

SENIOR BULLETIN

AAP Section for Senior Members

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Volume 18 No. 1 – Winter 2009

American Academy of Pediatrics



DEDICATED TO THE HEALTH OF ALL CHILDREN™

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Variations, taking into account individual circumstances, may be appropriate.

Message from the Chairperson

Lucy S. Crain, MD, MPH, FAAP
Chairperson, Section for Senior Members

Welcome to a new year, a new federal administration, and a glimmer of hope that maybe, -just maybe- things will be better for children and families, and even for grandparents in days to come. Of course, I'm writing this in between letters to my state legislators, protesting the imminent announcement of a threatened 6 month stop on enrollment of California's Healthy Families/SCHIP program due to our State's dire budget crisis. California is certainly not alone in singing woeful songs of fiscal gloom and doom. Yet, we have an indomitable sense of survival and knowledge that we've been there before as a nation and as individuals, and it will someday, somehow be all right again.

For those who remember the (other) Great Depression and for the rest of us whose parents and grandparents recalled it with great clarity, we realize that today's world is a very different place from that of 1929. The modern antibiotic era had not yet begun, lifespans were shorter, preventive vaccinations for smallpox and immunizations were just emerging. Children died of diphtheria, whooping cough, measles and scarlet fever, and were left deaf and blind by rubella. Polio epidemics were commonplace. Eleven years before the Great Depression, a pandemic of influenza swept across the globe, ravaging our children, youth, and elders with ferocity, and rendering the medical resources of that time helpless in its wake. In 1918, when he was 12 years old, my father's 18 year old brother died of influenza. My grandmother

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Message from the Chairperson Continued from Page 1

recalled the country doctor's lament, "I just can't do anything for him." My father was thus motivated to become a physician, committed to medicine and, especially to preventive immunizations, even providing free influenza vaccinations to his community each year. (If you haven't already done so, read the extraordinary book, *The Great Influenza*, written in 2005 by John Barry.)

Good diets, improved hygiene, and preventive immunizations (not just for children!) have become taken for granted in the ensuing 90 years. We now are besieged with nay-sayers doubting the benefits of childhood immunizations, perhaps never having experienced the risks of diphtheria, polio, measles, Hemophilus influenza B and pneumococcal meningitis, and other diseases so commonplace less than a century ago. Allegations of causal links with autism persist, despite convincing evidence to the contrary. We again worry about inadequate immunization rates among young children in various parts of the United States, in this era of globalization and ease of international travel and heightened risk of exposure to non-immunized contacts. Nonetheless, phenomenal research in molecular genetics and other areas is making inroads into potentially defining the causes of autism. When we acknowledge our chronologic advantage as senior pediatricians, we can only hope that this progress will not be side railed by economic or political factors, as we've seen that happen in the past. We are again reminded to remember the lessons of history.

Speaking of chronologic advantage, we do have a wealth of experience and knowledge among the approximately 700 members of this Section for Senior Members. I'm pleased to report that our Membership's outreach to invite new members has already attracted nearly 100 new members to this section in the past two months! I invite you to share your insights, and your experiences by submitting one page (or so) articles to our Section editor, Dr. Arthur Maron, for consideration of publication in the *Senior Bulletin*. I strongly encourage you to check our SFSM website, courtesy of our webmaster, Dr. Jerold Aronson and our AAP staff. Especially, I invite you to read through the Section's Strategic Plan proposal. We need your feedback on the plan before our section votes on its approval in early April. What have we missed? What's good about it? How would you like to become more involved with the Section and with the AAP? And how are you currently involved with child health and advocacy, and with life in general?

We've been having a healthy discussion with the Section on Practice Management about the differences in "Practice" and "Career" Management. I suspect the latter implies more attention to the lifespan of pediatricians. There are many transitions and adjustments to be had across our lifespans, and the AAP - especially this Section- has much information and many potential resources for anticipatory guidance across those transitions.

I wish a happy, healthy new year to all of you and I look forward to hearing from you.

Lucy S. Crain, MD

Section for Senior Members
2008 Child Advocacy Award

CHILD ADVOCACY – WE ALL DO IT

by Tom Metcalf, MD, FAAP

November, 2008

Many members of the AAP Senior Section were able to attend the afternoon of topics at the Boston meeting in October. The Section was most gracious in awarding me Child Advocate of the Year. Wow! An absolute honor for me. And a huge thank-you to Avrum Katcher and Estelle, Lucy Crain, and the AAP staff for making it all happen, and for being such wonderful hosts. I was able to meet with a number of top notch pediatricians, and spoke with the group about the advocacy I've engaged in during my career. I regarded it as a recruiting opportunity, to activate or re-activate pediatricians who might now have some time for community or other involvement on behalf of children. Arthur Maron, Editor of the Section Newsletter, asked that I write an article about what I said to the group that Monday afternoon. And so:

First, I am singing (writing) to the choir. For essentially all pediatricians are child advocates. I define child advocacy to be when we step out of our comfort zone and educate someone about what's good for kids. It may be when you educate parents in your office about immunizations, when some think the good effects of shots are not worth possible side effects. It may be educating the local PTA, or it may be when you speak with legislators in your State House, or a Congressman or woman in Washington. You're doing what needs to be done, or said, to make the world better for children, sometimes against opposition. But remember, when you advocate for kids you wear a "white hat". You typically do not receive benefit, monetary or otherwise, for your efforts, and your audience knows this, which separates you from "the suits" of pharmacy or insurance or business, and gives you credence. Never underestimate the value of this position.

There is no good time to start or increase your involvement in advocacy. The time is now. As Galen said, "If not you who, if not now, when?" I began as a service personality, probably genetically based – I take no credit. I am also a "fix-it" person, which often makes my wife Karen crazy, bless her heart. If the faucet in the hotel bathroom is loose, I start looking for a screwdriver to tighten it instead of calling maintenance.

I started child advocacy as I left residency, largely because of three pediatricians, two of whom were able to be at the Boston Senior Section meeting. Our Rochester Department Chair, Bob Haggerty, told us residents in so many words, "Your responsibility as a

pediatrician does not end at your office door. You have the training to influence the care of children in your community, in your state, nation, and internationally. Do it." Evan Charney, our continuity team mentor, and Bob Hoekelman, the ambulatory director, gave us the confidence that with a good data base and conviction, we could carry our messages verbally or in print to whomever we might, to pursue our dreams for kids – invaluable input.

The other seminal event was watching the news one evening, as Walter Cronkite showed probably the first televised sled test of a car seat and dummy. The seat was a Petersen, tubular steel with black plastic padding, identical to the one in which our first-born, Ian, was then riding. On impact, the seat buckled, jack-knifing over the dummy, which itself broke loose, vaulted forward and smashed into the back of the front seat. It struck me as ludicrous that such a seat was still on the market! The next day Karen and I bought a GM bucket Love Seat for Ian. I didn't get involved in advocacy at that time, but luckily someone else did, and seats improved.

