD, FAAP

If you accept the premise that nothing can not do anything, then you must not say that lack of oxygen causes the death of retinal cells. It doesn't do anything. That is the point, it does not do anything, so we must explain the results some other way. Lack of oxygen does not support the normal processes, but the real question is what are those normal processes? Why do some cells tolerate lack of oxygen better than others? What reactions are involved that make other cells more tolerant, for example, in the more mature infant? In other words, lack of oxygen does not explain anything. The matter is compounded by the fact that mature infants have been noted rarely to have retinopathy. If the lack of oxygen does not support a certain chemical reaction or series of reactions, what is that series? What is the innate mechanism of neovascularization like the innate growth mechanism in the plant? What inhibits the neovascularization in the "normal circumstances?" I am sure it is a very complex mechanism.

Again, you refer to biochemical changes that are caused by lack of energy. The lack of energy does not cause the changes, rather it does not support the reactions. The chemical reactions that do occur are part of the innate series of reactions that are already built in and perhaps go in a different direction than the normal pattern, or the reactions may go in the direction of accumulating toxic chemicals.

The whole idea of this concept is to try to get one to look at things a different way. If we accept the idea that lack of something causes something, then we are stymied right there. The real cause is then easy to overlook.

Be Safe, Not Sorry On-Line (Part 1)

by Jerold M. Aronson, MD, FAAP

Today, many of us are purchasing computers to "surf" the World Wide Web for continuing education, on-line banking and brokerage activity, and to communicate via e-mail. In this article I will cover:

- Part 1
  - Having the right computer hardware
    - PC
    - Modem
    - Internet Connection
  - Having the right software
    - Web browser
    - E-mail program
    - Virus, Spyware, and Spam protection
- Part 2 (to be published December 2005)
  - Safe "surfing" strategies
    - Using "secure" web sites, especially for financial transactions
    - Creating secure User ID and Passwords, and e-mail • addresses
    - Minimizing e-mail risks
    - Netiquette

Having the right computer hardware:

Most, if not all computers (PC or Apple) are internet-ready. That is, they contain either a built-in modem (communication hardware) or network connection devices (wireless or plug-in) or both. However, all internet-ready computers need an internet connection (ISP = Internet Service Provider) to function. You have several ISP choices depending upon the connection and web-surfing speed (broadband vs. dial-up) that you wish and the price that you are willing to pay.

The most basic type of Internet connection is called a dial-up connection. This connection is made through a modem (the communication mechanism in computers) that uses a regular telephone line to connect to the Internet. The modem must dial the telephone every time it wants to connect to the Internet, hence the name dial-up connection. The fastest modem that you can use for this type of Internet connection is called a 56K modem. Since a regular telephone line is analog, and a PC is digital, the modem converts the analog signals that it receives from the telephone line into digital signals that the computer can comprehend. These conversions take time; compared to other Internet connections and produces a relatively slow connection and ties up your telephone line. Thus, frequent users often install and pay for a second telephone line. However, dial-up is the least costly ISP and is generally sufficient for e-mail use and non-graphic intensive web surfing. A dial-up connection intermittantly connects your PC to the internet.

In contrast, "always on" broadband is a high-speed Internet connection that makes surfing the web more enjoyable. It also easily accommodates the video, audio, or complex graphics that are becoming commonplace on the Internet. Broadband connections are able to transmit both voice and data over the same line at the same time and are always on (no dial-up is required). A second telephone line is not necessary.

Broadband connections are provided either by the telephone company (DSL) or by your television cable company. Your choice will be based on local availability and cost. Each service may not be available in all areas. The company you choose will either provide or rent a special modem (and/or other equipment) that connects your PC to their cable or DSL line. You do not need cable TV to purchase broadband cable. However, most cable companies give price breaks on Internet access to their cable television customers. In general, the company that provides your broadband connection will either serve as your ISP or provide you with an ISP.

Cable broadband has several drawbacks. First, it is a shared connection, meaning you share the "pipeline" with your neighbors that can decrease your connection speed. In addition, because cable modem connections are always on, they, like DSL connections, make you more vulnerable to hacking and security breaches (more on this later). And cable broadband often is more costly than DSL.

DSL is a special telephone line that also provides high

Continued on Page 10

speed Internet access. DSL can be as fast as cable. The closer you are to the main telephone switching station, the faster your connection speed will be. If you are accustomed to using a regular dial-up connection, you may well be amazed by the speed of a cable or DSL connection. It will make surfing the Internet a much more pleasant experience. How fast is fast? Just for a quick comparison, if a file takes one hour to download over a standard 56K modem, it will take between 2.2 and 13 minutes (cable), and between 2.2 and 26 minutes (DSL). This will be important for users that like to listen and view both audio and video on the web, or plan to use their PC to send photos/video to family, friends, and colleagues. So if you want to do some speedy surfing, think broadband. Web sites like Broadband Reports at www.broadbandreports.com can help you figure out what services are available in your area and also have message boards where people tell about their experiences. Most public libraries have high speed broadband connections. Try out broadband or dial-up at friends or neighbors to see what you prefer.

Note – when choosing a connection and/or ISP, find out what actually comes with your account. Do they provide the hardware and software you need? Will they help you set up your computer so that you can make the Internet connection for the first time and is unlimited free technical support available? How many e-mail accounts and web storage space comes with your account? See if they provide free e-mail antivirus and anti-spam scanning by going to their web site. Sometimes these features must be turned on. Go to your ISP website online and select member/customer services.

Having the right software:

At a minimum, your computer will need a web browser, and software protection from viruses, spam, and spyware to surf safely. Broadband connection users should have and use "firewall" protection because the PC is "always on" and potentially vulnerable to "hackers". Some of these software protections (e.g. firewall) are built into new PC operating systems e.g. Windows XP SP2, or provided as "start-up" versions (usually anti-virus/spamware that you can view and install from your PC desktop. In general, Apple computers seem less vulnerable to hacking or viruses.

