

Senior Bulletin

AAP Section for Senior Members

Acting Co-Editor: Avrum L. Katcher, MD, FAAP
Acting Co-Editor: Joan Hodgman, MD, FAAP
Associate Editor: Donald Schiff, MD, FAAP
Associate Editor: Benjamin Silverman, MD, FAAP
Contributing Editor: Read Boles, MD, FAAP
Contributing Editor: Sol Browdy, MD, FAAP
Contributing Editor: Solomon Cohen, MD, FAAP
Contributing Editor: Joseph Girone, MD, FAAP
Contributing Editor: Eugene Wynsen, MD, FAAP

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American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™



Report From The Chair

David Annunziato, MD, FAAP

We hope that you are enjoying good health.

Your executive committee met in New Orleans at the NCE meeting. We could not complete our agenda in the short time allotted us. We also had several presentations from Academy representatives.

Jeff Mahony updated us as to the events planned for the 75th anniversary of the AAP in 2005. He urged the cooperation of the senior section in developing the "Coffee Table" book to be published describing, in 200-500 words, outstanding landmark changes which have occurred over the past 75 years. These anecdotal accounts will describe how we practiced, the diseases we treated and conquered, AAP changes, landmark legislation or anything else, which we may think is an important event. Sit and think for a few minutes and I'm certain you will think of a fitting event. Write it down and send it to Jeff Mahony at AAP headquarters. There was a deadline of December 31, 2003 but I'm certain any good article received after that date will be considered for publication.

John Chamberlain, MD member of the Council on Sections Management Committee joined us and reviewed with us our annual report and activities. We urged him to aid us in our efforts to waive the NCE registration fees for local seniors and help us to convince chapters to develop senior activities. Cosman continues to urge all sections to have liaison with all chapters. A recent

survey tells us that most chapters do not have a senior group or committee. We are developing means to help us in this endeavor.

We discussed developing liaisons with other groups with similar interests. It was suggested that we investigate a relationship with Generations United. Are you a member of that organization? If yes, please let Jackie Burke or me know.

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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

James Reynolds, MD

Membership/Budget

Avrum Katcher, MD

History Center/Archives

David Annunziato, MD

Staff

Jackie Burke,
Sections Manager
800/434-9016, ext. 4759
jburke@aap.org

Roxanne Shannon,
Sections Coordinator
800/434-9016, ext. 7864
rshannon@aap.org

Chairman's Report Continued from Page 1

The first timers breakfast went well again in New Orleans. About 280+ attended. We again were lacking a host at every table. In an effort to remedy this, we will ask the Young Physicians section to co-host this event with us.

Jackie Noonan, MD provided us with a wonderful program with outstanding speakers. I was still somewhat disappointed in the number of people who attended. We plan to have another section, like the young physicians, co-sponsor a program with us.

Toni Eaton, MD, our new nominating committee chairman along with Jim Holroyd, MD have developed a magnificent slate of potential officers for the senior section. Please vote and thank you Toni and Jim.

We have 12 nominees for this year's senior Advocacy award. We will review and choose one at our spring meeting.

Our senior bulletin continues in its high quality with new editors Avrum Katcher and Joan Hodgman. We thank them for their hard work and efforts on our behalf. Both have requested feedback. You will be receiving a feedback letter from them. Please respond.

As usual, we have great need for your input into what you would like us to be doing. Send us your thoughts.

May you be well and enjoying whatever you do.

Cordially yours,

David Anunziato, MD
Chairman, Senior Section

TECHNOLOGY INTERSECTS AGE

Due to advances in modern infertility technology a 63 year old woman has a baby. Several friends come to see this miraculous child. The mother tells them the baby is sleeping and seats them to wait. After some little time, the guests become restless and ask to see the baby while sleeping. The mother responds, "You will have to wait until she wakes up and cries. I've forgotten where I put her."

SECTION ON SENIOR

Executive Committee Meeting Summary

Monday, November 3, 2003 10:00 am-1:30 pm
As part of the AAP National Conference and
Exhibition (NCE)
New Orleans, LA

Members Present:

David Annunziato, MD, Chairperson
Joan Hodgman, MD
Avrum Katcher, MD
Jackie Noonan, MD
James Reynolds, MD
Don Schiff, MD
Benjamin Silverman, MD
Herbert Winograd, MD

Guest Present:

John Chamberlain, MD (p/t)
Antoinette Eaton, MD (p/t)
Robert Grayson, MD
Arthur Maron, MD

Staff Present:

Jackie Burke, Sections Manager
Roxanne Shannon, Sections Coordinator
Jeff Mahony, Manager of Project
Development (p/t)

The Chairperson convened the meeting at 10:00 AM on November 3rd and welcomed the members of the Executive Committee.

A plaque was bestowed to Dr. Avrum Katcher for outstanding service to the section as executive committee member. Dr. Katcher will continue as newsletter co-editor.

The minutes from the April 12-13, 2003 meetings were reviewed and approved.

Staff reviewed the action items from the April, 2003 meeting.

The following issues were discussed in detail:

1. Emeritus Recruitment: The section will continue efforts to recruit 2,700 emeritus members who do not belong to the section.

Generations United

It was suggested that an educational program be developed that focuses on senior and young

pediatricians working together to advocate for children. Dr. Grayson suggested that the executive committee use the Generations United organization as a model for such a program.

Annual Report

Dr. Chamberlain reviewed the section annual report with the executive committee. The Executive Committee discussed the following issues with Dr. Chamberlain and requested COSMAN's assistance with:

1. Waiving NCE registration fees for local seniors
2. Helping the section convince AAP Chapters to encourage local seniors to help fulfill the Chapters goals/initiatives.

First Timer's Breakfast

Dr. Annunziato noted that 280 attended this year First Timer's Breakfast. There were roughly 18 hosts. The idea of having Young Physicians to help host the First Timers Breakfast was brought forth to the section. It was agreed that Young Physicians could work in teams with seniors to host the breakfast. Also staff will recruit any registered attendee age 55+. It was suggested that Vice President's speech be shortened to allow more time for the hosts to mingle with their guests.

Cosman continues to request that the sections have liaisons to all chapters. The section has already challenged AAP Chapters to use seniors at the local level.

Staff reviewed the budget. The section finished the fiscal year with a positive variance in the core and noncore budgets.

Senior Guide

The section would like to produce a senior guide for the Chapters.

Educational Programming '04 NCE Program

The program for the NCE was reviewed. It was suggested that the award presentation be built into the advertised schedule.

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'05 NCE Program

Possible topics for the NCE program are, child advocacy, history of pediatrics.

Child Advocacy Award

There were 12 nominations for next years award, which will be reviewed in detail at the April 2004 Executive Committee Meeting.

Elections

Dr. Eaton noted that she and Jim Holroyd, MD would serve as the nomination committee for the 2004 Section Elections. There are three positions that will be open on the Executive Committee including the chairperson and two executive committee member positions.

Senior Bulletin Newsletter

Joan Hodgman, MD, and Av Katcher, MD will continue to serve as the co-editors. The section

discussed the frequency of the Bulletin's distribution and re-confirmed their decision to have four (4) bulletins per year, if possible.

The editors would like to get feedback from the membership to see how they can improve the Bulletin for the members.

75th Anniversary of AAP

Jeff Mahony presented the AAP's plan for a "coffee-table" style, illustrated book to commemorate the 75th anniversary of the Academy. The Academy requests contributions from its members about what pediatricians have accomplished to improve the health and welfare of children over the past century. The deadline for contributions is December 31, 2003. It was suggested that many issues of the Bulletin contain useful historical material, although without graphic illustrations. It was recommended that Mahony and his staff review past issues.

Editors' Note:

The Editors welcome contributions from any reader. Please prepare your article on a standard typewriter or word processing program. Send, preferably as an e-mail attachment, to Roxanne Shannon at rshannon@aap.org or, if you do not have access to e-mail, via the Postal Service to Roxanne Shannon, c/o American Academy of Pediatrics, 141 Northwest Point Blvd, Elk Grove Village, IL, 60007-10019. Articles should emphasize material of potential value to other Seniors. Topics may include novel activities others might care to adopt, work in caring for or advocating for children, with lessons to be learned from your experience, planning for your future financially, professionally, psychologically or personally, navigating changes or negotiating balances between your work and personal life, health maintenance or improvement, or other pertinent thoughts. If you would care to comment on articles appearing in this issue of the Bulletin, send a letter to the editors, also at one of the above addresses. If you prefer, there is a Senior Listserv for more casual communications and thoughts.

The Editors

PRESIDENTIAL CANDIDATES STATEMENTS

WHAT DO YOU VIEW AS THE KEY TO ENERGIZING AND INVOLVING THE GRASSROOTS MEMBERSHIP?

Eileen M. Ouellette, MD, JD, FAAP
Newton Center, MA

We must address the issues of concern to pediatricians and children and convince our members that their becoming involved will make a difference. We must actively reach out to pediatricians at all stages of their professional and personal lives. Each group has different interests and needs.

Residents: In collaboration with training programs, we must enroll residents into the AAP. Chapter leaders can provide residents with child advocacy education. They can invite and support residents' attendance at chapter meetings, describe chapter initiatives, section membership opportunities in the surgical, medical subspecialty and special interest groups at grand rounds, and assist residents to apply for CATCH grants. We can provide bulletin boards for medical students and residents to network and exchange information.

Young Physicians: We can provide new members with written information that explains the mission of the AAP, and describes its committees, sections, chapters and programs. Leaders should contact members to match their interests and expertise with local and national opportunities. We must provide leadership training to these pediatricians, and make childcare available at meetings. AAP web sites can provide special sections devoted to the interests and needs of young physicians.