During two years in the Navy I wrote articles for the base newspaper and worked on safety, and injury and child abuse prevention. Arriving in Utah in 1975 I became involved in the drive to pass car seat legislation, with the health department, the highway safety office, the PTA, and with ample help from Dr. Bob Sanders in Tennessee and Dr. Martha Bushore. It took us almost nine years (!) to pass a wimpy law, the 49th state to do so. Its chief effect was education, to make the public aware that a safer way to transport kids was available, and that they should use it. We had our first save within two weeks of the law's passage!

We've worked on many other safety issues in conservative Utah, via education, regulation, or legislation. We still need a primary safety belt law, and a cell phone law. Injuries are still the leading cause of death and disability from zero to 14 years of age, and motor vehicles the leading cause of death to age 38! But the number of pediatricians who are now involved in child advocacy is amazing. Where it was once one pediatrician with the safety groups, there are now more than 50 pediatricians working in Utah, and residents have a requirement to work in advocacy during their three-year curriculum.

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In 1985 a child from one of our polygamous communities presented to me with the extreme pallor and listlessness of megaloblastic anemia from drinking raw goat's milk without added folate. Just a pinch of folic acid cured the child, and I began to gain the trust of the community. Twenty-three years and one Catch Grant later, I and other pediatricians are still working to get the majority of these parents to immunize their kids; they all do use car seats and boosters and seat belts.

Finally, Janet Brooks, the Child Advocacy Manager at Primary Childrens Medical Center in Salt Lake and I are traveling Utah to present a roadshow on child injury prevention, to get physicians to build into their daily practice TIPP and other education for parents to protect their children from the leading cause of death and disability.

My first love, after my wife Karen, is still the fun of seeing kids in my office, and teaching kids, parents, residents, and medical students. But even in the office our greatest effect is in prevention. It's like janitor work – if you do it correctly, no one notices – screw it

up and everyone does. So advocacy follows naturally, with 3 P's:

PASSION – You must believe in that for which you advocate, and it must be evident in your manner.

PERSISTENCE – As in working with disabled kids, you must be energized by small victories.

PATIENCE – Most issues have been there for many years – you will change them only slowly – but they can be changed. A patient spouse is also invaluable.

FINALLY - Don't take yourself or your work too seriously. Realize you're usually a small cog on a big wheel, and that you can only do so much and still maintain your humor.

So . . . if you're not now advocating, ask yourself what really gets in your craw, what needs to be fixed. Find a group of like-minded folks, and Advocate! And keep smiling!

Dr. Metcalf may be reached at thojammet@q.com.

2009 Senior Bulletin Schedule

Articles for consideration should be sent to the Editor at artmaron@aol.com with copies to the Academy headquarters tcoletta@aap.org.

Spring Bulletin

March 17 articles due to Arthur Maron, MD, MPA, FAAP

April 20 mailboxes

Summer Bulletin

June 2 articles due to Arthur Maron, MD, MPA, FAAP

July 1 mailboxes

Fall Bulletin

August 25 articles due to Arthur Maron, MD, MPA, FAAP

September 26 mailboxes

Winter Bulletin

December 1 articles due to Arthur Maron, MD, MPA, FAAP

January 9, 2010 mailboxes

CRUCIAL CONSIDERATIONS FOR GRANDPARENTING: NOTES FROM THE 2008 NCE SECTION FOR SENIOR MEMBERS EDUCATION PROGRAM

The majority of our Section members do not attend either the annual AAP National Convention & Exhibition, nor our Section's Continuing Medical Education Program. The nearly 100 who did attend this year's program submitted outstanding evaluations for all presentations and speakers. For those who missed the outstanding program at the NCE in Boston, a summary of the three talks follows. You are encouraged to attend the 2009 Section Education Program in Washington, DC, and an announcement for that program is included in this issue.

CRUCIAL CONSIDERATIONS FOR GRANDPARENTS

-Foster Parenting and Grandparenting: Dr. and Mrs. Errol Alden, Office of the Executive Director, American Academy of Pediatrics

The Aldens spoke from personal experience as well as research and statistics about becoming trained to become foster parents, differences in support services among the states, and the realities and challenges of foster parenting. Dr. Alden noted that there are an estimated 670,000 children in foster care in the U.S. and that these children are twice as likely to have post traumatic stress disorders than are Vietnam veterans. A recent study reported that 50% of adults who had been foster children now have one or more mental health diagnosis and 25% have PTSD. While Mrs. Alden spoke poignantly about several of their foster children, one abandoned in a shopping mall with his meager possessions contained in a cardboard box, Dr. Alden reported that 40-60% of foster children have developmental problems and one in five have significant dental problems. Mrs. Alden related the common practice by foster children of hoarding and hiding food-under beds, in clothes closets, in pockets. She noted that survival skills had by most foster children include lying, stealing or hoarding food, and poor communication skills. Her insistence on routine and insistence on assigned household tasks and responsibilities were defined parental survival skills. She also insisted on clarity of limit setting and consistent nurturing, even to the extent of finding a family dog-for whom they were responsible and which gave the children "unconditional love"

Both of the Aldens stressed that among problems with the foster care system were multiple placements, poor reimbursement for health care, lack of access to medical records, inadequate nutrition, insufficient

Medicaid reimbursement, and complex barriers to accessing past histories. Continuity of placement and of care in general is the exception for most foster children and youth. Variable levels of oversight and tracking from one state or community to another can lead to poor health care coordination and inadequate information for new health care providers, but the positives from the presentation are that those children who have benefited from having the Aldens and other committed foster parents during their childhood and youth have had their lives forever changed for the better. They concluded with the note that President Bush has signed the 2008 Foster Connections to Success and Improving Adoptions Act, which hopefully will make dramatic improvements to the foster care and foster-adoption system and encourage more good foster parents to step forward.

Assuring Your Grandchildren's College Education: Matt Santangelo, Vice President, Trust Department, Merrill Lynch, Boston

Mr. Santangelo presented an outstanding overview of the process of wealth transferring over generations and stressed legacy planning for investing and careful exploration of options for money transfer vehicles. He stated that values define what is meant by financial legacy, ie: whether for education, health care, home purchase, starting a business, supporting a lifestyle, philanthropy or retirement, or all of the above. Noting that 70% of wealthy families lose their millions in the second generation, another 90% lose it in the 3rd generation, and only 10% retain wealth to pass on to the 4th generation, he counseled good strategic planning with reliable advisors. The bottom line for tax free annual gift exclusion is \$12,000 per recipient per year, or one million dollars in lifetime gifting to an individual. (Because of current federal tax law exceptions, the life time income tax exclusion is \$2million for 2008 and will be increased to \$3.5 million in 2009. Estate tax will have a grace period in 2010, per federal tax law changes.) This gifting is unlimited if made directly to a school, physician or health care institution for the specific purposed of education and/or healthcare of anyone. This includes foster or adopted children as well as biologic children.

