Message from the Chairperson

Eileen M. Ouellette, MD, JD, FAAP

The Executive Committee (EC) of our Section has had two changes recently. Dr. Will Brown completed his term. Will is an active advocate for children and is a frequent correspondent with political representatives and the White House. He was a breath of fresh air on the EC.

Dr. Renée Jenkins joined the EC on November 1, 2018. She is a past president of the AAP with a long history of service to children and the Academy. We are delighted to have her join us and we look forward to her participation in our Section initiatives.

We are also sad to lose Dr. Michael O’Halloran on December 31st, as he completes his stint as Section Webmaster. Mike agreed to take this task on for 2 years but then stayed on to oversee the completion of the new Collaboration Site. He has done a terrific job on this site, in conjunction with Katie Clark, our Section Manager.

We are fortunate to have recruited Dr. Thomas Whalen, a Pediatric Surgeon, who has agreed to assume this task. Tom has been a Webmaster in two organizations. We look forward to his participation on the EC, as well as his continuing the development of the Collaborative Site.

The EC met at the National Conference & Exhibition and considered a number of topics. Membership in SOSM continues to grow at a rapid rate as our AAP members in the baby boom generation age into Senior Section eligibility. The Section membership count is now 4,362 as compared to 2,204 in 2017.

Many members of the Section have been active in the AAP over many years and are looking for opportunities to continue to contribute to improving the health and welfare of children. I am hopeful that our newly established Subcommittee on Advocacy will provide one such opportunity.

Dr. Renee Jenkins has agreed to chair the Subcommittee with the assistance of Dr. Larry Shandler. Dr. Shandler, a former President of the New Mexico Chapter, has established a Senior Section in New Mexico. His experience will be invaluable in assisting us to develop an advocacy curriculum and in setting up Chapter Sections.

In addition to a discussion of the Senior Section Advocacy Project, we have had two conference calls to begin planning. We have had the valuable participation of Dr. Lisa Costello, from the Section on Early Career Physicians, Dr. Rachel Nash, from the Section on Pediatric Trainees, Jamie Poslosky, Senior Director, Advocacy Communications from our Washington office, Julie Raymond, Senior Manager, Member Engagement, Britt Nagy, Manager, Early Career Member Engagement and our own Katie Clark, Senior Manager, Member Operations.

Our initial plan is to organize the Advocacy Subcommittee by District, as each Chapter is different, and they are currently used to interacting by District. A Senior Section in Texas, our second largest state, will look very different from one in

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Rhode Island, our smallest state. I presented this plan to the Past Presidents Advisory Committee and to the current and Past Board Members meeting at the National Conference & Exhibition and was heartened by the enthusiastic response and by the number of people who have volunteered to assist us in developing this initiative. I spoke to the Chapter Executive Directors at the ALF and they were also enthusiastic.

We will move ahead with planning in the new year and soon we will look for volunteers among our members. Stay tuned.

We were rejected in our request that all SOSM members 80 years and above have their NCE registration fees waived. We were told that the fiscal note would be $300,000. We believe this note is incorrect. Someone simply multiplied the number of eligible seniors by the registration fee, whereas for the past 5 years only 10 to 25 octogenarians have attended.

We are resubmitting our request, and, with a more realistic fiscal note, we hope to have a more positive response this time.

I wish you all a very healthy and happy new year.

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**Dr. Goza voted AAP president-elect.**

Sara “Sally” H. Goza, M.D., FAAP, of Fayetteville, Ga., has been voted AAP president-elect. She ran against George C. Phillips, M.D., M.B.A., FAAP, of Overland Park, Kan.

Dr. Goza will take over as president on Jan. 1, 2020, following Kyle Yasuda, M.D., FAAP, of Seattle, who will serve as president in 2019. To read about Dr. Goza’s background, visit [http://bit.ly/2SrJk46](http://bit.ly/2SrJk46).
Winter 2019 Editor's Note
Lucy Crain, MD, MPH, FAAP
Editor in Chief, AAP Senior Bulletin

Happy New Year! When this issue of the Senior Bulletin is posted online, 2019 will be well into its first month. We'd like to think that a more hopeful outlook prevails for the children of our nation and our world.

As always, our authors have submitted a variety of topics well worth reading. Starting with advocacy, Dr. Schiff reminds us of several compelling topics which deserve pediatric attention. Dr. Boulter's liaison report from the AAP Committee on Federal Government Affairs (COFGA) highlights many of those. Dr. Peter Gorski, a Behavioral Developmental Pediatrician provides access to his recent letter on firearm violence published in the Miami Herald, underscoring how important it is for us to write to our local newspapers about the epidemic of firearm related deaths in our country and suggested preventive means. Dr. Will Brown, a Vietnam veteran, succinctly outlines “A Call to Action” for such advocacy. As we go to press, this week's anniversary of the tragic Sandy Hook massacre mandates that we not forget to speak up for children and speak out against gun violence!

Those who were fortunate to attend the November 3 Senior Section Education Program will recall the excellent program organized by Dr. Phil Brunell. For those unable to attend, summaries of their topics by the speakers are included, along with comments by Dr. David Clark on receiving the Section's Annual Donald Schiff Advocacy Award. (Thanks to Dr. Michael O'Halloran and others for providing photos from the event.)

We're also introducing grouping of articles on Global Health Issues and also on Physician Health and Wellness. The latter features a personal account by Dr. Luisa Stigol of her experience with long term survival after her diagnosis of ovarian cancer. My appended note reminds our readers that this cancer is most common among women in our senior age group, and that early diagnosis and treatment are crucially important for any hope of survival.

The frustration felt by many of us trying to obtain the CDC recommended new Shingles vaccine (Shingrex) when it is in inadequate supply in most parts of the U.S. is well described by Dr. Edgar Marcuse. It appears that advocacy for seniors, as well as for children, is indicated!

Letters to the Editor remind us that trying to remain apolitical in our Bulletin is often challenging. The AAP is a large organization comprised of members of diverse backgrounds and opinions. Listening to and sharing differing opinions is one of the functions of the Bulletin. Thanks to our contributors for reminding us of that.

We hope that you enjoy this issue of the Senior Bulletin. Check out the Guidelines to Authors and submit an article for consideration for an upcoming issue!
Reflections on Advocacy – 2018

Don Schiff, MD, FAAP – Advocacy Column

The tumultuous year which we will soon leave behind has provided more opportunity than most of us desire to ponder the best means to advocate for children. The chaos at our Southern border including the forced separation of children from their parents, some of whom may never be reunited, and the recent use of tear gas on children and their mothers is inhumane and an insult to our Nation’s morality. In addition, the daily attacks on our health care system with a special emphasis on depleting support for the Affordable Care Act (Obamacare), food programs, and other safety net programs continue under our current administration. Less well publicized deregulation of programs which protect us from elevated levels of lead in our drinking water (Flint) methane and other gaseous pollutants in our atmosphere are exclaimed as prideful efforts by our current administration. It is not a surprise that every day new issues confront child advocates forcing a recognition that we cannot allow this mindless situation to persist. Change requires that we pediatricians, the AAP, and our dedicated advocate allies for children must strive together to produce the lifesaving changes required. The results of the recent midterm elections have given us hope that this can be achieved as Nebraska, Idaho, and Utah each passed Medicaid expansion legislation. Maine which passed this expansion 2 years ago will now be able to put it into effect with the arrival of a new governor. Pediatricians and the Academy will maintain our vigilance and continue the battle with the anti-vaxers and other anti-science groups by defining and acting on life threatening issues. Three issues have reached an epidemic status. Pediatricians and the Academy leaders and membership have spoken out and supported changes in our lifestyle which if implemented would clearly be beneficial. First on this list of three must be drug (opioids) abuse, which has an increasingly advancing rate of morbidity and mortality. New research and changes in availability of opioids such as the reduction in prescriptions in the emergency rooms and dentist offices are important changes in policy. Gun safety and violence in our society is faced with the daily number of 17 deaths a day related to guns. In spite of the morbidity and mortality due to both legal and illegal guns “we” continue to believe that it is impossible to make the necessary legislative changes to increase safety for children and adults. This in spite of the agreement by the general public that gun safety is basic and the opposition by the National Rifle Association and similar groups can be overcome.

The overarching issue affecting our planet is of course global warming. Increasing evidence of its existence has been observed for decades but continues to be debated by those who refuse to accept its worldwide effects. Sea water which flows through the streets of Miami and Norfolk, Virginia and threatens to submerge entire Pacific Islands as well as major portions of Bangladesh are demonstrable experiences. Global Carbon emissions have recorded a new record high in 2018. The critical effort to prevent the average global temperature from rising an additional 2.7 degrees “F” can only occur if the United States takes effective measures to control our own emissions. Some will say that this is not a pediatric issue and that we should continue to concentrate on the problems presented by flaccid myelitis and the over use of antibiotics. However, my inclusion of Global warming in the threats to the lives and well-being of our children (USA & World) is exactly where it belongs in my opinion.

COFGA Liaison Report – December 2018

Suzanne Boulter, MD, FAAP – Senior Section Liaison to COFGA

The good; the bad and the ugly since the last COFGA meeting held in Washington, DC in September ....

First the Good:

First Pediatrician Ever Elected to Congress!!
Dr Kimberly Schrier was elected to the U.S. House of Representatives from Washington State. Her agenda is consistent with all the AAP initiatives for children.

Federal Budget appropriations – Increased federal funding was obtained in the last budget for NIH, Head Start, Children's Hospitals GME, National Center for Birth Defects and Developmental Disabilities, Lead Poisoning Prevention, Child
Abuse Prevention and Treatment, and poison control. First time funding was included for Pediatric Mental Health Care Access Grants and Screening and Treatment for Maternal Depression Grants.

**Tobacco** – Commissioner Scott Gottlieb of the FDA issued a threat of fines to manufacturers promoting products to children (which was far short of steps needed to reverse the serious epidemic of E cigarette use via vaping products). A lawsuit is also pending asking the FDA to reinstate the requirement for graphic warnings on tobacco product packages. More restrictions have been placed on E cigarettes since then. The most successful seller of this product – Juul Labs – stopped selling fruit-flavored nicotine pods to stores and shut down its Facebook and Instagram accounts in November as a result of FDA pressure. AAP is continuing to ask for additional restrictions on E cigarettes and flavored cigars to stem the marked increase in teens becoming addicted to tobacco products.