Mid-career Physicians: Pediatricians in their middle years are struggling with all the issues affecting medicine today: access, quality, reimbursement, medical liability, medication pre-approval and other regulations. We must continue to inform them regularly of AAP efforts on their behalf at the national, state and community level and convince them that their participation is vital to achieve our goals. We can teach them to contact and effectively influence their elected officials.

Seasoned Physicians: These pediatricians have

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Robert P. Schwartz, MD, FAAP
Winston Salem, NC

The first step in energizing the grassroots is to find out the concerns of our members.

How do we find out the concerns of our members?

- Provide AAP support for chapters to develop a member survey to aid in the identification and prioritization of issues. This would help chapters in formulating resolutions for the Annual Chapter Forum. The survey could also include a list of committees available for members to join.
- Encourage chapter officers to hold "town meetings" in various regions of their state to get feedback on issues from members.
- Schedule a time at the National Conference and Exhibition for members to ask questions and voice concerns to the Board of Directors.
- Create a place on the AAP members' only website to ask questions, with a mechanism for delivering a response in a timely manner.

How do we get members involved in the Academy?

- Focus on issues of importance to the membership such as fair reimbursement for physician services, contracting with managed care, malpractice, etc.
- Provide AAP support to chapters to enhance their newsletters and websites.
- Reduce chapter dues/meeting registration fee for members in their first years of practice.
- Reconfigure chapter committee activities so that the members can participate more easily by listserv rather than travel to meetings.
- Provide perks to established members for bringing new members to meetings.
- Involve residents in the AAP at an early stage of their career through the advocacy curriculum now required by the Residency Review

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Special Editors' Note:

Pediatricians who have considered volunteer work for a governmental or non-profit agency, as a pediatrician, have often found this was not practical because, if they have retired, and ceased to carry malpractice insurance, it is either unavailable or comes only at a burdensome cost.

The Senior Section Executive Committee has repeatedly discussed this issue but has been unable to contrive a solution of wide usefulness. The free journal, *Pediatric News*, for December 2003, page 40, carries a review article of the current status of this problem in several states. A few have arrangements for steeply discounted insurance at relatively minor cost. Most have done little to make this practical.

Are any of our readers aware of other solutions to this problem? If so, please send a Letter to the Editor so that we made distribute the information to others. If any of our readers would like to work on this problem, we would be glad to facilitate getting something done. Please write to:

Editors, Senior Section Bulletin
c/o Jackie Burke or Roxanne Shannon
American Academy of Pediatrics
141 Northwest Point Blvd
Elk Grove Village, IL, 60007-0927
Phone 1-800-433-9016
E-mail jburke@aap.org or rshannon@aap.org.

Errata . . .

The Editors of the Senior Bulletin regret that the following was not included with the article by Mamta Gautam, MD and Rhona MacDonald, *HELPING PHYSICIANS COPE WITH THEIR OWN CHRONIC ILLNESSES*, and we are indebted to the publishers of the originating journal for permission to reproduce this article and apologize for the omission.

West J. Med, 2001:175:336-338, Helping Physicians Cope with Their own Chronic Illnesses, Gautam, M., MacDonald, R.

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LETTERS TO THE EDITOR

To the Editors:

Readers of Karl Hess' article on Hunger and means to combat it might be interested in a recent editorial in the New York Times: *Banking for the World's Poor*. It begins: "Microcredit—tiny business loans extended to poor people in developing countries—is a proven development strategy...But the world's poor desperately need access to a broader range of financial services—microfinance is the more apt term..." The editorial goes on to praise the work of the type of agency Dr. Hess describes, and to point out that for-profit organizations are now entering this field, primarily because it has been found that default rates on microfinance loans are only a minute fraction of those on large corporate loans in many underdeveloped areas.

Constant Reader

To the Editors:

My opinion is that the AAP has neglected, and still does neglect, practicing pediatricians, the backbone of the Academy. The AAP neglects the problems of those in practice: over-regulation by government, governmental reimbursement, government paperwork—the dustup re: HIPAA is a good example, recertification submission, managed care autonomy, etc.

The AAP in its zeal to advocate for children, to appear untainted by professional concerns or lucre, has become

professionally unconcerned. So many pediatricians in my area think the AAP not only doesn't represent them and their interest, but doesn't care about them at all. They feel that the AAP is responsive only to pediatricians in academia, and Democrats in government, and that academic pediatricians completely run the Academy show. Practitioners feel that the AAP uses practitioners to boast of its numbers and to appeal to the public by citing practitioner membership, but in practice the AAP pays them no heed.

If you are arguing that the AAP's reach has progressively broadened and because of that the well being of children is no longer as focused as it was previously, that would seem to be true, but I don't see what that has to do with your final point, i.e., asking senior pediatricians what the Academy can do for you—a phraseology reminiscent of John Kennedy that suggests instead that seniors do something for the AAP.

*James Louis Reynolds, MD
Metairie, Louisiana*

To the Editors:

I would like to counter the question raised by the editors of *The Senior Bulletin* (September 2003): "What would you like the AAP and the Senior Section to do for you and what can individual pediatricians do to help the AAP and the Senior Section accomplish its goals?" I would propose the Acid Question: Would you advise

your children/grandchildren to become pediatricians?

Personally, in all honesty, I have difficulty in advising my children/grandchildren to become pediatricians. True, I enjoyed working with little citizens (and sometimes with their mothers). I frequently catch myself watching toddlers as they march into gyms with their mothers—and I have to smile to myself—each doing it in their own way. But I also count myself among those disgruntled pediatricians, who couldn't wait to leave practice. Call it impatience, stress and low income for starters. Today, add the mixed blessings of practicing in or in competition with HMOs, the poor economy and the continuing liability climate.

Do I have any suggestions to offer? I believe all medical specialties are affected to some extent by present conditions. For awhile I thought if I had a chance to do it over, I still would choose the medical profession but I would select another specialty, and at the same time I would like to pursue a parallel career, like writing. Because each provides sufficient time to do both, I would consider radiology, emergency medicine or dermatology. Dissenters may well say that the grass always looks greener on the other side of the street, and they could be right.

Finally, I realize that countries providing universal health coverage (England, Canada and Israel) have their own prob-

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PRESIDENTIAL CANDIDATES STATEMENTS Continued from Page 5

Eileen M. Ouellette, MD, JD, FAAP
Newton Center, MA

the experience and wisdom that are so vital to impart to our medical students, residents and young physicians. We can collaborate with pediatric training programs to develop pediatric preceptorship and mentoring programs. Senior pediatricians command respect from legislators and make excellent advocates.

Finally, we must collaborate with minority medical associations to identify pediatricians of diverse backgrounds and assist chapters and sections to mentor them into leadership positions. Involving all our membership will make our Academy stronger and more effective in advocating for children and pediatricians.

Robert P. Schwartz, MD, FAAP
Winston Salem, NC

Committee.

The key issue is the perception of the value of AAP membership. We should make it easier for young pediatricians, who increasingly are women, to have meaningful participation in the AAP. We must help them understand that we need their input, and even a limited amount of time can make a significant contribution. Personal contact from members in leadership positions will further stimulate efforts to increase grassroots involvement in the Academy.

LETTERS TO THE EDITOR Continued from Page 7

lems. Perhaps what is needed is a special blend of all three: universal, private practice and H.M.O.'s.

Sol Browdy, Park City, Utah

To the Editors:

In a recent issue Sol Browdy wrote about his experience when his driver's license was lifted after two severe one-car

collisions. For readers who may be having difficulty, we wish to call attention to efforts by AARP, described in several publications, on ways in which states are aiding older drivers. These are primarily risk reduction ventures, such as improved medical screening methods, alterations in licensing requirements and changes to highways at intersections,

road signs, more rumble strips, markers and so forth. AARP in all areas conducts Driver Safety Programs (full disclosure: we have taken these programs; they are classroom and didactic; they did change our driving behaviors) consisting of two sessions of four hours each.

Constant Reader

GRANDPARENTS CAN MAKE A DIFFERENCE

By Donald Schiff, MD FAAP

The American Academy of Pediatrics continues its proud history of leadership in childhood advocacy with the inauguration statement of its new president, Carden Johnston, and the introduction of the two candidates for Vice President on November 4: Eileen Ouellette and Robert P. Schwartz. These three leaders, as well as outgoing President Steve Edwards, forcefully reviewed our efforts to progress toward universal health insurance for all of our nation's children and pledged a vigorous move to achieve that goal, though our nation's sputtering economy, paired with the tragic war in Iraq, are formidable obstacles to any significant advances in reaching our goal.

As most readers of this newsletter are seniors, we are familiar with the major health issues which we face, including the very high costs of needed medications. A Act has been passed which may help many seniors pay for their medications within a confusing set of guidelines. This Act has become part of a political battle between the two major parties based upon a longstanding effort by the majority party to privatize the entire Medicare and Social Security program. The Act has become law, but effective dates are years into the future, and absent writ-

ing of regulations it is too early to know what its final form will look like.

In the background, another series of important trends in health care is intermittently reported. The total number of Americans without health insurance has risen to 43 million. Over 11 million children are uninsured at any single moment, and almost twice that number at some time during the past year. More employers are reducing their health insurance benefits for families, forcing breadwinners to pay an increasing share of their insurance premiums, *if* they can keep their coverage.

State governments facing unprecedented budget deficits are cutting Medicaid and S-CHIP programs, as well as child care and school support.

Enormous economic forces need to turn in a positive direction. Clearly this is beyond any of us as individuals. However, each of us can make a contribution in our own communities which will benefit children.

In addition to being informed as to whether our tax dollars are being spent wisely on our children, we can volunteer in schools to help out our severely stressed education systems, use our grandparenting experience in day care centers, and wherever possible, make life for children better.

