Message from the Chairperson

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

It is an honor to follow Robert Grayson, Herbert Winograd and David Annunziato in this role. I very much hope that all members of the Section on Seniors will work with the Executive Committee to ensure performance of our two groups of tasks:

Active support for programs of the AAP in all areas.

Active support for members of the AAP as they plan for, negotiate and navigate through changes in professional and personal life.

As one part of these goals, my predecessor, David Annunziato, and Jackie Burke, senior staff representative to our Section, have been working with enormous vigor and great success to prepare a Guide to Chapters for those who wish to start a Chapter Senior Section. We hope this will be available by summer. If you have ideas comments, suggestions, whatever, about how to accomplish this mission or any other existing or possible mission for the Section on Seniors, send them to Jackie, c/o AAP Headquarters, 141 Northwest Point Blvd, Elk Grove Village, IL 60007, or by e-mail at jburke@aap.org, with a copy to me at: 100 Old Clinton Road, Flemington, NJ 08822-5534, or by e-mail, stellave@earthlink.net.

Soon, if not already, your Chapter President or Executive Director will be hearing from a member of the Section on Seniors Executive Committee about how to help the Chapter determine if it would desire a Chapter Section on Seniors, and to offer assistance, if wished, to work in that direction. Now is the time to join with your Chapter officers to accomplish that goal.

Lucy Crain and George Cohen are interested in learning from members what are their wishes, needs, goals and plans for themselves as individuals and for our Section on Seniors. The last time that members were systematically queried was over 12 years ago. In March and April the Executive Committee will discuss
Message from the Chairperson  Continued from Page 1

proceeding with a new survey. What do you think? What do you want?

We continue to hear praise about the material in our Bulletin, now co-edited by Joan Hodgman and Arthur Maron. The schedule of four issues per year will continue. Have you topics which you would like to see included, or, even better, about which you will write up an article yourself? It is not necessary to be a successful author to be published just to have some thoughts that can be summarized in essay form for the benefit of other Section members. Academic and clinical pediatricians are welcome. For example last year Eugene Wysen wrote about probiotics as a tool for improving health in seniors as well as children. Others picked up on it; a few issues back Pediatrics featured several articles on this topic. Don't hesitate; join in! Send articles for publication to Joan Hodgman at hodgman@usc.edu and Arthur Maron at ARTMARON@AOL.COM.

Have you recently visited our new and improved Web Page? Just go to www.aap.org, scroll down the right side for the Sections menu, click and look for Section Home Pages, and then in the list click on Seniors. You'll find quite a list of material. We hope much of it will be useful for you. Soon we hope to divide this into text that should be held for members only, accessible through the Member Center, and that which will be open to Fellows at large, as well as to the general public.

Don't forget to schedule time for the AAP national meeting in Washington, DC, the second week of October, 2005. The program for the Section on Seniors will be on Sunday 9 October, 2005. The reward for long-standing successful advocacy for children will be presented, and the winner will be unveiled! Donna Butts of Generations United, will speak, as well as Jane Schaller on international child health, and Arlene Johnson on the Donovan program. Our business meeting will follow immediately, so as to leave time for the President’s Reception and the 75th Anniversary Celebration immediately following.

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

“Do you believe in life after Death?”
the boss asked an employee. “Yes, sir,” the employee replied. “Well, then, that makes everything just fine,” the boss went on. “After you left early yesterday to go to your grandmother’s funeral, she stopped in to see you.”
Letters to the Editors:

To the Editors:

Wheelchairs! They are like hearing aids, because they are important in order to reduce the impact of disability for millions, but they are also so expensive that a large proportion of those millions are unable to afford them.

AARP Bulletin recently highlighted a thoughtful inventor who has been able to make a wheelchair from “plastic lawn chairs, mountain bike tires and other inexpensive components.” They have been distributed via a not-for-profit organization to the underserved in underdeveloped countries. They will not ship, except to those who can not afford to buy.

Readers may wish to visit his web sites.

His name is Don Schoendorfer.
His organization is Free Wheelchair Mission.
www.freewheelchairmission.org/
Wheelchair design is shown at www.freewheelchairmission.org/thewheelchair.html

Whether or not this man and organization are willing to launch a subsidiary for distribution in the United States, and for those who are not destitute, I do not know. But this work is so intriguing, it would be worth while for anyone who cares to help to check it out.

Yours truly
Constant Reader

Congratulations

Donald W. Schiff MD, FAAP
Has been reappointed to a second term as a Contributing Section Editor of AAP Ground Rounds
Keep up the good work!

Help us celebrate our 75th anniversary by donating $75 to Friends of Children Fund. Your donations help support AAP programs that address emerging issues in children’s health.
Call us at (888)700-5378 or donate online at www.aap.org/donate

Give $75 for the 75th!
DIOXIN, DIET AND HEALTH RISKS

Many have noted newspaper stories about the political upheavals in the Ukraine. An opposition candidate for President was poisoned with Dioxin, with a near miss on death. Before and after photographs showed the change from a healthy-looking man of middle years to a seriously sick person with ugly lumps all over his face. All of us should be aware that Dioxin is a general term that describes a group of hundreds of chemicals that are highly persistent in the environment. They are formed as unintentional by-products of many industrial processes involving chlorine. Chemical and pesticide manufacturing, bleaching processes and waste incineration all produce Dioxin. The US National Toxicology program has classified Dioxins as “known to be a human carcinogen.” These chemicals are found in significant amounts in beef, dairy products, milk, chicken, pork fish, eggs and are also absorbed by inhalation. The chemicals cross the placenta and are present in the lipids of breast milk. Since these chemicals concentrate going up the food chain, and are not excreted from the body, the risk rises for all of us with age.


A Different Kind of Tsunami

by Donald W. Schiff, MD, FAAP

The battle over Social Security which is currently raging in the U.S. Senate serves as the first in a likely series of conflicts which will lead to reorganizing the basic financing of health and welfare programs in the United States. Additional concerns regarding the funding of Medicare and Medicaid over the next few decades will soon surface as economists, business leaders and statesmen seek resources to fulfill the promises made to various segments of our population, including the elderly.

This writer has no expertise in economics, but as an observer of the political scene, it appears most likely that major changes in entitlements and benefits will be proposed over the next few years to enable both our state and federal governments to continue to provide an ongoing though probably reduced level of benefits through these admirable programs.