**EPA**– Chlorpyrifos (pesticide in food chain resulting in adverse birth and developmental outcomes) once again has been banned. Acceptable lead level reference being decreased from 5 ug/dL to 3.5 ug/dL.

**Child welfare: *Family First Prevention Services Act*** – This act has huge potential benefit for vulnerable kids! Preventive services will be funded before any decision is made regarding placement out of the home for at risk children. These funds can be used for mental health and substance abuse services for both caregivers and affected kids. AAP is working with other partners to share information with pediatricians about what groups to partner with in each state. This is very good news for children at risk of neglect or abuse.

**Opioid abuse** – Legislation passed favorable to prevention and provision of services to infants, children and teens.

**Now the Bad and the Ugly:**

**Gun violence** –
No progress in spite of continuing mass shootings!! Immigrant issues.

**Public charge** – this term is defined as “someone who is primarily dependent on the government for subsistence”. Under the new proposal public benefits such as anyone in the family at risk for or needing WIC, SNAP, CHIP, ACA subsidies, or Section 8 housing assistance could seriously jeopardize their ability to get a visa or green card resulting in the family’s not seeking benefits such as Medicaid or CHIP for their children’s health care needs. Public comments are being accepted until December 10th. Flores settlement agreement – sets standards for conditions in detention centers; current administration is proposing rules to circumvent those standards.

**Family separation** – over 3000 children were separated from their parents this summer and placed in detention centers.

**Family planning** -This administration is promoting “abstinence only” as a requirement for federal funding and is removing reproductive health care access to immigrant unaccompanied minors.

**Health care** -Still the most critical issue for voters! Obamacare blamed for everything going wrong. Medicaid 1115 waivers are being encouraged and quickly approved. Many include work requirements but also mandatory drug testing of recipients, and removal of EPSDT benefits for 19 and 20-year olds. Junk insurance plans appealing to public; these plans cover almost nothing.

**Association Health Plans** – widely marketed; can cross state lines; little preventive care and no Bright Futures guidelines included.

**Short Term Limited Duration (STLD) Plans** – current administration allowing much longer duration (up to 12 months x 3 years) drawing healthy people away from other plans resulting in increased cost for other plans.
Summary
While current health care challenges for children may seem daunting in the current administration, our AAP Washington office is significantly involved in all the issues affecting children and is a highly respected organization in DC helping to make significant positive changes! Updates about immigrant issues, gun safety, tobacco and E-cigarettes, and the importance of voting are sent to our email addresses often. We have to remain optimistic and keep advocating for our children!

What Every Pediatrician Should Know
Section on Senior Members
National Conference & Exhibition Educational Session
Sunday, November 4, 2018 in Orlando, FL

9:00 AM Welcome Philip Brunell, MD, FAAP

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

9:55 AM Eileen M. Ouellette, MD, JD, FAAP, Chairperson of the SOSM Executive Committee Presenting The Donald W. Schiff, MD, FAAP Child Advocacy Award to David Albert Clark, MD, FAAP
10:10 AM Kevin Powell, MD, PhD, FAAP
Evidence-Based Medicine in a World of Post-Truth

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

Section on Senior Members Executive Committee Meeting
at the National Conference & Exhibition, Saturday, November 3, 2018

Executive Committee Fall 2018 Meeting:
Eileen M. Ouellette, MD, JD, FAAP, Chairperson
Katie Clark, Senior Manager, Membership Operations and Data Services
Michael O’Halloran, MD, FAAP, Webmaster

Executive Committee Fall 2018 Meeting:
Philip Brunell, MD, FAAP
Renée R. Jenkins, MD, FAAP
Lucy Crain, MD, MPH, FAAP

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Executive Committee Fall 2018 Meeting:
Shana Godfred-Cato, DO, FAAP
SOECP Liaison Edgar K. Marcuse, MD, MPH, FPIDS, FAAP
Debra Sowell, MD, FAAP
William Brown Jr, MD, MPH, FAAP

Dr. Ouellette, thanking William Brown Jr, MD, MPH, FAAP for his years of service as Executive Committee member.

Executive Committee Meeting:
Dr. Ouellette, thanking Michael O’Halloran, MD, FAAP for his years of service to SOSM in several capacities.
Advocacy for children and their families is a privilege, an honor, and a duty thus earning your PHD. In the memorable words of former congressman Davy Crockett (1786-1836) (Congressman from Tennessee 1827-1831, 1833-1835) “Be sure you’re right then go ahead”.

The basic components of advocacy are:
1. What resource are you seeking?
2. Who is your audience?
3. Why do you/should you have access?
4. What is your message?

Resource:

Clearly define what resource you hope to be able to provide for families. Commonly, it is funding for some level of healthcare such as immunizations, insurance coverage for specific medical conditions, or education to ameliorate a condition such as obesity or drug abuse. Some of the funding may be available or perhaps insufficient in federal and state public plans such as Medicaid, SCHIP, or Medicare. You may seek to have a mandate for private insurance companies to assume some financial responsibility in the care of children with complex and chronic medical condition.

Apart from government, there are many potential private donors that may devote some of their resources to a cause for children. In addition, numerous disease specific foundations support a specific issue such as Juvenile Diabetes, Cystic Fibrosis, Muscular Dystrophy and Childhoods cancers.

Audience:

Although advocacy is commonly targeted toward elected government officials and their staff, elected politicians are not the only audience. Knowing the background or previous occupation of the politician may be helpful. Many are lawyers or businessmen with limited scientific expertise.

Many regulations and decisions, especially in the states, arise in the multiple agencies of the executive branch. For example, child passenger safety regulations are the responsibility of the Departments of Transportation. School health regulations, including the use of glucagon and epinephrine pens come from the Departments of Education. The Department of Health oversees health care facilities, screening for newborn metabolic disease, and outbreaks of infectious diseases. Employees of these executive agencies often have the authority to implement a policy without additional approval of legislators. If more resources are necessary, they may know the insider route to accomplish your mission.

Access:

Why should they listen to you? Your access improves if you are a constituent in the district of a politician. You can vote and perhaps influence others to vote.

Your credentials are important. Your medical degrees imply a level of expertise regarding the issue for which you are advocating. You care for children, usually a soft spot for politicians especially if they have grandchildren. You may care for the children with complex disease such as cystic fibrosis, sickle cell.
disease, cancers, or genetic diseases. Some of those children and grandchildren are the offspring of the politicians, their staff, or the employees of the various executive branches.

As a well-educated professional, they may hope that you become a supporter, a potential scientific advisor, and perhaps even a contributor to their campaign coffers.

**Advocacy Message:**

Your message should be important, accurate, useful, and timely. More than one or two points is sufficient. The prime message will be diluted with raising multiple issues.

It should be well researched and accurate. Typical resources for Pediatricians include policy statements and position statements from the AAP, AAFP, AMA, and other reputable organizations. You do not have to quote a recent article in the New England Journal of Medicine. Rest assured the person to whom you are advocating has not read the article and even if they did, they do not have the scientific training to fully understand it.

The message should be useful enough that it can be passed along. It should not be filled with medical jargon (“Medi-calese”) nor must it be phrased (“Legalese”) to appease the many lawyers who are elected officials.

**In Summary:**

Know your limitations. You do not have to be the “lead dog”. Know your resources and colleagues.

I am forever indebted to the many excellent professional role models who trained me, encouraged me, challenged me and remain dear friends.

I personally have much to learn and much to share. Be open to learn from and be a mentor to your colleagues, students, residents, fellows, and other health care professionals.

I trust that you will be as important to me as are my fingers. I can always count on them and trust that I can count on you to be informed and engaged.

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**Summaries of Presentations by Speakers at the 2018 National Conference & Exhibitions SOSM Education Program**

**Purpose After Practice: My Turn Talking with Senior Members of AAP**

Irv Katz, Senior Fellow, Generations United ([www.gu.org](http://www.gu.org))

I said yes enthusiastically when our Executive Director asked me to give a talk to the Section on Senior Members at the AAP conference. Two reasons. First, kids are an integral part of the work of Generations United (which I represent) and who knows kids and how they are affected by today’s world better than pediatricians? Second, I’m a few years into the post-full-time employment phase of life and am in a position to appreciate the feelings and the options for fulfillment of our continuing yearning for purpose beyond self and family.

As expected, the members I spoke to and with were well familiar with the importance of intergenerational connections and of the large and growing phenomenon of grandparents—and other kin—raising grandchildren, a problem exacerbated by opioid and other addictions. It’s long past time for society to appreciate Grandfamilies as a common family type and provide them with the support they need. AAP and its members experience this phenomenon in their practices and have been great allies in raising awareness and addressing the issues of Grand families.

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As a “retiree” (not exactly true as I still work but not at one job full-time) and a social worker, I am interested in how we all deal with the years that follow full-time work. I spoke about the range of options, recognizing that we all seek fulfillment in different ways. I shared this graphic (source unknown), which I find helpful:

Some are happy with sports, cards, home-owners association, etc. Others of us still need to exercise our professional or vocational skills, to sustain some degree of the position we held in the community before retirement, to contribute to the well-being of others and the community, to keep a toe in the game. It can take a while to find the spot where all the circles overlap but it is worth the journey.

I was involved in Generations United for many years before I “retired” and it’s a privilege to be working for this organization and this cause. It is not out of nostalgia for the extended families of the past that drives the growing community of intergenerational connectedness. It is in recognition of two facts that are irrefutable: 1) we are organisms that learn and care for one another across generations, and 2) we have lost much of the organic intergenerational learning and caring in developed countries. Spilled milk and the old days will never return but thirty plus years of research and action demonstrate that new intergenerational bonds can be built and benefit young and old---and our communities as a whole—beyond the imagination.