I know that many readers are actively engaged in helping children on a weekly basis in many venues. I hope that you will share with us what you are doing. You can e-mail me at donroschiff@comcast.net.

Editors' Note: *Readers interested in intergenerational collaboration on public policy and local programs to improve the lives of children, youth and the elderly might wish to join Generations United, a not-for-profit voluntary organization operating many programs for this purpose.*

*Postal Address: Generations United
122 C Street, NW, Suite 820
Washington, DC 20001*

Electronic: gu@gu.org

Telephone: 202-638-1263

In addition, there is a National Mentoring Partnership which has encouraged development of many programs at state level to enable interested seniors to connect with young people in need of a mentor.

Editors' Note: *Dr. Stanley Godshall, who contributed the following article, is a family physician who trained at Hunterdon Medical Center in Flemington, NJ. Although he writes as much about adults as children, his comments are generic, and may be applied, in principle, to any ethnic group. We have heard from the AAP and other sources of the importance of ethnic awareness in health care. The literature increasingly documents the relationship between quality of achieved care and ethnic and other forms of awareness.*

CULTURAL EFFECTS UPON MEDICAL CARE AND MEDICAL PRACTICE AT SHIRATI HOSPITAL, SHIRATI, TANZANIA

By Stanley Godshall, MD

As you suggested, I am writing down some of my observations about the cultural effects upon medical care and medical practice at Shirati Hospital, Shirati, Tanzania. Susan, my spouse, and I spent five years in three unequal terms between 1978 and 1996 and have visited our friends there annually from 1998 through 2003.

1) Fatalism

This world view is so entrenched into the East African mind, especially the Luo tribe living along the eastern shores of Lake Victoria, that the people find it difficult to absorb the idea of cause-and-effect. In fact, the Swahili language has built into it language that excludes causality. For example, when a bottle of blood crashed on the floor of the surgical supply room, I went into the-room and asked (in English), "Who broke it?" My question was met with a chuckle and silence! It turns out that my question cannot be translated into Swahili. I was later told that people do not break things, but that "things just break!" "Imeharibika" is the Swahili word for "It broke (itself)." Or "it just happened by fate."

One night at 3:00 AM I was

called to the hospital in the usual way: a hospital guard brought a note written by a nurse-on-duty. The note read, "Please come. The patient in bed 2 women's ward. Her condition has changed." This usually meant that the patient was dying or was already dead. Sure enough, this was a 70 year-old woman who was twelve hours post-op. She had died of post-operative abdominal bleeding. I reviewed the vital signs written on the chart by her bed:

TIME	BP	PULSE
3:00 pm	120/80	70
3:15 pm	120/80	70
3:30 pm	120/80	70
3:45 pm	120/80	70
... etc.	"	"
12:00 pm	120/80	70
12:15 am	120/80	70
12:30 am	120/80	70
... etc.	"	"
2:30 am	120/80	70
2:45 am	120/80	70

According to the recordings of the student nurse, there had been no change in the vital signs during the entire post-op course until the moment of death. I tried to tell the nurse that this was not likely and that more careful recording may

have alerted us to the problem and perhaps we would have been able to prevent the patient's death. To this day I am sure that she saw no cause-and-effect between her negligence and the patient's death. Why? Fatalism.

I believe that fatalism and the lack of cause-and-effect thinking derives from centuries of experiences in the fields. In the North Mara Region of Tanzania one-third of the years the crops are good, one-third of the years the crops fail and one-third of the years the crops are borderline. Every year the farmers do exactly the same work and the results have no relationship to their efforts.

2) Myths

"I learned from a trusted medical assistant on one of my recent trips that when a child under the age of one year dies, everyone in the community-including the mother-knows that the child's father has been unfaithful to his wife! That explains some of the additional misery and sadness that a young mother suffers as she carries her dead baby from the pediatric ward.

There are many myths about
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We are delighted to reproduce a shortened version of an article by Robert Haggerty and Robert Chamberlin, originally appearing in The Pharos for Autumn, 2000, p11 to 16, with permission from the journal and from Dr. Haggerty. Readers are suggested to take note both of the difficulties and the accomplishments of the dedicated group Dr. Charles Janeway headed. Those who might be interested in work in developing countries would do well to read the original article, as well as the one by Dr. Godshall in this issue. In addition, attention is called to the article on The Hunger Project for Pediatricians, by Karl Hess, appearing in our September issue, this year. Hess describes a way of improving health via improving annual income through local efforts. Readers interested in pursuing work in developing countries will find Dr. Haggerty happy to make suggestions.

DR. JANEWAY AND THE CAMEROON PROJECT

By Robert J. Haggerty, MD and Robert W. Chamberlin, MD

Charles Janeway, son of Theodore Janeway MD, who was the first full-time professor of medicine in the United States at the Johns Hopkins, graduated from Yale University and the Johns Hopkins University School of Medicine. He trained in internal medicine at Hopkins and Harvard, and was recruited to the Peter Brent Brigham Hospital in Boston. His interest in infectious disease in children took him to the Children's Hospital where in 1946 he was appointed as Professor and Chief of the Pediatric service. This internist-turned-pediatrician developed one of the leading pediatric research and training programs.

In 1973, Janeway was asked by the US Agency for International Development (USAID) to organize a project in the Cameroon. From 1973-75 a Harvard team was established in Yaoundé, the capital. The program was designed to educate local professionals to maintain a permanent health care team in place after the withdrawal of the Harvard faculty in 1979. The main feature of the project was to prepare personnel to meet the health needs of a largely rural population rather than copy schools

focused on specialty medicine. Janeway was the coordinator, responsible for the recruitment of staff.

Nine health professionals were recruited who would work with Camaroonian counterparts. The team included a pediatrician, an obstetrician, a midwife and a pediatric public health nurse from Harvard, all of whom would work with local counterparts. From the beginning, the project was planned for continuity rather than a short-term task. Janeway and his colleagues felt they could develop a model that could be replicated in other developing countries.

Cameroon was, as now, an agrarian, equatorial country the size of California with a young population and very few physicians. Diseases of equatorial Africa were prevalent. Population growth and infant mortality were both high. In 1963, the World Health Organization was asked to develop a medical school. It began in 1969 with 40 medical students and 7 faculty! By 1972, there were 61 faculty, 44 of whom were Camaroonian. The central hospital in Yaoundé had a skeleton staff and students were often left with min-

imal supervision and much responsibility. In the pediatric area as many as a dozen critically ill infants, most with preventable diseases, would arrive daily. Early in the project, Harvard faculty assisted with the hospital care but were impatient to develop the preventive programs which were the goal of the project. In the hospital there was strict separation of inpatient and outpatient staff, making it almost impossible to develop an integrated service program. Janeway found it difficult to implement the plan for care of the whole community and for prevention, but 2 of his personal characteristics were persistence and patience.

By 1974, 2 Harvard physicians, in collaboration with 2 from Camaroon University hospital, began a special Maternal and Child health program. In spite of heavy pressure to service more patients, the program was restricted to 20-30 pregnant patients during each morning session, attended by 6-12 medical students. The intent was to provide students with clinical skills in preventive medicine and demonstrate the cost effectiveness of a well-run program.

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AIDS, such as, if a man becomes HIV positive he should undergo *sexual cleansing* by having sex with a virgin! Or, condoms cause AIDS!

3) Denial

Most people who die of AIDS are said to have died of chronic something else-like chronic malaria, chronic typhoid, chronic tuberculosis rather than from AIDS. The AIDS diagnosis carries with it extreme shame in Africa. Fortunately, community education is starting to change all of this. There is more openness.

One pastor who is HIV positive has been telling others about his condition.

4) Common choices of therapeutic options

Fractures were usually treated by local "bone setters." One day a 25-year-old man was brought to our hospital with a mid-femoral fracture from a Land Rover accident. By good fortune an orthopedic surgeon was scheduled to fly to our hospital the next day. Since the accident happened on a political campaign the patient had medical insurance to cover all

his expenses. I placed him in skeletal traction using ropes and sandbags. The next day the family took him out of the hospital to be treated by a bone-setter in their village. I saw many persons with crooked limbs walking around the village due to poorly treated fractures.

Mental illness was always treated by the local medicine man.

Jaundice was also treated by the local medicine man.

DR. JANEWAY AND THE CAMEROON PROJECT Continued from Page 11

Teaching primary care consisted of making ward rounds, giving lectures and working with students in a rural primary care clinic. The students being familiar with British pronunciation had difficulty at first with American English. There were no screens on which to project slides, nor curtains to shut out the light. The faculty projected slides on the wall and hoped for a cloudy day so they could be seen. Ward rounds were another challenge. A ward often contained a child with meningitis next to a child with diarrhea and malnutrition bedded down next to one with pneumonia. There were no separating curtains. The sinks were often plugged so that handwashing was impossible. Surprisingly, most patients got well in spite of the conditions. Family members did much of the bedside care. In the center of each room was a table on

which lumbar punctures and other procedures were carried out. A shortage of incubators led to the necessity of putting several infants in one. The hospital was unable to stock many medicines, and when a child was admitted the parents were given prescriptions and sent to the nearest pharmacy.

The number of surgical abortions, often performed under unsanitary conditions with disastrous results, was recognized as well as the poor condition of pregnant women who had closely spaced pregnancies. Family planning was therefore a high priority for a new clinic. In the first 9 months more than 1000 patients were served and the child-spacing clinic became one of the most appreciated parts of the project. In the Yaoundé region the average woman had 5 children by 26.6 years. This group was an espe-

cially high risk population, but with 11,000 deliveries yearly on the obstetric service, many high risk patients arrived at delivery with no prenatal care. Efforts were initiated in 1975 to organize a high risk pregnancy program.

