Message from the Chairperson

Eileen M. Ouellette, MD, JD, FAAP

This summer, I was stunned to learn from a dear friend since junior high school that she was repeatedly raped by her stepfather throughout her adolescence. I was shocked to hear that she had endured this heinous abuse silently and I was saddened to realize that it had taken her 70 years, until we were both 82 years old, to tell me about it.

I initially thought if only she had said something to me at the time my father would have tried to help her, but then I realized that from 1949 to 1954 there was realistically no help to be had. I don't believe there were effective child abuse laws then and no effective child welfare system to deal with child sexual abuse. Even if she had said something at school to a sympathetic teacher there were no laws mandating teachers to report child abuse. Her stepfather was a prominent businessman and she thought she would not have been believed.

So, she kept quiet. She married at 18 years old to escape from the house, had three children and found herself divorced at age 25 working three jobs to support her family. A friend subsequently offered her a business opportunity that she accepted and over a number of years she became a very successful businesswoman. She remarried happily and is now retired with a close and loving family.

In thinking of my friend’s life, her resilience in overcoming great suffering to lead what she reports as an eventually happy life, and how long it took her to recover and to share her experiences with me, I immediately thought of the two groups of children and adults recently in the news. These are the children of migrants who have been separated from their families by edict of our government and the children and adults in Pennsylvania who have been sexually assaulted by pedophile clergy.

As I write this column, over 500 migrant children are still separated from their parents and news reports state that they may never be reunited but will remain with foster families in the United States. This separation from families has rightly been termed child abuse by the AAP. These children are now scattered throughout the United States. They will require long term psychological help to overcome this shattering experience.

The abuse to the Pennsylvania children and adults goes back as long as 70 years, the same time frame as my friend’s abuse. Most of these survivors will also take years to become mentally healthy. Some will never recover.

The AAP has played a prominent role in improving the child abuse laws over the years and it is vital that we continue our advocacy role. Members of our Section on Senior Members (SOSM) are ideally suited to advocate at the state level for more mental health services for children in foster care and those who have suffered child physical and sexual abuse. Further, we are well placed to mentor young pediatricians to develop their advocacy skills.

Continued on Page 2
Accordingly, the SOSM is developing an advocacy initiative, in conjunction with the Section on Early Career Physicians (SOECP) and the Section on Pediatric Trainees (SOPT) to set up Senior Sections in each of the 59 Chapters of the AAP. We invite and urge our members to join us in developing this initiative.

We have spoken to the Executive Directors of the Chapters and they are enthusiastic. Our younger colleagues are similarly eager to move ahead. We have had an organizational conference call and we are planning to have a meeting of interested parties at the 2018 AAP National Conference & Exhibition (NCE) in Orlando in November. We don’t have a time or place to meet yet, but we will send out a notice and invitation in the next few weeks with further information.

I have heard from many of you that you have been active in leadership position in the AAP for many years and that you are seeking continued involvement. Others of you have not been active in the AAP but you are now retired, and you would like to volunteer in some way. This initiative is an ideal way to stay or become involved. If you will be at the NCE, please join us. If you will not be attending the NCE but are interested in participating, please contact Katie Clark at kclark@aap.org.

We are still seeking someone to serve as our Section Webmaster, as of January 1, 2019. The person will supervise our new Collaboration Site that Dr. Michael O’Halloran, Katie Clark and Susan Eizenga have so ably developed. Also, the person sits as a non-voting member of the SOSM Executive Committee. Please contact Katie Clark if you are interested. If you have questions, Michael has volunteered to discuss them with you.
Concerns held over from past issues of the Bulletin:

As of today-September 6, 2018, there are still 416 children who were separated from their parents at the US Border and remain not reunited. Many of those parents have been deported by the United States under President Trump's Zero Tolerance Policy, and their whereabouts remain unknown. It is increasingly clear that the consequences of the Zero Tolerance Policy were overwhelmingly severe, poorly thought out, and have resulted in 400+ children being kidnapped and at least temporarily orphaned. The issue remains with more than 2000 children forcibly separated from their parents at our border having sustained psychological trauma from their experiences at the hands of our Federal Government. As members of the American Academy of Pediatrics, we are indebted to AAP President Dr. Colleen Kraft who rightfully called these actions "Child Abuse" on national television. Dr. Kraft and fellow pediatricians have joined child advocates from the American Civil Liberties Union (ACLU), the clergy, and other volunteers and organizations in attempting to expedite the reunification of these children (including infants) with their parents. We appreciate Dr. Kraft's heroic efforts, as well as those of Dr. Lance Chilton and others at our borders whose articles appear in this issue.

On the persistent topic of gun violence, Dr. Raffensperger's article brings his insights. This issue is not going away.

Our co-editors and I are grateful for the varied interests, commitment, and writing by Section members and note that at least two of our published articles in this issue are from authors age 90+! Articles reflect topics ranging from Advocacy to Politics to all sorts of interesting reading in between. Enjoy! And keep them comin'.

Last, but not least: PLEASE VOTE! Information about the AAP election is included, as are reminders from Dr. Suzanne Boulter, Committee on Federal Government Affairs (COFGA) liaison. Every election is important. This November's election is crucially important! If you plan to attend the AAP National Conference & Exhibition in Orlando (11/02-11/06), be sure to attend the stellar Section Education program on 11/4/18 at 9:00 AM. And remember to apply early for your absentee ballot. Election day is November 6.

To quote Dr. Donald Schiff: “What Will it Take?” Your vote matters!
Over the past six months, I’ve traveled to the US-Mexico border with my AAP colleagues on three occasions. My first visit was in April, to see how immigrant children were being treated since the Trump administration’s zero-tolerance policy took effect. What I saw broke my heart. Children recounted the horrible violence from which they were fleeing: Youths forced to join gangs or commit criminal acts upon threat of death. Kids witnessing the beating or killing of a parent and being told they will be next. But the encounter I will never forget was with a little girl, a toddler, her face red from crying who had no mother to scoop her up to comfort her. That was because she had been forcibly separated from her mother by immigration authorities and was being cared for at a shelter for “unaccompanied” children run by the Department of Health and Human Services (HHS).

I left convinced that the AAP needed to shine a light on the family separation crisis and let the world know what was happening and to declare that families should be kept together, treated with dignity and released to community settings as they seek to start a better life.

With your help, that’s exactly what we did. Lawmakers and the media wanted to know more about what “zero tolerance” was doing to immigrant children and families, and I was invited by Oprah Winfrey to return to our southern border for an interview with Gayle King. From there, I went on to do more than 60 interviews with regional and national news outlets covering the crisis.

The media exposure created intense pressure to stop the practice of forcibly separating immigrant children from their parents, and within days, President Trump issued an executive order to end this policy. (Unfortunately, his vow to maintain the “zero tolerance” policy would continue to put more children in detention facilities, an environment that is no place for a child, even if they are with their families.)

Soon after, a U.S. district court ordered the federal government to end family separation and reunite the parents and children who had already been separated under the policy. The AAP and UNICEF USA issued a joint press release, praising the order and offering to help reunify and support the needs of these families.

The next day, I returned to the border with UNICEF USA CEO and President Caryl Stern and several AAP colleagues to see what was happening with these kids. We asked to see the Department of Homeland Security Processing Station and an HHS facility where separated children were being held, but we were denied access. Though we did not get to see the centers, colleagues with recent knowledge say they’ve seen little change to the conditions the Academy has spoken out against: sleeping on cement floors, constant light exposure, open toilets, insufficient food and water, lack of bathing facilities and cold temperatures.

We did, however, observe immigration court proceedings for unaccompanied minors at a Department of Justice Immigration Court in Harlingen. Despite a compassionate judge, who tried to keep tensions down and make sure the children understood what was happening, we could clearly see a nine-year-old girl’s tears and a fearful adolescent who could not keep his legs from shaking.

We also spoke with those who work with immigrants at the border and deal with the current immigration policies on a regular basis. They reported that the government deploys tactics to intimidate and discourage people from crossing the border legally at the bridges, the official ports of entry, to request asylum. Immigrants (even those with small children) often wait on the bridges for days, then end up crossing illegally via the Rio Grande, for which they must use a coyote allied with the cartels that control access.

To try to experience an immigrant families’ journey, Caryl and I walked the McAllen-Hidalgo-Reynosa International Bridge. We were struck by a giant cross erected on the Mexican side of the border honoring those who did not successfully make the crossing. On our way back, we encountered a distressed woman holding a weeping child on her hip. We tried to talk with her but were told by border patrol not to. We asked if we could bring her inside where it was cool and there was

Continued on Page 5
water and a restroom. The agent said yes and took her back to a room but would not allow us to go with her. I still wonder what happened to her. Were she and her daughter separated? Were they placed in detention?

Contrast that with our visit to Catholic Charities of the Rio Grande Valley’s Humanitarian Respite Center in McAllen, where parents and children were together – coloring, reading or kicking around a soccer ball – as they awaited their release to a community-based setting as the Academy recommends. Despite their trauma, I can’t help but feel these children will be okay, because they have that foundational relationship of a parent to help them be resilient and break the cycle of hardship and danger.

As further information unfolds surrounding reunification of children and parents and our federal leaders consider future immigration policy, the AAP will stay at the forefront. And we will continue to speak out to protect the health and well-being of children no matter who their parents are or where they were born.

What Would It Take to Change?

Don Schiff, MD, FAAP – Advocacy Column

I never expected that I would be using the word impeachment in any of my articles for this Newsletter. The American Academy of Pediatrics has always been and remains non-partisan in every political sense but has recognized that actions taken by our federal and state governments often have profound effects on the everyday lives of children and their families. Thus, actions and policy statements by the Academy leaders remain non-partisan and are undertaken as part of our advocacy for our Nation’s children. The question of the possibility of impeachment of the President has reached a point of everyday discussion due to his actions which are not directly related to policies toward children.