In view of the fact that 37% of newborns in the United States are delivered under the Medicaid system, and that over 50% of the Medicaid enrollees are children who expend only 20% of the costs of the Medicaid program, and that of the nine million uninsured U.S. children, half of that number are eligible for but not enrolled in Medicaid, it is clear that what happens to the Medicaid program is vital to the well being of the children of our nation.

The administration, in an effort to reduce our huge anticipated national deficit next year, is proposing a 60 billion dollar reduction in Medicaid, a program which has already reduced services to thousands of children and has continued to turn a deaf ear to the explanations by pediatricians of how an unconscionable fee structure constrains their options in providing the care that enrolled Medicaid children need.

The Academy of Pediatrics has recently reaffirmed its stance regarding its firm support for Medicaid. It is opposed to any form of block grant or state waiver which would further impair the quality or breadth of care for our nation's children.

As desirable as it would be to have every child in the United States covered by a comprehensive health insurance policy, the present need is for our advocacy to be directed at both state and federal levels to prevent the reduction in eligibility, benefit structure and reimbursement in order for children covered under Medicaid to receive the health care, both preventive and therapeutic, that they need and deserve.

I hear you saying, “OK, so what can I as an individual do?” The answer is familiar, but can be effective. Let those folks in the state house, the White House, and the national Capitol hear your voice. They do listen when we speak together. Join with other non-pediatric advocates and we can make a difference. Contact Don Schiff at donroschiff@comcast.net with questions or comments.
Living my “Bonus Years” – No Plans to be “Retired.”

by Jackie Noonan, MD, FAAP

Some time ago I wrote an article on how I failed retirement 101. After working for nearly a year a new chief was found and I returned to “my retirement.” When people began to ask, “are you completely retired now?” I decided to go to the Oxford Dictionary and was surprised to find “retired” defined as “withdrawn into seclusion or away from contact with the world.” I, therefore, refuse to be retired and instead I am enjoying my “bonus years.” This is a time when you have control over your time. I love being a doctor and I love teaching. Fortunately, the University of Kentucky continues to grant me a past retirement voluntary appointment which provides malpractice coverage. About twice a month I travel to Eastern Kentucky as I have for over 40 years and see children at regional heart clinics conducted by the Commission for Children with Special Health Care Needs. Usually a medical student or pediatric resident is on hand for one-on-one teaching. This makes me feel useful and keeps my auscultatory skills intact. I attend our weekly cardiology conference when it doesn't interfere with my other activities.

I share an office in the Student Affairs area and serve as a Senior Consultant (this justifies my office space). I love working with the medical students and teach a small group of freshmen a problem-based course called, “Patients, Physicians and Society.” It requires no preparation by me and allows me to share my enthusiasm for medicine with the next generation. A number of retired faculty have volunteered to teach this course. Another rewarding task you might consider, as I have, is interviewing prospective medical students. I am elated by the young people applying to medical school. I can assure you that the future of medicine will be in good hands. I also serve on an Institutional Review Board (IRB) which is a chore but helps keep me abreast with research activities. Pediatricians are needed on these boards to be sure research on children is carried out appropriately.

With the need to “Publish or Perish” no longer a factor, writing can now be “fun.” Noonan Syndrome has brought me some recognition, but I never had time to be as productive in that area as I wished. Now I serve on the Advisory Board of the Noonan Syndrome support group and spend considerable time in learning more of the natural history of Noonan Syndrome and of the adult with Noonan Syndrome. Since retirement I have written several chapters, published several papers and have plans to continue further long-term studies of this interesting condition. Although this is fun for me, it is not what everyone would plan to do in the bonus years. In your bonus years you can do what you choose.

I have also traveled, become active on a number of community boards, serve as medical associate for Children's Hospice, and do a little oil painting. All in all, I am staying busy but I’m also staying healthy — trying to eat healthy and exercise regularly. I am lucky to have good health and a lot of energy. I feel you need to “live every day of your life.” Working with medical students and young faculty keeps me “young at heart.” Working with the emeriti faculty at UK and the Senior Section of the AAP inspires me to continue to stay active, advocate for children and enjoy my bonus years.

“The incompetent servant, by whomsoever employed, is always against his employer. Even those born governors, noble and right honourable creatures, who have been the most imbecile in high places, have uniformly shown themselves the most opposed (sometimes in belying distrust, sometimes in vapid insolence) to their employer. What is in such wise true of the public master and servant, is equally true of the private master and servant all the world over.” Charles Dickens, Our Mutual Friend, published in chapters, 1864-1865. Dickens, of course, is writing of another era and another culture. But I wonder if some aspects of his strong point of view (to my knowledge he never held an ambivalent or weak point of view) might be applicable today?
Twenty years ago my wife spotted an unusual-looking bird in our back yard in Phoenix, Arizona. Neither of us had ever paid much attention to the avian population in our yard, and she asked me to pick up a book on bird identification at the bookstore near my office. That evening, I cam home with a copy of the Audubon Society Field Guide to North American Birds, but soon discovered that I had purchased the “Eastern Edition” and had to return the next day to pick up a copy of the “Western Edition”. Although some bird species are present throughout the country, there are major differences in many species depending on the geographic area. The bird that we saw turned out to be a Spotted Towhee and we have seen it only one other time in our yard.

Thus began our ongoing saga of bird watching. Since then, we have identified over 60 species of birds in our yard. We have a nucleus of common desert birds that are usually around most of the year- House Sparrows, House Finches, Mourning Doves, Northern Mockingbirds, Cactus Wrens (our state bird), Curve-billed Thrashers, Gambel’s Quail, Albert’s Towhees and Gila Woodpeckers. White-winged Doves arrive in April and presage the onset of summer. In the fall, Lesser Goldfinches show up at our feeders, and in winter, White-crowned Sparrows arrive. Several species of hummingbirds also grace our property.

We discovered that the Maricopa Audubon Society has regular field trips that are usually led by very knowledgeable birders and we were soon exposed to the marvelous world of our feathered friends. Southern Arizona is one of the premier birding areas in the country and we try to get down there during each of the seasons. A large population of Sandhill Cranes and raptors (hawks, eagles and owls) winters in the Sulfur Springs Valley east of the old copper mining town of Bisbee. In the spring, colorful migrating and resident breeding songbirds arrive. In the summer and fall, a variety of sparrows and shorebirds show up. I never thought I would spend much time visiting municipal sewage ponds, but many interesting shore birds and ducks seem to enjoy that sometimes odiferous environment.

