Message from the Chairperson
Aurrum L. Katcher, MD, FAAP
Chairperson, Section for Senior Members

As you are aware, the Senior Section continues to serve the needs of the senior pediatrician such as retirement and navigating other types of career transition financial, familial, personal and psychological preparation. Preparation must commence early in career. In addition, we advocate wellness and self-care to maintain the pediatrician's most important tool, the self. We encourage opportunities to serve children by advocacy, work on committees and other action groups. So our task may be viewed as a two-way street; and to aid children via the individual pediatrician on the other side to aid children via the Section on Senior Members of the AAP.

To accomplish all this we need your thinking. In the next edition of the Senior Bulletin you will find a survey form to assist planning those projects for the Section on Senior Members which will be of greatest value to all. Lucy Crain and George Cohen have done an excellent job to prepare this survey. Please be sure to fill it out and return. If we are to be of help to you, you can help us with your ideas.

For some time it has been recognized that the most effective senior projects will be those developed at the local or regional level: Chapters, geographic groups within Chapters or Districts. In order to help bring this about, a Planning Guide has been created by David Annunziato, our past chairperson, and Jackie Burke, our hard-working staff representative. We look

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**Executive Committee**

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**Message from the Chairperson** Continued from Page 1 _______

forward to having it ready for the NCE in Washington, DC. Copies will be available for Chapter officers and others who are working on Senior Committees at local levels or who hope to develop such groups. We believe you will find this a useful document, and, as always with our activities, we welcome your suggestions or comments to improve it. Tell us what you think!

Speaking of the NCE, Jacqueline Noonan has put together a great program for our Section on Senior Members program at the NCE October, 2005, in Washington, DC. This will be held on Sunday afternoon, location to be announced. After the Child Advocacy Award, at 1:30 PM, Donna Butts will tell us about Generations United, a wonderful organization for connecting with young people. Dr. Arlene Johnson will discuss the Donovan Program, and AAP Fellow Jane Schaller will tell us about International Child Health opportunities. Following the program, the Section business meeting and reception will be held.

We are delighted to report that the Senior Section web site will be supervised by Jerold Aronson, of the Pennsylvania Chapter. Jerold has enormous experience in this area, and, even more important, his wide range of activities and interests for his own Chapter, District and at national level, and his energetic and stimulating ideas, make him an extraordinarily qualified Webmaster. We look forward to implementing his ideas. Please keep in touch with the Section on Senior Members public web site and also the private web site reached via the Members only Channel of the Academy web site, at www.aap.org. Expect to see a great deal of useful information. And send us your suggestions!

With best wishes,

Avrum L. Katcher, MD, FAAP

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**Some Ideas for Your Bonus Years**

*by Jackie Noonan, MD, FAAP*

Have you ever wanted to take a course in history, anthropology or learn a new language? The University of Kentucky has a program named for one of the previous presidents. The Donovan Scholars Program offers anyone 65 or older free tuition to attend classes at UK. Most take a class or two and attend class with the regular UK students. Some who never went to college earn a degree. So far, over 40 have been granted a degree with 3 receiving a BA or BS, 11 a Masters and 5 a doctorate. If going back to school doesn't interest you, there are many other programs available such as art classes, theatre, live dancing and chorus to name but a few. In addition, Donovan Forums are held regularly and are varied and well attended. I’m sure your city has some similar activities for seniors. Get to know the senior facilities in your town. You could have a lot of fun and make new friends.
“Our Strength is as the Strength of Ten?...”
by Eileen M. Ouellette, MD, JD, FAAP

As many of you may remember, the classic Victorian melodrama consisted of a pure and helpless maiden who was repeatedly victimized by a dastardly villain. After many trials and tribulations, our valiant hero rescued the pure and helpless maiden from her binds on the railroad track just before the train came along. The dastardly villain cried “Curses, foiled again”. Our valiant hero usually concluded the tale with the words: “Our Strength Is As The Strength Of Ten Because Our Hearts Are Pure”.

Unfortunately, that line doesn't work anymore.

We are currently dealing with very serious threats to Medicaid, the safety net for our most vulnerable children: the poor and those with special health care needs. Our major concerns are the federal proposed ten billion dollar cuts over five years to Medicaid and the possible loss of Early Periodic Screening, Detection and Treatment (EPSDT), which state governors and legislators are seeking in the name of “increased flexibility for the states”.

In recent months, the AAP has developed five principles about Medicaid which we feel must be fought for with all our strength. They are:

1) The entitlement to Medicaid must be preserved.
2) There must be fair and adequate reimbursement for pediatricians.
3) EPSDT must be protected.
4) SCHIP must be preserved.
5) While tax credits may be all right for some, they are not good for all.

We have obtained organizational support for these five principles from all the Pediatric Academic Societies (PAS), American Society of Pediatric Department Chairs (AMSPDC), National Association of Children's Hospitals and Related Institutions (NACHRI), American College of Obstetrics and Gynecology (ACOG), American Academy of Family Physicians(AAFP) and the American College of Physicians (ACP). The American Medical Association (AMA) has endorsed our of the five principles. As yet, they do not support the entitlement principle.