However, multiple actions by the President and his cabinet and regulators or proposed by them will have damaging effects on our patients. A brief review of the issues which deserve our continuing examination includes economic inequality, global warming, environmental regression, diminished availability and benefits of medical care, immigration policies, and violence toward children.

Acknowledging the limited effect that pediatric advocacy can have on economic inequality does not suggest that we ignore the observation that the administration’s tax bill touted to raise worker’s incomes has been in place long enough to affirm that workers’ wages have not recovered the predicted boost. Food and housing insecurities are established health factors and are based upon family income. The same failed tax bill was also the vehicle used to remove the mandate for each individual to have health insurance, a requirement under the Affordable Care Act (Obamacare). This change helps undermine the stability of the insurance program. The acceptance of the need to reduce the advance of Global warming and its uncontrollable effects on our population remain controversial for some. The enhancement of the deleterious effect with the Presidents new support of the use of coal as an energy source and the relaxation of the regulations on the required increase in auto gas mileage will move us in the wrong direction. The administrations continuing goal of total repeal of the ACA remains and if the 2018 elections go their way it will be a high priority. Meanwhile essential funding has been removed and junk insurance has been put in place to further damage the program which is now approved by a majority of Americans. The recent cruel approach utilized by the immigration services when putting into place the administrations zero tolerance policy shocked the Nation and the world. Ignorance of the immediate and permanent Psychological effects produced by the separation of children from their parents was pointed out by our AAP President Dr. Colleen Kraft and many other pediatricians. They went to the border and incarceration sites attempting to stop this inhumane policy. Hundreds of children including hundreds who are under 5 years of age remain in this an unprecedented morass. No program to alleviate this situation has been revealed thus far. DACA remains no closer to resolution and continues to produce uncertainty and heartache. Congress continues to refuse to enable these innocent and deserving individuals brought to our country by their parents as small children without documentation and are now a valuable resource remains in limbo because of a lack of leadership by the administration.

The recurring tragedy of the violence toward children particularly in public schools has come into focus again stimulated by the review being carried out by Secretary Betsy DeVos and her department of Education on guns in schools. Competing
suggestions on how to diminish the loss of life in schools has included hiring extra school resource officers or utilizing local police officers. The policy being studied by DeVos would utilize funds taken from current program designed to promote academic achievement. These funds would be used instead in grants to schools for purchasing guns and training officers as well as teachers and principals. Strong opposition to this approach is increasing from the Nations educators and administrators. I do not believe that the President will be impeached. He in fact may be reelected in 2020. The policies of cabinet appointees and regulatory changes which I have described could continue to be our future if there is no change in the White House.

*Editor's Note (L.C.):* As Dr. Schiff notes in his above article, the American Academy of Pediatrics attempts to be non-partisan and his comments reflect his personal opinion, not necessarily those of the AAP….

**Council on Community Pediatrics (COCP)**  
*Chairperson's Column from Community Pediatrics News*  
*Lance Chilton, MD, FAAP*  
*Council on Community Pediatrics Chairperson*

I have learned to live with certain uncertainties. Will I get a good night's sleep, or will I be called in to a C-section? Will my patient live easily through this bronchiolitis episode or will she worsen and need intensive care? Will this family trust me to decide what immunizations their child needs, or will I need to trot out all the arguments I've made for years about the benefits of vaccines and the perfidious nature of Andrew Wakefield and Jenny McCarthy?

And this week – the end of July in Albuquerque – I've had to adjust to another uncertainty: will the reunited immigrant families arrive tonight, and will I be needed tomorrow at Lutheran Family Services? Alongside other pediatric, family medicine and psychiatry faculty members here at the University of New Mexico, I have volunteered to help with newly reunited immigrant families being “processed” here in Albuquerque before being sent to another destination. (I hate the term “processed” as if referring to a meat product, but that's the government term, perhaps to further dehumanize these families). When these children and parents are due to arrive is either a closely kept secret or more evidence of ICE malfeasance. So, my stethoscope and otoscope are packed and ready; other events in my life will have to wait once the families get here.

So, what? My very minor inconvenience and uncertainty is as nothing compared with that suffered by these families. From the time they were driven from their home countries, uncertain whether they'd live another day threatened by local violence, to their precariously uncertain perches atop La Bestia, that train north from Mexico's south border, to their uncertain passage through miles and miles of Mexico, to an uncertain reception at our own south border, these brave families' uncertainty most decidedly trumps mine.

And then to be separated from one another, “Children a la sinistra, parents al derecho.” When will they ever see one another again? — the ultimate uncertainty. I'll do my very small part and will continue to laud the very large part done by pediatricians on the border like COCP member Dr. Marsha Griffin, by spokespeople in televised and written form, like COCP members Dr.'s Janeth Ceballos, Alan Shapiro, Janine Young and especially Julie Linton, and by our AAP President (and COCP member) Colleen Kraft, whose advocacy on these children's and families' behalf has been extraordinary.

Thank you all. My uncertainty as to the decency and future of our country is reassured by all that you do.

**Addendum:** In the end, ICE sent only 57 reunited people through Albuquerque, not the 300 for whom Lutheran Family Services had moved heaven and earth to be prepared for. LFS had the help of the University of New Mexico School of Medicine, which moved bricks and mortar to schedule a supply of physicians to support these families. A vast quantity of donated clothes, food, money, and gift cards testified to the generosity of Albuquerque and New Mexico families, and much of the goods were given to others, such as our large homeless population. Why ICE only sent 57 is unknown to us; why ICE does anything is hard to explain.

*Continued on Page 7*
I did not myself see the children; UNM had scheduled me to examine and talk with them on Friday night, but no one came after Tuesday. My friend and colleague, Javier Aceves, MD, FAAP was there Tuesday night; Javier sent an attestation about his experiences there to be evidence in a lawsuit brought by the ACLU (and supported by the AAP’s Washington office). Part of it follows:

“In the month of July this year I was part of a team of health providers in Albuquerque, NM that participated in evaluating children and parents referred by Immigration and Customs Enforcement (ICE) through Lutheran Family Services for re-unification. We had an opportunity to hear families’ narratives and why they had opted to come to the US border seeking asylum despite all the known risks. About 30% of the families were from El Salvador, 30% from Guatemala; 30% from Honduras and few were from Brazil. The common thread in their stories was fleeing from violence. They could not understand why they “were treated like criminals” once they arrived at the US border. Children we evaluated presented a flat affect and a distrustful attitude; many of them were showing resentment towards their parents. According to ICE officials “parents were to blame for putting their children through these ordeals.” It took a sensitive and patient approach to build up enough trust to receive our care.”

To learn more about the Council on Community Pediatrics, click here.

**Senior Section Liaison to Committee on Federal Government Affairs (COFGA) Report**

_Suzanne Boulter, MD, FAAP_  
Liaison to COFGA for AAP Senior Section

August 2018

COFGA will meet in late September in Washington, DC. The two biggest items on our agenda will be the Get Out the Vote initiative (see #VoteKids at: [www.aap.org/en-us/Vote/Pages/default.aspx](http://www.aap.org/en-us/Vote/Pages/default.aspx)) and the updated “Blueprint for Children” which will be rolled out before the elections. It’s amazing that all 435 members of the US House of Representatives, 35 members of the US Senate, 36 state governors and over 6000 state legislators will be elected this November! A reminder - if you plan to be at the AAP National Conference & Exhibition on election day Tuesday, November 6th be sure to request an absentee ballot before you go to Orlando, so your vote will be counted!! These are critical times for children in our country with issues like border immigration, continued gun violence and insurance challenges for children under ACO models all unresolved. The updated Blueprint for Children will hopefully address these and other topics crucial to the health and welfare of our children.

Look for an updated report on the Senior Section website in late September/early October after the COFGA meeting and remember to vote in your state primary!
2018 National and District Office Candidates

The 2018 National AAP Election for president-elect and district officers begins Friday, November 2, 2018 and will conclude at noon CT on Sunday, December 2, 2018. This will also be posted online at the election website: https://www.aap.org/en-us/my-aap/national-aap-election-center/Pages/National-AAP-Election.aspx?nfstatus=200&nftoken=76855f2-4ee6-4ec9-86db-1209ab9055b6&nfstatusdescription=Set+the+cookie+token

President-elect Candidates

Sara “Sally” H. Goza, MD, FAAP Bio Fayetteville, GA

Dr. Goza is a general pediatrician and has had the privilege of taking care of children in her hometown of Fayetteville, Ga., for over 30 years. She is a managing partner in First Georgia Physicians Group. After graduating from Rhodes College, Dr. Goza attended Medical College of Georgia for her medical degree. Her internship and residency were at Cincinnati Children's Hospital.

Dr. Goza is on the Community Physicians Advisory Board for Children's Healthcare of Atlanta. She has been involved with the AAP Georgia Chapter for over 20 years, including serving on the Board of Directors, Medicaid Task Force and as chapter president. She currently is on the legislative committee, the fall planning group and the Board of the Pediatric Foundation of Georgia.

Dr. Goza was on the National Nominating Committee and was District X representative to the Board of Directors. While on the board, she was chair of oversight committees to practice, marketing/sales, strategic planning and finance. She was selected by her colleagues as the first at-large representative to the executive committee. She is the chair of the For Our Future Campaign Steering Committee.

Dr. Goza was involved in the Hub and Spoke quality improvement initiative and the development of the current AAP strategic plan. She represented the Academy at the Council for Medical Specialty Societies.

Dr. Goza is active in her community having served on the boards for Girl Scouts, Promise Place (domestic violence) and the Joseph Sams School for children with special needs.

George C. Phillips, MD, MBA, FAAP Bio Overland Park, Kansas

Dr. Phillips is division director of general academic pediatrics at Children's Mercy Kansas City and division director of general pediatrics at the University of Kansas Medical Center. Dr. Phillips leads 70 physicians in reshaping academic-based primary care in the Kansas City metro region, blending two separate units into a model that creates linkages through academic productivity, quality improvement and population health endeavors.