Conflicts between overworked clinicians and administrators and a lack of interest in local faculty in serving in the less attractive rural areas plagued the project. The same reluctance to serve the underserved and isolated communities exists in most developing countries. Faculty believed "that their personal involvement would remove them from opportunities that might well determine their fate in the institution". These factors favored an urban centralized operation rather than a more relevant rural operation. The

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difficulties outlined by Janeway are common to such enterprises and should be expected. He mentioned lack of inventory control, difficulty in getting parts for American equipment, inadequate telephone facilities and difficulty in finding jobs for trained local Cameroonians. Even by the end of the project, equipment from abroad was being held up in spite of written agreements to allow duty-free import. Travel within the country was hazardous and frequently unpleasant. Other practical problems arose. Benches for people to sit on while waiting were needed but the hospital did not have the money to buy them. A hurried call to Janeway produced several thousand dollars to buy them and other needed equipment. The funds probably came from Janeway's own pocket, an act typical of him.

A rural family health clinic finally was established. There, all members of the Harvard team worked collaboratively and demonstrated simple assessment techniques. It was the only place where students could participate in an integrated multi-disciplinary program. The clinic was firmly established with local professionals by the end of the project and was well attended by patients. Those who participated were enthusiastic about the on-the-job training with the Harvard faculty. Although we know that medicine is not a spectator sport, the students had been previously taught largely by lectures. Learning clinical skills is especially

important in countries where a diploma from abroad is considered more important than developing clinical skills. The Harvard group wanted to have the clinical training of Cameroonians continued after they left. Two Harvard nurses and 2 Cameroon nurses co-authored a community oriented nursing textbook, "The Nurse and Community Health in Africa". The nurses sent several letters to Janeway asking for financial assistance and help with Harvard copyrights. Again, Janeway's persistence and patience were required to get the book published.

What lessons can be learned from this small and focused project in a developing country? Most emerging countries in the tropics with low per capita income have similar high morbidity and mortality, predominately from preventable infectious diseases, especially among children under five. Contaminated water, lack of sanitation and protein-deficient nutrition are other major contributors to high childhood death rates, as well as a lack of child spacing. Female literacy can overcome these environmental problems, perhaps because women with even a modicum of education understand household hygiene and have a greater desire to practice family planning. Some would argue that a model primary care and preventive medicine program is not what a developed country should be providing to a developing country. Rather, they should concentrate on environmental health and fertility control.

However, studies have shown that mothers are not sympathetic to family planning until they believe that most of their children will survive childhood. Governmental commitment to expensive environmental programs requires a supportive population. An integrated maternal and child health program will increase childhood survival and build community support for broader health measures. Physicians have much prestige in developing countries. If physicians are educated to the twin needs of dedicated clinical care and public health measures, they can be powerful advocates for change in their countries.

In his final report, Janeway gave tribute to the talented group of Harvard health professionals who contributed to the project. "For us it has been a very instructive and enlightening experience through which our horizons have broadened and we have made new friends." How typically generous of him to ignore the frustrations and to emphasize the positive and the contributions of others. Janeway's example continues to be a beacon to all of us who are committed to help others in the developing world to have better health and with it, a better chance for peace.

Original by Robert Haggarty and Robert Chamberlin, Jr. for The Pharos, autumn 2000

Edited for The Senior Bulletin by Joan Hodgman

EVOLUTION OF NEWBORN CARE

By Joan E. Hodgman, MD

Director Emerita, Division of Neonatology
LAC+USC Medical Center and USC Keck School of Medicine

When I was a medical student and in pediatric training, newborn infants were not given medical care. They were given nursing care. Newborns were handed to the nurse who washed them, wrapped them and put them in their bassinets where they made it or not. We did not provide IV fluids, we did not do chemistries or x-rays. Microchemistries were not available and a potassium took 5 cc's of blood. With a patient blood volume of 80-100cc's, blood chemistries were well nigh impossible. Everyone knew that x-rays were useless as the machines of the time could not stop the breathing at 60-80/min. of infants with respiratory distress. Infants weighing less than 1000 grams were considered non-viable and no effort was made to save them.

As a student at University of California San Francisco during 1943-46 I saw one newborn infant, the one I delivered on the obstetrical service. Students were not allowed in the nurseries because of the fear of infectious epidemics, particularly diarrhea. It was later learned that these were due to a particular strain of E. coli and of course there were no antibiotics yet.

On my first night on call as a straight pediatric intern at UC Hospital, I had to relieve the house officer assigned to the nursery. When I told him that I had never been in the nursery, he offered to show me around. We entered the anteroom, he waved at the adjoining two rooms and said, "That's the normal nursery and that is the premature nursery. Good luck." Then he vanished down the hall, leaving me with my heart in my mouth. As it turned out, I did not need to be so apprehensive as the experienced night nurses knew exactly what to do with the limited options available.

For my pediatric residency from 1948-50, I came home to the Los Angeles County General Hospital (now called the

LAC+University of Southern California Medical Center). The hospital had a large delivery service of 15,000 to 18,000 deliveries per year, no special care nursery for term infants, but a premature center. The hospital was ahead of its time in admitting outside born premature infants, but because of the persisting fear of infection, these were carefully quarantined. The premature nurseries contained no ventilators, no monitoring equipment, no availability of blood gases. Gordon Armstrong incubators were used for the smaller infants. In order to access the infant, the lid needed to be raised allowing the heat and oxygen to escape. Standard rectal temperatures were taken with a thermometer that registered to 94 degrees F. The routine admitting temperature was NR standing for not registered. The thinking at the time was that the level of the temperature did not matter as long as it was stable. Infants were routinely not fed immediately, and the smaller infants were kept npo for as long as 72 hours under the misplaced apprehension that they would vomit and aspirate. Some of the smaller infants actually died of starvation and dehydration. The large service was covered by a pediatric resident half time and 2 rotating interns. My major responsibility each morning as a resident was to sign out the stack of charts of half a dozen or so infants who had died during the night.

Interest in newborn care intensified starting in the middle 1950's. Infant mortality had decreased dramatically except for the neonatal period focusing attention on neonatal mortality, and important strides were made in technology leading to the introduction of more sophisticated care into the nursery. In 1968, an increase in space allotted to the nursery service allowed us to open a neonatal intensive care unit with the ability to monitor vital signs and provide assisted ventilation. Neonatal mortality continued to fall and the rest is history.

THE "SECOND" EXCHANGE TRANSFUSION

By David Annunziato, MD, FAAP

The year was 1947, and babies were still dying from Erythroblastosis Fetalis. This was the terminology given by Diamond, Batty and Blackfan to the bundled group of four diseases, which previously were called congenital hemolytic anemia of the newborn, icterus gravis, fetal hydrops or stillbirth with erythroblastoses in the tissues. These conditions affected one of about every 200 births. In 1940, Landsteiner and Wiener had described the existence of "another human blood antigen" which they termed "Rh," because the antigen was originally discovered in Rhesus monkey blood. The British called it CDE factor.

The usual treatment of this problem had been multiple transfusions with "Rh" negative blood. The mortality rate remained at about 30%, accounting for some 3% of all newborn deaths. Many survivors suffered from kernicterus and other complications. Wiener, in 1944, postulated that exsanguinations with subsequent replacement of the baby's blood (Exchange Transfusion) should be helpful. I was told that some had tried this with disastrous results. Most experts agreed that babies, already in distress, could not handle the shock or near-shock of the procedure.

Alexander Wiener, the outstanding hemopathologist who with Landsteiner first described the Rh blood group system was continuing his dedicated quest for a successful treatment of the Rh problem.



Weiner was working with the well known Benjamin Kramer of the Brooklyn Jewish Hospital. Now, in Brooklyn, at that time, there was a not so friendly competition for pediatric recognition by two groups, those at the Long Island College of Medicine, chaired by Charles Weymuller and Kramer's group.

In 1946, Harry Wallerstein published his famous article in "Science", describing the first exchange transfusion. He accomplished this by the "simultaneous withdrawal of the Rh+ blood from the sagittal sinus, and the administration of Rh negative blood through a cannulated vein." The race was on to see who would be the first to do this in Brooklyn. I recall the preparation. There were almost daily planning meetings. We experimented with known concentrations of saline or glucose solutions using double ended bell jars with rubber

diaphragms. We removed 20 cc from one end and injected 20 cc at the other. We consistently found that we accomplished an 80 percent dilution of the original solution. This was in accord with the then current and future estimates of the procedure in vivo.

Suddenly and unexpectedly, the first case in Brooklyn appeared. Jimmy White was born prematurely weighing about four and one-half pounds. His mother was a first, too. She had sickle cell disease, was in her early thirtys and was Rh negative. She had had numerous transfusions and was hailed as the oldest patient with sickle cell disease to give birth.

We were ready. Bill Doyle, our very bright chief resident at the Long Island College hospital and I did, what I was told was the second exchange transfusion.

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DOCTOR JOE

By David Annunziato, MD, FAAP

As you know, the Historical Archives Advisory Committee with the help of many, is accumulating the living histories of the giants in Pediatrics, the innovators, the researchers, the great and renowned teachers and diagnosticians. I was thinking recently about the not-so-well-known pediatricians who have had an indelible impact on our lives. I am certain that each of us can think of one or two or more. Those who, while perhaps locally outstanding, will never be remembered with a living history, but will never be forgotten by those whose lives they touched. Let me tell you about one whom I revered.

He was a short man about five feet six inches tall. He wore thick horn rimmed glasses and sported a bushy crop of black hair, cut in the crew fashion. His mustache was full and squared at the ends. He had a stocky build and always wore a black suit. His ties were unremarkable at best. He had had Smallpox as a youngster in Italy and his face was notably pockmarked. This made it difficult for him to achieve a really clean shave. There usually were small stubbles of hair in some pockmarks. In other words, he was not handsome, indeed his countenance had much to be desired. But, he was Beautiful.