I now try to pick medical meetings with a good birding environment. I am a pediatric allergist and our annual Academy of Allergy meeting is in San Antonio in March, 2005. We plan to attend and then head down the Texas coast. There are numerous wildlife refuges from High Island east of Houston all along the coast to Brownsville. In the spring, migrating warblers have to cross the Gulf of Mexico and first hit land at places such as High Island. Sometimes after a storm, a “fall-out” occurs and thousands of birds collapse exhausted near the water to recuperate before heading north to breeding grounds. I am looking forward to a Florida meeting in 2006 since we have never birded in that area.

Our vacations have also centered on our birding interests and we have particularly enjoyed the Monterey Peninsula in Northern California as well as the areas north of San Francisco. We try to get to the Grand Teton in Wyoming periodically. We have birded the outer banks of North Carolina and last year made it to Cape May, New Jersey, where the fall hawk migration occurs in September and October. Another of our favorite spots is Point Pelee in Ontario, Canada, near Detroit where migrating songbirds arrive in the spring after a contentious trip across Lake Erie.

Sometimes this birding obsession can get out of hand. We drove up Mt. Evans in Colorado looking for Rosy Finches at 14,000 feet elevation, but couldn’t find them. There was a flock of Bighorn Sheep enjoying the altitude more than we did. One spring, we drove three hours to the Colorado River to see a Yellow-billed Loon. We drove up to a dock area where the bird had been sighted and, lo-and-behold, it was swimming 10 yards from shore. There were more bird photographers on the dock than there were fishermen.

One of the more rewarding aspects of birding has been the association and friendship of a number of people. Birders are avid “environmentalists” who are more aware than others of the destructive results of human actions on our planet-whether it is loss of rain forests in South America which destroys the warbler habitat, or urban sprawl that does not take into account the wildlife population that is being decimated. In Arizona, an acre an hour of desert land is being “developed”. (You don’t find many Bush Republicans in birding sanctuaries.)

Bird watching is something everyone can do. People with limited mobility can bird from the car in many places. It is good to start in your back yard and study the common birds. Spring breeding...
plumage is often different from fall and winter presentation. Juveniles may look different from mature birds. As in medicine, one needs to know all of the presentations of the common diseases in order to suspect the unusual; in birding, you need to know the characteristics and variations of common birds in order to recognize a less common species. If this avocation sounds interesting, buy a set of binoculars and a bird identification book (Ken Kaufman's Birds of North America or David Sibley's Guide to Birds), call your local Audubon Society and get started.

### SUMMARY OF CHAPTER SENIOR ACTIVITIES

*From Data Complied by Jackie Burke — September 2004*

#### Activities already commenced:

- Emeritus members do not pay dues: 1
- Emeritus members pay 50% dues: 1
- Senior Committee Formed: 9
- Formal mentoring of residents or young pediatricians: 1
- CME and Annual meeting at no charge to Emeritus or Seniors: 3
- Chapter history written by seniors: 3
- A senior invited to each Chapter Executive Committee meeting: 2

#### Potential Activities: Chapter might be Interested

- Forming a Chapter Senior Section or committee: 28
- Writing a Chapter History: 31
- Seniors encouraged or invited to join Chapter committees or action groups: 28
- Seniors encouraged or invited to assist in carrying out grants to Chapter: 23
- Seniors encouraged to mentor young pediatricians, residents, students: 31
- Seniors encouraged or invited to write for Chapter Newsletter: 20

Note: List of potential activities appeared to rubber stamp suggestions from national group, in that wording was the same for each activity.

This listing does not take into account the number of members of the Senior Section, or the number of members eligible to join the Senior Section, who are active in Chapter affairs. I suspect there are many in each state. Their work is under our radar, but not under the radar of the Chapter. We could all name many such.

A topic for discussion could be: Is it advantageous to individuals, to Chapter, to Senior Section or to AAP to make efforts to incorporate these many FAAPs, busy with their own interests and with Chapter affairs already, with us in some way?

Avrum L. Katcher

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On Easter Sunday morning, the sermon was intended for children. The preacher reached into his bag of props and pulled out an egg. He pointed to the egg, and asked the children, “What’s in here?” “I know,” a little boy exclaimed, “Pantyhose!”

Back in the old days, in the mists of time, a prospective father-in-law asked, “Young man, are you ready to support a family?” The surprised man, about to be a groom replied, “Well, no. I was just planning to support your daughter. The rest of you will have to fend for yourselves.”
The Role of the AAP in Pediatric Residency Education

by Arthur Maron, MD, MPA, FAAP

For those of us who still can recall some details of their pediatric residency, and have watched countless graduates of residencies enter our pediatric communities over the years, there seems to be a pervasive question about how pediatric residencies were structured and who was ultimately responsible for their content and quality. It was always kind of fuzzy to me when I was a young resident, and I didn't gain much insight during my years of practice until I was elected to the Board of Directors of the AAP representing the Middle Atlantic states. Prior to that, during decades of traditional primary care pediatric practice, there had always been a nagging question – seconded by many of my colleagues – that pediatric residency training was somehow disconnected from pediatric practice. I had walked out of my residency with a grand diploma, reasonable knowledge in treating diabetic ketoacidosis and tuberculous meningitis, and very little understanding of how to conduct myself in a growing practice. That continued to trouble me over the years, as I became involved in resident teaching as a voluntary attending. During that period, on the faculty with more and more full-time academic colleagues, I attempted to emphasize some of my own office experience in what might be dismissed as mundane pediatrics but seemed like every day in the office to me.

I really enjoyed interaction with young, enthusiastic pediatric residents; I found (as you have, too) that the best way to learn is to teach! I was not, however, involved in the structure and management of residency programs so my nagging questions went unanswered. Why do residents spend most of their time in the hospital managing very sick children to prepare themselves for office practice treating very well children? Why do residents spend all that time with “scut-work” unless maybe they are cheaper labor than phlebotomists? Why do residents spend almost a quarter of their residency in the neonatal intensive care unit and then start practice and are denied neonatal privileges? Why did the working hours for residents resemble the worst of fraternity hazing rituals?