The Section 529 Education Account which sets aside invested monies for a child's or grandchild's tuition,

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fees, room and board, books, supplies, and any related special needs expenses was discussed in depth. This enables earnings to grow free of federal income tax if used for education expenses. Concomitantly this means of investment reduces estate taxes, as contributions are considered completed gifts. If not used, the 529 plan investment can be rolled over to another grandchild or other relative or foster child, or to savings bonds, or the invested balance can be taken back for a 10% applied tax. The 10% tax is avoided if the grandchild for whom the 529 was intended gets a scholarship or if he/she goes to a military academy. Mr. Santangelo noted that applicable taxes vary by state. Differences were cited between the 529 accounts and the Uniform Tax to Minors Act, via which children can have access to any invested resources between 18 and 21 years of age.

Mr. Santangelo also commented on Crummey Trusts, enabling irrevocable insurance trusts, which enable limited withdrawal for education expenses during the lifetime of the insured. He also mentioned perpetual or legacy trusts, living trusts, and testamentary trusts, as well as the generation skipping tax (GST) which restricts the amount given away to a grandchild without flat or estate tax at \$2 million. In summary, there are many means via which grandparents can wisely invest without tax liability in assuring that their grandchildren have access to a college education.

(Disclaimer: The information contained in this summary should not be used in lieu of responsible financial advice, as my note taking may have overlooked important facts!)

Impact of Diet and Lifestyle on Future Generations:
Lisa Hark, PhD, RD, University of Pennsylvania

Dr. Hark gave a phenomenally animated and uplifting educational overview of diet and lifestyle and how grandparents can effectively influence both factors for themselves, their children and grandchildren. She described the "Healthy Kids: Healthy Futures" program which she developed to teach pediatricians to teach grandparents about preventing obesity, giving an in depth overview of the epidemic of obesity among children and adults in the United States. Defining overweight as having a BME between the 80% and 95% and obese as having a BME over the 95%, she noted that nearly 40,000 adolescents have been identified as having type 2 diabetes, commonly associated with obesity. She cited concerns about other co-morbidities, including hypertension, and noted that as children become more obese, they become more and more sedentary. She voiced concern that watching television is often associated with

snacking or overeating and obesity and strongly urged that school children and youth be restricted to less than two hours of television viewing. She discussed culture bias and demonstrated evidence of advertising unhealthy foods which unduly targets African American and Hispanic families. She described high fructose corn syrup as the "greatest invention since trans fats", noting that it's cheap and has lengthy shelf life and seems to be contained in almost all beverages, condiments, and other foods these days. She noted that the NHANES findings reported that as many as 85% of school age children consume at least one soda or carbonated beverage per day, and that 20% or more consume more than four sodas per day. Some teens were found to regularly drink 12 sodas per day. Citing the well known risks of demineralization of tooth enamel, increased caries, and decreased milk intake promoting inadequate calcium leading to bone mineralization, she encouraged our group to actively advocate against having such beverages available in schools or at home. Finally, she urged encouragement of grandchildren and others to consume more fruits and vegetables, to encourage outdoor activities, and to read labels on everything they plan to consume.

(Beforehand, Dr. Hark encouraged our Section Program planning committee to order healthy foods for our after program reception, and the array was perhaps the best ever!)

*Lucy S. Crain, MD, Chair,
Section Education Committee
George Cohen, MD, Co-Chair,
Section Education Committee*

**2009 NCE Section
for Senior Members Program
Controversies in Care:
What You Don't Know
May Harm Your?
OCTOBER 19, 2009 • WASHINGTON, DC**

Ethics and Aging: Practical
Considerations....Edmund Pellegrino, MD,
President's Council on Bioethics

Medical Politics: A Child Health Risk
Factor.....Woodie Kessel, MD, MPH, Assistant
Surgeon General of the United States, retired

Beyond Band-aids: How to Cure America's Sick
Health Care System....Ezekiel Emanuel, MD,
PhD, Chair Department of Bioethics, NIH

Happy New Year??

by Donald Schiff, MD, FAAP

Pediatricians, though primarily advocates for children, cannot ignore or remain unaware of the plight of families struggling against the realities of our current economic recession. Health care insurance premiums race upwards, and the trends toward most employers (59%) reducing health care coverage and increasing the portion of health care costs paid by employees continues. A recent report from the Commonwealth Fund states that almost nine million persons in the U.S. have lost their health insurance since 2000.

In 2007 41% of working age adults (72 million individuals) reported a problem paying medical bills, up from 58 million in 2005. Himmelstein reported in 2005 that of the 1.5 million families filing for bankruptcy in 2001, half cited medical illness costs as the reason.

Evidence for the depth of the recession has already appeared in the budgets of most states. The Center on Budget and Policy Priorities reports that 31 states and the District of Columbia face new mid-year budget shortfalls of 24.3 billion. The Rockefeller Institute of Government reports that states are slowing social program spending for the first time since 1983, and that a number of states are discussing cuts in Medicaid. Some have asked the federal government for additional Medicaid funds to help save their state program.

This turnabout threatens the positive movement of increasing Medicaid reimbursement rates, which have risen between 43-51% over the past 10 years for three of the most commonly used CPT codes. In spite of this improvement, these rates remain between 72 and 82% of Medicare rates.

With the appointment of Tom Daschle as the new Secretary of Health and Human Services, the Obama administration has chosen a veteran legislator and author of a new book on the crisis in the "Health Care System." This is a signal that in spite of the recommendations by some pundits that all major alterations in health care policy should be set aside and await improved economic conditions, it appears that a strong effort will be forthcoming to make many of the major changes that President-elect Obama proposed during the Presidential campaign. The replacement of John Dingell by Henry Waxman as Chair of the powerful Congressional House Committee on Energy and Commerce will give an additional boost to administration efforts to pass meaningful health care reform.

The programs which will benefit children are: (1) Expansions of Medicaid and SCHIP. Agreement by Congress and President Obama on a new SCHIP bill could quickly reduce the number of uninsured children from 8-9 million to under 5 million. The accompanying outreach would also lead to the enrollment of additional Medicaid-eligible but not enrolled children, further reducing the number of the uninsured. (2) Private insurance coverage would be extended to age 25 years in family plans. (3) A new national health plan would become available for purchase by individuals and small businesses. This plan resembles the insurance which is currently available to federal employees. (4) Pre-existing conditions would be covered. (5) Federal subsidies would be utilized to help individuals with too low an income to enable purchase of the new public insurance or any other qualified plan.