Note – always install firewall, and anti-virus software before you connect to the Internet for the first time to assure that you are protected.

Remember, there is a significant amount of security built into the utilities of the software that is bundled with your computer. This includes your operating system (especially the new Windows XP SP), E-mail clients like Outlook Express or task managers/e-mail clients like Microsoft Outlook, and Microsoft Internet Explorer, the most frequently used web browser. Review the default security settings on your software and set them to either the manufacturers default recommendations or choices that you prefer. See the Microsoft site at http://www.microsoft.com/athome/security/default.mspx for up-to-date information on how to optimally use these products.

Internet Explorer ("IE") is automatically loaded onto all PC's as part of the Windows operating system and is bundled with Outlook Express (software to manage e-mail communication, etc.) Other web browsers, e.g. Netscape, Firefox, Opera are available (see their websites for more information). However, I suggest that novices stick with what Microsoft provides as part of its operating system. Similarly, there are alternatives to Microsoft Outlook Express to manage e-mail. Users that plan to synchronize their PDA's (address book, etc.) must use Microsoft Outlook (usually found in Microsoft Office), that has many different task management functions beyond e-mail. One benefit of using Microsoft Outlook is that you can have Windows handle operating system and Outlook updates automatically. For example, in Windows XP, right-click on "My Computer," then "Properties," "Automatic Updates" and "Keep My Computer Up To Date" to protect your computer from "hackers".

Firewall software sets up a barrier against "hacker" (outside) access to your computer and its files and is essential if you choose a broadband connection. Windows XP has a built-in firewall. Assure that it is turned on. It works well for most users. Other firewall software (see Home Firewall Guide at http://www.firewallguide.com/) can be added. Their use may produce software incompatibility with other programs, however.

Anti-virus software is critical. Antivirus software programs are basically the same. For approximately $50, no matter which application you buy, you're purchasing a scanner engine and a year's worth of signature-file updates. An antivirus product scans your computer for evidence of viruses and then removes viruses when detected You need the updates to identify the latest viruses and worms, and most antivirus application now automatically download the updates behind the scenes, so you don't have to worry about it. The engines themselves *match patterns*, that is,

Continued on Page 11

they look at files on your hard drive and compare them to the signature files you just downloaded. If there's a match, the suspect file goes into *quarantine*, a protected folder on your hard drive where it can't hurt your system (again, this too has been automated so that you hardly ever notice this process). Lately, antivirus apps have added *heuristics*, the ability to sense a new virus or worm before a signature file has been downloaded based on malicious behavior. Also, most every antivirus app will check both incoming and outgoing e-mail messages for signs of infection. The differences, then, lie in the nuances of these apps. How much of your system resources do they hog? How fast or how often does the vendor release its signature-file updates? And what additional features does the software offer?

Popular anti-virus programs include, Norton AntiVirus 2005 (industry leader with starter versions usually supplied on HP and Compaq PC's), McAfee VirusScan 9.0 (starter version on Dell PC), and Trend Micro PC-cillin Internet Security 2005. Both Norton and McAfee market stand-alone anti-virus software. However, they can be purchased with integrated firewall protection at additional cost. PC-Cillin Internet Security 2005 (CNET's Editors Choice for 2005) includes an antivirus scanner, a firewall, antispam and antispyware capabilities, parental controls and more! Norton and McAfee anti-virus software slows all but the fastest computers, in contrast to PC-cillin. Calling Norton technical support is expensive after initial start-up. I suggest that you start with anti-virus programs that came with your PC before investing in a new product. And as before, during set-up, select auto-update to assure that your anti-virus software is updated regularly behind the scenes to maximize your protection. Typically, you will need to renew your "subscription" annually, to receive updates to protect against the latest viruses.

Antispam and antispyware software protect your computer from malicious mischief, performance deterioration, and identify theft. Spyware secretly gathers information about a person or a company and relays it back to advertisers or hackers. Spyware can infect a computer through a virus or through the installation of new software. Spyware aids identity theft and data corruption, and tracks users' online activities without their knowledge. Use anti-spyware programs such as Ad-Aware (www.lavasoft.com) or Spybot (http://www.safer-networking.org/en/download/) available either as "freeware" or purchasable. Microsoft recently announced a free anti-spam product for Windows XP SP2 that was to be released Summer-Fall 2005.

Remember; send your questions/concerns to jmaronson@aap.net. I'd love to hear from you. While all questions may not be able to be answered personally, your feedback will help identify topics for future articles.

Book Review

by Avrum Katcher, MD, FAAP

Baseball Before We Knew It!

by David Block

University of Nebraska Press, Lincoln, 2005

If you asked me, I'd have said that baseball was invented by Abner Doubleday in Cooperstown, NY, in 1839. Everyone knows that, at least everyone with an interest in the game. The museum of baseball is in Cooperstown. The records are available. Certainly there are related games, rounders and cricket in England, one, two or three old cat in the United States. But doubt Doubleday and Cooperstown? As soon doubt Antony van Leuwenhoek and the microscope!

Now David Block has enabled us to recognize our error. In a tightly written, carefully logical, and thoroughly supported by evidence volume of some three hundred or so pages, he shows not only the real origins of baseball (back in the thirteenth century) but also how the confusion and misunderstanding occurred. He even includes illustrations from the time of origin showing bat, ball, and making a hit. For centuries both men and women played, often together, under circumstances that included sexual pleasures for winners, and probably losers as well.

One could go on, describing the documentation in this delightful volume. However, perhaps for many this story is more than they ever wanted to know. But for the true baseball fan, this is a fascinating treasure, and well worth study.