Our Medikids bill seeking universal health care for children utilizing a public/private partnership will be reintroduced to Congress shortly. We will be seeking your aid through our FAAN network to contact your senators and congressman to seek their co-sponsorship, support and vote for Medikids and for our five principles. Our AAP members’ website has easy directions for emailing or faxing them.

Did you know that every individual contact with a member of Congress counts as 1000 votes?

Over 8600 AAP members (8,600,000 votes) contacted Congress last month urging no cuts to Medicaid and the establishment of a Medicaid Commission. Our members have been credited with making the difference in bringing about the establishment of the Commission.

Our children and we need your help. Please respond whenever you receive a FAAN alert. If you contact your federal and state representatives, OUR STRENGTH WILL BE AS THE STRENGTH OF ONE THOUSAND BECAUSE YOU ARE INVOLVED ADVOCATES.
Letter to the Editor  
in Response to the Forum Question  
_by Joan Hodgman, MD, FAAP_  

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

With increased technical skills, it is becoming possible to treat ever less mature and smaller infants. Mortality for the infant <750 gms. or 23-25 weeks gestation has been decreasing but immediate morbidity in the nursery and, more important, long term morbidity have been increasing (1). Mortality, nursery morbidity and long term impairment are more closely related to maturity at birth than to birth weight. Most concerning is the number of very immature infants with severe long term developmental handicap. Extremely immature infants do not grow normally in the nursery, ending up below the 5thile for weight, length and unfortunately for head circumference. The magnitude of the problem is not appreciated by the public and even by neonatal physicians if they do not manage their own follow-up programs. Quotes in the literature of 30% of surviving infants being “normal” is misleading as in this case only 30% survived and 70% of 30% were significantly handicapped. The “normal” designation is also misleading as these are infants without severe handicap at 2 years of age, where a developmental score above 70 is considered normal and the mean score for the infants is in the 80’s rather than the average 100.

No clear cut message has come from our country. The recent decision of support for resuscitation in the face of opposition from the parents only exaggerates the problem (see Mandatory Rescue by Wm Silverman in this issue). The decision was made by a judge who believes any liveborn infant, no matter how immature, should be resuscitated. Other countries, notably the Netherlands, have public policies regarding limits of viability. As a practicing neonatologist, it is my belief that we need to figure out how to successfully support very immature infants in order for them to grow normally and to give them a decent chance at a normal life. Until we can accomplish that, I believe it is poor medical practice and basically unethical to draw the limits of viability too low.


Editors' Note: Your comments in support of this position, or in opposition, are welcomed and encouraged. Thoughtful dialogue is always in order.

_“I have sworn upon the altar of God eternal hostility against every form of tyranny over the mind of man.”_ Thomas Jefferson, from letter to Dr. Benjamin Rush, 23 September, 1800._
A Real Crisis

by Donald W. Schiff, MD, FAAP

Now that the Administration’s intense campaign to revise Social Security from a safety net for the elderly into another welfare program appears headed for defeat, we can turn our nation’s attention to issues which demand our best creative abilities.

Medicaid, the program that covers 52 million of our citizens, more than the number receiving Social Security, is the primary health program for a third of our country’s children. Although the majority of the 300 billion Medicaid dollars are used to pay for services to the elderly, particularly for nursing home care, projected cuts as proposed both federally and by the states would certainly reduce health care for our most vulnerable and needy children.

The recently passed federal budget has incorporated a 10 billion dollar cut in the Medicaid program over the next 5 years. Governors and state legislators have devised sweeping changes, many of which are similar to those endorsed by President Bush and HHS Secretary Leavitt. Unable to agree upon a single set of recommendations, they, however, are consistent in their rejection of any shift of cost to the states.

Individual states have taken different approaches to the daunting task of balancing their budgets in the face of a Medicaid growth rate averaging 10% a year over the past 5 years. The major reasons for this rapid rise in health costs include drugs, hospital costs, and increasing enrollment in the program.

Colorado passed a tax on tobacco, which will provide a Medicaid budget able to give providers a small incremental increase in reimbursement. Kansas Governor Kathleen Sebelius has proposed a cigarette tax, which would be used to expand Medicaid coverage for women and children.

Other states have taken a more discouraging path, with Tennessee dropping 300,000 from their rolls, and Missouri dropping 90,000. Missouri Governor Matt Blunt states that not cutting Medicaid would force him to raise taxes, and that in his eyes, raising taxes is wrong. He believes that taking people off Medicaid will motivate them to improve their lot in life. Ohio Governor Taft has a plan to freeze and reduce provider reimbursement, and reduce adult services and the eligibility poverty level. Florida Governor Jeb Bush is promoting a plan whereby the state would convert Medicaid to a private insurance plan encouraging individual responsibility, but has not provided any details as yet.