Support for the "Think Big" approach to health care reform has appeared from all directions. Ezekiel Emanuel, oncologist and ethicist, on his blog reminds us that U.S. health expenditures are now over \$2 trillion annually, and that constitutes 16% of the Gross National Product. He believes that we must overhaul the whole system. The addition of more individuals covered by insurance would, of course, be helpful, but that this should only be considered a last resort if complete change cannot be achieved. Sessions and Lee, writing in JAMA October 22, 2008, make the case that successful health care reform should be and can be best accomplished in conjunction with major tax reform.

Even the health insurance industry has floated a trial balloon suggesting that mandatory care for all would be acceptable if everyone had health insurance - ? We will see??

Please e-mail your comments, questions or concerns to me at donroschiff@comcast.net.

A COMPENDIUM OF ERUDITE INSULTS

A Member of Parliament to Disraeli: 'Sir, you will either die on the gallows or of some unspeakable disease.' 'That depends, Sir,' said Disraeli, 'whether I embrace your policies or your mistress.'

'He had delusions of adequacy.' - Walter Kerr

'He has all the virtues I dislike and none of the vices I admire.' - Winston Churchill

'I have never killed a man, but I have read many obituaries with great pleasure.' Clarence Darrow

'He has never been known to use a word that might send a reader to the dictionary.' - William Faulkner (about Ernest Hemingway).

'Thank you for sending me a copy of your book; I'll waste no time reading it.' - Moses Hadas

'I didn't attend the funeral, but I sent a nice letter saying I approved of it.' - Mark Twain

'He has no enemies, but is intensely disliked by his friends.' - Oscar Wilde

'I am enclosing two tickets to the first night of my new play; bring a friend... if you have one.' - George Bernard Shaw to Winston Churchill 'Cannot possibly attend first night, will attend second... if there is one.' - Winston Churchill, in response.

'I feel so miserable without you; it's almost like having you here.' - Stephen Bishop

'He is a self-made man and worships his creator.' - John Bright

'I've just learned about his illness. Let's hope it's nothing trivial.' - Irvin S. Cobb

'He is not only dull himself; he is the cause of dullness in others.' Samuel Johnson

'He is simply a shiver looking for a spine to run up.' - Paul Keating

'In order to avoid being called a flirt, she always yielded easily.' - Charles, Count Talleyrand

'He loves nature in spite of what it did to him.' - Forrest Tucker

'Why do you sit there looking like an envelope without any address on it?' - Mark Twain

'Her mother should have thrown her away and kept the stork.' - Mae West

'Some cause happiness wherever they go; others, whenever they go.' - Oscar Wilde

'He uses statistics as a drunken man uses lamp-posts... for support rather than illumination.' - Andrew Lang (1844-1912)

'He has Van Gogh's ear for music.' - Billy Wilder

'I've had a perfectly wonderful evening. But this wasn't it.' - Groucho Marx

The exchange between Churchill & Lady Astor: She said, 'If you were my husband I'd give you poison.' He said, 'If you were my wife, I'd drink it.'

A NEW LOOK AT THE SIGNIFICANCE OF hsCRP

The following is excerpted from a statement issued by: ELIZABETH G. NABEL, MD, DIRECTOR, NATIONAL HEART, LUNG, AND BLOOD INSTITUTE

About 450,000 Americans will die this year of coronary heart disease — the leading cause of death for both men and women. Although we have made great strides in preventing and treating heart disease, we continue to explore the complex mechanisms involved in cardiovascular disease, and we are eager to refine risk assessment tools and preventive strategies to reduce the incidence of heart attack and stroke.

New results from three studies being presented at the American Heart Association (AHA) Scientific Sessions in New Orleans and published in scientific journals provide the strongest evidence to date that a simple blood test for high-sensitivity C-reactive protein (hsCRP) is a useful marker for cardiovascular disease. Importantly, a much-anticipated study demonstrates for the first time that hsCRP levels in the blood can be used to guide treatment decisions to effectively lower the risk of heart attacks, stroke, and death. Together, these studies show great promise in helping clinicians better identify and treat individuals at risk for cardiovascular disease — potentially saving millions more lives.

For years, growing evidence has suggested that inflammation plays a strong role in developing cardiovascular disease, especially atherosclerosis, or hardening of the arteries. nsCRP is one of the most widely studied markers of inflammation in cardiovascular disease.

But, whether measuring hsCRP adds any measurable value for predicting risk for cardiovascular disease independent of traditional risk factors, such as age, blood cholesterol levels, blood pressure, diabetes, and smoking has been a topic of great debate. Further, it has been uncertain whether hsCRP levels can be used to improve treatment decisions.

Two studies supported by the National Heart, Lung, and Blood Institute (NHLBI) show that adding hsCRP levels to assess risk of a first heart attack or stroke in middle-aged or older adults improves accuracy over the traditional assessment tools by between 5 percent and 14 percent. The information proved to be especially valuable in reclassifying the risk of heart disease and stroke among individuals considered to be at intermediate risk (10 percent to 20 percent risk of having a heart attack within 10 years) by traditional methods.

Using data from the 3006 participants in NHLBI's

Framingham Heart Offspring Study, Peter W. F. Wilson, M.D., of Emory University in Atlanta and colleagues from NHLBI, Boston University, and Tufts USDA Nutrition Center in Boston found that using hsCRP levels to assess risk provided a more accurate risk assessment over traditional risk scores among people otherwise considered at intermediate risk. The researchers suggest a two-stepped approach to assessing risk - using traditional risk scores first, then adding hsCRP levels to those found to be at intermediate risk — to guide clinical decisions.

In the second study, researchers used data from 10,724 men in the Physicians Health Study-II to prospectively develop the Reynolds Risk Score for Men, which adds hsCRP levels and parental history of early heart disease to traditional risk factors to assess men's risk. The new assessment tool was significantly more accurate than traditional risk factors alone in the study population.

The third hsCRP study, an international randomized clinical trial to test the effectiveness of treating individuals with high levels of hsCRP, demonstrates that a strategy of treatment decisions based upon hsCRP levels in otherwise healthy individuals significantly improves outcomes.

The study of 17,802 apparently healthy men and women was stopped early, after about 2 years, because of the strong positive results. The researchers found that a daily dose of a commonly used statin, rosuvastatin (Crestor), reduced the risk of heart attack, stroke, and death by nearly half (44 percent) in individuals with high levels of hsCRP (2.0 mg/L or higher) but with normal or low levels of LDL (130mg/dL or lower). The treatment reduced LDL cholesterol by 50 percent and hsCRP by 37 percent. Supported by AstraZeneca, U.S.