Gifting: Noble Gesture and Effective Tax Strategy

by Joel M. Blau, CFP — President
MEDIQUS Asset Advisors, Inc.
"Results. One client at a time."(sm)

With much uncertainty surrounding the future of estate taxation, many physicians are looking at ways to reduce the value of their estates today. While the IRS imposes federal gift taxes on donors, it is still possible, and often recommended, for individuals to give away thousands of dollars each and every year without the imposition of gift taxes. The tax law includes several key exceptions to a potential gift tax liability. If you are able to stay within the gift tax boundaries, you will be able to pass a considerable amount of wealth to family members during your lifetime with no gift-tax consequences.

The annual gift tax exclusion enables each individual to give up to $11,000 each year to a recipient without paying any federal gift tax. It is important to understand that this exclusion applies separately to each recipient. As an example, you can give up to $11,000 to each of your four children, for a total of $44,000, without triggering the gift tax. In addition, the recipients do not have to pay any tax on the gifts received. If you are married, the annual gift tax exclusion can be doubled if your spouse joins in the gift. This would allow you to gift each one of your children $22,000, for a total among your four children of $88,000, completely free of gift and income taxes. Over the period of 10 years, you would be able to gift, and thus reduce your taxable estate by, a total of $880,000, exclusive of any future potential appreciation associated with the gifted assets.

Besides direct cash gifts, you are also allowed to pay any qualified expense directly to a medical provider or educational institution, on behalf of others, without incurring any gift tax liability. For instance, if a grandparent wishes to make a "gift" of college tuition, the key is to write the check directly to the school and not the child's parents. Any gifts made to medical providers and educational institutions can be made *in addition to* the annual gift tax exclusion amounts.

If for any reason you go beyond the annual gift exclusion amounts, you still may not be immediately liable for gift tax payments. Gifts made in excess of the exclusion may be sheltered by the gift tax credit. This credit, which mirrors the annul estate tax exemption, can effectively shelter up to $1million of gifts in 2005. The gift tax credit is reduced by gifts made in prior years that used part of the credit shelter at that time. Also keep in mind that your family may save income taxes when you give gifts to other family members. Typically, the income generated or earned from the gifts is taxed at the donee's tax bracket, which is often times a lower personal income tax bracket than the donor's. This income tax saving strategy is easily accomplished when the gift includes income producing property given to a minor child.

As you consider the use of the annual gift tax exclusion, remember that the gifts are limited by the calendar year in which the gift is made. If you made gifts late in 2004, you can now make another gift in 2005 without waiting an additional 12 months.

Mr. Blau welcomes readers' questions. He can be reached at 800-883-8555 or at blau@mediqus.com

(DISCLAIMER-Readers are advised that information contained in this article is of proprietary origin, and no approval or recommendation by the AAP is implied or intended. –The Editors)

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From Lucy Crain

I'm sending you an article written by my son, Will, as one of the SF Chronicle staff writers who were invited to submit tributes to their mothers on Mother's Day. It was a lovely and much appreciated surprise! Since it does have some historic relevance, you might consider it for the section BULLETIN. Will's article and several others from other Chronicle writers can be found online at SFGate.com, May 8, 2005 if you search for Mother's Day tributes on that date.

Tribute to his mother

by Will Crain

My first-grade teacher, Mr. Gunderson, once told my class a story: A father and son are driving and get into a terrible car accident. The man is killed and the boy is seriously hurt. But when the boy arrives in the emergency room, the doctor on duty says, "I can't perform surgery on this patient. This is my son!" Mr. Gunderson asked us, "Who is the doctor?" Hands went up and my classmates shouted out guesses and theories, each more far-fetched than the last: The dead man was a stepfather; the dead man was a priest known as "father"; the dead man was revived by paramedics and returned to his job as a surgeon.

When I raised my hand, Mr. Gunderson said, "No, Will, I'm not going to let you answer." He knew it would be too easy for me to figure out that the surgeon was the boy's mother. He knew that because my mother is a doctor.

I suppose Mr. Gunderson's puzzle would be a lot easier for today's first-graders, now that female doctors can be seen any night of the week on reruns of "E.R.," but when I was at San Francisco's Commodore Sloat Elementary in the late 1970s, I didn't know many kids whose mothers worked at such a high-pressure job. I don't think I had ever really thought about it until that day in class. My father is a doctor too, so it didn't seem all that out of the ordinary to me.

But by any other standard, my mother's story is extraordinary. She was one of a handful of women in her medical school class at the University of Kentucky and she went on to become a prominent physician at UCSF, to be elected to the board of the American Academy of Pediatrics and to spend decades as an advocate for children with disabilities and other special needs. She went into semi-retirement a few years ago, but she still works harder than a lot of fully employed people I know.

To my sister and me, of course, she was and is just Mom. When we were kids, we came home from school to a baby-sitter who watched us until our parents came home. Mom took Fridays off so she could spend more time with us, and we could tell that she felt guilty about not being home more often. My sister and I figured out at a fairly young age that this guilt was Mom's weak spot, and we exploited it mercilessly whenever we wanted a new "Star Wars" action figure. I'd like to think I stopped doing that the first time Mom told me about one of her patients who had died, but I'm sure I didn't. I can't imagine what it's like to spend all day taking care of other people's sick children, some of whom are not going to make it, and then come home to find that your own kids are acting like spoiled brats. I suppose she could have worked that angle to find our guilty weak spots, but she never did. I think I'd better thank her for that.

Note from Avrum Katcher in response to above:

My own mother was a dentist. Her dad was a butcher, and sent one son to medical school and one to pharmacy school. When it came time for my mother who also wanted to go to medical school, the older two objected strongly. Because she was his favorite (I carry his pocket watch, which on his death bed in 1935 he gave to her for me) he could not just say "no," and with her approval sent her to dental school. There she was the only woman in the class, and the year book, which I have (it was about 1920 or so) described her as "the only chicken." She always practiced in an office in the home, scheduling appointments around my brother and me and our father.