I got to know Dr. Joe, as he was fondly called, as a student at Kings County Hospital (KCH) in Brooklyn where he was the Chairman of Pediatrics on the closed division. (There were

two pediatric training programs at KCH. The open division, not affiliated with the medical school, and the closed division, which was a medical school program.) His knowledge of pediatrics was truly remarkable. Frequently, after hearing a history he would discuss a differential diagnosis, but always ended by saying, "This child has"—always a correct and eventually proven diagnosis. When he arrived to make rounds, an entourage developed and followed him around the ward, listening intently. One of his dicta was: "Take a good history and you will know the diagnosis before you touch the patient in eight out of ten cases". With him, I believe it was ten of ten.

In part, I chose my internship at the private hospital where he also chaired the pediatric department in order to learn from him. Indeed many of the voluntary attendings at KCH used that hospital for their private patients. Dr. Joe made rounds there daily except Saturday. Residents from other hospitals came to make rounds with him every Sunday morning. I rarely missed those rounds even when I was on another service.

Some people called him the pied piper because when he entered the pediatric corridor, almost always with a disarming smile, the children flocked to him, not only his patients but many who had never seen him before. Invariably he scooped up one or two of them,

hugged them and he delivered many kisses. Remember, he was not a very attractive man but his love for children was immediately visible.

The following story serves to demonstrate his wisdom, pediatric knowledge and diagnostic ability.

One morning he called me at 7:00 a.m. and said he was sending in an eight-month old with fever for two days and who had vomited twice. She had no diarrhea. At about nine a.m. he appeared at the ward and said, "Well, what does the child have"? The residents and I had found nothing. The lab work was not back yet. Her X-ray's were normal. When I said we had found nothing, he glanced at the chief resident, walked to the nurses' desk, and wrote on a piece of paper. Then, putting it into his pocket, he proceeded to examine the child, then asked "what did you find on rectal"? We had not done a rectal. He donned a glove, did a quick rectal and, by-passing the residents, said to me "now you do a rectal". I did and to my surprise found a walnut sized mass on the right side. When he left that morning, he removed the paper from his pocket and tossed it on the nurses' desk. After he entered the elevator we all ran to look at the paper. It read "Appendiceal Abscess". Later that day I asked the mother if he had done a rectal exam at home. She replied, "I just spoke to him on the phone this morning and he

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told me to go directly to the hospital. He did not see her till she was here". There were some unhappy, embarrassed faces on the ward that day.

After he completed rounds the next day, I approached him and asked, "How did you know that baby had an abscess?" He smiled and said, "I've been waiting for someone to ask". He proceeded to explain that he asked the mother if the child cried on voiding and she said yes. He then noted that in an infant, the appendix is a pelvic structure which lies close to the bladder. When the appendix is infected, the child cries on voiding because the contraction of the bladder pulls on the painful appendix, especially if it has ruptured. He added that we should remember that in infants the thin walled appendix ruptures quickly. When I suggested that cystitis would be a more likely diagnosis from the history, he smiled and said, "except that the mother said that the baby cried more when held over her right shoulder than when held over her left shoulder". This lesson has held me in good stead over the years. I have made the diagnosis four times since then by history alone.

As an example of his kindness, sensitivity, understanding and gentility, I suggest the following: I was an intern on Pediatrics for only two weeks when one night we admitted a four-month old with obvious pneumonia which we verified by X-Ray done shortly after admission. Being quite ill, I stayed with the baby most of

the night. The baby died early the next morning in spite of our therapy. At autopsy we found a staphylococcal pyopneumothorax. At rounds the next morning we discussed the case at length. When Dr. Joe was leaving he asked me to walk with him to the elevator. While my stethoscope visibly hung from my neck, he asked "Do you have a stethoscope"? As I looked down and felt for my stethoscope, he softly said, "Use it more often" and he departed.

As the New Year approached, I had not been home for several days. My one year old was ill with vomiting and diarrhea. Upon speaking to my wife at about eleven one night, I became worried about his hydration. I called Dr. Joe, told him the story and asked if I could be allowed to go off a couple of hours to evaluate my son. I had no car and would have had to take the Long Island railroad since I lived a distance from the hospital in another county. He softly said, "no, you stay there, I will go and see your child". At about one a.m., he called me from my apartment and told me not to worry, that my son would be fine. He improved and became well very shortly after that visit.

I could go on and tell another hundred stories about this wonderful man. Permit me just one more. Dr. Joe had no children but his love for children was obvious. Suddenly at about age fifty, we learned that he had re-married. No one knew how his first marriage ended. Over the next four years, he fathered

four children including a set of twins. Wanting to spend more time with his family he left Brooklyn and started a new smaller practice on Long Island. Though still a distance away, we again brought our children to him for care. While I was a resident, he resigned his position as chairman at KCH five times. His resignation was refused each time and he continued.

One morning in 1960 he called me on the phone and asked if I would sponsor him for membership in the American Academy of Pediatrics. Flattered, I agreed.

Dr. Joe was a very private man. He died suddenly at age sixty or so of acute fulminating hepatitis. We went to his wake and for the first time met his wife. When we introduced ourselves, she said he had often talked about me. In my heart I knew that he had adopted me soon after I began my internship. I had many wonderful and bright teachers over the years but no one approaches the respect and love I had for Dr. Joe. He was truly a giant of Pediatrics.

Joseph Battaglia was born in Italy in 1901. All of his schooling was in the United States. He received his medical degree from the Long Island College of Medicine in 1924 and was certified by the American Board of Pediatrics in 1937.

Who was your hero?

FIRST SURGERY FOR TETROLOGY OF FALLOT

By Avrum Katcher, MD, FAAP

In 1944, when I was a first year medical student at Hopkins, one day there was an air of great excitement about the place. Members of my class tipped me off to get over to Hurd Hall, the hospital auditorium. Dr. Alfred Blalock, Professor and Chairman of the Department of Surgery, was to present his first three patients who had had subclavian-pulmonary anastomoses for Tetralogy of Fallot. One at a time, each patient was described to the packed room. All three, in order, were asked to enter the room, all pink. After the presentations, Dr. Helen Taussig, the pediatric cardiologist, and Dr. Arnold Rice Rich, Professor and Chairman of Pathology, were asked to comment.

Originally, Rich had been interested to learn why the pulmonary artery did not show the same degree of arteriosclerosis as did the aorta, particularly in hypertensive patients. He wondered what would happen if the pulmonary artery were subjected to the same blood pressures as the aorta. Blalock was experienced in vascular surgery; Rich asked him if he could create a suitable anastomosis. Working with his remarkable assistant, Vivian, Blalock anastomosed the subclavian to the pulmonary artery successfully in the dog.

When Taussig heard about this, she discussed the idea of human surgery to improve oxygenation in patients with Tetralogy of Fallot with Blalock and Rich. Blalock agreed to try it in the human. No IRB in existence in 1943-1944. And away they went. At the presentation of those first three patients, when Rich was asked to speak, he said, "I feel like Adam being asked to comment on the creation." Never forgot that moment.

THE "SECOND" EXCHANGE TRANSFUSION Continued from Page 15

sion ever done in this country. Following Wallerstein's technique, I extracted 20 C.c. of blood from the superior sagittal sinus vein, and he injected 20 C.c. of compatible, fresh, Type 0 Rh-negative blood via a cutdown in the sap

Incidentally, drawing blood from the sagittal sinus was an easy procedure, since we henous vein at the ankle. We then did this 20 times achieving what we had calculated to be an 80 percent exchange of this four-pound baby's blood. Jimmy White did well. routinely did our blood work on all new admissions using blood drawn from there. The next day a picture of Jimmy, held by a nurse and myself appeared on the

front page of the now-defunct Brooklyn Eagle newspaper.

The procedure was done in the clean treatment room in the neonatal unit. Everyone was properly, sterilely capped, gowned and gloved. We used 20 sterile syringes and needles. The blood given was warmed to body temperature and hung from an I. V. pole with three hot-water bottles surrounding the bottle. It required three hours to complete. We gave IV. calcium gluconate twice during the procedure. We did not use heparin. With all of our careful preparation there was still blood all over the place including the ceiling. After that first, we never used the sagittal sinus again but rather we cut

the radial artery at the left wrist and allowed the blood to escape into measuring cups. The problem with this procedure was that some babies later had a radial nerve palsy below the site. When Diamond in 1948 described the method of catheterizing the umbilical vein with plastic tubing and using a three-way stopcock, we followed that procedure.

Now, more than a half-century later, we can prevent almost all cases of erythroblastosis. It is gratifying to know that in my lifetime in medicine we have identified the cause, developed a treatment and a means to prevent a condition, which was commonplace and often life-threatening.

HIPPA FOR DUMMIES

By Joseph A.C. Girone, MD, FAAP

As a health care provider (formerly known as a physician) and/ or client (formerly called patient) you are affected by the HIPAA privacy regulations. This is the feds latest attempt to set a Guinness record for number of words describing a common sense situation. HIPPA stands for Health and Insurance Portability and Accountability Act of 1996. The vagueness and confusing words of the name itself is the first clue to its overstated purpose.

Good doctors and health care facilities (formerly known as hospitals) have been following many of the patient privacy rights voluntarily that are included in the HIPAA regs. Let's look at a few:

- Facilities are kept secure from intruders with locks, alarms etc.
- When a person no longer works at a facility, keys and ID badges are returned.
- "Quiet areas" are used for sensitive information exchanges whenever possible.
- Only the patient's name is called out in waiting rooms or on paging systems.
- Patient information is not left in public areas.