I hope you find the intergenerational message valuable and will find ways to help build a new intergenerational reality for the generations of today and tomorrow

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**Summary of Section on Senior Members H-Program**

**Franca S Posner, MSW, LCSW-C**

2018 National Conference & Exhibition SOSM H-Program Speaker

This presentation started with a statistic. Sounds like the start of a boring hour, right? But the attendees all agreed, 100% of those gathered, including the presenter are going to die! Once that basic fact was established, we were able to explore the top causes of death the 65+ population in the USA.

Although the pediatricians in attendance have been in private practice for many decades, unless they work in an acute care setting or hospice/palliative care setting, many have likely not cared for a dying patient since their residency or fellowship.

The importance of having conversations with loved ones about your personal values and wishes surrounding significant illness and debility, followed by completing an advanced directive conveying those wishes were stressed. Updating existing advanced directives is also important, as personal circumstances might have changed.

Whenever or however we ourselves or our spouses, siblings or other loved ones become increasingly debilitated, decisions must eventually be made regarding how to best care for someone challenged by a chronic or acute illness. While the answer might be different for each person and family, or even become different for an individual over time, there is no “right” answer to what is the best care to provide a loved one or seek for yourself. Keeping yourself and your family well educated regarding treatment options, advocacy and support groups, and local care options can be vital. Caregiver respite is a vital aspect of any caregiving situation.

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Lastly, when a loss occurs, seeking support during grief can be an important step toward emotional and physical well-being. While many communities offer grief support groups, some people prefer to seek support from family, friends, or a faith community. Still others might find individual therapy is the best fit to help them cope with their feelings after a death. Anyone who had a difficult or conflicted relationship with the deceased will likely benefit from greatly from counseling support.

The high incidence of depression and social isolation in the elderly is a significant public health issue, and often goes undiagnosed. The impact of deaths of a spouse, siblings, and friends, coupled with declines in mobility, hearing and/ or vision, and other age-related issues such a minor or significant memory problems can increase social isolation and depression.

Be proactive and educate yourself about local resources in your community. Update or create an advanced directive. Give your adult children or other family the gift of advanced funeral planning, as well as putting special wishes such as organ, tissue, or body donation in writing. Medical schools often struggle to have enough donations for anatomy lab, so this is an option to consider if it is in keeping with your personal values.

Some books to consider should you wish to explore these issues further are listed below.

*Being Mortal* by Atul Gawande

*Handbook for Mortals: Guidance for People Facing Serious Illness* by Joanne Lynn MD, Jean Harrold, MD, and Janice Lynch Schuster, MFA

*The 36-Hour Day* by Nancy L. Mace, MA and Peter V. Rabins, MD

*Swallowed by the Snake: The Masculine Side of Loss and Healing* by Tom Golden

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**The Motivation to Publish Harms the Quest for Truth**

*Kevin Powell, MD, PhD, FAAP*

The quest for knowledge and truth is a noble one, but fraught with difficulty. On repeated occasions throughout history, philosophers and scientists have concluded that too much of their knowledge is wrong. They start over from scratch. Most famously, René Descartes did this with “I think, therefore I am” in his 1637 Discourse on the Method. It also happened in 1910, when the Flexner Report closed half of American medical schools and revolutionized the remainder. Then again in 1972, Archie Cochrane advocated using randomized controlled trials and distrust medical knowledge vetted by any other means. Two generations later evidence-based medicine (EBM) has failed to purify medical knowledge. In 2005 John Ioannidis authored “Why Most Published Research Findings Are False.” Mark Twain is credited with the maxim “It ain’t what you don’t know that gets you into trouble. It’s what you know that ain’t so.” Ironically, it probably ain't Twain who said that.

The concept of truth itself has evolved. Scholars refer to the Classical Era of philosophy, the Modern Era after the Age of Enlightenment, and the Postmodern Era of the late 20th century. To understand this as a sports metaphor, classically a thrown football was a completed catch if the ball didn't touch the ground. Modernists therefore opine that truth is not absolute but dependent on the vision of fallible human referees. In the Postmodern Era, hermeneutics (The science of interpretation within a cultural context.) dominate. We abandon the simple definition and develop human constructs of “going to ground,” “maintaining control,” and “making a football move.” The resulting absurdity nearly tainted Super Bowl LII. I’ll assert we've entered a fourth era, the Transhuman Era, where instant replay is ubiquitous. Whenever a receiver crosses the goal line, all the players stop and stare up at the scoreboard screen until something electronic certifies whether or not a touchdown was truly scored.

The same phenomenon has happened in medicine. Twenty years ago, a feminist friend chose a home birth. I made a house call to examine the baby. The parents were appreciative. But today my exam no longer counts. At least four ma-
chines must examine a baby before s/he is discharged from a nursery. There is the glucometer, the hearing screen, the pulse ox, and the transcutaneous bilirubinometer.

In the Postmodern Era, an overreliance on hermeneutics has produced politics with tribal polarization and alternative facts. In the Transhuman world of Twitter and Facebook, the opinions of celebrities and the gossip masquerading as a newsfeed are as meritorious as the learned opinion of the gray-haired physician. Scientists and physicians have lost the social credibility they had when man walked on the moon.

Many factors have corrupted the quest for truth. Mercenary scientists betray the quest; instead they sow doubt. They impugn evidence showing harm from smoking, lead, and climate change. Clinical trials of psychiatry drugs funded by pharmaceutical companies led to an uproar a decade ago. Now every presentation at a medical conference has a disclosure slide. Unfortunately, this has not noticeably improved the reproducibility of research.

In the 1920s, RA Fisher developed statistical methodologies for research. Those methods have mutated into meta-analyses of underpowered studies reporting the relative ratios of propensity scores. Computers spit out P values. The analysis is no longer transparent to the typical physician. In 1994, Doug Altman, an Oxford statistician, called the quality of medical research scandalous. He attributed this partly to the academic emphasis on publishing. He urged us to do less research but do it better. In 2014, the former editor of BMJ, Richard Smith, reaffirmed this assessment. EBM is not working.

I believe in EBM, but I see the need for reform. One source of the malefeasance is insufficient training of the large number of physicians doing academic research. While I can offer a set of reforms based mostly on proper use of statistical tools, I do not believe those reforms will solve the underlying problem.

The larger impact flows from inadequate skepticism by these researchers. The classical scientific method relies on a reputable scientist’s maximal effort to disprove their own hypothesis. They only publish when they have exhausted all legitimate attempts at alternative explanations. The typical modern researcher is strongly motivated to publish. They will massage the data, even waterboard it if necessary, until it confesses something with a P value <0.05, truthful or not. As long as the eagerness to publish outweighs the skepticism, I do not expect reforms to be effective. The incentives of academic medicine must change.

Quixotic? Yes. I realize I’m challenging the entire structure for academic advancement. So, I am appealing to the senior pediatricians who have witnessed unimaginable changes over 50 years. Restaurants and bars are non-smoking. Infants are in car seats. Babies sleep on their backs. Atopic infants are being fed peanut butter. Fundamental, radical change is possible. President John F. Kennedy, speaking at the Parliament in Ireland, quoted the Irish playwright George Bernard Shaw, “Other people see things and say ‘Why?’ But I dream things that never were-- and I say: ‘Why not?’”

Advocacy Efforts to Note:

Peter A. Gorski, MD, MPA, FAAP authored a commentary published by the Miami Herald on November 20, 2018, offering a pediatrician’s perspective on gun violence as a public health epidemic.

“Mass shootings and terrorist attacks, while the most visible forms of gun violence, account for only a small fraction of firearm morbidity and mortality in the United States. They have also changed the questions and advice pediatricians now routinely discuss with children and families. As I witness a tide of citizens demanding universal access to the human right to healthcare, I hope that we will also act together to keep our children safe and enable them to live to their fullest potential. Health professionals, lawmakers, public officials, teachers, business leaders and neighbors — all of us are needed to stop the trauma, protect the public’s health and make America healthy again.”

If you would like to read the entire article, please click on the link below:

Advocacy Opportunities: A Call to Action!

Wm. R. Brown, Jr., MD, MPH, FAAP

“Yesterday is history, tomorrow yet a mystery. Today is a gift; that’s why we call it the Present.” Anonymous

The midterm elections are “yesterday.” There are 745 “tomorrows” until 11/3/20 and the general elections. What will be the ABC 20/20 report that night in 2020? That depends on what we as responsible citizens commit to for the next 103+ weeks.

TODAY, (11/9), I’m currently delayed by freight traffic east of LA on the SW Chief. From Union Station, I plan to go to the Bob Hope USO at LAX to await HA 9 to HNL, create and complete emails.

By November 2020 election there are potentially hundreds of thousands of newly-eligible voters, including naturalized citizens.

Suggested TO DO LIST FOR ALL SENIOR PEDIATRICIANS:

Concept: in conjunction with local school boards, administrators and election officials, organize and implement high school onsite eligible voter registration. Be creative. Have booths/tables at school athletic events, Homecoming dances, Proms, national holiday celebrations. Expand to community gatherings, county fairs, church gatherings, weekend mall tabling...imagination.

Prepare “Get Out the V O T E” registration/transportation activities. Make the “the FALL of 2020 the RISE in voter participation each of the 24 months, 103 weeks, or 745 days until our next important voting opportunity/responsibility. Just “do it.” Spread the word and action!

Global Health Issues

Global Work in Myanmar (Burma)

Catherine DeAngelis, MD, MPH, FAAP

I believe that remaining relevant is one of the most important criteria for happiness and sound mental health after retirement. That can be accomplished in many ways, one of which is for senior pediatricians to continue using our expertise by consulting or volunteering to help where we are needed, whether in our own or a developing country. The joys of working in a different culture include the knowledge and experience gained from the people with whom you work and the feeling of self-worth. That is why I agreed, when requested by the Minister of Health (MOH) of Myanmar, to work with the Rectors (Deans) and faculty of the five public (nonmilitary) medical schools to revise and upgrade the curriculum used by all schools. The funding for the revision and for the renovation of Yangon General Hospital was provided by an NGO from the United Kingdom.

Because he knew that my husband, Dr. James (Jim) Harris, a developmental Neuropsychiatrist, and I never travel outside the US without each other, the MOH asked him to help upgrade the psychiatric/mental health graduate education and services. In 2012 and 2014 we had minor projects in Myanmar funded by small grants we had from the Fetcher Foundation. We also had been there in 2016 when Jim spoke at an international conference in Yangon.