San Francisco's First 5 Commission

by Lucy S. Crain, MD, FAAP
Chair, First 5 Commission, San Francisco
Clinical Professor Emeritus, UCSF Department of Pediatrics

In case you've ever wondered how a state's "sin tax" on products such as tobacco can benefit young children, read on. In 1998, California voters overwhelmingly approved Proposition 10, conceived by actor-director Rob Reiner and other child advocates determined to improve the school readiness of California children and to make systems work better for our youngest children and their families. "Prop 10", the California Children and Families Act, created a new revenue stream for early childhood development programs with a dedicated 50cent/pack tax on every tobacco product sold in California. These revenues are dedicated by state regulation to improving services and opportunities for California's children in their first five years of life. The Act also established state and county Commissions on Children and Families to develop policy and priority guidelines and to define target areas, including school readiness, child care, special needs, child health, and parent/family support. It also directed that all regular meetings of the Commissions would be open to public attendance and input.

County distribution of the Proposition 10 tax revenues is based on the population of children in the 0 to 5 age group. San Francisco's census reports about 110,000 children from birth to age 18, and about 40,000 age birth to five. (Los Angeles County reports 110,000 four year olds.) As fewer Californians smoke, finite revenues necessitate concerted effort by the Commissioners to prioritize the identified needs of their youngest population and to attempt to make meaningful changes and improvements in addressing those needs in our community.

Although county Commissions generally address objectives targeted by the state, unique local concerns and needs are evident. Only the strategic plans of San Francisco and San Diego counties have identified homelessness as a specific priority issue. SF First Five has included child development and mental health, childcare, access to child health care, dental health, family support, and homelessness as specific priority issue, in addition to several other targeted priorities, such as the universal preschool program and the special needs project. The Commission works closely with the Mayor's Office, the Department of Children, Youth, and Families, Children's Mental Health Services, and the Department of Public Health, as well as numerous other public and private entities and agencies in San Francisco to better identify and address needs of young children and their families in our community.

Parent Action Grants are among the projects funded by SF First 5. These represent a myriad of innovative neighborhood based projects directed toward improving parent skills and child development. They are all parent conceived and directed, with grants averaging $2500 each, and have been remarkably effective in preparing parents to become more skilled advocates for their children. Technical assistance for a variety of needs, including grant writing in order to obtain funding for sustainability is among the support services provided by the Commission. The Parent Ambassadors Training Project is an ambitious project funded by the Commission. Upon graduation from the training, participants have received education and training on parenting skills, child development and safety, and health topics, as well as familiarization with local neighborhood and citywide resources. Parent Ambassadors are trained to become resources for other parents of young children throu ghout the City, to enable other parents to more effectively access local resources for themselves and to share information with other families. The Parent Ambassador's mission is to spread the word that supportive and helpful advice is available close to home for parents of young children throughout our city.

The New Parent Kit is a State Commission sponsored parent education collection available free of charge to any new parent in our state. The kits contain educational videos on parenting, childhood health, early literacy, and children's books and are available for the asking to all new parents in California. Several counties, including San Francisco, also distribute the kits by local means. Also, the Newborn Home Visiting Project of the San Francisco Department of Public Health (Maternal and Child Health Division), with expanded funding from SF First Five, distributes these kits during their newborn home visits, and kit request information is available at all local perinatal service units.

The State First Five Commission has also issued special requests for proposals, encouraging county commissions to apply for addi-

Continued on Page 15

San Francisco's First 5 Commission Continued from Page 14

tional funding to better address children with special needs and also universal preschool. (The Preschool for All Initiative). SF First Five funded the local High Risk Infant Interagency Consortium to conduct an intensive study of access to special services for children who have developmental disabilities or other special needs (such as cerebral palsy, attention deficit disorders, autism spectrum disorders, language and communication disorders, and mental/behavioral health concerns). Working with the local SF Unified School District, California Children's Services (CCS), Children's Mental Health Services, and Golden Gate Regional Center, the results of the findings were presented at a special hearing, and many improvements in early identification and referral and in interagency communication have been accomplished.

Commissioners have anticipated a trend toward decreased revenues due to decreased smoking and have targeted crucial services, which might not otherwise have been possible for young children. An example is $2million over 3 years which the SF First Five Commission has contributed to help "jump start" the Universal Health Insurance for Children citywide. Mayors and county supervisors know that having health insurance is the greatest guarantee of being able to receive cost effective preventive health care, including well child care and preventive childhood immunizations or vaccines. Again, this effort was accomplished in partnership with the Mayor's Office, the SF Department of Public Health (DPH) and the San Francisco Health Plan, as the Commission has paid the health insurance premiums for those young children (birth to 5 years old) who are not eligible for MediCal (Medicaid in California) or Healthy Families(SCHIP), and whose family income does not exceed 2 50% of the Federal Poverty Level. As First Five is mandated by the state not to supplant or sustain existing services, and as the funding for First Five decreases, the Mayor's budget and DPH will assume the support for universal health insurance for children and youth in San Francisco.

First Five has invested significantly in increasing educational opportunities for child care providers through funding scholarships, which have improved educational opportunities for child care workers, lessening staff turnover, and resulting in improved quality of child care. Also, the Commission helps support mental health consultation to child care programs, assisting teachers in identifying concerns regarding a young child's atypical behaviors and mental health or development issues, and addressing those concerns appropriately with parents and referral resources.

All of this opportunity to put advocacy into action is why I find that serving as a county Commissioner and chairing First Five San Francisco is the best almost fulltime volunteer job which a recycled (not really retired) pediatrician might have!