HIPAA requires all practices need to appoint a "Privacy

Officer". This person is trained to handle all matters that are HIPAA related for that practice. This involves time and money for the practice to initiate and sustain this position. As a patient, you may have noticed your registration at the desk takes more time and involves you acknowledging that you have received the "Privacy Practices" information. This printed information will involve more cleanup as the brochures may end up on the floor of the waiting room or the parking lot. God bless recycling. Even the "sign in" sheets should not reveal those who have previously signed in. The practice needs to purchase a shredder or obtain a shredding service to dispose of personal medical information.

Admittedly, computers, email, fax and answering machines need to be discussed with those who use them regarding patient privacy. Possibly privacy guidelines could be circulated by hospital or physician associations. Is an Act with penalties and an Office of Civil Rights necessary?

But all of this patient privacy material is the tip of the iceberg for what arrived in the Fall 2003 and what is to come. To determine what the Federal government really wants to accomplish,

look at the Act itself. Public Law 104-191 is an Act "to amend the **Internal Revenue Code** of 1986 to improve portability and continuity of health insurance coverage in the group and individual markets, **to combat waste, fraud, and abuse in health insurance and health care delivery**, to promote the use of medical savings accounts, to improve access to long-term care services and coverage, to simplify the administration of health insurance, and for other purposes."

It turns out what they really want to do is to develop standards for certain electronic health transactions, including claims, enrollment, eligibility, payment and coordination of benefits. The Hon. David L. Hobson in the House of Representatives on October 22, 1997 in a clarification statement said, "the intent of the law is that all electronic transactions for which standards are specific must be conducted according to the standards."

The Privacy section of the Act was the first to be put into effect. The next rule and standard of the Act was implemented on October 16, 2003: Modifications to Electronic Data Transaction Standards and Code Sets. This is a 62-page document

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(Federal Register, August 17, 2000) that addresses combating waste, fraud and abuse in the health care delivery system. This part of the Act standardizes the format for submissions to Medicare and Medicaid. Wrong format, no pay and can't resubmit. No penalty for incorrect private insurer submissions. This appears to be the real reason for the Act.

The next rule (49 pages, Federal Register, February 20, 2003) will go into effect April 21, 2005. This is the Security and Electronic Signature Standards. The summary states: "The use of the security standards will improve the Medicare and Medicaid programs and other Federal health programs and private health programs, and the effectiveness and efficiency of the health care industry in general by establishing a level of protection for certain electronic health information." This rule sets standards for the security of individual health information and electronic signature use by health plans, health care clearinghouses and health care providers. Enforcement is accomplished by HIPAA granting HHS the authority to impose civil monetary penalties against entities for non-compliance; in other words, fines and imprisonment.

Is HIPAA helping in any way?

Dr. David Kibbe, director of health information technology at the American Academy of Family Physicians thinks so. He feels HIPAA has raised the consciousness level among all the various stakeholders with regard to how information

technology can improve the quality of patient care, lead to greater efficiencies and give patients better service. Dr. Richard Sacks-Wilner, an internist in private practice disagrees. His view is that HIPAA fails utterly. It gives federal bureaucracy access to your medical records at will, without your permission. For enforcement, there are 34 "HIPAA police" for the entire country. The trial lawyers hit the jackpot again since they are the ones who will be the real enforcers. HIPAA is expensive. Dr. Sacks-Wilmer estimates \$40,000 for a solo practice and about \$100,000 for a seven per-

son practice. In his opinion, the only good part is that HIPAA makes the transactions between physician and the insurance companies standard.

As a health care provider and also potential or actual client, prepare for the rules that go into effect on April 21, 2005. Your tax dollars never stop giving: the US Postal Service, the IRS and now HIPAA. If you ever have a problem getting to sleep, just type in www.hhs.gov/ocr/hipaa/ on your computer browser and start to read. You will be asleep in minutes.

Editor's Note: *I wish to raise another consequence of the HIPAA rules not covered by Dr. Girone in his interesting article on the subject. The advent of HIPAA has seriously interfered with my ability to perform clinical research. I work in a large medical center with an active and busy NICU. We have over 10 years of the clinical information of all our very low birth weight infants on a computer file. This is an excellent source to answer clinical questions about the characteristics, complications and response to treatment of our most fragile patients. The patients' records are filed by name and hospital number. During the course of an investigation, they are not identified in any personal way. The patient's are selected by clinical criteria such as birth weight and gestation. The results are presented as means and ranges of the various factors studied. Since the advent of HIPAA, because the patients are filed by name, we are required to obtain parental consent to use the information in the file. This is well nigh impossible especially at a county hospital. Both our medical students and our fellows are required to complete research projects. The computer data base has been a productive resource especially for the medical students. The adherence of our IRB to the new law has seriously interfered with our ability to evaluate our NICU care and with the education of our trainees.*

Joan Hodgman MD
Co-editor Senior Bulletin

EDITORS' POSTSCRIPT:

AAP News for November, 2003, p225 and 230, reports that after the AAP and over 70 other medical associations and health care com-

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Editors' Note: *The following article by Eugene Wynsen was prepared to encourage further consideration and investigation of the usefulness of micro-organisms felt to be harmless in order to prevent or treat disease. We make no case for or against his thoughts, but present them for your interest. We encourage responses from interested readers. We also might remind you of the book Microbe Hunters by Paul de Kruif, published at least 50 or 60 years ago. This volume on distinguished researchers in the 19th century, included a chapter on Elié Metchnikoff, who enthusiastically encouraged use of the organisms mentioned, found in buttermilk and other soured dairy products, for health maintenance and treatment of disease. Readers also might check comments on Probiotics in the summary of the talk at the NCE by Dr. Fugh-Berman*

PROBIOTICS

By Eugene Wynsen, MD, FAAP

Probiotics are live micro-organisms which when administered in adequate amounts confer a health benefit on the host. (1) I have read about Probiotics, but I have little clinical experience with them. A variety of articles in lay publications, the pediatric literature and other scientific sources suggest that Probiotics are useful in many situations. Hospitalized children with rotavirus infection, for example (2) have the duration of symptoms shortened by up to 1.5 days, with decreased severity. Probiotics have also seemed useful in chronic bowel problems like irritable bowel syndrome, with suggestive benefits.

The literature contains many articles on the merits of different species of bacteria, in particular from the lactobacilli group. (3) Among these are *Lactobacillus acidophilus* GG, *Lactobacillus rhamosus*, and *Lactobacillus reuteri*. These organisms secrete substances that seem to be able to protect the bowel wall. They have been identified in other animals such as goats, rats, and of course, in humans. Breast milk seems to encourage growth of the lactobacilli, including the *Lactobacillus acidophilus*, *rhamosus*, and *bifidum* groups. As you all know from observing breast fed infants, their stools are distinctly different than formula fed infants.

I am not especially up to date on my bacteriology these days, but it is intriguing to contemplate the fact that these organisms could be used in the treatment and prevention of disease in children and adults. Children with diarrhea of various types, not limited to rotavirus, have been treated with Probiotics. Probiotics have been used in irritable bowel syndrome and also in inflammatory bowel disease. Testimonials are the worst type of clinical data to use in evaluating

any treatment, but they may be a useful clue. A relative in northern California told me of explosive diarrhea appearing at inopportune times. I suggested that my relative try both *L. reuteri* and *L. Acidophilus* GG; she found *L. reuteri* more effective. She was able to obtain it over the counter, but now it is difficult to find. I was unable to locate any at all in my area.

I wondered why it was not available. Apparently few or no physicians in this area recommend this product; and I thought that I am either the smartest of all...or the dumbest. Since these organisms are generally tolerated very well, I wonder why they are not used more often. With the great number of admissions for rotavirus, it would seem that even one day shorter hospital stay would result in significant decrease in discomfort and would be economically a great benefit. I checked with many pharmacies, and was generally greeted with "oh yes, we have it", but was given *Lactobacillus acidophilus*. Not one of them was familiar with the difference in species and varieties and the resultant different activities they possess. McNeil was producing *L. reuteri*, but discontinued it for marketing reasons, meaning that they were not making a profit since they did not sell enough. Another company, Biogaia (a Swedish company) makes a similar product, but it is not available in stores, and must be obtained through dealers, who will want to sell you all sorts of products that you likely do not want. Another company sells Culterelle, a product that contains *L. acidophilus* GG. A number of products contain *L. rhamosus*.

There is a considerable literature on organisms found in various species; they have found use in a number of areas, including infants, preemies,

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panies have signed letters requesting flexibility with noncompliant physicians and billing services, a TEMPORARY reprieve from federal standards regulating electronic communication between physicians and insurance companies has been offered. Centers for Medicare and Medicaid Services, the American Association of Health Plans, the Health Insurance Association of America, and the BlueCross BlueShield Association have all agreed temporarily to accept existing claim formats. The AMA has reported that barely a third of physicians feel they understand the new HIPAA transaction requirements; less than a quarter believe their office managers or staff understand.

We also thought you might be amused by the following true anecdote, with fictional identification, from Ben Silverman:

The Assistant Athletic Director of the University and I were watching an NCAA tournament lacross game. Near the end of the first half, a local attachman, his knee already in a brace, was checked, knocked down, writhed in pain, and had to be helped from the field by teammates and the trainer.

After the half-time break, the team returned to the field without the injured player. My companion leaned over the rail and hollered to the trainer, "Tom, how's Watson? Did he hurt his knee again?"