The MOH had requested that we spend three months or more with this project, but that simply was not feasible. Instead we spent two and a half weeks in April/May and again in October/November of 2018, during which I was able to accomplish establishing the foundation for the new curriculum and Jim consultation in Psychiatry. I provided supplementary consultation between those visits via email and will continue to do so as long as my help or suggestions are needed.

The successful result in two visits was possible because of the dedication and productivity of my partner, Professor Aye

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Global Work in Myanmar (Burma)  Continued from Page 14

Maung Han (chair of the curriculum committee and former Rector of Yangon 1 Medical School) and our special assistant, Professor Khin Mar Myint. One problem for me was remembering and pronouncing the Burmese names. Everyone has two or three names, but all are pronounced together as one name. The first name is the day of the week the person was born, so there are seven first names for everyone. We solved my problem by agreeing that we all would have one simple name, Aye Maung Han became “A”, Khin Mar Myint became Kim and I became Cathy.

One thing I learned from the start is that the Burmese, like my heritage Italians, love to eat and laugh. Every day when I arrived at 8:30 am at the Yangon 1 Medical School, breakfast was ready, and all present were eating. There was also a 10:30 snack break, lunch at 12:30 and another snack break at 2:30. We finished around 4:30 or 5 pm and they went home for dinner. Amazingly, the young were thin and while the older folks were heavier, there was only a rare obese person. My only eating breakfast and dinner at the hotel or restaurants caused grave concern, so I happily ate their delicious soups and tropical fruits.

The Burmese are very close to their families and have great respect for seniors. It is usual for several generations to live together or close by. The idea of a nursing home was unheard of.

The biggest issue to be resolved in the curriculum was the idea that psychiatry was an essential component of any medical education. Like most Asian cultures, psychiatry and “crazy” are associated and no one wants a “crazy” person in their family. Prior to the new curriculum, psychiatry consisted of a few lectures on depression, schizophrenia and Alzheimer Disease taught in the pre-clinical years by physiologists and pharmacologists. The new curriculum retained the pre-clinical lectures but now co-taught with psychiatrists and added a six-week clinical rotation in one of the clinical years and the possibility for a psychiatry elective in the final clinical year. One problem is that for the Yangon population, currently there is only one psychiatric hospital located an hour and a half drive from Yangon. However, the plan is for the renovation of Yangon General Hospital to include an inpatient unit and an outpatient clinic.

The basic foundation for the new curriculum is shown in the figure below. Hopefully, the first class to be taught this new curriculum will enter in December of 2018. The Foundation year faculty are ready and eager to start, and that would allow plenty of time for the following years to be finalized and ready. As I said over and over to the faculty, the curriculum, like the human body, will be in dynamic equilibrium and will change as knowledge increases and teaching methods advance. If you wait until all aspects are in place, the curriculum will never start.

What a great adventure this has been, and I hope future Burmese doctors and their patients will benefit from the new curriculum.

Figure: Blueprint for The Basic Curriculum Framework
How Germany Supports Families with Children

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

This past summer while traveling in Germany, my wife and I had the opportunity to share dinner with a couple from the US (roots in Baltimore) who had relocated with their toddler son to Berlin to pursue graduate studies. Our conversation turned to financial issues they faced living in Germany and it was enlightening to hear about the social and financial programs available to support families and encourage more participation by women in the workplace. For starters, the Maternity Protection Act of 1968 (Mutterschutgesetz), recently amended in 2017 ensures that pregnant women are not discriminated against when applying for jobs and are protected from dismissal from work during their pregnancy and for a period of 4 months after delivery. Women do not have to work during the last 6 weeks of pregnancy and are not allowed to work until 8 weeks after delivery. This is extended to 12 weeks following premature or multiple births or the birth of a child with a disability. During this period the woman is paid at the rate equal to her average remuneration over the last 13 weeks or 3 months before pregnancy. The Protection Act also mandates that employers adhere to workplace protections to ensure a healthy and safe workplace environment, including adequate facilities and break time for nursing mothers.

In addition to the Maternity Protection Act, there is a very generous parental leave policy (Elterngeld) for new parents. Employees are entitled to parental leave until their child turns three. They are not obliged to work during their leave and they enjoy special dismissal protection. Leave can be taken by the mother and father individually or jointly as long as they are not working more than 30 hours per week. For children born after July 1, 2015, up to 24 months of leave can be claimed between the ages of 2 and 7. The monthly parental allowance is roughly two-thirds of a parent's previous monthly income up to a maximum of 180 EURO (about 209 US dollars). It is paid for 12 months for one parent or up to 14 months if the mother and father share the allowance. There is a "Parental Allowance Plus" option which gives parents the right to receive the parental allowance for up to 24 months, or up to 28 months if the allowance is shared between the parents. While the duration of parental leave doubles, the amount paid remains the same as payments will merely be stretched out over a longer period.

Residents of Germany are also entitled to a Child Benefit Allowance (Kindergeld) from the government to help defray the cost of raising children. It can run from 194 EUR (about 225 US dollars) for each of the first 2 children up to 200 EURO for the third child and 225 EURO for each subsequent child and the benefit lasts until age 18 or to age 25 if the dependent is still in school or meets other requirements for an extension. The benefit is available to a parent, adoptive parent, step parent, foster parent or a grandparent providing a home for grandchildren.

Once a parent decides to return to work, there is significant government support for daycare. The cost of daycare across the 16 German states can vary from 1.8% to 9.0% of after-tax income and not every state offers a daycare subsidy. However, as of August 1, 2018 parents in Berlin will no longer have to pay any fees to place their children in municipal daycare centers. They will only have to pay for food.

These benefits obviously come at a cost. The first 9000 EURO (or 18000 for a married couple filing jointly) earned each year is tax-free. Any higher amount is subject to a progressive income tax starting at 14% and rising incrementally to 45% for very high incomes. On top of this is a value added tax (VAT) of 19%, a solidarity tax capped at 5.5% of one's income tax, a church tax of 8% or 9% of income for members of a church registered in Germany and a variety of social security contributions for health, nursing care, pension, unemployment and accident insurance. Interest, dividends and capital gains are subject to a flat tax of 25%.

It is interesting to compare benefits in Germany to what is available in the US. While several states (California, New Jersey, Rhode Island and New York) have mandated paid family leave plans, the US is the only developed country without a national mandatory parental leave policy. Subsidized day care is another area in which the US lags behind the rest of the world. Child care in the US is largely privatized, and couples can spend up to 25% of their income on such care.

On a positive note, the US Family and Medical Leave Act (FMLA) guarantees 12 weeks of job protected time off (unpaid) to fulltime workers in companies with at least 50 fulltime employees and applies equally to men and women. Because of major differences in political, fiscal, taxation and social philosophies and priorities it is unlikely that the US will catch up with Germany in support of parents and children. However, it is encouraging that legislative efforts with bipartisan support are underway to significantly increase child care benefits.
Physician Health & Wellness

Update on Shingles Vaccines

Edgar Marcuse, MD, MPH, FPIDS, FAAP

Conversations with Section on Senior member colleagues at the National Conference & Exhibition revealed that, like the nation, we are divided: between those frustrated by the difficulties they have encountered trying to get the new Herpes zoster vaccine and those who are dubious about either their risk for shingles or this new vaccine's benefits or risks. So, the editors thought a brief update in these pages was warranted.

Risk of shingles: Shingles or Herpes zoster (HZ) is an eruption of a vesicular rash often in a single dermatome caused by reactivation of latent varicella zoster virus (VZV) infection in trigeminal or dorsal root ganglia. The name shingles derives from a Middle English adaptation of the Latin *cingulus*, or girdle denoting a cinch or belt. The lifetime risk of shingles is 1 in 3. The incidence increases with age, above age 85 the risk is 50%. The mechanism underlying VZV reactivation is reduced cellular immunity. Pain or discomfort is associated with the rash 90% of the time, frequently preceding the eruption by days or even weeks. The rash usually resolves in 7-14 days, but the pain may linger on. Post herpetic neuralgia (PHN) is defined as prolonged pain that persists for at least 90 days following the rash; it is often debilitating. The risk of PHN increases rapidly after age 60: an 80 year has 10 times the risk for PHN of a 50-year-old.

The vaccines: In 2008 a live attenuated single dose Herpes zoster vaccine, Zostavax™ (ZVL) was recommended by CDC's Advisory Committee on Immunization Practice (ACIP) for those over age 60. ZVL contains 14 times the amount of the Oka strain of VZV in varicella vaccine, Varivax™. ZVL efficacy was 51% against HZ but declined rapidly in the year following administration and likely provided no significant protection after 8 years. Protection against PHN was 67% and declined more slowly.

A recombinant, 2 dose subunit HZ vaccine, Shingrix™ (RVZ) was licensed in 2017 and shortly thereafter preferentially recommend by the ACIP over ZVL for immunocompetent persons over age 50. RVZ contains a recombinant glycoprotein E, the most abundant protein in the VZ envelope, and an adjuvant system ASO1₉ which enhances the specific immune response to the protein. ASO1₉ is a liposome-based adjuvant system containing the immunostimulants monophospholipid and a saponin, QS-21, which together induce strong and long lasting humoral and cell mediated immune responses to the glycoprotein. In a study with a median follow-up time of 3 years RVZ has been shown to have an age- independent efficacy against HZ of >90% in those above 70 or 80 years, and against PHN an efficacy of 91% in those over age 50 and 89% in of those over age 70 with minimal waning over 4 years. The efficacy beyond age 4 years is uncertain. Unfortunately, there is no established laboratory correlate of immunity. An ACIP analysis noted that the number needed to vaccinate (NNV) 1 case of HZ is 11-13 and NNV to prevent 1 case PHN 100-187. The side effects that were severe enough to interfere with normal activity occurred in about 10% of RVZ recipients. Those included site pain, myalgia and fatigue for 2-3 days. Notably, systemic reactions are more common after dose 2. Reactions to the first dose do not predict reactions to the second dose. Prior vaccination with ZVL did not alter immunogenicity or reactogenicity.