Questions like these continued to trouble me during my years in practice, and seemed to be an issue for many of my AAP colleagues. But, candidly, we in practice were pre-occupied with other priorities and somewhat removed from the operational aspects of pediatric residency education. It was during my tenure on the national AAP Board of Directors that I gained some understanding of the enterprise. The Accreditation Council for Graduate Medical Education (ACGME), with five parent organizations such as the AMA and the AHA, had delegated to 24 specialty-specific committees the responsibility to monitor, evaluate and manage residency education in each specialty. The Residency Review Committee for Pediatrics (RRC), was the ultimate authority when it came to pediatric residencies. Very interesting. Traditionally, our RRC had nine members, although a resident member was added more recently. Of the nine members, three each were recommended by the AMA Pediatric Section, the American Board of Pediatrics, and the AAP. As I learned more and more about the RRC, it became clear that this body was literally in control of the life and death of residency programs. Periodic site visits were conducted, compliance with strict requirements was assessed, and accreditation was awarded or withdrawn based on the merits.

The RRC was itself guided by a set of carefully worded requirements, and all actions of the RRC were reviewed carefully by the ACGME. As my knowledge grew, so did my respect and appreciation for the RRC. Eventually, it all seemed to come together for me. The medical establishment in the U.S. had decided how best to educate and prepare future medical specialists, had developed very specific requirements for this training, and had constituted a credible committee to oversee the process.

Now I knew where to go to have my questions about graduate medical education in pediatrics answered. Now, I was completing my six years on the AAP Board of Directors and I was concerned that the direction taken by the RRC was not consistent with the preferences of the AAP and not necessarily consistent with the new evolution of graduate medical education. Those nagging questions I had previously were now over-shadowed by new questions about the future of pediatric education.

The turning point occurred when I was nominated by the AAP to assume one of our three positions on the RRC. I was still in traditional pediatric practice at that time, although I was, in addition,

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Recently, I was diagnosed with A.A.A.D.D. - Age Activated Attention Deficit Disorder. This is how it manifests itself:

I decide to wash my car. As I start toward the garage, I notice that there is mail on the hall table. I decide to go through the mail before I wash the car.

I lay my car keys down on the table, put the junk mail in the trash can under the table, and notice that the trash can is full.

So, I decide to put the bills back on the table and take out the trash first, but then I think that since I'm going to be near the mailbox when I take out the trash anyway, I may as well pay the bills first.

I take my checkbook off the table and see that there is only one check left. My extra checks are in my desk in the study, so I go to my desk where I find the can of Coke that I had been drinking. I'm going to look for my checks, but first I need to push the Coke aside so that I don't accidentally knock it over.

I see that the Coke is getting warm, and I decide I should put it in the refrigerator to keep it cold.

As I head toward the kitchen with the Coke, a vase of flowers on the counter catches my eye — they need to be watered.

I set the Coke down on the counter and I discover my reading glasses that I've been searching for all morning.

I decide I'd better put them back on my desk, but first I'm going to water the flowers.

I set the glasses back down on the counter, fill a container with water, and suddenly I spot the TV remote. Someone left it on the kitchen table.

I realize that tonight, when we go to watch TV, we will be looking for the remote, but nobody will remember that it's on the kitchen table, so I decide to put it back in the den where it belongs, but first I'll water the flowers.

I splash some water on the flowers, but most of it spills on the floor. So, I set the remote back down on the table, get some towels and wipe up the spill.

Then I head down the hall trying to remember what I was planning to do.

At the end of the day, the car isn't washed, the bills aren't paid, there is a warm can of Coke sitting on the counter, the flowers aren't watered, there is still only one check in my checkbook, I can't find the remote, I can't find my glasses, and I don't remember what I did with the car keys.

Then, when I try to figure out why nothing got done today, I'm really baffled because I know I was busy all day long and I'm really tired. I realize this is a serious problem, and I'll try to get some help for it, but first I'll check my e-mail.

Do me a favor, will you? Forward this message to close friends you know, because I don't remember to whom it has been sent.

Don't laugh — if this isn't you yet, your day is coming! And if I have sent this to you before, well, now you know why you're getting it again.
Senior Volunteers
by David Annunziato, MD, FAAP

As many of you know, one of my major thrusts as your senior section chairman, was and is to attempt to obtain immunity from malpractice to all who give of their time and great talents without reimbursement. I have already communicated to you via our senior bulletin regarding the Volunteer Protection Act, signed into law by President Clinton in 1997. It sounds good but this law has never been challenged in the courts. Thus the degree of protection it affords is unknown.

More Good News. With the help of Julie Ake at AAP headquarters and Dr. Gary McAbee who chairs the AAP medical Liability Committee, I have been made aware of some new legislation, probably part of HIPAA, which appear even better. It was not funded till this year and is in effect. It is the Free Clinics Federal Tort Claims Act Medical malpractice Program (FTCA). It extends coverage for malpractice to volunteers in approved free health clinics. In this program, the physician volunteer must apply to the program, be licensed and volunteer at an approved clinic.

I will outline as briefly as possible the FTCA for your review. Since this is a government communication, it is in the public domain and I will quote freely from it.

“IV. WHAT SERVICES ARE COVERED?

FTCA deemed volunteer free clinic health care professionals are eligible for medical malpractice coverage for health care service acts or omissions. HHS will deem a volunteer free clinic health care professional to be a federal employee for purposes of FTCA coverage for medical malpractice claims if specific credentialing and privileging requirements are met.

Only volunteer health care professionals who are licensed or certified are eligible for FTCA deemed status. A licensed independent practitioner (LIP) is a physician, dentist, nurse practitioner, nurse midwife, or any other individual permitted by law and the organization to provide care and services without direction or supervision, within the scope of the individual practitioner’s license and consistent with individually granted clinical privileges.

Primary source verification of:
   a. Current licensure;
   b. Relevant education, training, or experience; and
   c. Health fitness or the ability to perform the requested privileges (This can be determined by a statement from the individual that is confirmed either by the director of a training program, chief of staff/service of a hospital where the individual has privileges, or a licensed physician designated by the organization);

2) Secondary source verification of:
   a. Identification (via a government issued picture id);
   b. Drug Enforcement Administration registration, as applicable;
   c. Hospital admitting privileges, as applicable;
   d. Immunization and PPD status; and
   e. Life support training, as applicable; and

3) Querying the national Practitioner Data Bank (NPDB)
The free clinic should complete the credentialing process for the LIP prior to the practitioner providing patient care services at the free clinic.