These studies expand our understanding of the role of inflammation in detecting early signs of cardiovascular disease and identifying adults who are at risk for heart attack or stroke. These findings suggest that adding hsCRP levels to traditional risk factors could identify millions more adults for whom treatment with statins appears to lower the risk of heart attack.

Many clinicians now offer hsCRP testing to their patients, but until now the value of hsCRP levels to treatment decisions, especially in adults with desirable cholesterol levels, was unclear. As with any medical discovery, however, broadly adopting a new approach to detect or treat a condition should first be critically tested, preferably through large-scale

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event-based randomized clinical trials and proven to bear greater benefits than risks, including costs.

In the meantime, however, we must not lose sight of the essential truth of what we already know to prevent heart disease: Cholesterol still counts, and we have proven ways to lower it and lessen its impact. The value of following a heart-healthy eating plan, being physically active, maintaining a healthy weight, and not smoking cannot be overestimated. And, statins can significantly reduce the risk of heart attack in those at high risk.

Let us continue to use our current knowledge as well

as apply new discoveries based on solid evidence to take action for the betterment of individual and public health.

Resources:

— What is Coronary Artery Disease?, http://www.nhlbi.nih.gov/health/dci/Diseases/Cad/CAD_WhatIs.html.

— NHLBI Workshop Report, July 10-11, 2006: C-Reactive Protein: Basic and Clinical Research Needs, <http://www.nhlbi.nih.gov/meetings/workshops/crp/report.htm>.

THE COMPUTER SWALLOWED GRANDMA

The computer swallowed grandma.

Yes, honestly its true!

She pressed 'control' and 'enter'

And disappeared from view.

It devoured her completely,

The thought just makes me squirm.

She must have caught a virus

Or been eaten by a worm.

I've searched through the recycle bin

And files of every kind;

I've even used the Internet,

But nothing did I find.

In desperation, I asked Jeeves

My searches to refine.

The reply from him was negative,

Not a thing was found 'online.'

So, if inside your 'Inbox,'

My Grandma you should see,

Please 'Copy, 'Scan' and 'Paste' her

And send her back to me.

This is a tribute to all the Grandmas *and Grandpas* who have been fearless
and learned to use the Computer.....

They are the greatest!!!

We do not stop playing because we grow old;

We grow old because we stop playing.

NEVER Be The First To Get Old

Letter to the Editor

Dear Editor:

After 30 years of Pediatric private practice in New Jersey and then 10 years of teaching hospital clinic practice in New York, I finally retired at age 70 and my wife and I moved to Tallahassee, Florida. While living in New Jersey, we received excellent medical care at Mt. Sinai Hospital in New York and Monmouth Medical Center in New Jersey.

We chose Tallahassee for our retirement because our youngest son lives here and he and his able wife could provide assistance when needed. We are in an HMO with Medicare Advantage. Our primary care physician is excellent and the HMO has a sterling reputation. However, the various subspecialists are less controllable and this is where care is often marginal.

When I was able to travel to Mayo Clinic, Jacksonville the care was superb. However, in a Medicare Advantage Program (sometimes I believe it should be renamed Medicare Disadvantage) visits to Mayo are not covered by Medicare and on a retiree's limited and diminishing income with respect to the rising cost of living, Mayo visits are not affordable.

What prompted my concern is a recent experience with a gastroenterology group and a radiology group. I have a history of diverticulosis/diverticulitis and visited my gastroenterologist for evaluation of rather severe LLQ cramps. He sent me to the local hospital radiology group for CT scans with contrast of abdomen and pelvis. And this is where the problem arises. The instructions given me were to call a number to obtain the reports and if not available within 14 days, to call the gastroenterology office. I telephoned the number several times and finally 11 days following the procedures, the report I received was "the studies are normal" I find it difficult to accept that any radiologist would give such a limited report. My symptoms have decreased but periodic less severe cramping persists so I called the gastroenterologist's office, explained the symptoms to a clerk, and was offered an appointment the end of January, almost two months from now. I don't believe that the clerk attended a good medical school. When I protested, I was given an appointment two days from today with a nurse practitioner.

I felt that I was left hanging with a limited telephone report in this atmosphere where compassionate care is frequently replaced by computer care.

The entire point of my story is this: Seniors look for affordable housing, good recreation, cultural programs and Tallahassee, a wonderful city with friendly caring people, has all of these features. However, seniors would be well-advised to inquire as well as to the availability of consistent quality care in the community to which they are moving. Florida certainly provides this in cities such as Jacksonville (Mayo Clinic), Gainesville (Shands Hospital) and Miami (U. of Miami Medical Center). So Seniors-inquire about medical care availability before you relocate!

Sheldon G. Leibow, MD, FAAP
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Tallahassee, FL 32317
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Editor's Note: *Readers are encouraged to share, with us, their experiences with our health care delivery system. We stand on the threshold of a new administration in Washington, and there is some reason to believe it will be more responsive and amenable to innovation.*

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

The Use of Force

by William Carlos Williams (1883-1963)

They were new patients to me, all I had was the name, Olson. Please come down as soon as you can, my daughter is very sick.

When I arrived I was met by the mother, a big startled looking woman, very clean and apologetic who merely said, Is this the doctor? and let me in. In the back, she added. You must excuse us, doctor, we have her in the kitchen where it is warm. It is very damp here sometimes.

The child was fully dressed and sitting on her father's lap near the kitchen table. He tried to get up, but I motioned for him not to bother, took off my overcoat and started to look things over. I could see that they were all very nervous, eyeing me up and down distrustfully. As often, in such cases, they weren't telling me more than they had to, it was up to me to tell them; that's why they were spending three dollars on me.

The child was fairly eating me up with her cold, steady eyes, and no expression to her face whatever. She did not move and seemed, inwardly, quiet; an unusually attractive little thing, and as strong as a heifer in appearance. But her face was flushed, she was breathing rapidly, and I realized that she had a high fever. She had magnificent blonde hair, in profusion. One of those picture children often reproduced in advertising leaflets and the photogravure sections of the Sunday papers.

She's had a fever for three days, began the father and we don't know what it comes from. My wife has given her things, you know, like people do, but it don't do no good. And there's been a lot of sickness around. So we tho't you'd better look her over and tell us what is the matter.

As doctors often do I took a trial shot at it as a point of departure. Has she had a sore throat?

Both the mother and father almost turned themselves inside out in embarrassment and apology. You bad girl, said the mother, taking her and shaking her by one arm. Look what you've done. The nice man . . .