Chuckles

1. Jesse Jackson, Jim Baker and Jimmy Swaggert have written a new book. It's called "Ministers Do More Than Lay People."
2. Transvestite: A guy who likes to eat, drink and be Mary.
3. The only time the world beats a path to your door is if you're in the bathroom.
4. I hate sex in the movies. Tried it once. The seat folded up, the drink spilled and that ice, well, it really chilled the mood.
5. I'm so depressed. My doctor refused to write me a prescription for Viagra. He said it would be like putting a new flagpole on a condemned building.
6. My neighbor was bit by a stray rabid dog. I went to see how he is and found him writing frantically on a piece of paper. I told him rabies could be cured and he didn't have to worry about a Will. He said, "Will? What Will? I'm making a list of the people I want to bite."
7. Definition of a teenager? God's punishment for enjoying sex.
8. As we slide down the banister of life, may the splinters never point the wrong way.

“On Medical Stories and Myths”

“THE STORY BEHIND WORDS”

by Maurice Liebesman, MD, FAAP

I have a friend who owns a place in Bethany Beach, in southern Delaware and not too long ago my wife and I were invited to spend a weekend with them. We were looking forward to that visit since we enjoy their company and we like to visit the shore. After breakfast Anita, our hostess, suggested that since the weather was too cold to go to the beach instead we should go shopping for antiques. She is very much into antiques and, among many other treasures; she is proud of her collection of green glass from the “depression era”. We were driving around on Route 26 when we saw a sign that attracted our attention: “The Back Porch - Real Antiques and Stuff” (stuff probably refers to objects that would like to have been antiques but are missing the birth certificate). We stopped the car and entered the store. After looking around for a while the owner approached us and, with a timid voice but very proudly said: “If you are interested in furniture you have to take a look at this beautiful *credenza.* I just got it at an auction of one of the du Pont’s estates.” I looked at my wife and very softly I whispered into her ear, “Isn’t that a sideboard, honey?”. “Yes” she answered” but in the antiques lingo they called it a *credenza”.* “Why…?”- I inquired. Nobody in the store knew the answer.

A few weeks later I was looking through the pages of the May 2005 issue of National Geographic and… WOW!, to my surprise I found the story of the word *credenza.* Apparently, since times immemorial, one of the most efficient ways of becoming a leader of a kingdom was to eliminate the rival. Not by popular vote, mind you, but simply by …eliminating them. Poisoning was the most subtle and frequently used method. History has many examples. The Borgia family, for instance, became very powerful in Florence mostly because of their ability to use poison as a political tool. It is told that Mithridates, King of Pontus, an enemy of Rome, had prisoners nibble his food before he tasted it. Roman emperor Nero had slaves do the same thing and the rumor is that Napoleon’s death was conveniently, politically, arsenically induced. During medieval times, when invited to dine, rulers did not trust each other. It was the tradition that the food to be served be tested in advance. For that purpose it was placed on a sideboard table called ***credenza***. This Italian word comes from the Latin ***credentia*** which means: confidence (***Credere***, to believe). The open display of the food was the host’s way of saying:”Believe in me, have confidence in me, the food is NOT poisoned”.

Even nowadays, no matter how honest and ethical you are and how many years of free labor you contributed to your hospital making rounds and serving on committees, the administration still insists in checking your ***credentials*** …every two years. Talk about trust!

I was always interested in languages and etymology, not because I am looking for a definition of a word but because I like to discover the stories hidden behind each word and what it meant to the people using them many years ago. In doing the research for this essay I found many interesting stories behind some terms we pediatricians frequently use. For instance, when we attend a Seminar or a Symposium, are they equivalent terms or not? When is a pediatric meeting a Seminar and when is it a Symposium?

Seminar comes from the Latin *seminarium* which means: a place where seeds are planted. (Semen = seed). A Seminar therefore is a meeting where a group of advanced professionals plant the seeds of their knowledge and experience to a group who comes to receive that general information. For instance: “The 2005 Annual AAP/Arizona Chapter Seminar on Advances in Pediatrics”

Symposium comes from the Greek but it is a little more complicated. *Posis* means drinking. A potion is something that people drink. *Sym* means together, as a group (look into the meaning of sym-phony, symbiosis, etc.). Originally symposium meant drinking together but unlike what you imagine a dinking party to be by today’s standards, in a Greek symposium, the wine was consumed only AFTER the meal when it was time for some form of entertainment or discussion, including philosophical debate. I suspect it was the equivalent of today’s “Let’s get together and discuss it over a cup of coffee” (the ancient Greek’s idea was more fun …). The wine was almost invariably mixed with water since drinking it straight was considered a characteristic of barbarians. The attendees at a Greek symposium reclined on couches and were crowned with garlands of flowers but they did not get CME credits. Nowadays a symposium is a meeting or

Continued on Page 17

conference for discussion of a specific topic. Example: "The 2005 Annual AAP/New Jersey Chapter Symposium on Treatment of Adolescent Hypertension".

The last entry of today's essay is the meaning of the word most commonly used around the American Academy of Pediatrics: ***Academy***. Where does is come from? I did my research and I found that, once upon a time, there was a big war in the Near East (so what else is new..?) when Helen, daughter of King Tyndareus was abducted by Paris and taken to a destination unknown. The Athenians were desperate to rescue their beautiful princess (who, according to gossip was only twelve years old!) but they did not know where she was taken. Apparently Helen's location was revealed to her rescuers by a man named Akademus who told them she was kept a prisoner in the city of Troy. Well, that did not seat well with the Athenians, who really got mad at the Trojans and started a war using wooden horses and other sophisticated weapons. Legend says that Akademus was rewarded for his information by the grateful King who gave him a piece of land, an olive grove near Athens which upon his death was donated to the city. It was then refurbished, landscaped, water fountains were added and became a popular park known as the Grove of Akademus. In the 4th Century, Plato, who happened to live in Athens, set up his famous school of philosophy near the park. He was known for strolling in the gardens while teaching his students. For this reason, Plato's school became known as "The Akademia". During the Renaissance this concept was resurrected and ever since then, any prestigious institution devoted to higher learning would favor the title of "Academy".