Dr. Phillips received his undergraduate degree from Duke University and his medical degree from the University of South Carolina. He completed pediatric residency training and a primary care sports medicine fellowship at the University of Kentucky.

From 2002-’15, Dr. Phillips was on faculty at the University of Iowa, where he held several leadership positions, including residency program associate director, continuity clinic director and chief of primary care sports medicine services. Dr. Phillips also served on the Board of Directors of the University of Iowa Physicians' faculty practice plan. In 2014, Dr. Phillips graduated with distinction from the executive M.B.A. program at the University of Iowa Tippie School of Management.

Dr. Phillips is past secretary of the AAP Section on Residents (now Section on Pediatric Trainees), past president of the Iowa Chapter and a former member of the Chapter Forum Management Committee. He is a member of the Kansas Chapter's Committee on Public Policy and Legislation and the AAP Committee on Membership.

He and his wife, Robin, reside in Overland Park, Kan., with their son, Carter, and daughters, Kelsey and Allison.
Changes to Senior Section Website

Michael O’Halloran, MD, FAAP - Webmaster

Many of us have known that the AAP web presence has not been optimal for a long time. I’m happy to say that our Board of Directors has approved a complete overhaul.

We saw this described in this Summer’s Bulletin where it was outlined for us by Mary Claire Walsh, Director, Digital Communications and Online Strategy and Robert Katchen, Sr. Vice President, Information Technology

The effort is known as the Digital Transformation Initiative (DTI).

DTI activities has created a big change for the Senior Section website; and indeed, for the websites of all AAP Sections and Councils. The DTI has determined that the Section web pages will be refocused to highlight the work AAP groups do and now serve as key recruitment tools to increase awareness and engagement of AAP members. As such, they now have a small amount of information explaining the activities of the section. Our own Section on Senior Members SOSM website now contains a Sample Bulletin which is the most recent bulletin published, Mission, Vision, and Values of the SOSM, an explanation of the Senior Membership category, an explanation of the Donald Schiff, MD, FAAP Child Advocacy Award, how to Get Involved and a “Join Now” link.

The remaining SOSM content has now been shifted to what is referred to as a Collaboration Site. This is a members-only, password protected site requiring the use of your AAP login.

In the DTI article in this summer’s Bulletin we saw directions about how to access this new password protected SOSM collaborative website. Here is a quick review.

1. Log into AAP.org as you normally would with your AAP Login and Password.

Don’t have an AAP account? Click here.

AAP Login:  
Forgot AAP ID?

A login can be your email or your AAP ID

Password:  
Forgot password?

Click on MyAAP
2. Once in MyAAP, click on the blue “Collaborate” tab.

Welcome to MyAAP!

As a member of the AAP you are part of the definitive voice on healthcare and policy development for children. Being a member also means you have access to exclusive content and resources designed to assist you in these efforts. MyAAP is your home for essential member-benefit content including advocacy tools, leadership resources, member directories and important membership information.

3. Now you are on a page where the Academy has listed the sections to which you belong. Click on “Section on Senior Members”. You are in!! Now take your time and look around.

I think you will like what you see. There are clear headings leading to various topics including advocacy advice, how to start a chapter senior committee, the archive of all the Bulletin newsletters since 2003, information on career transition, an archive of the Senior Section webinars, a preretirement checklist, and much more. While you are there, look towards the bottom of the Newsletter archive page for an interesting and fun look at articles of special interest mined from the Bulletins by Dr. Manny Doyne.

Our SOSM staff Manager, Katie Clark and I are still working on getting content from the old website onto the new SOSM website and getting it, all updated. If you see anything that you especially like, have suggestions for content, or want to make corrections, please contact Katie Clark kclark@aap.org or me mjohall.ec@gmail.com.
Website Content Manager/Webmaster

Michael O’Halloran, MD, FAAP

Help Wanted

The Rewards:
- Promoting the welfare of children.
- Working with some amazing people whom have been major players in their local communities and in the AAP.
- Being exposed to pediatric practice from different parts of the country has been very interesting. There are differences, but mostly there are similarities.
- Expanding knowledge in the digital world.
- Opportunity to feel one have helped fellow pediatricians.

The Work:
- Oversee the content of the SOSM Website and Collaboration Site
- Be watchful for content of possible interest to SOSM members
- Work with SOSM Staff and Bulletin Editors on ways to improve functionality and usability
- Advise the SOSM Executive Committee on related topics
- Evaluate/review the website periodically for continued relevance and repair any broken web links
- Reply to user comments and inquiries in a timely fashion
- Unofficial (amateur) photographer for the group at Executive Committee meetings
- Attend 1-2 virtual or face-to-face SOSM Executive Committee Meetings per year and participate on conference calls as necessary
- Travel expenses will be paid for by the Section
- The webmaster position is a non-voting member of the SOSM Executive Committee
- The webmaster position is voluntary (i.e.: non-salaried)

Additionally, I have enjoyed creating some original content and keeping it updated.

Time Commitment: We of course don't punch a clock, so the time involved will depend on the person's work habits and efficiency. My habits tend to be time intensive. When things are moving along smoothly, a couple of hours a week are sufficient. At times, I have needed 10 hours or more per week but a larger part of that is not strictly web management. It is responding to other business of the committee as an ex officio Executive Committee member and some is working on content that I created and keeping it up to date.

Qualifications: Must have experience as a Web master or related work experience. Must be a member in good standing of National AAP and the SOSM.

Application Process:
Please submit a letter of interest in serving as Senior Section Webmaster along with your Curriculum Vitae relevant to the position by November 5, 2018 to Katie Clark, Senior Section staff at kclark@aap.org or call (630) 626-6065 if you have any questions.

Term: 2 years; renewable subject to SOSM Chairperson approval.
Straight Shooters Need Only One Shot

John Raffensperger, MD, FAAP

We don't know what is in the mind of deranged persons who murder innocent school children. Perhaps, the ability to fire multiple bullets without reloading, gives them a sense of power and the feeling, that they can shoot their way to freedom after a murdering spree. It would be desirable to ban all semi-automatic weapons, especially assault rifles, but this would only add fuel to the flames of conflict between those who favor gun regulation and the ardent supporters of the second amendment. An appeal to legitimate hunters and target shooters to limit the capacity of every gun to no more than two or three bullets might be an acceptable solution.

At about the age of ten years, I would tie a single shot .22 rifle on the handlebars of my bicycle and go across the river to hunt rabbits. When I asked for a repeating rifle my Dad said, "If you shoot straight, you need only one shot". He could also have mentioned the big game hunters in Africa who pursue lions and elephants with doubled barreled rifles that fire only two bullets. A good marksman will rarely require more than two shots to down a quail, a deer or a wild hog. A single shot rifle or pistol is all that is necessary for practice on paper targets and the sport of shooting clay targets requires shotguns that shoot only two shells. There is no place for guns that fire more than three shots in hunting or target practice.

There are precedents for limiting the capacity of firearms. Federal laws to protect Migratory Waterfowl have, since the 1930's, restricted shotguns to three shots. Hunters readily accepted this regulation to protect ducks and geese. The National Firearms act of 1934 outlawed machine guns, to prevent the mass killing by gangsters, such as the St. Valentine's day massacre, during the Al Capone era. Why, then is there so much opposition to regulate guns for the protection of school children? The answer lies in the political influence of the National Rifle Association that cares more for the interests of arms manufacturers than innocent school children.

While I was at the Cook County Hospital of Cook County and then at the Children's Memorial Hospital in Chicago, the incidence of gunshot wounds in children rose when high caliber, semiautomatic rifles and pistols became available. This had a great effect on pediatric surgical practice. It starts with a middle of the night call from the emergency room, “a gunshot victim is on the way. We don't have details but will call again.” The surgeon may hope it is a minor injury that the ER docs and the residents can handle and try to go back to sleep, while waiting for the second call. More likely the surgeon will have to mobilize a sleepy OR crew, the blood bank and depending on the injury [injuries] another surgeon or more residents. The high velocity, large bullets in today's rifles and pistols smash the liver, spleen or kidney and puncture many ragged holes in the intestine. Injuries to great vessels such as the femoral or subclavian artery require meticulous repair and damage to the heart may even call for the 'pump' team. A bullet to the head usually reduces the brain to pulp.

When the last stitch is tied, the night will have turned to morning and the seven thirty elective case will be on the way to the operating room. One could say, 'the whole day is shot'. One of my colleagues, a 110-pound woman who spent a night repairing multiple wounds in a six-foot-tall, fifteen-year-old victim of a gang shooting said, “this isn't why I chose pediatric surgery”.

Marches, protests and mass hysteria have failed to influence politicians and has further entrenched the gun lobby. It is time for sensible people to find a middle road between “taking away their guns” and doing nothing. Pediatricians and other community physicians have the opportunity to convince hunters, target shooters and other sportsmen of the desirability to limit the capacity of all civilian firearms, rifles, pistols and shotguns to no more than three bullets.
Mindfulness Meditation: It Really Does Help!

Joseph R. Hageman, MD, FAAP
Senior Clinician Educator at Pritzker School of Medicine

It was April 2007; I could no longer practice in the intensive care unit and forced clinical retirement was becoming a reality. I was sitting at my desk at Evanston Hospital in Evanston, IL. I just happened to notice that there was an organized group meeting at 4:30 pm on Tuesdays where attendees could come to learn about mindfulness meditation. The meeting was run by one of our psychologists, Dr. David Victorson, and was very informal. I decided to attend as I was just being started on duloxetine and Neurontin for depression with a significant neuropathic pain component as well, and I was having trouble concentrating on what my plans were going to be.

What he taught us was the concept of mindfulness: “the awareness that emerges through paying attention on purpose, in the present moment, and non-judgmentally to the unfolding of experience moment by moment (1).”