Many governors appear to believe that market forces and personal responsibility can be utilized to improve Medicaid. They seek the power to set premiums, co-payments, and deductibles. They also want to change a basic benefit fundamental to child health care by removing the provision that treatment must be given for any health problem discovered in a periodic health exam in children under 21 (EPSDT). Jane Perkins, a lawyer who has represented Medicaid recipients at the National Health Law Program, said, “it would be a tragedy if such changes are made.”

The pressure to find a way to control the Medicaid budget is enormous and will lead to many states cutting services and testing methods to limit eligibility and enrollment. It is probable that pediatricians, working with other child advocates, will be forced to institute lawsuits in many states (we just won in Oklahoma) to ensure that children receive care under the current law.

Meanwhile, block grants which would limit both federal and state funding for Medicaid will again be a favored approach to controlling costs while reducing service. Be on the watch! Please direct your questions, comments and ideas to me at donroschiff@comcast.net.
Health Volunteers Overseas (HVO) Brings Rewards!

by Caroline Dueger, MD, FAAP

Eleven years ago, Dr. Caroline Dueger retired from her pediatric practice and has been on the road ever since. Dr. Dueger has worked in Nepal, India, Papua New Guinea, Nigeria, Latvia, the Dominican Republic and Belize in addition to serving as a locum tenens physician on several Indian reservations in the United States. A resident of New Hampshire for the past 40 years, Dr. Dueger serves as the Program Director of Health Volunteers Overseas (HVO) pediatric education project in Siem Reap, Cambodia. She has traveled to Cambodia four times since 1999 to provide clinical education and training to physicians at the Angkor Hospital for Children (AHC).

“AHC needed pediatric training for young Cambodian physicians who had recently finished their general medical degrees,” said Dueger. “When we first started in 1999 we were teaching how to give a thorough physical exam. Now we are also recruiting pediatric neurologists and infectious disease specialists. Five years ago, the out-patient clinic saw about 50 patients per day. Last month, they treated more than 470 patients in a single day.”

In 2003, Dr. Dueger completed a 3,000 mile bike trip from San Diego, California to St. Augustine, Florida and raised more than $13,000 for the construction of a bacteriology lab at AHC. “The hospital deals with a lot of infectious diseases but lacked the funds to build a bacteriology lab,” said Dueger. She spent two months on the road, riding more than 70 miles per day, to raise funds for the lab.

Dueger’s volunteer work with HVO allows her to mentor health care providers who treat the most vulnerable patients – children. In developing countries, children suffer disproportionately from poor health related to chronic malnutrition, infectious diseases such as HIV/AIDS, accidents/trauma and other causes. HVO’s pediatric programs address the needs of children by upgrading the skills and knowledge of the health care professionals who work most closely with them.

Founded in 1986, HVO is a private, non-profit organization dedicated to improving global health through education. HVO’s pediatric programs are staffed by highly qualified, North American health professionals who come from both private practice and academic settings and include many retirees. HVO currently has active programs in Cambodia, Guyana, Malawi, St. Lucia and two sites in Uganda (Kampala and Mbarara).

HVO volunteers teach, train and mentor local health care providers, giving them the knowledge and skills to make a difference in their own communities. Duties include delivering lectures, conducting ward rounds and demonstrating various techniques in classrooms, clinics, and operating rooms. Volunteers may also be involved in teacher training, curriculum development, and mentoring of students. Program goals differ depending on the educational needs and technological capacity of the country. Each HVO program is managed by a volunteer Program Director in North America who is a health professional with HVO experience. Program Directors screen and orient volunteers, sharing information about the sites, local customs, housing arrangements and local health conditions.

Most programs require that volunteers serve for one month although shorter assignments are sometimes considered. Spouses and families occasionally accompany volunteers on assignment and are often able to volunteer at the site or in the local community according to their background and experience.

Many sites provide room, board, and daily transportation for volunteers once they arrive. Since HVO is registered as a nonprofit with the US Internal Revenue Service, most travel and living expenses and related costs incurred by a volunteer are a tax-deductible donation.

Interested volunteers should first become a member of Health Volunteers Overseas and then complete the Volunteer Profile Form to initiate the placement process. HVO provides an in-depth and comprehensive orientation packet to all volunteers which includes The Guide to Volunteering Overseas, a program description with local contact information, trip reports from previous volunteers, and State Department Background Notes which detail visa information and health precautions.

For more information about how you can volunteer overseas through HVO, please visit the web site (www.hvousa.org) or contact the Program Department today (202) 296-0928. Your skills and experience are needed in developing countries world-wide.
Mandatory Rescue of Foetal Infants
by William A. Silverman, MD, FAAP

Benevolence [purportedly in the service of others] is nothing more than the exercise of power in disguise.