For heaven's sake, I broke in. Don't call me a nice man to her. I'm here to look at her throat on the chance that she might have diphtheria and possibly die of it. But that's nothing to her. Look here, I said to the child, we're going to look at your throat. You're old enough to understand what I'm saying. Will you open it now by yourself or shall we have to open it for you)

Not a move. Even her expression hadn't changed. Her breaths however were coming faster and faster. Then the battle began. I had to do it. I had to have a throat culture for her own protection. But first I told the parents that it was entirely up to them. I explained the danger but said that I would not insist on a throat examination so long as they would take the responsibility.

If you don't do what the doctor says you'll have to go to the hospital, the mother admonished her severely.

Oh yeah? I had to smile to myself. After all, I had already fallen in love with the savage brat, the parents were contemptible to me. In the ensuing struggle they grew more and more abject, crushed, exhausted while she surely rose to magnificent heights of insane fury of effort bred of her terror of me.

The father tried his best, and he was a big man but the fact that she was his daughter, his shame at her behavior and his dread of hurting her made him release her just at the critical times when I had almost achieved success, till I wanted to kill him. But his dread also that she might have diphtheria made him tell me to go on, go on though he himself was almost fainting, while the mother moved back and forth behind us raising and lowering her hands in an agony of apprehension.

Put her in front of you on your lap, I ordered, and hold both her wrists.

But as soon as he did the child let out a scream. Don't, you're hurting me. Let go of my hands. Let them go I tell you. Then she shrieked terrifyingly, hysterically. Stop it! Stop it! You're killing me! Do you think she can stand it, doctor! said the mother.

You get out, said the husband to his wife. Do you want her to die of diphtheria?

Come on now, hold her, I said.

Then I grasped the child's head with my left hand and tried to get the wooden tongue depressor between her teeth. She fought, with clenched teeth, desperately! But now I also had grown furious—at a child. I tried to hold myself down but I couldn't. I know how to expose a throat for inspection. And I did my best. When finally I got the wooden spatula behind the last teeth and just the point of it into the mouth cavity, she opened up for an instant but before I could see any-

Continued on Page 13

thing she came down again and gripping the wooden blade between her molars she reduced it to splinters before I could get it out again.

Aren't you ashamed, the mother yelled at her. Aren't you ashamed to act like that in front of the doctor?

Get me a smooth-handled spoon of some sort, I told the mother. We're going through with this. The child's mouth was already bleeding. Her tongue was cut and she was screaming in wild hysterical shrieks. Perhaps I should have desisted and come back in an hour or more. No doubt it would have been better. But I have seen at least two children lying dead in bed of neglect in such cases, and feeling that I must get a diagnosis now or never I went at it again. But the worst of it was that I too had got beyond reason. I could have torn the child apart in my own fury and enjoyed it. It was a pleasure to attack her. My face was burning with it.

The damned little brat must be protected against her own idiocy, one says to one's self at such times. Others must be protected against her. It is a social necessity. And all these things are true. But a blind fury, a feeling of adult shame, bred of a longing for muscular release are the operatives. One goes on to the end.

In a final unreasoning assault I overpowered the child's neck and jaws. I forced the heavy silver spoon back of her teeth and down her throat till she gagged. And there it was—both tonsils covered with membrane. She had fought valiantly to keep me from knowing her secret. She had been hiding that sore throat for three days at least and lying to her parents in order to escape just such an outcome as this.

Now truly she was furious. She had been on the defensive before but now she attacked. Tried to get off her father's lap and fly at me while tears of defeat blinded her eyes.

Commentary by Avrum L. Katcher, MD, FAAP

For many years I read this story aloud to medical students and residents at what eventually was called Robert Wood Johnson Medical School of Rutgers University. While editing a Commemorative Issue of the Journal of the Medical Society of New Jersey, I ran across the story in a book of Williams' short stories, compiled by Robert Cole, MD*, the psychiatrist who combines the practice of medicine with thoughtful consideration of patients and how medical science and human sensibility and function come together, or, in the work of some physicians, alas, do not.

Some of you know Williams, as one of the finest poets of our country: others may not. If you do not, look in your library, or in a used book store for a volume of his poems, or short stories, or his novels. He wrote copiously, but not about medicine, so that there is but limited opportunity, except through the medium of his writings, to understand his approach to clinical practice. He is often spoken of as a pediatrician, indeed in later years his son, trained in pediatrics, joined him in the office. But he one said he had delivered over 3,000 babies, and he was always ready to care for adults. He would come out at any time, day or night, to see some unfortunate soul in the home, do what he could.

Williams, a humanist, had many thoughts about the nature of his poetry, but as John Ciardi, PhD, another member of the elite in poetry in the United States commented, in two contexts, first, "Seagulls have not produced a notable theory of flight"*** and then "a passionate energy...massively poetic gift." The doctor who was a poet wrote stories about his health care, in writings which penetrated to the heart of the medical encounter, described, in the words of Sir James Spence, "The essential unit of medical practice is the occasion when, in the intimacy of the consulting room or sick room, a person who is ill, or believes himself to be ill, seeks the advice of a doctor whom he trusts. This is a consultation, and all else in the practice of medicine revises for it." Spence wrote 70 or 80 years ago, Williams worked at about that time, but Williams and I both are satisfied that the practice of medicine has, in that respect, not changed over the interval.

How did this man do this? His son, the pediatrician William Eric Williams, said that his father got by on three or four hours of sleep a night. He also had the knack of shifting gear in a moment. He kept with him a stack of 3x5 cards, and if he had five or ten minutes to spare between patients, he would jot down a case history, or a poem that had come into his mind, or thoughts that later he could expand. Then, evenings, before or after his evening hours, he would go upstairs to his little office and could write 10-12 pages before falling asleep. The younger Williams also quoted his father, "How I do long for a full expression of everything that is in me, a free outpouring of everything I feel... I have love of men and women and children and trees...but there is still a part of me that yearns for the unknown perfection-not a religious, heavenly perfection but a full blooded earthy perfection that is fragile as all life and as sweet."***

Continued on Page 14

The story, *The Use of Force* describes an encounter with two unsophisticated parents, a daughter old enough to know her own mind and Dr. Williams. He suspected almost immediately that she had diphtheria and requested permission to examine her throat and tonsils. She would have none of it. A battle ensued. As you will see, eventually he opened her mouth by force. Think over what is described. What were the choices? How might you have behaved? Have you ever been angry with a family or patient? Do not hesitate to write a letter to our Editor Arthur Maron about your viewpoint?

*The *Doctor Stories*, compiled by Robert Cole, MD,

published by New Directions Press, New York, 1984. I am grateful to New Directions for permission to reproduce the story which follows this note.

**Ciardi, John, PhD private communication.

***William Eric Williams, *Journal of the Medical Society of New Jersey*, Volume 80, Number 9, September, 1983.

This was a commemorative issue entirely about Williams. If you are able to locate a copy, it is well worth having.

The AAP Section for Senior Members would like to thank Mead Johnson Nutritionals for their support of the Child Advocacy Award.