I have had a chance to practice mindfulness every day and these concepts reinforced every Tuesday over about a year and found it to be very helpful. It went along well during lap swimming every day for about ½ hour, 7 days a week. I was able to swim in a mindful manner so not only did the swimming help me with the neuropathic pain, it also enabled me to relax and let the thoughts about the present circumstances and the future come and go, moment by moment.

Mindfulness meditation also helped when I needed to focus because after a 10 minute period of meditation, I had more success working on putting together PowerPoint lectures on common pediatric topics for the medical students at Evanston Hospital. I found that I was not as preoccupied with the idea that I was no longer able to practice pediatrics clinically. Mindfulness meditation helped me relax after my bedtime routine, and I was able to fall asleep after a period of a few minutes of letting all of those thoughts just pass in and out of my mind or be stored in an appropriate category for further evaluation later. If I still had trouble, I have a pad and pencil to write them down.

More recently, when I was director of pediatric resident research for the program at Comer Children's Hospital, University of Chicago, Mallory Taylor, Melanie Brown and I were involved in an education project about mindfulness meditation with the pediatric residents in which the Headspace app (https://www.headspace.com/headspace-meditation-app) was a tool utilized to introduce mindfulness meditation. Mallory, a pediatric resident, presented two introductory lectures about mindfulness meditation. Ultimately, she presented a poster at the 2015 Pediatric Academic Society and the paper was published in Pediatric Annals (2).

I am now reviewing a few audio compact disc presentations by Jon Kabat-Zinn (3,4) about the basics of mindfulness meditation and a book by him, Mindfulness for Beginners (4). I have found this book to be very helpful in reinforcing the principles basic for the practice of mindfulness.

References:


Editor's note (C.D.): For full disclosure, I had my husband, Dr. Jim Harris, also review this manuscript with me. He has been practicing mindfulness (meditation) since 1970, when he spent three months in a Buddhist Monastery after serving as the US Public Health Service physician for peace corps volunteers. Our friend, Jack Kornfield, was a peace corps volunteer in Thailand when Jim met him. Jack became a Buddhist monk and remained so for several years. Then, Jack and Joseph Goldstein brought the mindfulness meditation movement to the US at the Insight Meditation Society Retreat Center, in Barre, MA. Jack now has a meditation center, Spirit Rock, in Woodacre, California. Editors need all the help we can get!
The Evolution of Pediatric Mental Health Treatment in Primary Care

Thomas F. Boat, MD, FAAP, former Chairman of Pediatrics and Dean of the College of Medicine, University of Cincinnati
Emanuel “Manny” Doyne MD, FAAP, Emeritus Professor of Pediatrics, University of Cincinnati College of Medicine

One of the biggest changes we have witnessed in the last quarter century of pediatric practice (other than the introduction of the Hib and Pneumococcal Conjugate vaccines) is the increased incidence of pediatric mental health issues, and the development of a movement to try to diagnose and treat some of these patients within the scope of a primary care setting. The most recent National Survey of Children's Health found 20% of pediatric patients had an identified mental health diagnosis (ADHD, depression, conduct disorder, anxiety etc.).

The AAP was central to the movement beginning with the Mental Health Task Force formation in 2004 “…in response to the growing need to address children's mental health concerns in primary care, articulated mental health competencies for primary care; developed guidance for addressing systemic and financial barriers to providing mental health care in primary care settings; and provided tools and strategies to assist pediatricians in applying chronic care principles to children with mental health problems.”

These developments made this issue a huge priority for practitioners and a difficult mountain to climb because of training deficits. Leaders like Jane Foy, Peter Jensen, Paula Duncan, Kelly Kelleher, Danielle Laraque and others were central to the Academy’s efforts. The first office-based guideline for primary care was entitled: ADHD: Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents and was published in 2000 and revised in 2011, followed by the Guideline for Adolescent Depression in 2007. In addition to training gaps there was some opposition from the child and adolescent psychiatry group in delegating this care to “non-mental health experts.” However, Peter Jensen, from Columbia, convinced his colleagues that the numbers were overwhelming and that there would never be enough child and adolescent psychiatrists to manage the problem.

According to a recent article in Pediatrics (reference 1) 65% of pediatricians believed they lacked the necessary training in the treatment of children with mental health problems. One of the only solutions is to develop a comfort level with this population and to understand that training is readily available, and reimbursement is achievable. The advent of integrated practices has permitted clinicians the opportunity to diagnose and treat common behavioral disorders. In Ohio, Dr. John Duby has developed a program within the Ohio Chapter and now has a platform available for Maintenance of Certification called “Building Mental Wellness (http://ohioaap.org/projects/building-mental-wellness/). The other challenge is convincing the RRC, which develops the required curriculum for residency training, to strengthen the mental health training for all residents. Some programs provide electives in these areas either with child psychiatry or psychology but there are very few trainees who would not benefit from these programs. The National Academy of Medicine, the American Board of Pediatrics and a multidisciplinary Task Force have been working on this issue. Hopefully we will have some meaningful changes as a result of these groups lobbying efforts in the Spring of 2019.

Mental health care has come a long way in behavioral therapy and a much wider armamentarium of pharmaceutical agents are available for ADHD, depression and anxiety particularly compared to the limited number of agents previously available in the 60’s and 70’s such as Haldol, chlorpromazine and methylphenidate.

Developing a comfort level is something that can be achieved in a career and the satisfaction (and sometimes frustration) that ensues provides the practitioner with a feeling of improved professional responsibility.

New challenges for the future role of pediatric practice include:

1. Behavioral health promotion from pre-conception to adolescent mental health
2. Increasing prevalence of these disorders and prioritizing pediatric practice as an ideal setting for identification, evaluation and treatment
3. Behavioral health risk prevention (awareness of Adverse Childhood Experiences)
4. Two generation parenting and “grand family” considerations including maternal depression screening

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The Evolution of Pediatric Mental Health Treatment in Primary Care  Continued from Page 14

Those of us in the “mature” age group can be valuable resources for mentorship and education of this generation’s clinicians. It’s a valuable journey with a few potholes along the way.

References:

On Retirement from Rabindranath Tagore

GITANJALI

I thought that my voyage had come to its end at the last limit of my power, - that the path before me was closed, that provisions were exhausted, and the time come to take shelter in a silent obscurity.

But I find that thy will knows no end in me. And when old words die out on the tongue, new melodies break forth from the heart; and where the old tracks are lost, new country is revealed with its wonders. –

Life After Medicine

Luisa Stigol, MD, FAAP

I had a busy full-time practice at Dedham Associates. In 2004, a diagnosis of ovarian cancer suddenly obliged me to interrupt my work. After my last chemo, my future was uncertain. My energy was not the same. Will I be able to return to my practice?

I needed a goal to pursue. The Boston Museum of Fine Arts (MFA) had been a source of solace during my busiest times in the office. I applied to be a volunteer and began as an assistant at the Department of Accessibility that deals with visitors with special needs. After all, I did it so many times before my retirement.

My work at the MFA was fulfilling. We prepared our tours based on information received from our coordinator. One day, instead of the five physically disabled but sighted young adults I expected, only one twelve-year-old arrived. He had no speech and was unable to fix his sight on any object. His only way to communicate was to shake hands with his mother, if he understood or was pleased.

Flexibility was one of the requirements of our work and I had to use it! I succeeded in my tour of Egypt, rich in history and mythology. I stopped at sculptures blind visitors were allowed to touch. I had never been in that legendary country, but I studied the collection of the MFA and at the Met Museum. It served me well that day.

Even though we both had worked with the deaf and had given tours to the blind, the next day was our first with deaf-blind visitors. We expected nine people, but sixteen people arrived, young and old, an excited and mixed crowd with sensory and physical limitations but unimaginable enthusiasm. Again, we went to the inexhaustible Egyptian gallery I stopped one by one at the large ancient Pharaoh's sculptures that could be touched. I waited for the visitors to receive their interpreters’ versions: American Sign Language (ASL) for the deaf who could see but not hear. ASL, modified, touching the hands of the deaf-blind. One of them kept holding with joy one column in pink granite, probably one of the first ever built by man, discovering the reliefs of a god and a pharaoh. Everybody was fascinated with the sculpture of Sekhmet, goddess of storm, war, disease. Doctors were considered her acolytes, since they could heal those she had damaged. Pharaoh Amenotep III was sickly and ordered to build one daily, hundreds of them, to cure her disease.

Later, I led a tour for seven visitors with different stages of Alzheimer’s. It was the year 2016, the 100th anniversary of the description by Dr. Alois Alzheimer. An elderly participant in this tour asked me: “In what city are we today?”

Continued on Page 16
Another visit was one with a woman who used to paint. She arrived in her wheelchair, brought by her attentive husband, unresponsive to my greetings. As we walked through galleries, I continued informing her about their content. I chose to stop at an exhibition of American contemporaries of Arthur Dove. I began to talk in simple terms about his stylized landscapes, even though she did not seem even to see them. Suddenly, she began adding a few comments and began to be involved. She refused to stay longer in front of Stuart Davis large oil “Jazz.” It was too “busy” for her. After 45 active minutes I asked her if she preferred a cup of tea or a visit to another gallery. “A cup of tea”, she answered. The three of us enjoyed a normal conversation at the cafeteria. It was as if I had witnessed a miracle!

At our curator’s request the American glass artist Chihuly exhibition, we could use extra crystal pieces in tours for the blind. My first visitor was a blind psychotherapist with experience in European museums. She was enchanted with the possibility of also touching pieces as I described the exhibition to her.