On June 23, 1930 a group of pediatricians met at the library of the Harper Hospital in Detroit to discuss the establishment of a new organization solely dedicated to pediatrics and pediatricians. They were not happy with being a Section of the American Medical Association and wanted to break away. They debated about calling themselves the American College of Pediatrics but Dr. Isaac Abt, who was the Chairman of the Department of Pediatrics at Northwestern University School of Medicine and a powerful leader of this group, suggested the name American Academy of Pediatrics. Well, you know the rest of the story.

Arrivederci!

Seniors — Be Aware
Neither Reputation Nor Costs of Healthcare are Related to Quality of Health Care

by Avrum Katcher, MD, FAAP

We are all aware that advancing age is associated with an increase in morbidity until the end of life. Seniors should also know—and many may not—that variations in diagnosis and treatment exist, from one geographic area to another, from one hospital to another. These variations do not correlate with results, outcomes, post treatment states of health, even after controlling for variations in premorbid health, socioeconomic and genetic factors, behavior and other possible influences on outcomes. For some decades a medical literature has been building on this discrepancy.

Our readers will find it worth while to look at a series of three careful articles, appearing in the Washington Post on 24, 25 and 26 July, 2005, written by reporter Gilbert Gaul. The three are titled, in order, Bad Practices Net Hospitals More Money, Accreditors Blamed for Overlooking Problems, and Once Health Regulators, Now Partners. All examine data from the Medicare program as well as other information. Back issues of the Post are available without charge via the Internet by opening the Post web page at www.washingtonpost.com.

Some of the early studies, emanating from a group at Dartmouth, examined Medicare costs and results of care in New England. These revealed dramatic geographic differences which could not be accounted for by patient characteristics, but which did appear related to the number of specialists, hospital beds and technology. No other explanatory factor has been found. More recent examples of these variations are found in a study, performed by the Dartmouth group, of data from Florida. In year 2001, Medicare patients in the Fort

Continued on Page 18

Myers area underwent spine surgery at a rate of 6.9 per thousand. In Miami, the rate was 3.2. Nationally, it was 4.5 per thousand. Nationally the average total bill per patient submitted to Medicare was $40,000. There is no evidence that results varied according to method of treatment.

Who watches hospitals? We all know the answer, the Joint Commission on Hospital Accreditation. The second article of this series is devoted to the work of this group. Reporter Gaul amasses evidence to suggest that questions should be raised about the rigor of hospital inspections, and the existence of potential conflicts of interest. Whether or not these questions have merit, the information provided is sufficient to make a reasonable person wonder.

The third and last article discusses the Quality Improvement Organizations, established by law in every state, to measure quality, work with hospitals and doctors to improve care, and investigate patient complaints. Again, questions are raised about the rigor of the work these groups do, about the extreme privacy of their function, and about their overt "view of themselves not as regulators but as partners of hospitals, nursing homes and doctors, working to improve care." The concept sounds good, but what are the results? It appears that no one knows.

Are the very suggestive implications from this series justified? It would not be up to me to say; I have not personally reviewed the literature. However, as written, this is an impressive series. Perhaps the main problem is the lack of transparency exposed. Those of us on the Medicare programs need to think about our personal care, and how it compares with best standards. In addition, since pediatricians are now caught up in a great debate about how to improve care: should it be via the malpractice route, through legal combat, as the trial attorneys claim, or should it be via self-examination, development of useful information about the results of different methods of care, and adoption of what works, as well as careful and transparent study of every untoward result? The stress on our colleagues still in practice is immense. Those of us who have left patient care are also aware that the statute of limitations for the care of children has many years to run. Some have long-term coverage, but some of the insurance companies providing that coverage are bankrupt.

If we are all fortunate, both as pediatricians caring for children and as patients ourselves, this controversy will result in real improvement in health for us all. For myself, I try to keep up with what is known relative to my own health care. Among other resources, I use the Guide to Clinical Preventive Services, for 2005, the recommendations of the U. S. Preventive Services Task Force, from the Agency for Healthcare Research and Quality, www.ahrq.gov.

The AAP Historical Archives Committee And the Oral History Project

by Howard A. Pearson, MD, FAAP

October 2004

In 1992 when I was president of the American Academy of Pediatrics, I had a number of discussions with Dr. James Strain, who was AAP Executive Director and David Annunziato, who was on the Board of Directors about the Academy's lack of a commitment to preserve historical pediatric information and records. The Academy had just finished construction of a substantial addition to its headquarters in Elk Grove, Illinois, and it seemed that there might be some space to consider setting up a History Center. The AAP had a Division of Library Services and the Bakwin Library which support the Academy's various missions with computer bases, a variety of government publications and professional and public journals. The library also has two professional librarians, one of these, Susan Bolda Marshall, MALS, has become indispensable in the Oral History Project.

In 1992, largely because of the recommendation of Jim Strain, Dave Annunziato, and me, the Executive Board established a Pediatric History Center, and designated a small room adjacent to the Bakwin Library for this. The room was only 15 by 18 feet, but it was a start. It has been tastefully fin-

Continued on Page 19

ished and we have been assigned adjacent storage and shelf space.

In 1993 the Board approved creating and modestly funding a Historical Archives Advisory Committee, consisting of me as Chairman, David Annunziato, Larry Gartner and James Strain. Shortly after this the Committee was enlarged to include Doris Howell and Jeffrey Baker. Jeff Baker, from Duke, is the only one of us with formal training having earned a PhD in medical history. Susan Marshall is our faithful and effective staff person, and we have also been able to hire an excellent part time archivist, John Zwicky, PhD.