U.S. Federal Judge

The tragic story of a foetal infant (delivered in a Texas hospital after premature onset of labour during the 23rd week of gestation and resuscitated despite the parents’ express request against this action) was reported here in 1998. The marginally-viable foetus survived with blindness and severe brain damage. Subsequently, the parents sued the hospital for battery and negligence in the resuscitation of their daughter, and the jury ruled in favour of the parents. Now a new chapter has been added to this melancholy saga: It demonstrates our stubborn refusal to recognise that the profiteers from reproductive processes in humans, as in all species, often err. And the recent development reveals the destructiveness of thoughtless benevolence which occurs so often when organised efforts are made to bring about revolutionary change in timeless custom.

The hospital appealed its losing decision in the lawsuit, and the Texas Supreme Court reversed the original judgment. ‘Although the parents had explicitly refused to give consent to their daughter’s resuscitation,’ the higher Court now ruled, resuscitation is ‘an exception to the general rule that a physician commits battery by providing medical treatment without consent.’ The Texas justices proclaimed that for the first time in American jurisprudence there is a rule of ‘emergent circumstances,’ i.e. where death is likely to result immediately unless the treatment is administered, a physician does not need consent—actual or presumed—to treat. Needless to say, the new ‘emergent circumstances’ exception to the requirement for parents’ consent can be expected to have far-reaching practical consequences in American delivery rooms.

In a recent issue of an ethics journal, the Texas decision was hailed as a ‘step forward’ in providing a needed framework for decision-making in the ‘treatment of extremely premature babies.’ Non-treatment decisions, made prior to birth and postbirth evaluation, would be based on “speculation” that would not promote the child’s best interest, the author opined. (The claim that the right of a marginally-viable foetus trumps all ‘parental authority to withhold treatment on the basis of expected disability, low quality of life’ or the competing interests of family and community, was embodied in the confusing Child Abuse Amendments enacted into law after the ‘Baby Doe Wars’ during the 1980s.)

I find these nightmare-like developments frightening. For the first time in human history, parents are now required to relinquish their right to refuse mandatory resuscitation at the impending birth of an incompletely-developed foetal being! The lawyerly arguments fail to acknowledge that substantial numbers of loving, highly-ethical parents (including many intensivists and nurses) prefer ‘comfort-care-only’ as a valid and eminently humane alternative to the prolonged pain and suffering of resuscitation and intensive treatment of a foetus who is about to miscarry. And, how, in the name of common decency, can rescuers justify their decision, free of all personal risk, when they override parents’ refusal? They (the resuscitators) are allowed to walk away scot-free when their arbitrary action results in the devastation of a young family. The activists are not required to pay one cent of the crushing life-time financial cost if the foetal infant survives with severe damage. The aggressors’ words of explanation, ‘We tried our very best,’ make a caustic sound in the ears of an embittered family saddled with an on-going unrelieved emotional burden.

The ethics journal’s author repeated the often-asserted view that extremely premature neonates ‘require immediate treatment to stabilise the situation’ so they can be fully assessed. But this routine custom ignores the large areas of medical ignorance about treatments for extra-uterine foetuses. Doctor Jerold Lucey, chief editor of Pediatrics, recently commented on the woeful situation: ‘These fetal infants are receiving many therapies, both prenatally and postnataally,’ he pointed out, ‘that have never been tested on this unique population.’ (For example, the safe limits of the most frequently used ‘drug,’ supplemental oxygen, are simply

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unknown. And, he might have added, the mournful history of large and repeated therapeutic disasters in neonatal medicine should be humbling. We should explain [to parents] how little we know and explain the bleak outlook for intact survival....’ Lucey advised.

In 1998, I wrote about doctors’ constant yearning for relief from anxiety brought on by uncertainty.2 The easy-to-follow rule to guide decisive action in the face of complexity (promulgated by the Texas ruling and now advocated in an ethics journal) promises to provide quick comfort to the con-science of the aggressive tri-umphalist by supplying much hoped-for conviction of certitude, self-righteousness and lawfulness. The social cost in human misery, I predict, will be immense.

References:

Editors’ Note: This saga is representativewhat can be accomplished by a dedicated group of altruistic, ded-icated professionals. Ironically—and perhaps tragically—it is also another example of how these efforts can be frustrated in our current managed-care takeover of medical practice.

The Growth and Development of “Mobile Med”

by George J. Cohen, MD, FAAP

In the mid 1960’s H.A. Meyers-burg, a practicing psychiatrist, was president of a volunteer program tutoring minority children mov-ing from a racially segregated pub-lic school system to an integrated one in Montgomery County, MD. Knowing that several of the tutors were health professionals, he invited us to his home to discuss our observations of the medical care of these children and their families. Most of these families were working poor with no health insurance, limited—if any—sick leave and often ineligible for the county’s skimpy medical assist-ance benefits. Although the chil-dren were able to receive immunizations and well child care at the county health department, clinic hours often conflicted with parents’ working hours. Many of the parents had chronic health problems, such as asthma, hyper-tension and arthritis, for which access to physicians’ offices was difficult.