The following week, five cognitively affected boys arrived in their wheel chairs. I was assigned a teenager, about age 16 blind, speechless, with his head bent down over his chest. He responded to his assistant with a turn to the left of his head. His hands were hanging without moving. First, I handed him one by one the crystal pieces and helped him to touch, explore and rotate them. At the crowded galleries, I stopped on my knees, told him stories related to what I could see. At the end of the hour-long tour, his assistant told him to thank me if he liked the tour. He raised his head and let out a loud, low pitched sound. I was so moved that I had to find a place to cry…

After twelve years and many such experiences, I moved to NYC and now volunteer at the Metropolitan Museum. My role is more modest, but I am proud to be part of this great Museum and its Department of Education.

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**Choosing Pediatrics**

*Robert Yim, MD, FAAP*

Dr. Ernest G. Hand was always and seemingly forever, family physician, surgeon, obstetrician and all things medical for our community. When my sister had a frightening non-stop nosebleed, he inserted a catheter into her right nostril, drew it out through her mouth, attached a gauze pack and cinched it up tight against her posterior pharynx thus tamponading the bleeding right in our living room. Always available, we worried and wondered, “Does he ever sleep?” We were concerned about his driving ninety miles per hour to Reno Washoe General hospital. The police tolerated his driving. Recognizing the speeding Lincoln, they looked the other way, allowing him to hurtle towards Reno. When it became known in the community I was taking pre-med at the university, it was immediately assumed I would be Dr. Hand’s heir apparent. He took me on house calls and we talked at length in his office, always redolent of some strange antiseptic. Upon completion of medical school and still feeling some obligation to the practice waiting at home, I enrolled in a split residency, half Internal Medicine and half Pediatrics at the University of Maryland Hospital.

It was the patients I met during those exciting years as a resident that would determine the specialty I eventually chose. For example, the elderly gentlemen on the medical ward when I asked the routine question, “What is your chief complaint?” replied, “Myriads of periods before my eyes, Doctor.” There was Sarah the brave stage four cancer patient with whom I fell in love, who taught me how to deal with the terminally ill. I have to mention Minnie, the patient admitted to our “Obesity Ward” when we were trying the famous Duke University weight loss “rice diet.” Puzzled by why she lost no weight, I solved the mystery by hiding in the nurse’s station and caught her removing a roast chicken from under her mattress.

On the pediatric ward, a little five-year-old girl suffering from night sweats and prolonged fever was suspected of having tuberculosis. The diagnosis depended upon finding the bacilli in washings from the stomach by inserting a long rubber tube through her nose into her stomach. An uncomfortable procedure in the best of hands; in a child this was always accompanied by loud crying and a battle royal. Several attempts made by nurses and house staff was to no avail. After discussing her case at length on morning rounds, I asked the nurses to have the set-up the long rubber tube, ice, etc. ready the following morning and I would try again first thing before rounds. I arrived on the ward, bright and early, after...
a good night’s sleep with no calls, carefully reviewed how I would insert that tube and gave a silent prayer in the elevator. On the ward, I cheerfully approached her bed and saw my young patient sitting bolt upright, tears streaming down both cheeks and a red rubber tube in place. She had done it herself! Benjamin, age three, stood beside my desk as I wrote his prescription. His gaze was fixed steadfastly on me. Each time I looked down at him there was that unblinking stare. Finally, I asked, “Why do you keep looking at me?” He replied, “Why do you have such an ugly nose?”

Small wonder I chose pediatrics to be my “life’s work.” Where else would I find patients so honest, so forgiving and so adorable? When I told my father, the consummate business man, I had chosen Pediatrics, he sadly shook his head and said, “Big mistake. Should do surgery. You cut ‘em, you charge ‘em more.”

I have just shared my choice with you. After forty-two years of solo pediatric practice and long retirement, I ask myself, “Why did I choose this reportedly least lucrative of all specialties. Why did I willingly volunteer to accept phone calls late in the night from anxious parents? Why did I choose a specialty my internal medicine colleagues say, “It’s like being a veterinarian. They can’t tell you what’s wrong!” Who Knows? I only know when I reflect on those years, I always smile and say with honest conviction, “I have no regrets.”

**On Rare Occasions There May Still Be a Role For Witchcraft in Pediatric Practice**

*William Purcell, MD, FAAP*

Fifty-seven years ago, in 1961 shortly after I opened the first pediatric practice in a small rural North Carolina city a young girl was referred to me by a family physician from a nearby town. The concern was that this eleven or twelve-year-old girl was having frequent episodes of extremely severe abdominal pain and the episodes had been going on for about a year. There was no vomiting or diarrhea and the episodes of pain and crying lasted less than an hour.

The physician had done numerous tests that were all normal. He had tried several medications without benefit. He asked for my help in solving this problem.

As the first pediatrician in town I considered this a wonderful opportunity not only to help the patient but to introduce the real need for a pediatrician in this rural community. At the same time, I realized that it was a time to establish my reputation with the referring physician.

After a completely negative physical examination and normal blood, urine and stool tests, abdominal x-rays and an upper GI series revealed no abnormalities.

With my reputation on the line and somewhat in desperation, I asked the mother a lot of questions and finally asked if the daughter had been seen by any other physicians. She replied “Well yes, she was having some behavior problems about a year ago and I took her to a witch doctor in South Carolina to see if he could help and I believe he put a spell on her. Since then her behavior has been much better”.

I consulted with the referring physician and since both of us had taken our internships and specialty training in Charleston we knew something about South Carolina witch doctors and some of their methods. We believed that her abdominal pain was related to the spell and that the only way to dissolve the spell was to try some kind of safe witchcraft.

We decided to admit the patient to the hospital and with her mother consenting and with the pediatric nurse helping, the referring physician and I closed the shades, cut off the lights, lit a candle by her bed and started an IV. In the semi-darkness I then told the little girl that we had some medicine that we believed could get rid of her episodes of abdominal pain but only if the medicine made her feel warm all over. We then proceeded to inject an extremely small dose of nicotinic acid, otherwise known as niacin or vitamin B3, a medication that makes most feel warm.

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The little girl sat up in bed and exclaimed “I feel warm all over! I’m cured”. We then discontinued the IV and discharged her from the hospital. She never had another episode of the abdominal pain.

In the thirty-six years of my pediatric career that followed I never knowingly practiced witchcraft again but must admit that I never had a similar opportunity. Even though the patient was cured, for obvious reasons this was not a case that the new pediatrician in town wanted to talk about. His reputation and establishing the need for a pediatrician in the community had to wait for more traditional opportunities.

Movies and Medicine

Beryl Rosenstein, MD, FAAP
Professor of Pediatrics at the Johns Hopkins School of Medicine

Movies can be entertaining and also can provide teachable moments for those of us providing patient care. Listed below, in no particular order, is a list of films, many oldies and goodies that, if not already seen, you might put on your “to view” list for fall viewing.

**Patch Adams** (1998)
Based on a true story, Robin Williams plays a think-outside-of-the-box physician who tries to heal his patients with laughter and empathy. Sometimes humor is the best medicine.

**Mash** (1970)
A classic film that chronicles the often-irreverent activities and antics of a group of rebellious physicians and staff who operate a field surgical hospital during the Korean War.

**The Last King of Scotland** (2006)
The gripping story of Scottish physician on a medical mission to Uganda who ends up as the conflicted personal physician to Idi Amin, the country’s brutal and erratic dictator.

**Girl Interrupted** (1999)
Based on the 1993 memoir of Susan Kaysen, the film explores her 18 months stay in a mental institution in the 1960s. It presents a terrifying and probably realistic look at how mental illness was once, but hopefully no longer treated.

**Awakenings** (1990)
Based on the British neurologist Oliver Sacks’ memoir, the film follows a group of post encephalitis lethargica catatonic patients languishing in a Bronx hospital and then given L-Dopa as an experimental treatment.

**Wit** (2001)
A renowned professor is forced to reassess her life after she is diagnosed with terminal ovarian cancer.

**Philadelphia** (1993)
A man with HIV who is fired by his law firm because of his condition hires a homophobic small time lawyer as the only willing advocate for a wrongful dismissal suit. It is interesting and gratifying to see how societal views have changed.

**The Doctor** (1991)
When a self-centered doctor is diagnosed with cancer, he undergoes a transformation in his views about life, illness and relationships. He becomes better able to get closer to his patients and undertakes a life outside of his career.
**Movies and Medicine** Continued from Page 18

**Something the Lord Made** (2004)
The true story of the unlikely and complex collaboration between a white southern surgeon (Alfred Blalock) and a black surgery technician (Vivien Thomas) who worked together at Johns Hopkins in the 1950s to develop the Blalock-Taussig shunt for patients with Tetralogy of Fallot.

**One Flew Over the Cuckoo’s Nest** (1975)
The classic story of the patients in a mental institution who rebel against the legendary abusive nurse Ratched.

**Sicko** (2007)
One of the Michael Moore documentaries comparing the highly profitable American health care industry to health care delivery systems in other countries. The film is a good endorsement for a single payer health system.

**My Left Foot** (1989)
A man born with cerebral palsy learns to paint and write with his only controllable limb- his left foot.

**My Own Country** (1998)
The true story of an East Indian infectious disease doctor (Abraham Verghese) who settles in Johnson City Tennessee. The film chronicles the challenges he faces from family and community in treating AIDS patients in a small city in Middle America.

**Outbreak** (1995)
Army doctors struggle to find a cure for a deadly Ebola-like virus brought to America by an African monkey from Zaire and spreading throughout a terrorized California town. The film speculates on how far military (USAMRID) and civilian (CDC) agents might go to contain a deadly outbreak.

**And the Band Played On** (1993)
The story of the unfolding of the AIDS epidemic in America and the political infighting within the scientific community that hampered early efforts to confront the epidemic. The film vividly portrays the role that patient advocates can play.

**Lorenzo's Oil** (1992)
A true story drama of the clash between the scientific community and desperate parents who are engaged in a relentless search for a cure for their son who has adrenoleukodystrophy. The film was based on the pioneering research carried out by Dr. Hugo Moser at the Kennedy Krieger Institute in Baltimore in the 1970s.