The trainer responded by waving his arms across his body to denote a negative response, while shouting, "HIPAA, HIPAA," The AAD turned to me and said, "Uh, oh, it's more serious; he got his hip this time." Seniors who are out of the practice loop should be aware that HIPAA is the acronym for the new pervasive medical privacy regulations; university team trainers are bound by these regulations.

adults and animals.(4) Rats grow better with *L. reuteri* and zinc. There are a number of products that contain these organisms, for example in yogurt. Ross laboratories has done some research on the safety of *L. reuteri*, and found them safe for children, infants and adults. (4,5,6,7)] Are we missing the boat, or is this just a lot of hype?

References:

1. Sanders, M.E., Probiotics: Definition, importance to microbiology and health, and optimal standards for human use. American Society for Microbiology, May 18-23, Washington DC.
2. Shornidova A.V. et. al. Bacteriotherapy with *Lactobacillus reuteri* in rotavirus gastroenteritis. *Pediatr. Infect Dis. J.* 1997 Dec: 16(2): 1103-7.
3. Biogaia References relevant to probiotic use of

Lactobacillus reuteri List revised April 2001. 115 references

4. Ruiz-Palicio G., et al, Tolerance and fecal colonization with *Lactobacillus reuteri* in children fed a beverage with a mixture of *lactobacillus* spp. 1996" *Pediatr Res.* 39(4) part 2: 18A abstract 1090
5. Vesikari T.,Karovonen A-V, (2001) Safety and feasibility study of *lactobacillus reuteri* administration to neonates. Study report
6. Wolf B.W., Et al. Safety and tolerance of *lactobacillus reuteri* in healthy adult male subjects. *Microb. Ecol. Health Dis.* 8:41-507.
7. Wolf B.W.et al. Safety and tolerance of *lactobacillus reuteri* supplementation to a population infected with the Human Immunodeficiency Virus. *Food Chem. Toxicol.* 36:1085-1094

HERBS AND DIETARY SUPPLEMENTS RISKS AND BENEFITS

A presentation by

ADRIANE FUGH-BERMAN, MD

GEORGETOWN UNIVERSITY SCHOOL OF MEDICINE

Senior Section Pharmacy Section Joint Program at AAP NCE

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This is a report based on syllabus provided by speaker and notes taken by Avrum L. Katcher, MD. Any errors are the responsibility of Dr. Katcher. Information provided should be verified by a professional with knowledge of the field.

Pediatric use of Complementary and Alternative Medications (CAM) in multiple surveys varies from 9% to 70%. Multiple disorders are so treated; examples include ADHD, depression, asthma, irritable bowel syndrome, malignant tumors. A 1998 survey found that more than half of AAP respondents in Michigan chapter would use or refer patients in selected situations for CAM therapies.

Harmless herbs for children include catnip, other mints, (but may worsen GERD) fennel, ginger or chamomile, always excepting relatively rare allergic reactions. In contrast, there are many hepatotoxic plants including Chaparral, Kava, Heliotrope, Senecio, borage and many others. Other toxic plants include coltsfoot, comphrey, Jamaican bush tea, senna (GI toxicity with bleeding). A number of herbals used for GI upsets may contain lead or mercury. Topical garlic produces rash, burns, ulcers. Many topical herbal creams were found to contain steroid (unlabelled) in up to five times higher concentrations than in creams for adults.

Echinacea is commonly used to treat URIs. Several studies find no evidence of a preventive effect; there is some suggestive evidence it may decrease symptoms and duration. However it may increase atopy and asthma. St. John's wort has been said to lighten depression, but it induces cytochrome 450, thereby interacting with many drugs by increasing their metabolism and lowering blood levels. Chamomile cream for treatment of eczema, marketed as Kamilosan, produced no difference. Aloe vera juice promotes superficial epithelialization and is widely used for topical healing of injuries that are not deep. The leaf extract contains anthroquinones and is a potent laxative. Oral probiotics, such as Lactobacillus GG or Bifidobacterium lactis Bb12, in infants, (see related article by Eugene Wynsen, MD, in this issue of the Bulletin) have been said to reduce the risk of atopy or improve atopic dermatitis.

Pediatricians will do well to become familiar with cultural diagnoses and treatments in the area where they practice. Most, but far from all, folk beliefs and practices are not harmful. It is wise carefully to ask parents what they are using, encourage them to share fully their beliefs and practices, and avoid discouraging or disparaging remarks for those local customs which are not harmful. On the other hand, those which are dangerous should be discouraged, and the difference explained.

PERSON TO PERSON

HELPFUL STORIES ABOUT CHRONIC OR HANDICAPPING CONDITIONS

By Avrum L. Katcher, MD, FAAP

Two books have come to my attention, one quite recently; the first brought the other, published some 50 years ago, to mind. This came about when the Editor of *Pediatrics* published a short quote as filler not long ago. It was so thoughtful I had to investigate further. For those of you who missed this, a part of the quote was:

“Doctors...in their willingness to visit patients’ homes, had agreed to expose themselves to the context of patients’ lives...Those doctors never indulged in false consolation, but the depth of understanding that they gained by submitting themselves to the lives of their patients—as opposed to demanding that their patients come to them, however painfully—gave them a far better chance of meeting the sick as their equals...”

The author, essayist and poet, Reynolds Price, from North Carolina, was an early success as a writer, and became a full Professor of English at Duke. He has published novels, plays, poems, translations from the Bible, and radio and television material. Price became aware in 1984 of pain and motor weakness then dis-

covered to be due to a neoplasm entwined in his upper cord. He had multiple surgeries, became paraplegic, and never recovered use of his limbs, at least up to the time of a memoir he published in 1994: *A Whole New Life*, published through Atheneum, New York.

Much of this volume concerns details of the effect of his disease on his mental and physical functioning. But features of his experiences are important for anyone who must deal with the medical establishment, or who may be forced to learn to live with some condition that will not go away, or that will get progressively worse.

Price is clear, unmistakable eloquent in his description of the many physicians with whom he interacted. He describes warmth and insensitivity, understanding and callousness, helpful and heedless behavior. It is worth reading through just in order to ask yourself the question, under other times, other situations, could I have acted like that towards my patients or their families? As an example:

“The...radiologist with whom I spoke, a man from

Texas, assured me that in my case they were ‘burning that sucker out of there.’ He beamed as if we were smoking a badger out of its den with certain success. My presiding oncologist saw me as seldom as he could manage. He plainly turned aside...He seemed to know literally no word or look of mild encouragement or comradeship.”

On the opposite side, Price relates how friends who called or wrote, with their assurances that somehow he would not die of his cancer, that he would manage to go on, gave him energy and determination, and the wherewithal to combat both his depression and his disease. And most important, he describes what he feels is crucial for anyone else who must go and grow through a grievous illness:

“You’re in your present calamity alone, as far as this life goes. If you want a way out, then dig it yourself, if there turns out to be any trace of a way. Nobody—least of all a doctor, can rescue you now, not from the deeps of your own mind, not once they’ve stitched your gaping wound.

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LUCK OR FATE? — A PERSONAL ASSESSMENT

By Sol Browdy

Luck is chance, a producer of good or bad fortune; the events, favorable or unfavorable, that it brings. Fate is the power, thought to control all events and impossible to resist; a person's predestination.

In chapter ten of my memoir *Life the Second Time Around*, entitled "Where Do I Go from Here? A Potpourri of Thoughts," I track a series of the life events important for me, for which I am most thankful. Were they instances of luck or fate is an intriguing question? Does it matter? Not really. You be the judge, while I offer my assessment. "L" stands for luck; "F" stands for fate; and "COMBO" stands for a combination.

1. My immigrant parents: mother from Odessa, the Ukraine; father from Nizhan, Russia had the gumption to pick up and leave Europe and settle in America. COMBO. Ed. Note: Also includes personal choice, free will—not just fate!
2. The Army for drafting me in 1941 after graduating pre-med at Temple University, Philadelphia and having no medical school to attend. Fate decreed stateside service as an enlisted man. COMBO.
3. My dad owned a delicatessen and confectionery store, frequented by a busy obstetrician who loved mother's home-made gefilte fish. It was he who informed me that Wake Forest College had become a four year medical school under the name of Bowman Gray School of Medicine (now Wake Forest University School of Medicine). While still in the Army I applied, was interviewed, and accepted. COMBO.
4. World War II depleted the supply of physicians and dentists. As a result the federal government set up Army Specialized Training Programs (ASTP) to train doctors and dentists. I was released "at the convenience of the government" to be trained as a medical officer. We studied through the summer, so I caught up one of the two years served as an enlisted man. On completion of the medical training I would pay back the government two years' service as a medical officer. L.
5. If I were not stationed at Camp Stoneman, California, I never would have met my future wife's brother a dentist from Chicago also in ASTP. After my military service I intended to look for a pediatric residency in Chicago. All he had to say was, "Why-don't-you stop by and visit my parents in Chicago I have twin sisters?" COMBO.
6. I courted the younger and prettier of the twins We married while I was stationed overseas in Germany and honeymooned in Berchtesgarden. Our housing was located in Nuremberg; we were assigned a maid. We had a ball, visiting many countries including Switzerland and cities like Paris. COMBO.
7. While visiting Garmisch, Germany we went for a hike up rather steep mountainous terrain. On reaching the crest, we spied a bobsled surrounded by a group of Germans. We soon learned that this was the famous Olympic bobsled run; the only way to get down was for us to sit on a sled between two of the Germans and negotiate the course! It was a memorable harrowing and foolhardy experience; I particularly remember the thrill of riding the ninety-degree turns! COMBO.
8. Naturally we could not escape having any ill fortune. Our first living male infant had a congenital inherited disease intimately known to pediatricians: cystic fibrosis. He survived four months. Because of the one in four chance of recurrence, we were advised to forego having any other children. But mainly on Elaine's insistence we bucked the odds and subsequently had two loving unaffected children! COMBO. Ed. Note: Free will again.
9. Even though I had my first heart attack at the age of 62 and a quadruple bypass at 65—to mention chronic pulmonary disease—I remain alive and reasonably active at 80. COMBO.