The health professional tutors agreed that we should and could help these people, but did not know how to go about it. I was able to recruit a lawyer friend who got us chartered (as Mobile Medical Care, Inc) and later helped us get certified as Medicaid providers. Dr. Meyersburg obtained a small grant from a local family founda-tion, the county Red Cross chapter recruited volunteer nurses and gave us some clinic supplies, and Berry plan physicians working at NIH volunteered to see patients with us. Dr. Meyersburg’s dream was a small van outfitted as a mobile clinic, but the cost was well above our small budget. In a low income African-American com-munity, its dynamic chairman of the citizens’ association arranged for us to use a local church for our clinic site. We were “mobile” by hauling supplies from Dr Meyersburg’s basement to the church for an evening clinic once weekly, starting in April 1970. Patient visits increased so rapidly that we went from a walk-in pro-gram to an appointment system, with walk-in patients squeezed in for handling of acute problems. Patients were (and still are) asked to pay on a sliding scale based on their reported income and assets (honor system) and we have never turned a patient away for lack of payment.

When it became obvious that Mobile Medical Care Inc, (Mobile Continued on Page 9
The Growth and Development of “Mobile Med” Continued from Page 8

Med) was successfully addressing a real need, the county government gave us a small contract and offered us unused space for our office (instead of Dr. Meyersburg’s basement), as well as clinic space in low income housing buildings. Now we were even more mobile.

Our volunteer board of directors brought in money from donations and fund-raising events, and we were able to hire an executive director and small office staff to coordinate the program as it grew. Additionally, the director and staff developed more contacts with funding sources, including United Way, which became the source of a large part of our financial support. With funds from a federal community development block grant, we were finally able to buy a small van, staff it with a physician and driver-outreach worker and send it to homeless shelters, soup kitchens and other sites of homeless persons. In addition to providing acute care to these needy patients, we encouraged them to make appointments for more comprehensive care at our fixed sites.

Our very part-time medical director recruited volunteer physicians and nurses from among retirees, active practitioners and government personnel, as well as volunteering himself when sites were shorthanded. As a local physician, I was able to enlist the help of a number of colleagues from a variety of specialties to serve as our consultants. After the first few years of our providing primary health care services a local delegate to the state legislature introduced successful legislation that established free licenses for volunteer physicians who receive no remuneration for their work in the state. Our insurance broker was able to get professional liability coverage on FTE basis (number of volunteer physician hours worked, rather than number of individual physicians working). More recently the county government has included our volunteer providers and those of other volunteer clinics in the county’s self insured professional liability program.

Among our board members was one who had held a number of public offices; with her contacts and skills we were able to obtain a state matching grant to purchase a small building for our headquarters. More recently she helped us get a matching grant to buy a van outfitted with 2 exam rooms which enable us to offer more in depth outpatient care.

We have been members of a coalition of “safety net providers” since its inception 10 years ago. The coalition coordinates specialty consultations, medication purchases, information technology and collaborative health care activities with our county government. As members of the coalition have increased our capabilities of caring for needy patients, the numbers of working poor, homeless, immigrants and other underserved county residents has grown even more rapidly.

Hopefully, some day there will be a system of universal health care, but until then Mobile Med is committed to doing our best for as many patients as we can.

Our county supplements Medicaid and SCHIP with local programs so that virtually all our needy children have a source of care. However, several years ago Maryland adopted a managed care model for Medicaid which had requirements that were unrealistic for our program, eg hospital privileges for all our MDs and 24/7 physician coverage. So Mobile Med is no longer a Medicaid provider and we rarely see children as our patients. With a long ago rotating internship and internists and family nurse practitioners at my side in the clinics, I’m now a general practitioner at Mobile Med. But I’m glad that I still teach in the outpatient clinic at DC Children’s Hospital so I can continue to work with kids.
Oral Board Exams
by Jim Strain, MD, FAAP

I’m sure our seniors remember the oral examinations for certification by the American Board of Pediatrics. I was privileged to be an examiner for a number of years, and thoroughly enjoyed the experience. I’m sorry the oral examinations were phased out. They provided an added dimension to the testing process which I think was unique and valuable, however with the increasing number of graduating residents, it became impossible to orally examine all of the candidates.

As an examiner, I had several interesting experiences, but one in particular comes to mind. On one particular day, I greeted a young lady at the door of the examining room and in the course of introductions she mentioned she was in practice with her father who was a pediatrician. You may remember that a candidate was examined by four different examiners each of whom was responsible for testing a specific body of knowledge. I was giving the examination on a “long case” that required a workup, diagnosis and treatment of a complicated pediatric problem.

The young lady did quite well. She discussed the case in a very logical way ordering the appropriate diagnostic tests and arriving at a reasonable differential diagnosis. After she had chosen the most likely diagnosis, I asked her “what would you do next?” There was a long pause and she finally said, “I would go ask daddy”.