Update your Personal Profile

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

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

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

Did You Know?

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

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

Our toll free number is 888-227-1772.



When you no Longer Need Life Insurance

by Joel M. Blau, CFP™ and Ronald J. Paprocki, JD, CFP™

MEDIQUS Asset Advisors, Inc.

“Results. One client at a time.”^(sm)

Life insurance can serve a number of purposes, the most common being the replacement of family income in the event of the insured's death. Frequently, life insurance is purchased concurrent with a life changing event such as marriage or the birth of a child. A variety of formulas is used to ensure that, at the time of a premature death, the life insurance proceeds will be sufficient to meet the surviving family's needs. These needs often include replacement of lost earnings to pay ongoing expenses, college education funding, pay off an existing mortgage, and future retirement income for the surviving spouse.

Therefore, it is not surprising that most individuals purchase life insurance early in their careers when they have not accumulated substantial assets. But as time passes and their assets grow, and those original “needs” such as education funding are handled through savings or investments, the need for life insurance may be drastically reduced. When this situation occurs, it's time to reevaluate life insurance needs.

If you determine that the life insurance you bought years ago is no longer necessary to provide for a surviving family in the event of your death, it can be canceled or gifted to your favorite charitable not-for-profit entity. The policy owner, typically the insured, can transfer ownership of the existing policy to the charity. Additional tax-deductible charitable contributions can then be made to help the charity pay any required life insurance premiums. With this unique gifting strategy, the donor benefits from both a current income tax deduction, as well as a feeling of satisfaction that they have given a much more substantial gift of death benefits at some point in the future. The charity benefits from receiving a large lump sum at the time of the donor's death. If the charity's needs are more near term, as the new owner of the policy they would have the ability to surrender

the policy and receive any cash value associated with it. The amount of the current income tax deduction is based on a number of factors and is limited to the lesser of:

1. The donor's cost basis (the total amount of past premiums paid, less any policy dividends received in cash as well as any outstanding policy loans);
OR
2. The specific policy's value, which will vary with the type of policy. For Ordinary Life, it's the cash value of the policy, plus any pre-paid premiums. For a paid up insurance policy, it's the present cost of a comparable policy purchased at the donor's current age.

For those who are not comfortable relinquishing ownership of a policy, another option would be to name the charity as the beneficiary of an existing policy. While this option does not provide the donor with a current income tax deduction, it does provide the donor with greater flexibility such as retaining the right to change the charitable beneficiary to another entity or individual, as well as having the ability to access any cash value within the policy. The tax advantages of this strategy are deferred until death, when there may be estate tax benefits based on the size of the donor's estate.

Now may be a good time to assess your financial situation in order to determine if those old life insurance policies are still needed for their original intended purpose. Regardless if it's transferring ownership of the policy, or simply changing the beneficiary to a charitable organization of your choosing, you may find you have the ability to give a gift that can have a substantial impact for many. When contemplating such a change, be sure to consult with your tax and insurance advisors to determine the most effective way of utilizing insurance policies for your charitable interests.

Mr. Blau and Mr. Paprocki welcome readers' questions. They can be reached at 800-883-8555 or at blau@mediquis.com or paprocki@mediquis.com.

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CONSUMER - ORIENTED HEALTH INFORMATION

We are providing a link whereby you can download a CDC pamphlet dealing with consumer-oriented health information. It may be of interest to you or someone you know who is not a health professional but is faced with health care decisions.

www.fda.gov/cder/medsinmyhome/index.html

Health Literacy Town Hall Meetings

Following the Surgeon General's Workshop on Improving Health Literacy, held September 7, 2006, the Department of Health and Human Services held a series of Town Hall Meetings throughout the country to learn about promising health literacy practices and to obtain input into a National Action Plan.

Summaries of the 4 Town Hall Meetings are now available on the Office of Disease Prevention and Health Promotion's Health Literacy Improvement Web site at: www.health.gov/communication/literacy/TownHall/default.htm.

You can find the link to the Health Literacy Improvement Web site, and links to other HHS resources, at AHRQ's Health Literacy and Cultural Competence Resources Links at: www.ahrq.gov/browse/hlitres.htm.

"FACE THE MUSIC"—Broadway, 1932

*Just around the corner,
there's a rainbow in the sky,
So let's have another cup of coffee,
and let's have another piece of pie.*

This is the opening lyric of a song from the musical comedy *Face the Music* which opened in 1932. It was sung by a chorus of cast members representing people who had been comfortably off and were now not so, and hoping for a return to the good old days. The immortal Irving Berlin wrote the lyric and music for this show; Moss Hart did the book. Berlin's lyric, above, which is 76 years old, would do well for today.

Avrum L. Katcher, MD, FAAP

Have an Issue?

Join the Section for Senior Members Listserv by contacting tcoletta@aap.org.

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

AND NOW, FOR SOME WORDS OF WISDOM...

Sometimes, when I look at my children, I say to myself, 'Lillian, you should have remained a virgin.'
- *Lillian Carter (mother of Jimmy Carter)*

I had a rose named after me and I was very flattered. But I was not pleased to read the description in the catalog: - 'No good in a bed, but fine against a wall.' - *Eleanor Roosevelt*

Last week, I stated this woman was the ugliest woman I had ever seen. I have since been visited by her sister, and now wish to withdraw that statement. - *Mark Twain*

The secret of a good sermon is to have a good beginning and a good ending; and to have the two as close together as possible. - *George Burns*

Santa Claus has the right idea. Visit people only once a year. - *Victor Borge*

Be careful about reading health books. You may die of a misprint. - *Mark Twain*

By all means, marry. If you get a good wife, you'll become happy; if you get a bad one, you'll become a philosopher. - *Socrates*

I was married by a judge. I should have asked for a jury. - *Groucho Marx*

My wife has a slight impediment in her speech. Every now and then she stops to breathe. - *Jimmy Durante*

I have never hated a man enough to give his diamonds back. - *Zsa Zsa Gabor*

My Irish coffee provides in a single glass all four essential food groups: alcohol, caffeine, sugar and fat.
- *Alex Levine*

My luck is so bad that if I bought a cemetery, people would stop dying. - *Rodney Dangerfield*

Money can't buy you happiness. But it does bring you a more pleasant form of misery. - *Spike Milligan*

Until I was thirteen, I thought my name was SHUT UP. - *Joe Namath*

I don't feel old. I don't feel anything until noon. Then it's time for my nap. - *Bob Hope*

I never drink water because of the disgusting things that fish do in it. - *W. C. Fields*

We could certainly slow the aging process down if it had to work its way through Congress. - *Will Rogers*

Don't worry about avoiding temptation. As you grow older, it will avoid you. - *Winston Churchill*

Maybe it's true that life begins at fifty. But everything else starts to wear out, fall out, or spread out.
- *Phyllis Diller*

By the time a man is wise enough to watch his step, he's too old to go anywhere. - *Billy Crystal*

And, the Cardiologist's Diet: - If It Tastes Good . . . Spit It Out!