Temporary Privileging Requirements for LIPs
The free clinic should strive to complete the privileging process prior to the LIP being allowed to provide patient care services. However, if the free clinic has established temporary privileging policies and procedures, it can grant temporary privileges to a LIP.

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The free clinic should have an appeal process that a LIP can undertake if the free clinic decides to
discontinue or deny his/her clinical privileges. An appeal process is optional for other licensed or certified
health care practitioners.

A long review of the credentialing and privileges of an LIP are included in the act.

III. WHAT IS THE APPLICATION PROCESS?
A free clinic must sponsor each volunteer free clinic health care professional that participates in the
Program. A free clinic can sponsor volunteer free clinic health care professionals by submitting a FTCA
deeming application to the HHS Secretary through the Free Clinics FTCA Program. The free clinic sub-
sequently can sponsor volunteer health care professionals annually by submitting a FTCA annual renewal
application. The original deeming letter from the HRSA Associate Administrator will list the due date
for annual renewal applications that will stagger free clinics' application submission dates.

This is an outline of this notable legislation. Several model application forms are included in the text. If you
are considering volunteer work, you should review the legislation in detail. I would be happy to supply a copy
to anyone upon request. Please see Bob Mendelson's article on this subject in the latest issue of A.A.P. news.

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**My Wife, the Good Listener**

*by Bill Kueffner*

As Yogi Berra might have said, “You can hear a lot by listening”. Everyone recommends being a good listener
and, luckily for me, my wife Nancy took that advice. She diagnosed my sleep apnea by carefully observing my
breathing sounds as I slept. She heard me snore a bit, then no sound for well over half a minute. When it kept
happening, she worried more and more. I was blissfully unaware of all this until one night I was pulled awake
by our son, Paul, because Nancy wasn't strong enough to do it by herself, and she was frightened by my inter-
mittent breathing. For help, we then turned to one of our local internists who is interested in sleep apnea. This
led to a formal overnight sleep test by a branch of the Gaylord Rehab Center, where her fears were confirmed.

The main reason to recount our experience is to alert all spouses to quietly check out their roommate's night
breathing from time to time. I was later able to make a long-distance diagnosis for my sister after hearing a some-
what similar story from her husband.

My CPAP (Continuous Positive Airway Pressure) machine works well to keep me breathing normally at night,
and Nancy sleeps better now, too.

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A very elderly gentleman, (mid nineties) very well dressed, hair well
groomed, great looking suit, flower in his lapel smelling slightly of a
good after shave, presenting a well looked after image, walks into an
upscale cocktail lounge.

Seated at the bar is an elderly looking lady, (mid eighties). The gentleman
walks over, sits along side of her, orders a drink, takes a sip, turns to her
and says, “So tell me, do I come here often?”
Many physicians have been taking advantage of the historically low mortgage rate environment by purchasing second homes. According to the National Association of Realtors, 445,000 second homes were purchased in the United States last year, representing a 25% increase from the previous year, with the trend expected to continue.

Unlike primary residences, many second homes are also used as rental properties to generate supplemental income. This added revenue can help defray property taxes and maintenance costs. Regardless of the use of the rental income, the tax code as it relates to vacation homes can be complicated. Certain rules apply to the income the owner receives from renting the home and the expenses they incur from maintaining the home. How the income and expenses are treated depends on whether the property is considered a “personal residence” or a “rental property” for tax purposes. This is determined by examining the number of days and the respective usage of the specific property. If the property is used personally for the greater of 14 days or 10% of the total days it is rented (assuming the transaction is based on a “fair” rental price), it is considered a personal residence.

When the property is not rented for more than 14 days a year, it is not considered to be a rental at all. In this situation, the property taxes and mortgage interest are typically 100 percent deductible, subject to certain limitations just like with your primary personal residence. Additionally, any rental income received does not need to be reported, and thus is not taxed. In this case, the typical expenses related to “rental properties”, such as maintenance and depreciation write-offs, are not allowed.

On the other hand, if the property is rented for more than 14 days, and personal use exceeds the 14 days a year, or 10 percent of the total rented days, if greater, the property is treated as a personal residence with a dual purpose. In this case, the IRS rules state that generally rental expenses (such as the allocable portion of interest and taxes, operating expenses, and depreciation on the rental part of the residence) are deductible on the taxpayer's Schedule E of IRS Form 1040. Since the property is considered dual purpose, any excess rental deductions may be carried forward to future years and will be deductible up to the amount of rental income received in the following year. This essentially means that the owner cannot report a loss on their 1040 return in order to offset other income. Keep in mind that the IRS limits people to two homes regarding their mortgage interest deduction. If you do happen to own more than two homes, interest payments on those additional properties are not tax-deductible. On the other hand, regardless of the number of properties owned, property taxes continue to be typically 100 percent deductible.

If the property is not used as a home and is rented more than 14 days, it is then considered to be “rental property”. In this situation, the owner must report all rental income and expenses. Unlike when a property is considered a “personal residence with a dual purpose”, the deductible rental expenses can actually be more than the gross rental income. These deductions, however, are mandated by a complicated list of tax rules which become subject to passive activity loss restrictions.

Due to the potentially complicated treatment of second homes for tax planning purposes, it is recommended that you consult with your tax advisor prior to making the purchase.

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

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INVESTING IN 2005: A PRESIDENTIAL POST-ELECTION YEAR

by James L. Reynolds, MD, FAAP

Senior Section Financial Planning Committee

Some say it’s definitely possible to time the stock market by the 4-year presidential-election cycle. Such a method is worth consideration at the time of this writing, March, 2005, when the market has been volatile and not doing well.

The strategy is historically justified. One finds a definite predilection for equities to do well in pre-election and election years, and to falter significantly in post-election and mid-term years. In one evaluation of the presidential election-year theory, based on the S & P 500 Index from 1950-1995, the market rose in 91% of election years—not bad odds—and the odds were even better—100%—in pre-election years. That’s remarkable since it’s hard to think of any investment strategy predictably 100% successful in specified years.

Perhaps it’s not surprising that, in a democracy, politicians would be doing right by the stock market in pre-election and election years in order to garner constituents’ votes. Cynically, once they are in office, they may not be as attentive to the electorate’s economic well-being.