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“Generous people—true practical saints, some of them boring as root canals—are waiting to give you everything on Earth but your main want, which is simply *the person you used to be*.

“But you’re not that person now. Who’ll you be tomorrow? And who do you propose to be from here to the grave, which may be hours or decades down the road?”

“Have one hard cry, if the tears will come. Then stanch the grief, by whatever legal means. Next find your way to be some-

body else, the next viable you—a stripped-down whole other clear-eyed person, realistic as a sawed-off shotgun and thankful for air, not to speak of the human kindness you’ll meet if you get normal luck.”

I can not comment. I’ve not been there. Just at 78, I do not know what portends. But if and when, I hope I can do that.

Now the other book. In 1952 the Editors of Lancet published a slim volume, *Disabilities: How to Live with Them*. The epigraph, attributed to one G. R. Girdlestone, said “It isn’t

what happens to you that matters. It’s how you take it.” Inside are 47 first person singular stories, most by non-medical persons, some by physicians, about what happened to them. Loss of limbs, sight, hearing, congenital deformities, diseases of uncertain cause, the list is as long as a person’s life. All are characterized by exactly the courage shown by Reynolds Price. All should be read by any physician. Probably unobtainable except via an old or used book store. Try Alibris. But so worth while, so very worth while.

LUCK OR FATE? — A PERSONAL ASSESSMENT Continued from Page 25

10. I survived a cardiac arrest on an indoor tennis court, overcoming odds where only 4% of out-of-hospital arrests survive unscathed, which I credit for sending me into my second life. COMBO.

11. When my 10-year old pacemaker was checked, it was registering a steady decline in battery charge. A replacement would be needed within six months. A highly reputable surgeon at the University of Utah Hospital did not mince his words, recommending early surgery. When I asked whether the surgery could be postponed until my return from a week’s vacation in Hawaii, he thundered back: “In no way!” Then he proceeded to add insult to injury by telling me that though I wouldn’t feel “too bad” postoperatively, I should not expect to return to my normal activities for three weeks. That again was bad news. At surgery, when the surgeon used the cautery for the first time, it became obvious that the pacemaker no longer was

functioning. The battery, literally, had died on the operating table. But quick as a bunny, the surgeon implanted a temporary pacemaker via the femoral route and proceeded with the implanting of a dual device, which functions both as a pacemaker and defibrillator. I had dodged a bullet; the surgeon lived up to his reputation. COMBO.

12. In July 2002 two motor vehicle accidents happened to me, which could have maimed or killed me, but which should be included in this compendium of Luck or Fate. That story was published in an earlier edition of the Bulletin. They were instances of COMBO.

In summary, according to my tally, almost all of these events were instances resulting from multiple factors: luck, predestination and free will. I have a hunch that for many of us who consider ourselves lucky, the same is true, we really have our destiny and our personal qualities as well to thank!

HIDDEN EXPENSES ARE NO TREASURE WHEN SEARCHING FOR MUTUAL FUNDS

By Joel M. Blau, CFP
MEDIQUS Asset Advisors

With the most devastating bear market performance since the great depression still weighing heavily on investors' minds, many are now looking more closely at the expenses that have become part of the drag on their investment returns. Stock and bond investors are closely analyzing trading commissions and purchase markups in order to determine if they have received a fair value in return for the expenses incurred. Those who feel they have received an unfair value are turning to professionally managed mutual funds. More investors than ever before are incorporating mutual funds in their overall portfolio, and along with this increased interest comes a greater variety of funds to choose from. While there are many variables to evaluate when selecting a fund, perhaps the most misunderstood is total fund costs and their impact on fund returns.

The first expense of a mutual fund deals directly with its purchase. Load mutual funds offered through stock brokers and other financial advisors have a built-in upfront or contingent deferred sales charge that ranges from 2% to 5.75%. Discounts are available for larger purchases, typically

beginning at the \$50,000 level. A portion of this "load" or sales charge is passed on to the broker to compensate him or her for their dealings with the client. In this case, the broker provides the research and assists the client in selecting the specific load fund that meets their objectives.

The alternative to broker assisted "load" funds would be "no-load" mutual funds. These funds, also known as "no help" funds, do not have a built-in sales charge because the investor buys the fund directly from the fund company without going through a broker. The investor does his or her own research, places the trades and monitors the investment. The fund company can provide historical information to review but generally will not provide overall financial planning advice. (Editors' Note: A number of fund companies, such as Vanguard, TIAA-CREF, T. Rowe Price, USAA and others do provide extensive services, including opportunity to speak with a representative broker, financial planning tools, and extensive records. In addition rating and evaluation services, such as Morningstar or Lipper, also provide detailed means of comparison

among funds. Each reader should consider for herself or himself whether to make use of a financial advisor, or individually investigate and compare different funds, preferably with the aid of one of the rating and evaluation services.)

With either type of mutual fund it is important to realize that you do not get something for nothing. There are internal costs with all mutual funds that are disclosed in the required prospectus. This summary of expense disclosure will break out internal fund costs that are being assessed to all shareholders. Other than sales charges, the primary expense will be management fees. This is the cost of research, salaries, and the transaction costs associated with the fund portfolio. Another category is termed "other expenses". This would include shareholder services (processing and mailing of statements and customer service personnel), legal, transfer agent, and custodian expenses.

Often times marketing expenses such as advertising and brochures will also be included in this category. When comparing expenses between load and no-load

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funds, you may begin to notice a greater no-load expense ratio. This is due to the fact that no-load funds generally have higher marketing expenses since they are sold directly to the public. That is why you may notice more print and television ads for no-load funds. These added costs are shared by all shareholders within the funds. Some funds also charge a 12b-1 fee, which is a market-

ing-related expense for no-load as well as load funds. In the case of load funds, some of the 12b-1 expense is paid to the broker as compensation for maintaining the client relationship.

As you evaluate different funds, you will realize that annual total fund expenses will range from .25% to over 2.5%, with an average of about 1%. Keep in

mind that there are many factors to investigate before you invest in a fund, such as management style and historical returns over varying time periods. Consider fund expenses as yet another factor that should not be ignored.

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

PEDIATRICIANS WHO VOLUNTEER!

Pediatricians who have considered volunteer work for a governmental or non-profit agency, as a pediatrician, have often found this was not practical because, if they have retired, and ceased to carry malpractice insurance, it is either unavailable or comes only at a burdensome cost.

- The Senior Section Executive Committee has discussed this issue several times, but has been unable to contrive a solution of wide usefulness.
- The free journal, *Pediatric News*, for December, 2003, page 40, carries a review article of the current status of this problem in several states.
- A few of them have arrangements for steeply discounted insurance at relatively minor cost.
- Most have done little to make this practical.

Are there any of our readers who are aware of other solutions to this problem?

If so, please send a Letter to the Editor so that we made distribute the information to others.

If any of our readers would like to work on this problem, we would be glad to facilitate getting something done.

PHYSICIAN WELLNESS

ARE YOU INTERESTED IN:

- Your own *emotional, psychological, physical and spiritual well-being*?
- The balance between *personal and professional needs and responsibilities*?
- *Sustaining the meaning* in practicing pediatrics?
- Exploring *core values and beliefs* that underlie our roles as healers?
- Enhancing your *sense of control* over your work environment and life choices?
- Brining *more well-being* into your practice?

If so, we suggest you join the
Special Interest Group (SIG) on Physician Wellness!

The SIG is open to all AAP members. There are no dues and no required attendance at meetings. Your interest, input and support are welcome to whatever extent you are able to provide them. We welcome your participation. We will soon be releasing an extensive report of an AAP survey of members on this topic.

If you would like to join, fill out this form and send to

Bob Sebring, c/o AAP
141 Northwest Point Blvd.
Elk Grove Village, IL 60007
or via e-mail bsebring@aap.org,
or via fax, 847/434-4996:

— — — PLEASE PRINT — — —

Name: _____

Address: _____

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THE NEW ENGLISH LANGUAGE OBTAINED FROM THE INTERNET

By Sol Browdy, MD

The European Commission has just announced an agreement whereby English will be the official language of the European Union rather than German, which is the other possibility. As part of the negotiations, Her Majesty's Government conceded that English spelling had some room for improvement and has accepted a five-year phase-in plan that would become known as "Euro English". In the first year, "s" will replace the soft "c". Certainly, this will make the sivil servants jump with joy. The hard "c" will be dropped in favour of the "k". This should klear up konfusion, and keyboards kan have one less letter. There will be growing publik enthusiasm in the sekond year when the troublesome "ph" will be replaced with the "f". This will make words like fotograf 20% shorter. In the 3rd year, publik akseptanse of the new spelling kan be ekspekted to reach the stage where more komplikated changes are possible. Governments will enkourage the removal of double letters which have always ben a deterrent to akurate speling. Also, al wil agre that the horibl mes of the silent "e" in the languag is disgrasful and it should go away. By the 4th yer peopl wil be reseptiv to steps such as replasing "th" with "z" and "w" with "v". During ze fifz yer, ze unesesary "o" kan be dropd from vords kontaining "ou". After zis fifz yer, ve vil have a reil sensibl riten styl. Zer vil be no mor trubl or difikultis and evrivun vil find it ezi tu understand ech oza. Ze drem of a united urop vil finali kum tru. If zis mad yu smil, pleas pas on to oza pepl. Zen ve vil rul ze world!!

Editors' Note: *Perhaps the author of this suggestion, and Dr. Browdy, may recall the efforts of playwright and essayist George Bernard Shaw to bring about the adoption of phonetic spelling in Great Britain in the early 1900s. He failed completely.*