**Concussion** (2015)
A true story based on the 2009 article “Game Brain” about the heroic effort by Nigerian born neuropathologist Bennett Omalu to expose the devastating CNS effects of repeat concussions on NFL players. Omalu’s groundbreaking work on CTE, initially refuted by the NFL, has now been validated by a number of recent studies.

**Danish Girl** (2015)
A deeply moving story, (loosely inspired by the lives of Danish artists Lili Elbe and Gerda Wegener), which explores the groundbreaking and tragic life of a transgender pioneer.

**Rain Man** (1998)
A beautifully acted movie loosely based on a true story, of two brothers, one of whom is a mega- autistic savant. The film is a moving and often humorous portrayal of mutual enlightenment and acceptance. Dustin Hoffman gives a remarkable Oscar winning performance as the brother on the spectrum.
CRAZY RICH ASIANS
On track to become the summer’s top grossing blockbuster (more than $76.8 million in its first 2 weeks since release August 15), this is a great feel-good comedy with an exclusively Asian cast. Nick Young (acted by Henry Golding) falls in love with NYU Economics professor Rachel Chu (Constance Wu) and invites her to Singapore where he is to be best man at his friend Colin’s (Chris Peng) wedding. He also tells her that he wants to introduce her to his family, failing to disclose that he is the heir apparent and only son of the “crazy rich” Young business empire. Meeting Nick’s family is fraught with prejudice against “Chinese-Americans” by Nick’s mother Eleanor (Michelle Yeoh), who can wilt the strongest girlfriend with her disdainful glances, his matriarch grandmother who hires a private detective to delve into Rachel’s background…(But you have to see the movie to learn about that!), and all of Nick’s jealous ex-girlfriends. Fortunately, Rachel has college friends who live in Singapore, so she is not without allies. With a huge supporting cast, over the top opulent sets, glamorous designer gowns and beautiful actors, this film defines eye candy! The plots and subplots multiply as the film progresses to a surprise ending. 120 minutes, PG-13.

WON’T YOU BE MY NEIGHBOR?
This documentary of the life of Fred Rogers, creator and star of Mr. Roger’s neighborhood is an engaging tribute to this most outstanding spokesman for children’s television. Without his Congressional testimony to save funding for quality children’s broadcasts, today’s programming for children would be even worse. The best features of the movie are film footage of Mr. Rogers speaking directly to children about challenging issues: the Vietnam War, death, divorce of parents, being afraid, tolerance of differences, and many other topics. He was definitely one of a kind! A talented musician and an ordained Presbyterian minister who never preached in church, Mr. Rogers provided his special “sermons” in his comfortable neighborhood safe place for children. I suspect that the PG designation was due to the frank discussion of Rogers’ final illness and death, but it is still an excellent movie for families. PG-13, 94 minutes

THREE IDENTICAL STRANGERS
This is a documentary based on the true story of triplets separated at birth and adopted individually to three New Jersey families who were not informed of the multiple birth status of their babies. The first two boys only serendipitously learned of that status because of their physical resemblance on enrollment in community college at age 19 in 1980. Their third identical sibling was identified after seeing photos of his doppelgangers in newspapers and on television. With new-found celebrity, they opened a popular restaurant in New York. However, mental health issues and new insight into their backgrounds emerged along with unfolding of information about a carefully guarded research project in which they were innocent participants throughout their childhoods. Parts of this movie are intense indictments of the intrusive nature of observations of child behavior posing as meaningful research in the 1960s and present strong support for today’s stringent human subjects reviews for approval of such projects. The partnership of the private adoption agency with this research project further adds to a sense of unethical collusion and fosters hope that such projects cannot happen in modern times. The stories are told through interviews with the triplets themselves over time and are profoundly moving. The movie is based on the book of the same title by Tim Warder, who directed this film. 96 minutes, PG-13.

MISSION IMPOSSIBLE-FALLOUT
Another non-stop action thriller complete with noise, guns, knives, and plutonium bombs. The best motorcycle-car chase scenes ever in Paris are a major feature in this star- studded cast (Tom Cruise as Ethan Hunt, Angela Bassett as CIA director, Alex Baldwin, Rebecca Ferguson, Henry Cavill, and others). M-5 agents compete with CIA agents to find three plutonium fuses before an international bomber accomplishes his mission of destroying as many people as possible and ending civilization as we know it. At times, it’s hard to distinguish the good guys from the bad ones, but it predictably ends with the Mission Impossible team proving its merits once again. PG 13, 147 minutes

THREE FOR STREAMING or DVD: RED SPARROW
I thought that this movie about pretty young Russian women being trained as spies to deal sexual favors for international secrets was far-fetched and unbelievable. Then, Maria Butino was arrested in the current investigations of Russian intrigue and probable collusion in our country. Perhaps the movie plot, although confusing in its complexity, makes sense after all. Jennifer Lawrence plays a famous Russian ballerina, Dominika, whose artistic career is ended early in the movie...
by a tragic accident onstage. The acting is excellent and the cinematography outstanding. Excessive violence and torture prevail. 139 minutes. R rating well deserved.

**PHANTOM THREAD**

For those who are fascinated by the design and fashion industry of the 1950s era, this well-made film might satisfy. It depicts a frankly eccentric designer (Daniel Day Lewis) who lives with his sister (Leslie Manville) and his strange relationship with a waitress (Vicky Krieps) who becomes his favorite model and eventually his wife. Others will find it a snoozer. The only real action other than the fashion shows evolves when the model harvests poison mushrooms which she prepares and serves to her soon to be husband, causing him to be dreadfully ill and increasingly dependent on her (a variant of Munchausen's Syndrome?). It is a strange movie. R rating. 130 long minutes.

**MOLLY'S GAME**

Poker buffs may enjoy this movie about the management of high stakes games among very rich gamblers. Based on the true story of Molly Bloom (Jessica Chastain) who transformed from being a competitive skier to becoming the administrative assistant for a poker parlor mogul. An ambitious and intelligent young woman, she eventually ran her own poker games with increasingly wealthy clients in various parts of the US until she was arrested by 17 FBI agents with automatic weapons. It's entertaining in a Las Vegas/gambling sense with enough foul language, drugs, and violence to merit an R rating... Definitely not a family movie. 140 minutes.

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**Book Review**

To Tell the Truth – Based on the Author's Forty Years of Clinical and Trial Experiences in Abusive Head Trauma-Shaken Baby Syndrome Cases

Written by Dr Robert M. Reece, MD: Publisher E-Book Bakery

Reviewed by: Emanuel “Manny” Doyne, MD, FAAP

Dr. Reece, an internationally recognized expert in Child Abuse who has worked at Cincinnati Children's, Tufts, Boston City, Boston Children's and Rainbow Babies Hospital in Cleveland has written a fictional case study of an infant who died of supposed shaken baby syndrome. It is a disquieting discussion of the tension created between caretakers, police, the legal profession, physicians and the press in cases such as this.

The author provides us with a bird's eye view of the chronology of events in the legal process from the incident through the arrest, autopsy, work of the both the prosecutor and defense attorney and the criminal proceedings. It provides the uninitiated with a look at the discovery process, the recruitment of expert witnesses on both sides, the use of the media and the effects on the defendant and the parents. Embedded within the text is the ongoing “controversy” about the validity of the diagnosis from diametrically opposed viewpoints which still is an issue in our current environment. I wonder what John Caffey would have to say?

The “real world” presentation of this case certainly gets your attention and stirs your emotion. Any physician that has been in a courtroom for any reason will admit it was an eye-opening experience in terms of the process. The quote “...mainstream medicine is all wrong about this...” is sure to get your attention. And also, the issue about selecting the right “expert witnesses” is quite troubling. One of the defense experts states “I don't believe everything in pediatric journals...a lot of it is rigged. “And a comment which is very pertinent today in our current political climate is the desire to pick jurors who are “anti-intellectual.”

This book should be required reading for anyone involved with or about to involved with this type of situation which includes medical students, residents, primary care physicians, lawyers, social workers etc. It is impactful and educational at the same time. In his comments about Dr. Reece's book Dr. Robert Block, past AAP president states: “...the book is a compelling story (that) brings the reader face-to-face with a startling reality: sometimes criminal cases are influenced by more than 'the truth, the whole truth and nothing but the truth.'”

(Editor's Note (L.C.): “To Tell the Truth” can be ordered at Amazon or use bit.ly/ReeceToTell)
“Fascism, a Warning” Written by Madeleine Albright

Book Reviewed by Herb Winograd, MD, FAAP

I have read horrifying stories from Bram Stoker to Stephen King which, I realize are fiction, and do not keep me awake, but none, compare to Mrs. Albright’s knowledgeable, true story anthology of the ascendancy of famous past and lesser known current despots. The rise from obscure backgrounds by Mussolini, Hitler, Stalin and more recently, Castro, Chavez, Erdogan, Orban in Hungary and, of course, Putin are all included.

Regardless of personal political leanings, (and I admit to being an apostate Republican, not yet a Democrat), I am frightened by these stories about small people who reached power by intimidation, lying, bullying, eliminating opposition by not only personal attacks but disposing of democratic institutions by fiat. This is a compelling collection. Only my firm belief in our beloved Constitution keeps me from roaming the midnight halls. Thomas Jefferson and his brilliant colleagues are my only Ambien and will be yours, too, when you finish this necessary volume.

Editor’s Note (L.C.): Available through Harper Collins Publisher or Amazon since 4/10/18; 304 pages.

Young and Old: Three Books Briefly Reviewed

By Richard Wicklund, MD, FAAP

“Without You There Is No Us”

This is a peek into life in North Korea by a woman who taught English at the Pyongyang University of Science and Technology (PUST) for one academic year. The young men who were her students (there were no young women students,) lived within restrictions hard to imagine. Teaching English and a little critical thinking was challenging and even dangerous. Internet access was creeping into North Korea at that time. Young men learned the English language. Now “ambassador” Dennis Rodman, Pres. Donald Trump, Pres. Kim Jong-un and his sister Kim Yo-jong, Pres. Moon Jae-in and many others contemplate the future of North Korea. This book is a gem.