The Committee at its first meetings identified three projects that might be pursued:

1. To obtain oral histories of living pediatricians and other leaders who have made a contribution to the health care of American children
2. To collect important pediatric documents, books and memorabilia, including documents of the AAP.
3. To construct a central electronic archival catalogue of historically important pediatric documents located in other archives around the country.

Not much has been accomplished in establishing an electronic pediatric archival database, and we learned that this is already being done by the National Library of Medicine and other electronic libraries, and placed on the Internet.

We do have an interesting initiative in the second aim: collecting memorabilia. In 1973, Dr. Robert D. Gauchat donated his collection of more than 600 pediatric feeding utensils, so-called "baby feeders," to the AAP. Some of these have been displayed in Elk Grove Village and at the AAP Washington office. In 1998 at the recommendation of the Advisory Committee, the AAP purchased the large collection of feeders of Dr. Larrie Sarrf of Milwaukee. Our collection now includes some pieces that date back to the Roman Empire and Middle Ages. They give insights into how babies have been fed over many centuries. We are working with Dr. Darroll Erickson and the American Collectors of Infant Feeders, and hired Ms. Jennifer Searcy, a doctoral student in museum studies to organize and catalogue the AAP collection and put them all with photographs in proper historical context on the computer. Dr. Erickson is organizing "loaner" displays that can be lent to pediatric organizations, including AAP chapters, for public display. They evoke considerable interest, and are real conversation pieces.

We have acquired some historically important textbooks as gifts from pediatricians; but amassing an exhaustive historical library is not our intent – for space reasons if none other. If pediatricians wish to donate books from their library, the Committee and staff will be glad to review the titles and receive them as a gift to the Historical Library if they are especially important and not already in the collection. We have offered to be a repository for the records of pediatric organizations, such as the American Pediatric Society and the Society for Adolescent Medicine.

Our most important, and most successful, initiative is the Oral History Project. Oral History had its roots in the sharing of stories and legends over the millennia and has evolved into a respected academic area. Many universities have established departments in this discipline. The AAP oral history project was launched in 1993. There was considerable discussion about how to do these. We had formal presentations from the private Winthrop Group and the Oral History Department of Columbia University who offered to conduct oral histories for us on a contractual basis. We hired the Columbia Group do oral histories on Bill Nelson and Saul Krugman. The results were rather unsatisfactory and expensive. It should be admitted that both Drs. Nelson and Krugman were interviewed not long before their deaths and had difficulty with memory and concentration; but it was also apparent that interviewers coming from non-medical backgrounds were not familiar with many aspects of pediatrics that we were interested in. This led to a decision that we would utilize pediatrician interviewers, rather than professional historians. I think this was a good decision.

In late 1995 notices were placed in various AAP publications, soliciting volunteers to participate as oral history interviewers. Seventeen were chosen on the basis of a strong interest in medical history, and in many instances historical publications. In April 1996, these volunteers came to Elk Grove Village for a one day "crash course" in oral history taking given by Janet Nolan, PhD, associate professor in the Department of History at Loyola University in Chicago. The curriculum of this training session included defining the purpose of the project, points to cover and useful hints on inter-

Continued on Page 20

 Continued from Page 19

viewing procedures. The need for careful advance preparation was emphasized. During the same time frame, a list of potential interviewees was generated from the recommendations of individual AAP fellows, as well as from committees, sections, chapters and districts. From a very long list, a shorter list was prioritized by the Committee on the basis of a number of considerations including their contribution to pediatrics and their age. There is some urgency to the task. We unfortunately lost Drs. Frank Oski, Jay Arena and Sydney Gellis before we were able to interview them. We were, however, able to take the oral histories of Drs. Tom Cone, Lou Gluck, Katherine Bain and Joe Butterfield before their, sometimes unexpected, deaths.

Prior to the interview, the Archives provide the interviewer with CV's and bibliographies, publicity articles from the AAP files and other materials. The interviews usually take between 4 and 8 hours, and are tape-recorded. The recording is transcribed and edited by both the interviewer and interviewee. We try not to edit too much, lest spontaneity and spirit be compromised. A penultimate version is proof read and indexed by Susan Marshall and printed in an attractive format which can be purchased. Completed oral histories are also available on the AAP Members Only web page. It has been estimated that it costs about $4,000 to complete an oral history, even though all of the interviewers are volunteers. It has been possible to pay for some of these through contributions from colleagues and friends. Our original 17 interviewers has been truncated because of death, illness and time commitments, so there are currently fewer than 10. We have received Board approval and funding to train another 5 interviewers but we need more. If the Oral History project is to continue expeditiously, we are going to request that training be given to a total of 10 new interviewers. As of today, 25 oral histories have been completed and about 50 are in various stages of preparation.

Several sub-projects have evolved. We especially would like to do oral histories of leading women pediatricians and have done 9. Funding for these has been provided by the Friends of Children, thanks to intervention of Eileen Oullette who has joined us as an interviewer. In 1996, the Section on Perinatology, donated funding for oral histories on leaders in neonatology. Dr. Larry Gartner is spearheading this project and doing many of the interviews himself. The Section on Surgery has commissioned oral histories on the winners of the Ladd Award, and the oral history of Dr. Ovar Swenson has been completed.