How could you possibly fail someone who would “go ask daddy”?

She passed.

Editors’ Note: I did myringotomies and tympanocenteses in my early days in practice. We all learned to do them in residency. Neither the attendings nor the ENTs taught us, we taught each other. See one, do one, teach one was the motto. Later in practice, I had an associate who liked surgery and was big on myringotomies. We both inserted tympanostomy tubes in 1960. We made our own tubes from polyethylene tubing and put the children to sleep with Venithine ether. It worked quickly, wore off quickly and was not followed by nausea or respiratory irritation. I would not touch these procedures now with a ten foot pole, but it was routine then. In the late 40’s and early 50’s there were strenuous debates between the pediatricians and the ENTs. I was a resident then and a young practitioner. My seniors pushed hard for antibiotics while at the same time they talked about how they had done tympanocenteses to drain the middle ear in the preantibiotic days. The ENTs would have it that tympanocenteses alone would handle the problem without antibiotics.

Acute Otitis Media (It’s a SNAP)
by Avrum Katcher, MD, FAAP

The treatment of acute otitis media continues to be without universal agreement in regard to the management. Now there is a growing acceptance of the idea that acute otitis media can be treated by watchful expectancy and management of pain but with limitations. One approach along this line is known as SNAP (1) (Safety Net Antibiotic Prescription) in which the patient is evaluated and if the criteria are fulfilled, the patient is sent home with management of watchful expectancy, pain management, a prescription to fill if the patient does not improve, and instructions to call if the patient gets worse. I have tried in the past in my practice to limit the amount of antibiotics with some success, but a lot of back as well. Parents did not take to the idea very well, and sometimes left the practice when they were not given antibiotics when they wanted them.

I would like to present some aspects that we should think about. There are caveats to the SNAP approach. First, the treatment with this set of criteria is not set in concrete. One has to use judgment and experience in the process. And there are other considerations, including patient acceptance. But I wonder if following this approach that the parents of the children are going to think that they do not have to treat any ear infections. They will say to themselves when their child has an ear ache that the pediatrician is

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not going to do anything but give pain medications anyway, so why waste time, money, and effort in going to be checked out for this complaint? They will just treat their child at home with pain medication and save themselves the trouble of going to the doctor. Many times they will be right and there will be no ill effects. But sometimes they may be sitting on a time bomb, and may wait too long for that one otitis that is not the usual and miss the subtle signs of more serious complications. Lack of follow up for problems of serious otitis media is a concern also.

I recall as a child having an ear-ache on the left and going to my mother to complain about it. She told me to go upstairs and lie down. I was not very happy with that advice, because I thought to myself, “What good is that going to do?” “Why doesn’t she do something?” But obediently I went upstairs and lay on the bed on my left side. I recall looking out the window at the trees, dolefully waiting it out. I do not remember anything after that, but it must have turned out all right, since I am still here.

On the other hand I had a patient whose parents were Christian Scientists, and their child had an ear ache which they treated at home waiting for him to get better. He was sick for a couple of days, but he did not improve. After a lot of soul searching the mother brought him to me. He was very sick with bilateral mastoiditis, and complications of a thrombosis of the right middle cerebral vein, as well as extension of the infection into the mandibular joints on both sides. He was hospitalized and treated with the help of an otolaryngologist and did recover. But he had residual adhesions of both temporo-mandibular joints and could only open his mouth a small amount, which made eating very difficult. He required extensive treatment by the dental team, but never really got good function of his mandibular joints. It was a major disaster for him.

Now, I realize that this complication would not occur very often. But once is too often. With the millions of acute otitises each year, how many will turn out like the story above? With olding of antibiotics in the treatment of acute otitis media has been used for some time in other countries, including Britain and other European countries. But the rate of mastoiditis in Europe is almost twice the rate in the USA. How many should we be expected to accept as inevitable or as a trade off for preventing drug resistant bacteria? And though it may be rare, how will we know if it is increasing over what one would expect as unavoidable with present techniques? Will someone be keeping track of the number of cases of mastoiditis, meningitis, etc. that may occur? And will pediatricians and parents be alerted to this increase if it occurs?

With the widespread coverage by the media that may result in rapid dissemination of this approach of treatment to the public, pediatricians will need to be alert to educate their patients and parents about the potential hazards of ignoring the subtle signs of complications of acute otitis media and be prepared to treat them promptly. Also, there will still need to be follow up for residual problems of serious otitis that may occur.

Reference:

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**Cell Phone Calls**

*by Alan A. Fisher*

**ADSi Membership Chairman**

There was discussion on dahlias last week about whether one needed to register cell phones with the Do Not Call list. Here is a statement that the Federal Trade Commission issued on Friday and publicized on the daily news clips today.