Vaccine supply and cost

Demand for RVZ has been higher than anticipated creating backorders and frustrating both providers and patients. The manufacturer, GlaxoSmithKline, states it has increased the supply, is shipping doses every 2-3 weeks. Nonetheless shortages will likely persist in 2019. Ensuring a supply for second doses is a high priority. Note the second dose should be administered 2-6 months after the first. If more than 6 months has elapsed the second dose should be given as soon as possible; the series should not be restarted. The manufacturer's website lists providers in a zip code purported to have the vaccine. Although Medicare Part B covers many common vaccines coverage for shingles vaccine is available only through a Part D drug plan or a Medicare Advantage plan. Coverage varies between policies and is not state specific. (NB: The author paid $85/dose in WA State.)

If Shingrix is unavailable and immediate immunization is desired, ZVL remains an option and can be followed 8 or more weeks later by RVZ.

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Update on Shingles Vaccines  Continued from Page 17

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2. Recommendations of the ACIP for use of Herpes Zoster Vaccines. MMWR January 26, 2018 67(3) 103-108


4. Personal communication: B Young Public Sr. Account Manager Vaccines GlaxoSmithKline Pharmaceuticals November 10. 2018

Facing Cancer

Luisa Stigol, MD, FAAP

In the year 2004, I was seventy-four years old, an active pediatrician at Dedham Medical Associates, a multi-specialty group about twenty minutes away from the center of Boston. It was fun to be closely associated with The Children's Hospital; I was always learning and able to offer those resources to my patients. It filled my days.

I had separated from my husband ten years before because he refused to take care of himself, but I had continued supporting him in what was possible. To see him deteriorating was not easy for me or our daughter. He died in February of that year.

My children had moved to different parts of the world, and in August, I visited one of our daughters, Odile, who lived in New York. Her guest room was not yet ready, so I had to share her futon with her annoyed cat, which walked over my belly one night. I woke up in great pain. The next morning, I examined my belly and felt a supra-pubic mass. A few days later, at my gynecologist's office I learned that I had palpated the fundus of my uterus, which had been pushed forward by a large ovarian cyst. My dear gynecologist seemed shocked. I had postponed my regular yearly check-up because I had been busy with my husband's repeated hospital admissions and my work. Besides, my HMO's had decided that, at my age, a Pap could be done every two years.

I left my gynecologist's office, sat in my car and was so disoriented that I did not know how to go to my office even though I had driven this road many times in the last thirty years. Four days later, I was operated on with success; the ovarian tumor was big but localized. It was classified as Stage 1, cell class 3 and required chemotherapy. I refused because I had seen its effects on my dear cousin, a friend, and a patient's mother.

Cancer was not new in my family. I had lost my thirty-two-year-old mother to pancreatic cancer when I was twelve. I consider myself fortunate because I had lived seventy-four years and had led a full life! However, my youngest daughter, Odile, insisted I see the oncologist already arranged by my gynecologist, despite my decision not to have chemotherapy. Dr. Ursula Matulonis, head of Women's Oncology at the Dana Farber Cancer Institute (DFCI) spent one and half hours with me! She insisted that I had a 90 % possibility of survival, so I agreed to the chemotherapy. Odile came from NY to Boston for each chemotherapy session and carried my small radio, so I could lie down in a small room and listen to music. I thought the IV nurses who cared for me were angels. The side effects of the chemotherapy were hard to endure, but I found a presentation on line suggesting that three chemotherapy treatment might be enough in cases like mine. Ultimately, I had only four instead of planned six. However, I was still unable to perform any activity for a long time. I felt as if I had abandoned my patients. Suddenly a big wall separated me from the people who had filled my days. I had always considered get-well cards an American mania, but now they were my link to my patients. The children's drawings made me smile all day.

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I had no energy and could not conceive of any activity except for my radio and books, and I ordered a big box of books. After the third chemotherapy, the books stayed in the box. Eating with no appetite was difficult, but one of my caretakers was Russian and I could swallow the borsht she made. It also helped at the other end.

Whether alone or with a nurse’s aide in the apartment, the computer was my main support. I wrote every day, sometimes at three in the morning. I had no family in Boston and only occasional visits; some days I was too weak to receive the occasional long-distance calls from my family. Retrospectively, I realize I was frequently hyper-critical of the nurses or other personnel at the DFCI.

Someone named Karen recommended me to a support group at Beth Israel Hospital. It became the central activity in my life: my peers, my role models, my survival. I remember that in one activity offered to us, so we could relax, a replica of Chartres’ labyrinth was extended on the floor. After one the meetings, I drew a copy of “The Ronde” of Matisse, to represent us, with some touches. It had such an impact, that I began to draw often and later to paint for the benefit events we had, with the group supporting me with this too. It was also appropriate since I had begun to volunteer at a Museum.

The force, the caring, the solidarity, the compassion of that group of women who were also undergoing chemotherapy for cancer and so aware of dying, made me think of the contrast between them and others who are healthy, but are depressed. Fourteen years post-diagnosis, I still happily greet every day, and I am ready to deal with what it brings.

Brief Notes on Ovarian Cancer (Editor’s Note)

Ovarian cancer causes more deaths than any other female reproductive system cancer in the US, and 90% of ovarian cancers occur in women age 40 and older.

Dr. Luisa Stigol’s account of her personal discovery and long-term recovery and survival from ovarian cancer is atypical (with the exception of her age) for this major cause of death for females in the United States. The majority of cases of ovarian cancer occur in women age 60 and older. “It whispers” is the deserved reminder by the Ovarian Cancer Society, as it usually presents with symptoms of bloating, constipation, urinary frequency and other non-alarming complaints and less commonly with back pain, vague abdominal discomfort and/or vaginal spotty bleeding. Initial diagnosis is by advanced gynecologic examination, ultrasound, and CT or MRI scans accompanied by a CA 125 diagnostic blood test.

Early diagnosis and treatment, (as with Dr. Stigol’s history) is crucially important. The cancer is commonly diagnosed at stage 3 or 4 when oncologic treatment has limited success. The CA 125 is not done routinely as part of female physical exams. It is not considered reliable in pre-menopausal women and, as with the PSA (prostate specific antigen) in males, it’s not been found to be cost effective in large population studies. Genetic testing, as with breast cancer, has potential importance in treatment choices.

Yet, 21,000 plus women in the U.S. are annually diagnosed with ovarian cancer. Although it accounts for only 3% of all female cancers, it is the 8th most common cancer in all Americans and the 5th leading cause of death from cancer in women.

If you're concerned about any of these symptoms, check the CDC website and their patient information materials, and see your gynecologist as soon as possible. (Don't put it off!) Be assured that there's a world of research on this and other gynecologic cancers, including new genetic information and treatments targeting specific cell types.
Pediatric Dental Disease: A Promising New Tool and Strategy
Suzanne Boulter, MD, FAAP – SOSM Liaison to COFGA
Edgar K. Marcuse, MD, MPH, FAAP – SOSM Executive Committee

Oral health is an integral component of overall child health and well-being. Early childhood caries disproportionately affects low-income children, children of color, and Native American children. Expanded access to preventive and basic restorative oral health care for populations at high risk for dental decay is urgently needed in many US communities. A new tool has the potential to increase access to care for early childhood caries in children’s primary teeth especially if combined with a new strategy employing midlevel dental providers.

Silver diamond fluoride (SDF) is the new tool. Like fluoride varnish, SDF is only approved for dentin desensitization in individuals over age 21 but many clinical trials are now underway using it “off label”. SDF contains 280,000 ppm of silver and 44,800 ppm of fluoride. Used appropriately on large cavitated lesions SDF significantly kills bacteria and stabilizes collagen degradation arresting the progression of carious lesions without the need for caries removal. In appropriate patients this results in the avoidance of “drill and fill” and in some cases avoidance of the operating room. SDF has recently been recommended by the American Academy of Pediatric Dentistry (AAPD) as a “best practice” intervention as part of comprehensive caries management. Currently there is insufficient evidence to recommend SDF on permanent teeth, but solid evidence is accumulating for benefit on severely cavitated primary teeth.

Application of fluoride varnish has become an evidence-based part of preventive oral health care during the well child visit. SDF is another adjunct treatment for patients who are uncooperative, uninsured, or have no access to pediatric dental services but have large cavitated lesions. SDF is inexpensive and is applied about twice a year with a micro brush. SDF should be used as part of comprehensive caries management which includes counseling about brushing, fluoride, diet and regular visits to the dentist. The most serious side effect is significant black staining of the carious lesion plus of skin and clothing from any inadvertent contact with the silver. Use of SDF on anterior teeth is restricted because of the unsightly staining although dentists can remove the stains. The American Academy of Pediatrics Section on Oral Health does not currently have recommendations on the use of SDF during well-child visits, but they are actively reviewing the evidence and will address the issue in the next policy statement on use of fluoride products as evidence accumulates from studies. Some links from the dental literature with information on SDF including a brief U Tube video on how to apply are listed below.

Use of SDF is one of the strategies that could expand access to oral health services for children by utilizing a new group of midlevel dental providers, dental therapists, who can provide both preventive and basic restorative care. Dental therapists have a minimum of 33 months of training that, like that of dentists, must meet national accreditation standards. There is a growing body of evidence demonstrating the safety and efficacy of their care. States that now allow dentists to hire these practitioners include Maine, Vermont, and Minnesota. Dental therapists now practice under pilot authority in Oregon and are authorized to practice in Native American Tribal clinics in Alaska and Washington. Many other states are actively exploring authorizing care by dental therapists for vulnerable populations who suffer disproportionately from untreated dental problems in low-income settings such as Federally Qualified Health Care Centers, tribal health programs and other practice settings that primarily serve children on Medicaid, or who are from families having incomes less that 133% of the federal poverty level.

A resolution cosponsored by the Section on Senior Members recommends that the AAP support the licensing of dental therapists to practice in low-income settings in all U.S. states. This resolution will be considered at the 2019 Annual Leadership Forum.