In post-election years from 1950-1995, the S & P 500 index, was positive only 45% of the time, and in mid-term years was not much better, 55%. So in those years, one’s equity portfolio might be expected to advance or decline as predictably as a coin toss would come up heads or tails. As expected, the stock market rose annually about 70% of the time over the entire 46 years from 1950 -1995.

If the market is analyzed on the basis of the Dow Jones Industrial Average instead of the S & P 500 index, one finds essentially the same bias, although the positive years were not as startlingly frequent as when the S & P 500 was used as the market surrogate. The market annually performed well in only 64% of the Dow years. Of pre-election years, 79% were positively performing, and 69% of election years saw a rise. Only 52% of post-election years showed a gain in the DJIA, while mid-term years did little better: 55%.

The difference between the S & P and the Dow percentages is not so much the difference between the two market surrogates used, but in the much longer, and presumably more statistically reliable, time span, 1886-2001: 116 years of analysis. (Both calculations were exclusive of dividends.)

Over the long term, knowing the Dow odds of about 50% that the equity market will decline in post-election years, should one be out of stocks this year and into Treasuries or a money market fund?

Updating the S&P-500 data through 2003 makes stock investing no more encouraging: The average return in the post-presidential years from 1950-2003 was only an irrelevant 1% higher, 46%.

Before answering the prominently pregnant question of whether to invest in American stocks this year, there are other considerations. One of these concerns another seasonal market-timing method, namely, one called Best Six Months.

A 46 year (1950-1995) analysis based on investing in the S&P 500 index reveals that a Buy-and-Hold strategy results in an average annualized return of 8.40%, while investing each year only in the six months period between November and April, the Best Six Months strategy, results in a return of 9.90%. The risk-adjusted returns between the two strategies are really impressive: 7.3% vs. 34.4%!—a subsequent gain of 7.9% vs. one of 52.4% would be required to make up each loss, respectively. The worst yearly loss for Buy-&-Hold was 41.3% vs. 16.6% for Best Six Months.

So, if one is inclined to equity-invest this year, one should consider being out of stocks from May through October, apart from the flip-of-a-coin success of stock investing in a post-presidential-year.

Another reason for avoiding American equities this year, beside it being a post-election year, is the current likelihood we are in a secular bear market. Secular, i.e., long-term, bear-and-bull equity markets cycle, on average, every 18 years. The last secular bull market, from 1982-1999 was the most spectacular of the 20th century and lasted 18 years, so the odds are that we are now in a secular bear market. It was ushered in by the extraordinary bearishness of the three-year 2000-2002 debacle. There are the familiar alternating bull-and-bear short-term market cycles, of course, within the long-term cycles. The years 2003 and 2004 were positive, but the current

Continued on Page 14
short-term 2? year bull market is ageing. The average length of a short-term bull market is 2? years.

Other negative factors, or what some see as negative factors, for stock investing are:

1. A very low yield curve — the difference between short and long-term interest rates. There are fears that the yield curve could even invert, and only once (in 1966) since 1960 did an inverted yield curve not result in a recession.

2. High oil prices

3. The world threat of terrorism, and the war in Iraq

4. The January S&P 500 index fall: from about 1213 on Dec. 31, '04, to about 1195 on Jan. 18, '05.

Every January in which the S&P 500 index has fallen since 1950 has preceded a down or flat stock market(2).

5. A weak dollar.

6. Increasing budget and trade deficits.

It's too depressing to go on.

Acknowledging the preceding doom-and-gloom prospect for successful investing in the 2005 U.S. stock market, are there alternatives?

Bonds are an unlikely candidate since interest rates are currently well below average and the forecast is for continued increases during the year. High-yield (junk) bonds, the yields of which are now unusually low, are particularly vulnerable. The low yield curve also suggests avoidance: “When the yield is low, it's time to go; when the yield is high, it's time to buy.” Preferred convertible bonds may currently be the best bond types in which to invest.

The only bright spot now seems to be investment in market segments or sectors rather than the general market as represented by the major stock-market indices, the Dow (DJIA), the S&P 500, and the Nasdaq Composite.

Financial writers currently suggest moving from small- to large-capitalization stocks. Large-cap funds at the beginning of Feb. had a P/E ratio of 19 over the past year, while that of the small-cap funds was 25, more than the 20% multiple relative to large caps due to the small caps’ shakier footing. But although large-cap funds are currently cheaper, small-cap funds continue to do better. Small caps have had a nice 6-7 year run vs. the large caps, so it’s likely they will not do as well as their large-cap counterparts in the future. Over the past five years, the average small-cap fund has had an annualized gain = 5% vs. a 4% loss for the nation's average large-cap funds, according to Lipper, Inc.

Another market segment that may do better than the major-market indices is high-yield stocks. The current trend is increased dividend payouts, and there are a number of stocks that are both forecasted to accumulate and pay good dividends. Four recommended in a recent financial magazine(3) are:

1. Bank of America (BAC), 4%
2. BOC Group, ADR (BOX), 3.9%
3. ConAgra Foods (CAG), 3.7%, &
4. FPL Group (FPL), 3.7%.

The number of dividend increases in the past five years for those stocks are 5 for BAC, CAG, & FPL, & 4 for BOX

Robert Barker(4) recommends the following high-dividend stocks:
1. AmSouth Bancorp (ASO)
2. 4%; Ameren (AEE), 5.1%
3. Bank of America (BAC), 4.0%
4. ConAgra Foods (CAG), 3.7%
5. Merck (MRK), 5.1%
6. Pinacle West Capital (PNW), 4.5%
7. Southern (SO), 4.3%, and
8. Washington Mutual (WM), 4.4%.

Merger funds are a possible 2005 investing prospect since mergers are currently in vogue. “The fourth quarter of 2004 was the best for mergers and acquisitions since the fourth quarter of 2000,” (5). Worthy of consideration are: Arbitrage Fund, Gabelli ABC fund, Enterprise Merger & Acquisition fund, and Merger Fund (closed).

Special equity market sectors and segments that are recommended to do better than the American-market’s general indices are:

1. Natural Resources
2. Energy & Energy Services
3. Transportation
4. Gold
5. Foreign Markets, and

On the other hand, one assumes more risk investing in these specialized markets.