For Release: April 15, 2005

The Truth about Cell Phones And the National Do Not Call Registry

If you’ve received an e-mail telling you that your cell phone is about to be assaulted by telemarketing calls as

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a result of a new cell phone number database, rest assured that this is not the case. Telemarketing to cell phone numbers has always been illegal in most cases and will continue to be so. In response to recent e-mail campaigns urging consumers to place their cell phone numbers on the National Do Not Call Registry, the Federal Trade Commission and Federal Communications Commission issue this advisory to give consumers the facts. One e-mail making the rounds says: “JUST A REMINDER...In a few weeks, cell phone numbers are being released to telemarketing companies and you will start to receive sale calls. YOU WILL BE CHARGED FOR THESE CALLS...To prevent this, call the following number from your cell phone: 888/382-1222. It is the National DO NOT CALL list. It will only take a minute of your time. It blocks your number for five (5) years. PASS THIS ON TO ALL YOUR FRIENDS...”

Another version claims:

“The Federal Trade Commission has set up a “do not call” list. It is called a cell phone registry. To be included on the “do not call” list, you must call from the number you wish to register.”

Here’s what you need to know about the National Do Not Call Registry program:

* FCC regulations prohibit telemarketers from using automated dialers to call cell phone numbers. Automated dialers are standard in the industry, so most telemarketers are barred from calling consumers on their cell phones without their consent.

* The federal government does not maintain a national cell phone registry. Personal cell phone users have always been able to add their numbers to the National Do Not Call Registry - the same Registry consumers use to register their land lines - either online at www.donotcall.gov or by calling toll-free 1-888-382-1222 from the telephone number they wish to register. Registrations become effective within 31 days of signing up and are active for five years. There is no cut-off date or deadline for registrations.

* Business-to-business calls are not covered under the Registry. For More Information To learn more about the National Do Not Call Registry and the rules that enforce it, visit the FTC at www.ftc.gov or the FCC at www.fcc.gov. For more information about a planned “wireless 411” directory, visit http://www.qsent.com/wireless411/index.shtml. The FTC works for the consumer to prevent fraudulent, deceptive, and unfair business practices in the marketplace and to provide information to help consumers spot, stop, and avoid them. To file a complaint in English or Spanish (bilingual counselors are available to take complaints), or to get free information on any of 150 consumer topics, call toll-free, 1-877-FTC-HELP (1-877-382-4357), or use the complaint form at www.ftc.gov. The FTC enters Internet, telemarketing, identity theft, and other fraud-related complaints into Consumer Sentinel, a secure, online database available to hundreds of civil and criminal law enforcement agencies in the U.S. and abroad.

FTC MEDIA CONTACT: Jen Schwartzman
Office of Public Affairs
202-326-2674

FCC MEDIA CONTACT: Rosemary Kimball
Office of Public Affairs
202-418-0511
No matter what your age may be, now is the time for considering how you will manage when your income is no longer created by your employment. Many of us may seek advice from a variety of sources, but here is information about four web sites where you may find authoritative advice. They are culled from an enormous list of sites by TIAA/CREF, the enormous not-for-profit pension savings plan serving only employees of not-for-profit organizations, such as educational institutions or hospitals. Take note whether the site is directed to those who are still saving for retirement, or those who are already retirees. In addition, is the site objective, existing to provide information and service, or non-objective, offered by a financial firm. As far as accuracy, any of these sites may be quite accurate, or wildly inaccurate. It is necessary to evaluate carefully. With these caveats, be aware of:

MEDICARE: www.medicare.gov. As web sites go, this is moderately, but not extremely cluttered, and the menus are relatively sensible. Each subheading offers a clear-cut option. I clicked on the option for comparing hospitals, chose my state (New Jersey) and then selected my community hospital and several neighboring institutions, both community and academic. Soon I had before me a variety of comparisons for treating heart attacks, congestive heart failure and pneumonia as inpatients, ranging from the frequency of use of beta-blockers and aspirin, to the proportion of patients given discharge instructions. I was astonished that some institutions performed as poorly as they did on what seems to be basic treatment steps. Other menus, for administrative issues, eligibility, drug plans and many other common concerns were easy to follow. As a person on Medicare for 14 years, a veteran of struggling with the system, I wish this had been available when I first signed up.

SOCIAL SECURITY: www.ssa.gov. Same conclusion: I wish this had been available when I first signed up. By starting benefits about six months before turning 65, my monthly payment has been reduced ever since, and the total benefits received are much less than the six months of early payments provided. One drawback on this web site is that it is significantly more cluttered than that for Medicare. As many of you may know, one side effect of aging is an increased difficulty in attending to a wide range of visual stimuli at one time. A cluttered web site is harder to navigate. There is a moderately useful search feature at the top, but it may be misleading. I clicked on the topic of “fees for representatives.” This did not lead to members of Congress, nor to how much I’d have to pay for hiring someone to help me navigate the system. Rather, it had a list of 13 questions to help persons who earn a living representing claimants, but nothing to help the claimant herself or himself. Many other options, however, were much more useful.