STUDY OF ANCIENT AND MODERN PLAGUES FINDS COMMON FEATURES

from: The National Institute of Allergy and Infectious Disease (NIAID)

In 430 B.C., a new and deadly disease — its cause remains a mystery — swept into Athens. The walled Greek city-state was teeming with citizens, soldiers and refugees of the war then raging between Athens and Sparta. As streets filled with corpses, social order broke down. Over the next three years, the illness returned twice and Athens lost a third of its population. It lost the war too. The Plague of Athens marked the beginning of the end of the Golden Age of Greece.

The Plague of Athens is one of 10 historically notable outbreaks described in an article in “The Lancet Infectious Diseases” by authors from the National Institute of Allergy and Infectious Diseases (NIAID), part of the National Institutes of Health. The phenomenon of widespread, socially disruptive disease outbreaks has a long history prior to HIV/AIDS, severe acute respiratory syndrome (SARS), H5N1 avian influenza and other emerging diseases of the modern era, note the authors.

“There appear to be common determinants of disease emergence that transcend time, place and human progress,” says NIAID Director Anthony S. Fauci, M.D., one of the study authors. For example, international trade and troop movement during wartime played a role in both the emergence of the Plague of Athens as well as in the spread of influenza during the pandemic of 1918-19. Other factors underlying many instances of emergent diseases are poverty, lack of political will, and changes in climate, ecosystems and land use, the authors contend. “A better understanding of these determinants is essential for our preparedness for the next emerging or re-emerging disease that will inevitably confront us,” says Dr. Fauci.

“The art of predicting disease emergence is not well developed,” says David Morens, M.D., another NIAID author. “We know, however, that the mixture of determinants is becoming ever more complex, and out of this increased complexity comes increased opportunity for diseases to reach epidemic proportions quickly.”

For example, more people travel more often over greater distances and in less time now than at any time in the past. One consequence of the increased mobility in the modern age can be seen in the 2003 outbreak of the novel illness SARS, which rapidly spread from Hong Kong to Toronto and elsewhere as infected passengers traveled by air.

To better understand and predict disease emergence, Dr. Morens and his coauthors stress the need for research aimed at broadly understanding infectious diseases as well as specifically understanding how disease-causing microorganisms make the jump from animals to humans.

In a narrow sense, epidemics are caused by particular microorganisms, and the study of infectious disease has historically been microbe-focused. For example, the Black Death (bubonic plague), which killed some 34 million Europeans in the middle of the 14th century, was caused by the bacterium *Yersinia pestis*. In a broader sense, however, epidemics are caused by complex and not fully predictable interactions between the disease-causing microbe, the human host and multiple environmental factors, the authors note. The Black Death, for instance, was borne westward along newly established land and sea trade routes from its probable origin, China, into multiple European countries. Similarly, patterns of human movement along trade routes, specifically truck routes throughout Africa, played a role in the spread of HIV throughout that continent. Greater consideration must be given, say the NIAID authors, to broader, interlinked factors such as climate, urbanization, increased international travel and the rise of drug-resistant microbes, and the ways in which these factors combine to spark new epidemics.

Aside from commerce and travel, the NIAID authors point to several other factors that underlie many notable emerging diseases: poverty, the breakdown of public hygiene practices, and susceptibility of human populations to microbes against which they have no pre-existing immunity. This last factor played a key role in the smallpox epidemic that afflicted the Aztecs of 16th century Mexico. Smallpox had ravaged European communities for centuries, but until the Spanish arrived on the Yucatan coast in 1519, the disease was unknown in the New World. Historians believe that some 3.5 million people in central Mexico died in the first year of the epidemic.

Epidemics also can spur advances in public health, note the authors. They point to the yellow fever epidemics of 1793-98, which began in the then-U.S. capital, Philadelphia. Though the entire federal government and most Philadelphians fled, those who remained formed an emergency government and

Continued on Page 19

mobilized such marginalized groups as African-Americans and immigrants to fight the outbreak. In 1798, Congress established the Marine Hospital System — forerunner of the modern U.S. Public Health Service — to provide, at public expense, medical care for sick and injured merchant seamen. Historians generally agree that a prime impetus for creating the Marine Hospital System was the yellow fever epidemics.

Modern epidemiology began in reaction to another epidemic, says Dr. Morens. In the early 1830s, as cholera made its way along waterways from Asia towards Europe, French officials attempted to prepare their country in advance of an outbreak. Teams of scientists were sent to Poland and Russia to observe the outbreaks there. Throughout France, coastal health agencies and new quarantine stations were established; in Paris, a network of health inspection offices was created to coordinate inspection of wells, cesspools and latrines of both public and private buildings. Despite these efforts, cholera arrived in Paris on March 29, 1832, with explosive effect — within two weeks, there were 1,000 cases, 85 percent of them fatal. Daily newspapers published lists of cases allowing armchair epidemiologists to see trends in illness and deaths. “For the first time in history,” write the NIAID authors, “a large-scale emerging epidemic was scientifically investigated in ‘real time’ using census data in a prospective population-based approach that featured

analyses of morbidity and mortality stratified by age-group, sex, occupation, socioeconomic status and location.”

NIAID conducts and supports research — at NIH, throughout the United States, and worldwide — to study the causes of infectious and immune-mediated diseases, and to develop better means of preventing, diagnosing and treating these illnesses. News releases, fact sheets and other NIAID-related materials are available on the NIAID Web site at <http://www.niaid.nih.gov>.

The National Institutes of Health (NIH) — The Nation’s Medical Research Agency — includes 27 Institutes and Centers and is a component of the U.S. Department of Health and Human Services. It is the primary federal agency for conducting and supporting basic, clinical and translational medical research, and it investigates the causes, treatments, and cures for both common and rare diseases. For more information about NIH and its programs, visit www.nih.gov.

Reference:

DM Morens, GK Folkers and AS Fauci. Emerging infections: A perpetual challenge. “The Lancet Infectious Diseases” DOI: 10.1016/S1473-3099(08)70256-1 (2008).

**New Resources
for Culturally Effective Care in Pediatrics**

The AAP Committee on Pediatric Education (COPE) Web site features two new resources for culturally effective care. One document has educational goals and objectives for culturally effective care for residents in pediatrics.

The other features a listing of resources for medical education on culturally effective care. Both documents provide information for pediatric residency program directors and others interested in providing such care for the pediatric population.

Visit <http://www.aap.org/visit/cope.htm> to view these resources.