SOURCES:

Silver diamond fluoride:
Dental therapists

Institute of Medicine, Committee on Oral Health Access to Care. Improving access to oral health care for vulnerable and underserved populations. National Academy of Sciences, 2011

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**Frailing**

*Marilyn Heins, MD, FAAP, Formerly Vice Dean and Professor of Pediatrics at the University of Arizona College of Medicine and Founder of ParentKidsRight.com.*

My 88th birthday has occurred. This is a humongous number no matter which way you look at it. My musician son just told me I have lived a year for every key on the piano keyboard! How am I doing? I used to reply I am still vertical, but I hereby coin a new word. When people ask me how I am, my answer is “I’m frailing.” It means I am not yet frail, but I can see fragility on the horizon…with my good glasses of course.

Frail is a word I would never use to describe myself until recently. Robust, Chunky. Energetic. Hard-working. But such words describe a former me. These days I walk slowly. My creaky knee troubles me. Balance is something I have to think about…a far cry from that little girl on a bike or the woman on a tough hiking trail. Plumbing issues mean knowing where every restroom is. I keep track of several prescription drugs. I forget more easily and recall less speedily.

On the positive side, I am still alive. For every 100,000 white females born the year I was born, only 37,745 are still alive. My male colleagues have not fared as well: for every 100,000 white males born in 1930 only 25,139 are living.

When we are young, we know our life will end but don't pay much attention to the passing of time. Maybe because life is so fulfilling and interesting the future seems endless. But now even those of us who weren't good at math can count the possible number of days we may have left.

The epitaph of the book “Number our Days” by Barbara Myerhoff about elderly Jews is a prayer adapted from two psalms that ends “So teach us to number our days, that we may get us a heart of wisdom.” We oldies know our days are numbered. Let us hope we also get a heart of wisdom so that we can accept ourselves as we are today. And that our wisdom helps us do our damnedest to enjoy each day. We must also accept what our capabilities are now. And accept that, like time, the trajectory of our “frailing” goes in only one direction. There is no Fountain of Youth.

I plan to pay attention to what can affect both the quality and length of my life. Our wise parents immunized us against deadly childhood diseases. Now we have to “immunize” ourselves against loneliness and falls, two important risk factors for both mortality and morbidity.

Loneliness is associated with inactivity and dementia. 46% of women over 75 live alone compared to 23% of men. However elderly men living alone do not fare as well as women who are better connected with friends and relatives.

Is there a cure for loneliness? Yes, friends and activity. I am happy doing what I am doing right how, writing. I can do that anywhere I have a desk and a computer, so I have signed up for an independent living facility in Tucson.

I will give up my lovely home and many possessions when I downsize. But gerontologists advise us to make such a move earlier rather than later. Why? We still have energy for the physical move and the spirit to adjust and make new friends. Plus, who wants to get so frail that their children have to make the decision for them! I look forward to new friends and on-site activities.

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We old folks fall because of slower reflexes, less coordination and muscle strength, loss of proprioception, and visual problems. Sadly, not all falls can be prevented which means doing all we can to eliminate the preventable ones.

Ironically, while writing this I had a fall. It was broad daylight, but down I went. Nothing broken. Just a bit of facial blood and a few bruises (my kneecaps are still purple) but I am fully ambulatory. I dodged a fall bullet.

Alas, I have developed a bad case of PFSD, Post Fall Stress Disorder. I am so scared of another fall I make every effort to prevent one. I walk carefully and even more slowly than before. I use stair rails in public buildings and walk even more carefully in new places or in the dark. I do balance and strengthening exercises as well as take a morning walk around the neighborhood every day.

I eliminated “fall traps” like scatter rugs and am working my way through those boxes of “Stuff I will go through any day now.” I increased lighting in the house and garage to accommodate my aging eyes. I never walk in socks and only wear proper shoes. Long ago I realized high heels are for models not oldies.

Finally, I am redoubling my efforts to stay positive in my thinking. I am working hard on another kind of balance. I resolve to keep busy but pay attention to when I need a break. And enjoy the quietude of doing nothing, a new skill for this old lady.

Reflections

Praise Addiction

Lance Alix Chilton, MD, FAAP

There is no lack of articles written about physicians’ preparation for retirement. Most of those are written as first person accounts by those already retired or contemplating retirement. I had to sit down with a medical librarian at my home institution to figure out search terms in Pubmed -- it’s not like looking up heat stroke or type II diabetes or pneumococcus type 19A. We settled upon “physician retirement [psychology]” after trying a variety of other terms. Most advice to older physicians (like us!) about retirement start with making sure we have enough money to live in retirement. Then there’s the injunction to be sure to have developed other interests and to consider volunteering in or outside medicine, foreign travel, and finding new or reinvigorating old hobbies (stamp collecting? environmental activism? religious activity?).

What I’ve seen only rarely in Pubmed-discovered articles is a discussion which may be as important as all of these others -- what does one substitute for the near-constant praise and adulation of patients? Unlike a toll collector, a policeman or a steel mill worker (if there are still any of those), we can count on being thanked 20 or more times a day, and usually effusively, for a job well done. I’ve always said that if one of my patients per week leaves unhappy or angry with my care, I count it a very bad week. Well, with retirement, that adulation ceases rather suddenly. To be sure, we meet former patients in the grocery store, and they say, “Dr. Chilton, do you remember me? I really liked coming to your office.” That encounter’s joy is diminished somewhat by not remembering who that grown-up little kid is.

I suppose praise addiction, which is the term all over the web (but not in Pubmed!) is similar to the opiate addiction that comes after successful treatment of severe pain – it just sneaks up on you. It’s insidious. And we risk going into withdrawal from it, with nothing like naloxone or suboxone to make things better. You start taking the drug – getting the praise – and then you’re hooked. Withdrawal is painful.

For those of you who have already retired and are feeling withdrawal symptoms, I feel (and share) your pain. For those of your senior section members who are still working (maybe because you feel you have more to give, maybe because you fear praise withdrawal), consider what you can do to avoid the pain of a sudden decrease in adulation. You might find other activities that give you endogenous pleasure and self-reinforcement or you might seek community engagements or advocacy activities that bank on the positive image you’ve made for yourself in your town over the past decades.

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I would maintain that having a plan for avoiding sudden cessation of daily – hourly – positive feedback from your patients is almost as important as having a financial plan for retirement. Martha Beck has a thoughtful but hard four-step course for weaning yourself from praise addiction at https://www.cnn.com/2012/03/05/living/overcome-praise-addiction/index.html; not false news!).

A Picture is Worth a ...

Sanford Schneider, MD, FAAN, FAAP

The year I completed my neurology fellowship, the Vietnam War was still raging and two years previously, Neil Armstrong had walked on the moon. The investigative tools for assessing the anatomy of the brain were limited to two, the pneumoencephalogram [PEG] and carotid arteriography [CA]. The introduction of the CT scan in the 70's followed by the MRI were incredible advances in visualizing the brain. Occasionally, when my child neurology fellows automatically order an admission MRI/MRA, I rarely remark that in the Neanderthal history of neurology, studies of the brain were limited to the dangerous and invasive PEG and CA. I always regret the remark, as it is received with questioning expressions, identical to the quizzical facial expression I noted on my college educated grandson when I mentioned that I had a slide rule glued to my hip during my college years. Collectively, they cannot believe that the computer and MRI have not always existed.

Technology is unrelenting in altering medical practice. As a child neurologist, I utilize not only MRIs, MRAs, but new diagnostic studies, evolving technologies, and genetic interventions. Positron emission tomography, video EEG monitoring, neural transmitter epileptic antibodies, comparative genetic microarrays, and gene-splicing technologies have evolved into clinical practice. Despite the availability of such cutting-edge technology, most patients referred to my neurology clinic by pediatricians, ER and family physicians ask the question: “Does this child have epilepsy?” Many of these children have already been placed on antiepileptic drugs [AEDs]. The only perquisite for referral is for the child to have an EEG, preferably including sleep in an EEG laboratory, where the laboratory and EEG reader do large number of children. The EEG is very helpful but is not as useful as a complete history and careful neurology examination.

The decision to place the child on an AED must be a well-thought-out responsibility, as the child may be maintained on medication for years with the potential of side effects and social stigmata. Compounding the decision to place a child on an appropriate AED is the knowledge that a whole host of childhood syndromes may mimic epilepsy. A partial list includes cyanotic and non-cyanotic breath holding, benign paroxysmal vertigo, somnambulism, micturition syncope, Bickerstaff migraine, orthostatic hypotension, infant and childhood masturbation, benign infantile myoclonus, shuddering attacks and psychogenic seizures. An EEG may be diagnostic in separating non-epileptic syndromes, but up to 10 per cent of normal children may have paroxysmal EEGs and approximately 20 per cent of epileptic patients will have normal routine EEGs, which limits the diagnostic quality of the EEG. History taking also has its limitations as the seizure episode is usually a description by very distressed parents or passed on by teachers, baby sitters, or other children. However, there is a readily available technology, carried by nearly every parent or caregiver, rich or poor, which is the ubiquitous and marvelous cell-phone that can frequently video the event, which may distinguish a seizure from a non-epileptic event.

A brief patient scenario will make my case. A non-English-speaking mother and father and an English- speaking 16-year-old sister accompanied a four-year old girl maintained on an AED for epilepsy. An EEG, while on medication, in our laboratory was a normal awake study. The parents stated that the child had frequent episodes of staring off and twitching of her lower legs lasting 2-3 minutes. Her pediatrician had concluded these episodes were epileptic and placed her on levetiracetam (Keppra). The child's examination and family history were unremarkable. The 16-year-old contributed that her sister's seizures only occurred while lying in bed staring at the ceiling while clutching her giant stuffed panda. The parents had videoed several of the episodes; clearly the event was childhood masturbation. The subsequent conversation was more difficult than the diagnosis, as I discontinued the levetiracetam and assured the parents that the child was normal. The cell-phone in my clinic has become a powerful diagnostic tool and now a video of the event[s], if possible, is requested of every new potential seizure patient. A picture continues to be truly worth a thousand words.
A Dodger Fan

Paul M. Winick, MD, FAAP

Since starting my pediatric practice in 1968, I always knew that being empathetic and a good listener were hallmarks of a good doctor. I was always dismayed when a friend or a patient's parent would tell me their physician lacked these skills. I realized that caring for a twelve-year-old boy when I was a young intern had ingrained these values into my core.