In this presidential post-election year, one can only sympathize with President Truman who said, “I was in search of a one-armed economist, so that the guy could never make a statement and then say, ‘On the other hand …’”

REFERENCES
3. Smart Money magazine, March, '05
4. BusinessWeek magazine, Feb. 7, '05
The Uniqueness and Colorfulness of the Yiddish Language

by Sol Browdy, MD, FAAP

There may be other languages which have associated attractive variants, but I doubt that any of them can compare with Yiddish. Yiddish has been the mother tongue of millions of Jews throughout Europe, and wherever they migrated and settled, it was Yiddish rather than Hebrew which served as the language of communication among the Jews. And so millions of us Jews in America and throughout the world who grew up in Yiddish-speaking homes learned it accidentally.

The principal parent of Yiddish is so-called Middle High German but it also has borrowed from English, Russian and Polish languages. Several hundred Yiddish words can be found in Webster's Third International Dictionary. Among them are the following: gezunheit (good health; also bless you! as on sneezing; schlemiel (clumsy dope); schlaimazel (unlucky person); mazel (luck); kibitz (to meddle); shikker (drunkard); shalom (peace and hello); tzimmes (fruit compote); gefilte fish (stuffed fish); kosher (proper Jewish food); mitzvah (commandment, good deed); shabbes (Sabbath); mesheug (crazy); mishmash (a mess, confusion); shnook (a dolt); and shmatta (fabric remnant which youngsters take to bed and suck on for comfort; often nicknamed blan blan when the object is an old blanket.

From a humorous and picturesque standpoint I am partial to Yiddish phrases where literal translation doubles the pleasure and fun. Yiddish not infrequently employs profanity and restricted words. Some of my favorites border on being epithets. The source of most of the following phrases and words is A Dictionary of Yiddish Slang & Idioms by Fred Kogos. I assume his labeling some of the expressions as taboo implies they should be restricted in use:

Gai kucken ahfen yam! (taboo) Don't bother me! Get lost! (Lit., Go defecate on the ocean!)
Gai in drerd arein! Go to hell! (Go down into the earthly grave.)
Hak mir nit in kop! Stop bending my ear (Lit., Stop banging on my head)
Hak mir nit kain tshelnik. Don't bother me (Lit., Don't bang on the tea-kettle)
Ich zol azoy vissen fun tsores. I should know as little about trouble (as I know about what you are asking me)
Kush mich in toches! (taboo) Kiss my behind! Stop annoying me!
A Leben ahf dein kop! Words of praise like: Well said! Well done! (Lit., A long life upon your head)
Me darf nit zein shain; me darf hoben chain. You don't have to be pretty if you have charm.
Pisher (taboo) Male infant; a nobody; a little squirt (Lit., a urinator)
Redn tzu derv ant Talk in vain or to talk and receive no answer (Lit., talk to the wall for all the good it will do you)
Shlog zich kop in vant Go break your own head! (Lit., bang your head against the wall)
Shmendrik Fool; nincompoop; an inept or indifferent person
Shutup es in toches! (taboo) Shove (or stick) it up your rectum!
Toches-lecker (taboo) Person who will do anything to gain favor; apple polisher
Vos draistu mir a kop? What are you bothering me for? (Lit., Why are you twisting my head?)
I am very much a regular guy and not much of a drinker but, occasionally, I enjoy a glass of wine with my dinner. For the summer, one of my favorite drinks is gin and tonic. Imagine my surprise when, while reading books on medical history, I found out that both the gin and the tonic-water were created by physicians and exclusively for medicinal purposes. Wow! Let’s first start with the history of gin. The art of healing changes with the times. When I went to medical school, ADHD and Reflux had not been exploited yet, cephalosporin would have been something related to the head, MRI could have meant anything you wanted it to, if you like to play with words and Direct-to-Consumer advertising was unthinkable. And that was only a few decades ago.

What we know is that in ancient times, the cause and the cure of diseases were linked to gods, magic and superstition. You may also remember that Aesculapios used to cure sick people by inducing sleep inside his temples. Then came Hippocrates with his theory that diseases possessed their own individual nature and their course was totally independent of supernatural intervention (short of being an agnostic…)

For the purpose of this essay, let’s take a leap and land in the early 1600’s when medical philosophy was divided into 2 schools of thought: 1) the Iatrophysical School, which prevailed in southern Europe (Italy, France) and 2) the Iatrochemical School prevalent in northern Europe (Holland, Germany). In the Iatrophysical School, its followers believed that the nature of disease was based primarily on mechanical principles (e.g. locomotion, respiration, digestion). The most prominent physician of this school was Giovanni Borelli (1608-1679), a follower of Galileo who explained his theory in his treatise “De Motu Animalium”. By contrast, the followers of the Iatrochemical School insisted that all the physiology and pathology of disease was based on chemical (humoral) principles. A prominent representative of this school was Franciscus de la Boe (1614-1672), who name Dr. Sylvius. He was a professor at the University of Leyden (Holland) who classified disease according to his theory of acidosis/alkalosis. He also recognized the importance of saliva and pancreatic juices in the process of digestion and insisted that the sweetness of the urine of diabetic patients was due to chemical changes in the body. He may also have been interested in children since he wrote a treatise: “De Morbis Infantum”. Franciscus de la Boe was fascinated by the function of the kidneys and thought that many ailments could be cured by increasing diuresis. He knew that around the 12th century, alchemedic monks in Italy, used juniper berries as a flavoring agent in distilled spirits. He also knew that in Europe, during the Bubonic Plague (1347-1350), juniper berries were given to patients to increase diuresis with the hope that the decrease of water volume in the body would reduce the size of the very much enlarged nodes. Therefore, de la Boe created a concoction based on juniper berries, mixed with grains and other botanicals; its purpose was to flush the urinary system. He called this “new” medicine “genievre” which is French for juniper, the Dutch renamed it “genever” and even...
tually the English, who, by nature, are not Francophiles, anglicized it and called it “gin”.

So, if the medicinal properties of the juniper berries were known before de la Boe was born, why was he credited with the invention of gin? The answer is simple. He was the very first one to write down the recipe. Documentation, documentation, documentation! The original formula included botanicals such as juniper berries, coriander, angelical root, orris root, anise, caraway seeds, fennel, lime, lemon and orange peel, bitter almonds, calamus root, licorice, cardamom, cassis bark, ginger and cinnamon. De la Boe’s developments occurred in Holland and the Dutch were happy and contented enjoying their beverage. It was a fortuitous act of war that propelled gin across the sea. When England’s Queen Elizabeth I, sent troops to Holland to help the Dutch fight against Spain, the British soldiers, before battle, consumed the typical local beverage, which was promised to boost their ability to fight. The soldiers called this miraculous beverage: “Dutch Courage”. When they returned to England, they took with them, as souvenirs, a few bottles of “Dutch Courage”. Before you could blink your eyes, gin became the national drink of England.