Even a brief reading of the Oral Histories reveals information and insight that serve to flesh out the bare bones of a curriculum vitae with personal recollections and anecdotes. Most of the oral histories describe people of modest financial backgrounds and a number of them came from rural backgrounds. A few were immigrants. Only a few had physician parents; but most had an early physician role model, sometimes a family doctor. All had strong academic performances in a wide variety of colleges. Entrance to medical school varied, from walking into a nearby Med School and enrolling on the spot to making multiple applications – but nowhere near the 15-20 applications made by today's students. Dr. Gerry Schiebler recalled that he got into Harvard as part of the "10% Pennsylvania quota." Several described a "10% cap" for Jewish students that was operative in many medical schools in the 1930's and 40's. Two of these people directly attributed their ultimate acceptance into medical school to the direct intervention of religious non-Jewish college teachers, one a Jesuit priest. Several oral histories described wartime experiences. Milton Markowitz was on an LST off Omaha Beach on D-Day. Berry Brazelton was a physician on north Atlantic convoys for more than a year. Lew Barness spent two years in the occupation army in Japan mostly doing infectious disease. Henry Barnett was an army physician at Los Alamos during the Manhattan project and was an observer at the first A-bomb test at Alamogordo, New Mexico. He also went to Nagasaki shortly after the A-bomb detonation. Tom Peebles was a decorated bomber pilot in the South Pacific. Gerry Schiebler, a first generation German American, recalled that his family was reported for suspected espionage by his neighbors and his house was searched three times by the FBI.

The oral histories give personal accounts of interactions with some of the great names in pediatrics and describe some of the organizations and hospitals in which they worked. A number described private practice and house calls. But most tellingly, they reveal something of the personalities and recollections of very interesting people. They should be a significant resource for future medical historians who want to learn about American pediatrics as it was practiced in much of the 20th century.

Children

To those of us who have children in our lives, whether they are our own, grandchildren, nieces, nephews, or students...here is something to make you chuckle. Whenever your children are out of control, you can take comfort from the thought that even God's omnipotence did not extend to His own children. After creating heaven and earth, God created Adam and Eve. And the first thing he said was "DON'T!"

"Don't what?" Adam replied.
"Don't eat the forbidden fruit." God said.
Forbidden fruit?? We have forbidden fruit?? Hey Eve…we have forbidden fruit!!!!!"
"No Way!"
"Yes way!"
"Do NOT eat the fruit!" said God.
"Why"
"Because I am your Father and I said so!" God replied, wondering why He hadn't stopped creation after making the elephants. A few minutes later, God saw His children having an apple break and He was angry!
"Didn't I tell you not to eat the fruit?" God asked.
"Uh huh," Adam replied.
"Then why did you?" said the Father.
"I don't know," said Eve.
"She started it!" Adam said
"Did not!"
"Did too!"
"DID NOT!"
Having had it with the two of them, God's punishment was that Adam and Eve should have children of their own. Thus the pattern was set and it has never changed.
BUT THERE IS REASSURANCE IN THE STORY! If you have persistently and lovingly tried to give children wisdom and they haven't taken it, don't be hard on yourself! If God had trouble raising children, what makes you think it would be a piece of cake for you?

THINGS TO THINK ABOUT!

1. You spend the first two years of their life teaching them to walk and talk. Then you spend the next sixteen telling them to sit down and shut up.
2. Grandchildren are God's reward for not killing your own children.
3. Mothers of teens now know why some animals eat their young.
4. Children seldom misquote you. In fact, they usually repeat word for word what you shouldn't have said.
5. The main purpose of holding children's parties is to remind yourself that there are children more awful than your own.
6. We childproofed our homes, but they are still getting in.

ADVICE FOR THE DAY:
Be nice to your kids. They will choose your nursing home one day.

AND FINALLY:
IF YOU HAVE A LOT OF TENSION AND YOU GET A HEADACHE,
DO WHAT IT SAYS ON THE ASPIRIN BOTTLE:
"TAKE TWO ASPIRIN" AND "KEEP AWAY FROM CHILDREN"!!!!!

AAP Section for Senior Members

Strategic Planning — Member Survey

Name ______________________________ Age __________

Address ______________________________

Phone ______________ FAX ______________ E-Mail ______________

1. To which of these technologies do you have access?

❐ fax machine ❐ computer ❐ E-Mail ❐ Internet ❐ CD-Rom

2. I am: ❐ in practice full time ❐ in practice part-time ❐ retired

3. The type of practice I am currently in is:

❐ Pediatric Group ❐ Hospital Employee ❐ HMO Employee ❐ Government Employee
❐ Solo Pediatrics ❐ Multi-Specialty Group ❐ Academic Practice ❐ Other __________

4. My major area of practice is:

❐ Clinical ❐ Teaching ❐ Research ❐ Administration ❐ Other __________

5. Have you attended an AAP national meeting in the last five years?

❐ Yes ❐ No

6. Have you attended a Section on Seniors meeting and/or program in the last five years?

❐ Yes ❐ No

7. Are you currently on any Section on Seniors committees or serving in any other AAP leadership positions?

❐ Yes ❐ No

8. Are you interested in serving in such a capacity? ❐ **Yes** ❐ **No**

9. Are you currently active in your AAP chapter? ? ❐ **Yes** ❐ **No**

10. Are you interested in becoming active at the chapter level? ❐ **Yes** ❐ **No**

Survey Continued on Page 23

Survey Continued from Page 22

11. What are the top five challenges or issues for children in the next 3-5 years?

12. What are the top five challenges or issues for Section on Seniors members in the next 3-5 years?

13. Please rate the importance of these Section on Seniors membership benefits.

	Very Important	Somewhat Important	Not Important
Educational programs addressing the needs of senior members			
Educational programs addressing child health issues			
Social interaction with other seniors			
Networking on specific issues			
Service/advocacy opportunities			
Retain relationship with the Academy			
Section newsletter			

Please complete this survey and return it in the enclosed envelope or FAX the survey to 847/228-7035 by September 30, 2005. Thank you for your participation!

SENIOR BULLETIN

AAP Section for Senior Members

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