John dozed in a fugue-like state. His Dodger blue shirt hung next to his autographed Dodger cap. His ghostlike face was covered with large and small areas of bruising. His skin was shriveled and was peeling in places. John was dying--diagnosis acute myelogenous leukemia. He had undergone three courses of chemotherapy—all were unsuccessful. There were no further treatments. My fellow interns suggested the most merciful approach was to keep him pain free and let him die in his sleep. But they had not talked to John. He had not shared with them his dream to see his transplanted Dodgers win the pennant and then the World Series. I gently woke John, so we could watch the last regular season Dodger game. His Dodgers and had already clinched the pennant. Although I was a Dodger fan, I professed to be a Yankee loyalist so that I could bond with John. The Yankees would be playing the Dodgers in the World Series. “Hey champ,” I kidded him. “Your Dodgers were lucky to win the pennant. They surely will lose to my Yankees in the World series.” When the Dodgers won the game, John shrieked with happiness. He said, “I really wanna see my Dodgers play and beat the pants off your Yankees. I wanna see them become champions of the world.” I vowed I’d do everything in my power to keep John alive, so we could share the World Series together. We could, at least, share our love for baseball since I had no more healing skills to share with John. “See you for the series, champ,” I said. “We’ll watch my Yankees murder those Dodgers.”

The next evening, I sat at home sipping a glass of wine. I was just beginning to enjoy my first leisure evening in three days, when the phone rang. The ward nurse apologized. “Doctor, I know you’re not on call, but you left instructions to be notified if anything happened to John. He looks terrible. He’s pale and sweaty. His heart rate is extremely rapid. He’s having difficulty breathing, grunting with each respiration. He appears to be losing a lot of blood from his G.I. tract. His stools are tarry and test positive for blood.”

I realized that John was probably in heart failure, caused by intestinal bleeding. The clotting factors in his blood were low. “Please do a stat hemoglobin and hematocrit and type and cross John for three units of blood,” I told the nurse. “Until the blood is available hang Ringers Lactate in his IV. I’ll be right over, but if anything happens before I get there call a code.” I remembered the vow I had made.

The blood and I reached the ward at the same time. John looked so tired -- so terminal. I knew that, unless I gave him the blood rapidly, he would not survive the night. I made a surgical incision into John's ankle and threaded a large bore catheter into the exposed Saphenous vein. I attached the blood to the catheter and hand pumped the lifesaving fluid into his body. By sunrise John had received all the blood. The G.I. bleeding had stopped! He was no longer in congestive heart failure! John opened his eyes, smiled and said, “Hey Doc, I hope we're on for the World Series tonight.”

We watched all the games in his room. We were experiencing the thrill of a potential last game together, wearing our team caps, drinking Coke and eating pizza. The Dodgers had won the first three games. I had borrowed the Yankee hat from a friend in order to keep up the charade.

“Hey champ, my Yankees will easily win this game,” I kidded. He said, “Ain't gonna happen Doc, the Dodgers will sweep and be world champions.” I must admit that even if I were a Yankee fan, I'd be rooting for the Dodgers to win. The Dodgers clinched the world championship. John fell asleep with a smile on his face, secure in the knowledge his team was a winner. His dream had been fulfilled.

Several days later, I sat at John's bedside holding one of his hands while his mother held the other. The priest had just left after administering the last rites. Rain pelted the windows and the dark clouds looked like they would release moisture forever. As my eyes filled with tears, I quietly bid John a silent good-bye. It would be hard to lose my first patient, but I had learned more from him about courage then I had given him in return. Like his beloved Dodgers, he too, was a champion, and along the way I'd become a doctor.
Part I: Learning to Live with the Death of My Patient

John T. McCarthy, MD, FAAP

I first met Katie* soon after I began a Pediatric Internship at The Children's Hospital in Denver, Colorado in June 1969. Katie, a petite, vivacious 13-year-old girl from a little town in southwest Nebraska, had been referred to The Children's Hospital for treatment of a newly diagnosed Acute Lymphocytic Leukemia (ALL). She was admitted to the Oncology Service led by Charlene Holton, MD, a tall Texan who rode into town with the latest treatment protocols for a cadre of childhood cancers. Sprinkling her sentences with well-placed “Y'all”, she oozed optimism and warmth and made everyone feel a part of her team. I felt fortunate to be one of the Pediatric Interns assigned to her service for the next 2 months including night call every 3rd night. Dr. Holton stressed the importance our interactions with our patients and their parents. Katie became my first patient while she fought to recover from ALL. I remember many times in the next two months when I was paged to restart an IV for Katie. She was so apologetic for bothering me in the wee hours of the morning. I told her that that was my favorite time of day. If she was up for a chat I'd linger and asked her if there was anything she would like to eat. “Cookies like my mama used to make,” she winked.

By the time our two months were up, Katie got herself into remission and went home with her grateful parents, I transferred to the Adolescent Unit to begin my new rotation. I thought Katie would never want to see me again because I viewed myself as her mean old intern who enjoyed torturing her. I sure hoped Katie would stay in remission.

Fast forward 10 months toward the end of my Pediatric Internship while on my last rotation: New Born Nursery. I got a page to the Adolescent Ward and befuddled, stopped by at the nurse's station to get the scoops. They tearfully told me that Katie was now terminal, but she insisted on seeing me. This news hit me like a ton of bricks. Why me? What could I do? I walked slowly down to the end of the hall and as I neared Katie's room, I could hear the “whoosh” of an Oxygen mask coming from her room. Timidly I knocked on her door, and her parents waved me in with a smile of recognition. Katie sitting up struggling to breathe. I reached out, hugged her, and asked her if there was anything I could do. "Just sit with me, Dr.,” she requested. For the next hour, I just sat with her. Katie relaxed removed her mask no longer in distress. I felt honored that she had chosen me to help ease her passage and mine. What a powerful moment and gift that was, Katie. I will never forget you. Dr. Holton discharged her home to be with her family until the end a few weeks later.

(*Name changed to protect identity.)

Movie Reviews

Winter 2018-2019 Movie Reviews

Lucy Crain, MD, MPH, FAAP

A STAR IS BORN

The fourth edition of this film about a previously undiscovered and talented artist longing to make it big is already a top grossing movie since its release. Starring, directed, re-written (with Will Fetters and Eric Roth) and produced by Bradley Cooper (Did you know that he could sing?) overshadowed by Lady Gaga (Did you know that she can really act?), this promises to be one of the series of yet to come 2018 Oscar contenders. Cooper plays Jackson Maine, an already successful country singer, who draws adoring crowds everywhere he goes and drinks excessively, despite attempts to keep him under control by his big brother (well-acted by Sam Elliott). Jackson happens into a drag bar one night, looking for more gin and meets the evening's guest performer. You guessed it. She is Ally, played by Lady Gaga herself! With Jackson's help, Ally is plummeted into stardom and with her discovery by another producer she ascends into glitz super star status. Meanwhile, although now married to Ally, Jackson self-destructs his career, his marriage, and himself with alcohol and drugs and self-pity. It is a well-made and well-acted movie with terrific music. (Wear earplugs! Some of the crowd scenes are deafening!).

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Walking out of the theatre, someone asked me if I’d seen the “first version” of the movie. At that time, I answered “Yes, but I don’t remember much other than Judy Garland was great in it.” Later, I googled the movie’s history and wondered: Was that stranger asking if I’d seen the 1932 version “What Price Hollywood?” with Constance Bennett or the 1937 “A Star is Born” with Janet Gaynor and Frederic March (Both before my time, thank you!). I was a young teenager when I saw Judy Garland and James Mason in the film re-make in 1954 and honestly don’t recall very much about the 1976 version with Barbra Streisand and Kris Kristofferson. So, the time is right for the 2018 version of the story, and the 135 minutes of non-stop entertainment (especially the first half) delivers. -Rated R for language, alcohol, and drugs.

**GREEN BOOK**

Starring Oscar winner (Moonlight, 2016, Best Supporting Actor) Mahershala Ali as Dr. Don Shirley and versatile Tony Mortensen (as Tony Vallalonga or Tony Lip), this is an exceptional Oscar worthy movie about race relations and the deep South melded with family life in the Bronx and much more. Based on a true story, writers Nick Vallelonga (Tony's son), Peter Farrelly (also the director), and Brian Currie have done an excellent job of highlighting many of the stereotypic racial issues of our society then and now. An outstanding feature of the movie is the powerful music on radio and in live performances throughout the story, which makes it an even more moving and memorable film. The story begins with Tony Lip (You'll have to see the movie to learn why Tony Vallalonga earned the “Lip” nickname.) performing his bouncer skills with expertise in his role at the Copacabana in New York City.

The Copa was to close for several months of remodeling, and Tony soon was looking for a job. His interview with Dr. Don Shirley- a world acclaimed pianist and mainstay of the Don Shirley Trio- in Shirley’s apartment above Carnegie Hall is worth the price of admission! Surprisingly, Dr. Shirley contracted him to be his driver for a scheduled tour through the Deep South of 1962. The trip across parts of Indiana, Kentucky is beautifully filmed with lovely scenery and a modicum of racial tension. Arrival in Mississippi is met with more overt racial prejudice and incidents. Meanwhile, the two men predictably bond as friends, with the sophisticated, classically educated pianist learning to enjoy his first tastes of Kentucky Fried Chicken and to learn about Little Richard’s and Aretha Franklin’s music from the tough Tony. (Dr. Shirley’s piano expertise is achieved by a body double for Ali.) And Tony learns some writing and social skills from Dr. Shirley, much to the appreciation of Tony’s Bronx based wife played by a delightful Linda Cardellini.

**PS:** *The Green Book for Negro Motorists* was the guide published 1936-1964 for Negro people traveling in the South and other parts of the segregated US. It might come as a shock to many who have always lived in the North that people of color were denied stays at hotels, restaurants, and even water fountains and washrooms as recently as the era of this film.