“The Legendary Jackrabbit Johannsen”
By Alice E Johannsen (His Daughter); 1997. McGill–Queen's University press.

Jackrabbit loved cross-country skiing and skied almost his entire life. He was born in Oslo, Norway, in 1875. He studied in Berlin when the internal combustion engine was being invented. He lived until 1987. This book is a good reflection on a long life. Another gem. You will probably have to find it on Amazon.

“Around the World On Two Wheels”

Hans loves to ride his motorcycle. From the age of 68 to 90 he has ridden over 600,000 miles. This book is a testament to the abilities of people who are getting older. Hans is Swedish, but he lives in Harahan, Louisiana, near New Orleans. A third gem.
Draft No. 4: On the Writing Process
by John McPhee Farrar, Strauss and Giroux,
New York, 2017 192 pages

Book Review by Edgar K. Marcuse, MD, MPH, FAAP

What do oranges, the Swiss army, canoes, the monopoly game board, the merchant marine and scotch whiskey have in common? All attracted the omnivorous curiosity of John McPhee. He is arguably the finest writer of creative non-fiction of our day, for it is on his shoulders that Malcolm Gladwell, Michael Lewis, Richard Preston and Mark Kurlansky all stand.

In the eight essays of Draft No. 4 he reflects on myriad aspects of the writing process: interviewing subjects, arrangement of story components, frames of reference, structure of a piece, fact-checking and rewriting. What makes this volume a delight is gaining just a bit of insight into how a sagacious observer of nature, human endeavors and individuals can share his enthusiasms through the written word and in so doing expand the reader’s appreciation of the world.

The reader learns that a writer is one for whom writing is more difficult than for other people; that in the summer of 1966 he “spent nearly two weeks lying on a picnic table under an ash tree near his back door, fighting fear and panic because he had no idea how to begin a piece of writing”; that for years his office furniture included of a four by eight foot plywood sheet on which he would arrange three-by-five cards, with codes words representing story components; of the challenges of interviewing Woody Allen whom he described as a “flat-headed, redheaded lemur with closely bitten nails and a sports jacket” and Jackie Gleason who “is kind, generous, rude and stubborn, explosive, impulsive, bright and mischievous … an outgoing, flamboyant man to whom privacy is sacred”; of a mantra he writes in chalk on the class room blackboard: “A Thousand Details Add Up to One Impression” – explaining “few (if any) details are individually essential, while the details collectively are absolutely essential”.

The book is filled with engaging anecdotes some drawn from his years teaching a writing course in Princeton where he grew up, the son of a physician. He relives his encounters with New Yorker editors and fact-checkers and incorporates a few pearls such as: “‘Farther’ refers to measurable distance. ‘Further’ is a matter of degree”. He tells of his quest to figure out “what the hell” sprezzatura is - a term used by a student in an assignment. McPhee’s writing throughout Draft No. 4 is the epitome of sprezzatura: “effortless grace, doing something cool without apparent effort.”

A painful awareness of an advantage enjoyed by another with a desire to possess the same advantage is the dictionary definition of envy. I am envious of those of you who have not read McPhee for you have the joy of discovery ahead. With a wee dram distilled with water from Josie’s Well I will placate my envy by rereading my favorites.

*Footnote: Among McPhee’s published works are books or essays titled: Oranges, The Swiss Army, The Making of a Birch-bark Canoe, Looking for a Ship, The Search for Marvin Gardens and Josie’s Well. The last two are in my favorite collection of his early essays, Pieces of the Frame.
Update on Healthcare Surrogacy of My Friend

Debra Sowell, MD, FAAP, Bowling Green, Kentucky

For those of you who missed the first tantalizing saga, my best friend from high school has early onset dementia. We are now 60, she was diagnosed officially 5 years ago. She has no children, was never married and was an only child. Unfortunately, both of her parents passed away just prior to her diagnosis. I paid her bills, set up meds in pill container and took her to the grocery weekly. Also, when we had leftovers, we would take extra food. Another three friends from church started assisting me when I was out of town. One of them volunteered to also take her to church every Sunday.

Fast-forward:

1. Arranged for Supplemental Security Income (SSI). Medicare (health insurance would start 14 months after the SSI was approved). She was without health care insurance for 2 years before I started the process…so she had no insurance for a total of 38 months except for a one-month period where she had a spin down Medicaid card after having spent 5,000 dollars of her money on diagnostic testing/dental appointments/ear appointment, etc.

2. Sold her car because she was driving and getting lost and was paying random people at the gas station to put gas in the car. She also was having randoms write out a check for her at the grocery when I could not go.

3. Had to employ sitters to stay with her to remember meds/make sure she ate/turned stove off, etc.

4. Unplugged stove because she was driving and getting lost and was paying randoms at the gas station to put gas in the car.

5. Had to ask postman to hold mail unless door was closed as she had started greeting him each day in the nude.

6. Increased sitters to all day, until she was in bed at night because the wanderings outside/far from her home were getting dangerous. They are including her stealing a dog out of a fenced in area because she thought he looked sad.

7. The state in their infinite wisdom, placed her in a semi-private nursing home bed (not a memory center) in a small town 20 miles away. This lasted truly 17 minutes and she was in a straight jacket headed back to our local ER for admission to the psych ward.

8. I relinquished my POA on her checking / retirement accounts and her healthcare surrogacy to the state of Kentucky, so they could sell her house to maintain her care. We had paid bills out of this for 4 years. I did arrange/pay in advance for her funeral before relinquishing the funds. Originally, she did not want to give me the POA for her home because at that time I think she actually understood enough that this might become a possibility that she would have to leave her home/…. Her Mantra for months was, “it’s my house and I am staying in it.”

9. The state gave her health care surrogacy part back to me, so I could sign DNR orders because the state is not allowed to. They (the state) still pays the bills when they can, and “we” try to visit when possible.

So, what is the point of this rambling story? …

Even if you are not an only child, old maid with deceased parents—At the very least, get a healthcare surrogate…discuss with them beforehand your wishes about DNR, feeding tube, going on the ventilator etc. I would also recommend long term care insurance and some nest egg in addition to retirement funds to pay for whatever life brings.

PS. Just recently, I have learned from cousins in another state that there are at least 5 family members who are affected with dementia currently.
Confessions of a Liberal

Lawrence D. Frenkel, MD, Chair, Senior Section AAP/NJ

There is nothing more important to a nation than the quality of life guaranteed to every inhabitant. There may be a considerable amount of debate about how this goal could be funded and achieved. History should have taught us that communism and perhaps even socialism does not work well, in part because these forms of government invariably destroy the rewards of human initiative. On the other hand, experience in the United States (US) and elsewhere since the industrial revolution of the early 1800's has demonstrated that totally free enterprise does not succeed, either because of human failings such as greed, corruption, lack of empathy and integrity, or because some members of the population are unable or unwilling to function in a competitive environment. It would seem to be our duty to move toward a more perfect society which guarantees a minimal quality of life for all. It will take talent, generosity, and altruism to devise common sense, economical, and efficient government programs to achieve the goals described below.

The basic components to guarantee a minimum quality of life for every citizen and legal resident include: 1. the right to access high quality, affordable health care. 2. the right to a free, quality education up through vocational training and/or junior college. 3. a right to obtain safe, healthy, and appropriate housing at an affordable or subsidized price. 4. no one should have to go to bed at night hungry. 5. the hourly wage for adult labor should be pegged at a level to help provide a quality of life. 6. Every individual should be equal under the law and every citizen should have the right and expectation of uninhibited voting in local, state, and federal elections.

A few specifics might be in order. With regard to health care, our current federally funded Medicare program seems to be comprehensive and generally of high quality. It seems to operate fairly efficiently with reasonable administrative costs and fairly reasonable reimbursement to providers and allows for partnerships with private health insurance programs. It should be given the power to negotiate prices for drugs with pharmaceutical companies. The expansion toward a Medicare program for all (including federal employees and members of congress) could start with the replacement of Medicaid. The quality of the Medicaid program does not seem to be equal to Medicare, does not provide adequate compensation to providers, and burdens state budgets significantly.

Several developed countries have created educational programs, which pay for vocational training and college education for all of its citizens and legal residents. This is a win-win benefit for both the individual and for the nation. An educated work force dramatically increases the economic and social stability of the country.

Quality housing improves an individual's wellbeing and feeling of worth, health and safety, may decrease crime and improve school quality. This is especially important for children when one considers lead, insect, vermin and mold exposure, as well as issues of physical safety and fire danger.

The availability of quality nutrition is an important part of good health and ability to learn. The Food Stamp program and WIC funding for pregnant women, infants and children as well as subsidized school meal programs, food banks and kitchens are helpful. These efforts should be expanded.

The opportunity to get a job and earn a living wage fosters a feeling of wellbeing and better mental health. It reduces the incentives to crime, alcoholism, and drug abuse. It also facilitates the opportunity to find affordable quality housing and to purchase nutritious food. It should include important benefits such as health insurance, retirement, maternity leave and paid vacation.

These efforts are not merely altruistic. Many individuals in the United States are powerfully influenced by two important phenomena: The first is the profound and generally undeserved disparities in the standard of living between the hard-working population of men and women who make up the vast majority of individuals living in the United States and the wealthiest 1%, the so called millionaires and billionaires. The second is the stunning growth of the non-white population in this country, which will soon make the white population the minority, with its potential massive political and social implications. Attention to the above noted quality of life components guarantees could preserve the relative peace and tranquility in the country.