By 1688 the port cities of Bristol, Plymouth, Portsmouth and London were producing half-million gallons of gin per year. In 1689, when William III (a Dutchman, born in The Hague in 1650) ascended to the throne of England, the stage was set for a higher production. Rumor has it that by 1727, gin consumption in England equaled nearly one gallon per person per year, (5 million gallons for 6 million people!). It got to be such a problem that in 1736, to discourage small home-based entrepreneurs, the Parliament introduced the “Gin Act” which imposed a 50 Pounds license for anyone distilling gin. In their book “The Martini Companion”, Regan and Regan, claimed that by the mid 1700’s Londoners consumed so much gin that theater plays had to be cancelled. Audiences were unruly and half of the actors were too drunk to remember their lines. In the late 1700’s “Gin Palaces” opened, where people could go and get drunk on a regular basis. In the early 1800’s, James Burroughs, a British pharmacist opened a distillery where botanicals were infused into a neutral spirit for 24 hours and were afterwards pot-distilled for eight more hours. He baptized his tonic as “Beefeater London Distilled Gin”.

A major change in the gin market came in 1870 when “dry gin” was created as opposed to regular gin which had a taste to it. This change caught the palate of wealthy Americans traveling to England. Soon, all sophisticated New Yorkers were demanding the “dry” version. During Prohibition, bathtubs were filled with grain alcohol, distilled water and juniper flavoring, and the “Martini” became the fad of the 1940’s and 50’s. The drink grew to be very popular among all kinds of people… including those without a kidney condition!

These are just a few facts about the origin and medical history of one of my summertime favorites. As I conclude, let’s first toast to the memory of Dr. Franciscus de la Boe: Cheers! And, congratulations for having documented your recipe. Second, a warning to all of you readers: if you believe that Dr. de la Boe was correct, you may reconsider drinking gin before you go to bed!

In the next chapter we will continue this series with the medicinal origin of tonic-water. Until then…

Salud!

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**An elderly gentleman had serious hearing problems for a number of years. He went to the doctor and the doctor was able to have him fitted for a set of hearing aids that allowed the gentleman to hear 100%. The elderly gentleman went back in a month to the doctor and the doctor said, “Your hearing is perfect. Your family must be really pleased that you can hear again.”**

The gentleman replied, “Oh, I haven’t told my family yet. I just sit around and listen to the conversations. I’ve changed my will three times!”
Did you ever have the urge to share with your friends a clever e-mail you received thru the internet?

Well, now we are asking you to share it with us. This newsletter is starting a new column and we are asking you to be a contributor. Send us your clever e-mail to the attention of Roxanne Shannon at rshannon@aap.org and, if appropriate, it will be printed.

To give it a good beginning, in this issue we will start with a contribution from Maurice Liebesman, from Wilmington DE who sent us the following:

“WHAT IS A GRANDPARENT”
(taken from a class of 8 years old)

1. Grandparents are a lady and a man who do not have little children of their own, so they like other people’s.
2. A grandfather is a man grandmother.
3. Grandparents do not have to do anything because they are old. It is good because they drive us to the store and give us quarters.
4. When they take us for walks, they stop to show us things like pretty leaves and caterpillars.
5. They do not say “hurry up”.
6. Usually grandmothers are fat, but not too fat to tie your shoes.
7. They wear glasses and funny underwear.
8. They can take their teeth and gums out.
9. Grandparents do not have to be smart.
10. They have to answer questions like: “why isn’t God married?” and “how come dogs chase cats?”
11. When they read to us, they do not skip. They do not mind if we ask for the same story again.
12. Everybody should have a grandmother, specially if you do not have television, because they are the only grown ups who like to spend time with us.
13. They know we should have a snack-time before bedtime and they say prayers with us every time.
14. They give us kisses even when we’ve acted bad.
15. My grandmother lives at the airport, and when we want her, we just go there to get her. Then, when we’re done having her visit, we take her back to the airport.
This brief note intends to alert Seniors-and pediatricians of all ages-to this very thoughtful volume, written with passion underlyng thoughtful logic, about one of the great questions of our age: How is it best to spend money (in fancier words, utilize resources) for better health of our citizens?

Callahan's principal point is that our research establishment, commercial, academic, governmental, proceeds on a self-chosen path-way without any ethical consideration of whether or not any outcomes of the enormously expensive projects make any but marginal difference to the health of individuals or of citizens as a group. He believes that changing goals to lay out methods and routes for bringing what we already know effectively to individual patients would be a far more useful task.

This volume was reviewed by the distinguished health care economist at Princeton, Uwe Reinhardt, in Science 12 March 2004, Vol. 303: 1613-1614. Reinhardt has summarized the book beautifully. My purpose is to encourage all members of the Section on Seniors to read both the review and the book. See why Callahan says, "I believe that [a research] imperative pervades our culture, finding reflections within science, politics, research advocacy and public sentiment. It parallels the more familiar 'technological imperative'. if technologies exist they ought to be used, and usually will be used. They cease to become psychologically optional."

Callahan does not deny the enormous value of research that has been performed, leading to vast improvement in the health of almost all of us. What he says is that there are many persons who do not take advantage of what they might do today, to improve their health, and that we desperately need to know why, and how to help these individuals. There are also a number of groups in our nation whose health does not match what might be attained, as a group, and similarly, we need to devote ourselves to understanding why, and how they might be helped. Both on the individual level and the group level, he agrees that often it is the person involved who needs not outside material help but help to learn to help one-self. In either case, resources used in such a way should be far more beneficial than looking for a marginal improvement in the action of a medication.

This reviewer might say that perhaps both kinds of research are needed, along with debate on a national level about how to accomplish the best bang for a buck.

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**SENIOR FORUM**

We encourage our readers to share their wisdom and opinions with colleagues in a special section of the Bulletin identified as the SENIOR FORUM. Although we will pose a particular question in each issue, feel free to contribute a “Letter to the Editor” on this or any topic which will be considered for inclusion in the next issue.

**Senior Forum Question:**

“What management decisions are appropriate for premature newborns on the threshold of viability?”

Your response is welcome  
*The Editors*