**JULIET, NAKED**

Based on a Nick Hornsby novel and directed by Jesse Peretz who also directed Little Miss Sunshine, Juliet, Naked is a delightfully entertaining film. Lovely Rose Byrne is in an unsatisfactory, childless relationship with her boyfriend of 15 years played by Chris O’Dowd. The boyfriend is obsessed with a long-retired rock idol Thorne played by Ethan Hawke and has a daily blog about Thorne's musical history. Girlfriend writes a contrarian response to boyfriend's fawning reviews of ex-rock star's music, and voila', the rock star responds to her e-mail and they forge an internet relationship. It’s filmed in England with some great beach scenery and complicated fun. It’s enjoyable, and well worth seeing either in the theatre or on the smaller screen at home. R rating, 105 minutes.
Letters to the Editors

Mona S. Mange, MD, FAAP
Clinic Volunteer for Immigrant Health Care and Public-School Volunteer from Tulsa, OK.

Thanks for sending me the AAP senior bulletin. I am saddened by the fact that you and others mention in the bulletin many times how bad the present administration is and what ills it is doing. Some bad things are happening indeed, but also good things are happening. Not once in the whole bulletin did anyone mention the economy and how well it is doing, or that the level of poverty is down, or the number of people on food stamps is down and that the economy is doing so well and everybody that wants a job can get one. Minority groups have the lowest unemployment rate and that we are not depriving families of their children by feeding them instead we are allowing the families to buy and prepare food or even grow their own gardens, and then eat together. However, you all mentioned how nonpartisan the AAP is. Perhaps your definition of partisan is different from mine or the dictionary’s. This is just my honest opinion. Thank you.

Letters to the Editor

Robert Earl Yim, MD, FAAP

Thought I would start your week off with a cheerful story.

Last night Mrs. Yim and I were at a restaurant waiting for a table with other diners. Soon we were all engaged in friendly conversation. A waitress finally came over and said, “Dr. Yim, your table’s ready.” One of the group said, “Oh. You’re a physician! What kind of doctor are you?” I replied, “I belong to the specialty everyone loves.” Without a second’s hesitation, he replied, “You’re a children’s doctor!” I was very proud.
Reading to Children: Grandparents and Grandkids

Wm. R. Brown, Jr., MD, MPH, FAAP

Update: Charlie and I are still reading together.

I’ve always had a “grandparent’s” chair in the examining room and encouraged their participation in the lives of their progeny’s progeny. A fun and productive activity is reading WITH not TO one’s grandchildren…selecting a book, describing illustrations and identifying images, page turning, word/phrase repetition, repeating the story together.

Here I am with grandson Charlie in Cleveland at 12 months old and in the second, he’s 18 months old, reading together...have fun. Charlie turned 3 years old last November. The last picture is of he and I still having fun reading together.

Update: December 2018

Dr. Brown and Charlie are reading together once again.
Donor-Advised Funds
Matt Southworth, AAP Department of Development Summer Intern

In recent years, donor-advised funds have skyrocketed in popularity as a giving vehicle. Between 2011 and 2016, the number of donor-advised funds in the United States grew from 188,000 to 285,000 – a 51.2% increase, or 8.53% year-over-year. In the same period, overall contributions to these funds rose from $10.19 billion to $23.27 billion, representing growth of over 128%.1 In fact, in 2015, the Fidelity Charitable Gift Fund overtook United Way as the number one recipient of charitable gifts in the U.S.2 Why are people flocking to use donor-advised funds for their charitable giving? The three main reasons are that they are relatively cheap, flexible, and provide immediate tax benefits to donors.

A donor-advised fund is a charitable organization that acts as an intermediary and holding tank in the charitable giving process. Let’s say you have some money you’d like to give to charity but aren’t sure exactly who you would like to benefit. You could donate it to a donor-advised fund and receive an immediate tax benefit. Your money would then be invested and grow, to be disbursed when, where, and how you want. You could split it up and donate a little to multiple causes, or you could donate it all to your favorite organization. These charitable funds act like a foundation, only they are not subject to the same costs and restrictions. For example, foundations are required to give away 5% of their assets annually whereas there is no such requirement for donor-advised funds. Despite this, however, grant payout from donor-advised funds consistently tops 20% annually.1

It is easy to get started with a donor-advised fund. Many high-profile investment companies such as Fidelity, Charles Schwab, and Vanguard have services to help you set up your own. If you are interested in starting your donor-advised fund, these would be a good place to start your research. For more information, contact Jill Taylor, AAP, Director, Donor Relations, (630) 626-6033, jltaylor@aap.org.

A Good Time to Review Beneficiaries
Jeff Witz, CFP®

There is never a bad time to revisit the beneficiary designations you have made over the years. Unfortunately, once various beneficiary forms are completed, they are often forgotten until the time of death. Alternatively, in many cases, executors find that no beneficiaries have been named at all, creating confusion, anger, and time delays in settling an estate. In still other instances, the named beneficiaries may no longer be members of the family due to divorce, or worse yet, have died.

One of the main reasons for this oversight is that many of the financial accounts requiring a beneficiary designation are established far earlier in life. There may be a life insurance policy purchased when you were first married, an IRA that you opened prior to marriage, etc.

Having a sound financial plan dictates that you ensure there are designated beneficiaries for all your retirement plan accounts, life insurance policies and other assets, and that these individuals are the intended recipients based on your current family structure. It is often not as straightforward as it first appears. Following these guidelines should help you avoid the most common and costly mistakes:

Do not leave the beneficiary lines blank. If you don’t name specific beneficiaries for your accounts, or if you name your estate as the beneficiary, your heirs will likely end up in probate court. This can be time-consuming, costly, and public. If assets go to your estate, they are subject to the reach of creditors. A better option is to choose individual beneficiaries and list them on the forms.

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**A Good Time to Review Beneficiaries**  Continued from Page 29

**Use trusts for beneficiaries who are minors.** In some states, minors face restrictions until they turn 18 or 21. If you designate a minor as a beneficiary, a court will appoint a guardian to manage the funds until the child reaches the age of majority. These guardians may or may not have the minor's best interest in mind. Alternatively, you might establish a trust to control the funds upon your death. Thus, you maintain control of the assets during your lifetime and the trust provides protections and guidelines for how the minor can use the funds after you are gone.

**Understand the key rules.** Beneficiary designations on retirement accounts and insurance contracts will override your will. If you want someone other than your spouse to inherit retirement account assets, your spouse must sign a written waiver. Without the waiver, a non-spouse beneficiary designation will be invalid upon your death.

**Inform your beneficiaries.** Do not keep your beneficiary designations a secret. Also, let the people you have designated as beneficiaries know where to find important documents and contact information for your professional advisers. On the other end, make sure your advisers have the vital contact information.

**Double-check names and numbers.** Make sure they are spelled correctly and that figures are accurate. This is particularly important when listing Social Security numbers as well as telephone numbers and addresses.

**Use percentages instead of dollar amounts.** For example, suppose you have an IRA worth $100,000, and you designate a nephew as beneficiary of $75,000 of that amount. If the IRA drops in value to $75,000 or below at your death, your nephew gets the entire amount—any remaining beneficiaries receive zero. Perhaps a better way to meet your objectives is to give your nephew 75% of the overall account value.

**Name contingent beneficiaries.** If your primary beneficiary has died and you have not updated your accounts with a new primary, the assets would go to your contingent (or "secondary") beneficiaries. If a contingent beneficiary was never named, the assets are transferred to your estate (see above). Avoid potential problems by indicating contingent beneficiaries in appropriate places.

Finally, don't stuff all the paperwork in a desk or drawer somewhere and forget about it. Make the proper beneficiary designation adjustments when warranted and review these periodically with your advisor to ensure they remain up-to-date and make financial sense.

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

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**Member News**

**New SOSM Collaboration Site**

In 2018, SOSM began working on the new member-only website. The site has been designed to be a home where members can find and share valuable information and resources pertinent to practice management.

**THE WAIT IS OVER**

The new collaborate site is housed on AAP’s SharePoint Collaboration platform and can be accessed here:

https://collaborate.aap.org/SOSM

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COLLABORATION SITES 1.0

The site will be an ongoing project, so we are starting with making sure that all our members can log in and access vital resources such as News Bulletins, how to get involved, award information, events/activities, and so much more!

1. When logging in for the first time, you will need to log in to www.aap.org with your AAP ID and password, or the login information you have set up (*Please note: Should you have any issues, please contact Customer Service directly.*) For quick and easy access to your collaboration sites, click on the “My Collaboration Sites” button.

2. You will be routed to AAP Collaborate where you will see links to each of your collaboration sites. To access the Section on Senior Members, click on the Section on Senior Members (SOSM) link as seen below. That’s it – you are now in the SOSM Collaboration site.
3. To access any of the subsites, you simply click on “Learn more>>>”. The subsites consist of: Health and Wellness, Advocacy: Caring and Volunteerism, Education, Career Resources & Transitions, Senior News Bulletin and Pictures.

4. To log out go to the top right and click on the drop box to right of your name and select “sign in as a different user”.

Questions and/or feedback should be directed to AAP Staff:
Katie Clark kclark@aap.org or (630) 626-606
Susan Eizenga seizenga@aap.org or (630) 626-6129

Suggestions Wanted

The Section on Senior Members Web site has a tab called Advocacy and Volunteerism. We are soliciting our members for other suggestions that have been fulfilling for them as they transition to retirement or actually retire. Examples could be participating in literacy programs for children, working with social services agencies such as Big Brother/Big Sister or YWCAs, YMCA's or JCC's etc.

Please submit these suggestions to Manny Doyne (Emanuel.doyne@cchmc.org or emanueldoyne47@gmail.com)
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 emanuel.doyne@cchmc.org. Articles and letters should be submitted to the Editor at lucycrain@sbcglobal.net with cc to Susan Eizenga seizenga@aap.org. We look forward to hearing from you and to reading your articles in the Senior Bulletin.

2019 Senior Bulletin Schedule

Spring Bulletin - Electronic
February 11, 2019   Call for Articles
March 11, 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
August 12, 2019   Call for Articles
September 9, 2019   Article Submissions Due
October 18, 2019   Bulletin Online

Winter Bulletin - Electronic
November 11, 2019   Call for Articles
December 9, 2019   Article Submissions Due
January 17, 2020   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={E73B-6D0E-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](http://www.aapmentorship.chronus.com) and sign up to be a mentor and/or mentee today! AAP login and password required.