All of this may be a tall order but should be possible in this nation. It depends on our ability to elect quality legislators, select fair-minded members of the judiciary, and elect an inspired and inspiring president. This depends on broad voter protection and participation.
Section on Senior Members Program
Orange County Convention Center, W224G
Date: 11/4/2018
Start Time: 9:00 AM
End Time: 1:00 PM
CME: 3

Faculty
Katz, Irv | Posner, Franca | Powell, Kevin |

Description
What Every Senior Pediatrician Should Know

This is the only program designed specifically for senior-aged pediatricians and is open to all attendees. National experts will provide details on how to handle personal affairs after the death of a spouse or significant other, study alternative truths in medicine, and explore staying connected to pediatrics after retirement.

Agenda
9:00AM
Welcome
Phil Brunell, MD, FAAP

9:05AM
Toxic Stress: Lessons Learned for Maintaining a Quality Pediatric Practice When Dealing With Terminal Illness and Death of a Spouse or Loved One
Franca Posner, MSW

9:55AM
Presentation of Donald Schiff, MD, FAAP Child Advocacy Award

10:10AM
Evidence-Based Medicine in a World of Post-Truth
Kevin Powell, MD, PhD, FAAP

11:00AM
Break

11:15AM
Avoiding Depression and Maintaining Wellness in Retirement: Elements of Child Health Advocacy
Irv Katz

12:05PM
Business Meeting and Refreshments

1:00PM
Adjourn

AAP National Conference & Exhibition Schedule Change to Begin in 2019

Beginning with the 2019 National Conference in New Orleans (October 25th through 29th), the AAP National Conference & Exhibition education program will shift up a half day. In addition to the Pediatrics for the 21st Century program on Friday afternoon, a series of educational sessions will be held beginning at 1:00pm, followed by the President's Welcome Reception and AAP Kids’ Camp on Friday evening. The Saturday through Monday schedule will not change. On Tuesday October 29th, the National Conference will officially end with the closing Plenary Session at approximately 12:30pm. Questions or concerns regarding the National Conference can be directed to nce@aap.org.
Rising Interest Rates May Affect Your Retirement Income

Jeff Witz, CFP®

In June the Federal Reserve, commonly referred to as the Fed, raised interest rates for the second time in 2018. During the announcement, they also signaled they may raise rates another two times before the year is over. While generally a signal that the economy is strengthening, it does mean the rates on credit cards, home equity loans, and other types of borrowing will increase. Another common side effect of rising interest rates is that the price of existing bonds and bond funds generally fall. Many seniors own sizeable bond positions and rely on them to generate retirement income, so it is important to review how rising interest rates may affect investment portfolios.

Individual bonds, bond mutual funds and ETFs react differently to rising interest rates. Individual bonds pay a stated interest rate until they mature, so when held to maturity, investors are spared the impact of price fluctuations caused by rising interest rates. However, if investors are looking to sell a bond before maturity, they may have to do so at a discount. Why? Now that interest rates have increased, potential buyers can purchase that same face-value bond on the open market and receive a higher interest rate. To entice potential buyers to purchase your (now) less valuable bond, you must offer it at a discount, and there is still no guarantee you can sell it.

Changes in interest rates don't affect all bonds equally either. Generally speaking, the longer the bond’s maturity, the more it's affected by changing interest rates. For example, a bond that matures in twenty years will usually lose more of its value if rates go up than another bond that matures in five years. Also, the lower a bond’s “coupon” rate, the more sensitive the bond's price is to changes in interest rates. For example, a bond with a coupon rate of 3% will experience more price fluctuation than a bond with a coupon of 5%. The lower the coupon rate, with all other things being equal, the less valuable the bond and the bigger a discount that needs to be applied if the intention is to sell the bond. Bond mutual funds and ETFs react a little differently to rising interest rates. Since a bond fund doesn't have a specific maturity date, often the fund's total return will go down. Total return encompasses both change in prices and interest rate payments. If interest rates rise, the values of bonds held by the fund fall, negatively affecting total return. However, the fund continues to receive interest payments from the bonds it holds and will pass those along to investors regularly, maintaining current yield. Even in a rising rate environment, owning bond funds may make more sense to some investors. For example, bond funds tend to offer greater ability to sell at a given price, if you need to on any given day, and more diversification relative to individual bonds.

Whether you own individual bonds or bond funds, rising interest rates could cause some short-term difficulties. For individual bonds, if a bond needs to be sold to provide retirement income, it may need to be sold at a discount to attract a timely buyer. If you have bond funds, the short-term total return may be reduced. If you rely on income payouts from these funds to supply your retirement income, you may experience a reduction in payouts and may need to replace the lost income from other sources. Overall, bonds and bond funds remain an important investment asset and an integral piece of a well-diversified portfolio. However, now may be a good time to speak with your financial advisor to discuss the role bond holdings play in your portfolio and if any changes should be made.

Jeff Witz, CFP® welcomes readers’ questions at 800-883-8555 or at witz@mediqus.com.

This material has been prepared or distributed solely for information purposes and is not a solicitation or an offer to buy any security or instrument or to participate in any trading strategy.

Please consult your tax advisor regarding any questions you may have with respect to your personal tax liability.
Member Stories

Check out how members are engaging with the AAP and what inspires them to stay involved. Visit our AAP Get Involved page and click on the “Member Experiences Gallery” in the upper right to see their stories. And while you are there... share your own! We'd love to hear from you.

Guidelines for Senior Bulletin Articles

Lucy Crain, MD, MPH, FAAP Editor

Section members periodically ask for details of articles which are to be considered for publication in the Senior Bulletin. The Bulletin is published quarterly and, by popular request, are now all online but readily amenable to printing at home. Our Bulletin is not peer reviewed, nor does it strive to compete with scientific publications.

There's an 850-word limit for articles (with occasional exceptions). We welcome a wide variety of topics, including book reviews (500-word limit) and letters to the editor (350 words or less). We discourage lengthy life histories and scientific submissions which should more appropriately be submitted to peer reviewed publications. Generally, shorter is better and deadlines (published in each issue) are observed. We consider non- copyrighted “fillers” and occasional cartoons for most issues but cannot use all we receive.

The editor may defer publication of articles in order to reserve them for a periodic special focus issue and also has the right to refuse publication of inappropriate submissions. (Authors will be informed if this is the case.) Opinions expressed are those of the author, and we reserve the right not to publish material including obscene content and political rants. Fortunately, pediatricians are generally respectful of these considerations before submitting articles, and that is appreciated. Letters to the Editor are also sought for most issues and may relate to past articles or suggest topics of interest.

Questions about articles contemplated or in progress can be directed to me at lucycrain@sbcglobal.net or Co-Editor Dr. Manny Doyne at emanuel.doyne@cchmc.org. We look forward to hearing from you and to reading your articles in the Senior Bulletin.

2018-2019 Senior Bulletin Schedule

**Winter Bulletin - Electronic**
November 9, 2018 • Call for Articles
December 7, 2018 • Article Submissions Due
January 18, 2019 • Bulletin Online

**Spring Bulletin - Electronic**
February 11, 2019 • Call for Articles
March 12, 2019 • Article Submissions Due
April 19, 2019 • Bulletin Online

**Summer Bulletin - Electronic**
May 13, 2019 • Call for Articles
June 10, 2019 • Article Submissions Due
July 19, 2019 • Bulletin Online

**Fall Bulletin - Electronic**
July 8, 2019 • Call for Articles
August 12, 2019 • Article Submissions Due
September 20, 2019 • Bulletin Online
The Best of the Bulletin

Since its inception in 1992 the Senior Bulletin newsletter of the Section on Senior Members has been published quarterly. Hidden within the past issues are articles that needed to be unearthed for you, our members. We hope you find them thoughtful, memorable, entertaining and educational. We have published an initial list of the “Best” and will add to it over time. We hope you will enjoy this new product, found here on our SOSM Collaboration Website.

If clicking on “here” above doesn’t work, here’s the link: https://collaborate.aap.org/SOSM/Pages/Newsletters.aspx?RootFolder=%2FSOSM%2FSenior%20Bulletin%20newsletter%2FBest%20of%20the%20Bulletin&FolderCTID=0x01200092B0E35AC5C1B54987AFBA9168EDA4B4&View={E73B6D0E-0A89-40C7-B9EC-AA09A2DA0B09}

A special THANK YOU to Manny Doyne, MD, FAAP for envisioning the Best of the Bulletin and seeing it through with a little help from his friends (Dr.’s Mike O’Halloran, Lucy Crain, Art Maron).

AAP Mentorship Program

Mentorship is an important tool for professional development and has been linked to greater productivity, career advancement, and professional satisfaction. The AAP recognizes that mentorship is critical in helping nurture future leaders and a key opportunity to engage existing members and leaders. The AAP Mentorship Program seeks to establish mentoring relationships between trainees/early career physicians and practicing AAP member physicians. A primary goal is to promote career and leadership development. Mentors will have opportunities to further develop leadership skills and learn about emerging trends from the next generation of their peers. Mentees will gain a trusted advisor and learn methods to enhance career advancement. And all parties will form professional relationships and share advocacy, professional, and research interests.

Becoming involved is very easy. The only requirement to participate is to be a national AAP member in good standing. Participants need only sign-up and complete an online mentor/mentee profile form (you can sign up to be both a mentor and mentee if you so choose). The profile form collects information on education/training, subspecialty interests, practice/professional/clinical interests, and the amount of time the participant is willing to commit. Mentors/mentee pairs will have the ability to meet traditionally in person if they choose a local match or use one of several online tools to meet virtually.

The program is set-up for both “traditional” long-term relationships, as well as short-term “flash” mentoring. The flash mentoring component allows for mentees to contact mentors for quick questions, set up 1-2 meetings, as well as participate in online topical forums and Q&A forums. Therefore, the time commitment and expectations can be tailored to fit each mentor/mentee pairs’ needs.

[Please note: Administrators reserve the right to deactivate participants after 6 months of inactivity.]

Visit www.aapmentorship.chronus.com and sign up to be a mentor and/or mentee today! AAP login and password required.

Remember to Vote KIDS!