LIFE STYLE CHOICES: www.retirementliving.com. This is a commercial site with a one-time lifetime charge of $19.95 for detailed information, but much of what they offer is available without charge. The options include information on lifestyles in different communities, a long list of retirement housing, ranging from active living to nursing homes, taxes and other information about each state and communities within the state, and many other choices. Many of these are offered as advertisements by the sponsors, for example, the varieties of housing. I am unable to comment on the veracity of the information provided, but just reading the pages that come up gives one the impression that at the least, it is a very useful beginning.

LEGAL ADVICE www.nolo.com. Many years ago, on several occasions, I went to this site for a general overview on a legal issue. It was—and appears to be still—very useful. The web site is a bit crowded, and working one’s way through the menus can be tiresome, but an enormous amount of information is available. As a current trial, I selected the menu under “Property and Money” and went from there into information for landlords who have a property to rent out. (Full disclosure: I do not.) All sorts of useful information popped up. How to evaluate a prospective tenant. What information about that person should one ask for. How to check the information given. What happens if an eviction seems necessary. Tax consequences. Landlord’s liabilities. And many more. Nolo also sells more extensive reports as books and articles. There is a comprehensive section on retirement and eldercare.

CONSUMER INFORMATION: www.pueblo.gsa.gov. And as final

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choices, the first web site is the place to go for Federal publications of one sort or another, to get an overview on a topic when you are not sure how to proceed. Above all, I recommend the Consumer Action Handbook, published each year, with comprehensive listings, organized by state, of such useful information as major corporation contacts, state securities administrations, state and local governments, Federal agencies, and much much more. And, of course, one may always turn to www.aarp.org.

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**Computer Savvy for Seniors**

*by Jerold M. Aronson, MD, FAAP*

Former Chair of the Section of Computers and Other Technology

Do you remember your first computer? I do! The year is 1983 and I am sitting at my desk in front of a Kaypro 10. This 26 lb. steel “luggable” was one of the first personal computers along with the Apple 2E, Commodore 64, and the venerable IBM 286 PC. In fact, my Kaypro still sits in my closet. I can’t bear to part with it via E-Bay.

Today, in 2005, older US adults are flocking to the web, representing the fastest-growing segment of the Internet community according to AARP. The perceived techno-phobia of senior adults is crumbling as more and more of us become PC users. In 2002, 38% of AARP members owned a PC and 17% were online. Online use provides access to E-mail and information about health, finance, and travel as well as up-to-date information from the American Academy of Pediatrics and access to the AAP Members Only Channel.

This column is for you and me; the non-techie who wants to use a PC to improve the quality of our lives; rather than the computer “techie wanna-bee” from MIT who wants to build their own PC. We will explore simple problems (purchase, use, enjoyment) that require simple solutions – no more, no less. That’s my objective. Although I use a Windows PC, I will try to objectively inform about Apple issues, as well. Over the next few issues, we will look at:

- Why you should purchase and use a personal computer (PC).
- How to use your PC safely and protect your identity and privacy.
- Whether you should upgrade your existing PC or purchase a new PC.
- Use of your PC to improve the quality of your life, financial health, leisure and AAP relationships.
- Navigating the World Wide Web (WWW).
- Other topics that you recommend. That’s right, I said “you”. Please contact me with comments/questions/topic suggestions at my AAP e-mail address jmaronson@aap.net. Any Apple user interested/willing to collaborate with me on this column, please contact me, as well.
- Let’s start with some principles for purchase and ownership:
- Decide what you want to accomplish with your PC. Get educated about your choices.
- Take a test drive - visit “big box” stores to compare brands and models and explore features to match your preferences.

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Computer Savvy for Seniors  Continued from Page 14

- Make some basic decisions about computer hardware (central processing unit, printer, monitor, etc.) and software (the programs which make the hardware work).
- Take the plunge!

What might you use a PC for? A recent AARP survey found the following computer uses in decreasing frequency:

- personal correspondence (e-mail) with family, and friends. (72%)
- research a particular issue (legal, financial, travel, etc) subject. (59%)
- access news. (53%)
- try the latest adventure games and CD-ROM puzzles. (52%)
- research or purchase air travel/hotels/vacation or consumer items (47%)
- obtain weather information. (43%)
- perform volunteer work for various organizations. (25%)
- Others including producing memoirs, editing and archiving photos and videos, monitoring investments, tracking genealogy, start a post-retirement business, make greeting cards to send to friends and relatives, write letters to legislators, government agencies, make friends and combat loneliness via communication, or whatever your imagination encourages you to do

Get educated: Investment in learning pays off for years. Learn the basics: — take a class (local library, school district adult evening programs), buy a book, attend local computer user group meetings, talk with friends/neighbors and grandchildren, consult Web sites, or read some technology magazines at the local library. Evaluate brand name products through Consumer Reports or computer magazines. Two books of note are:

"It's Never Too Late to Love a Computer" (a friendly first guide) by Abby Stokes
“Easy Computing for Seniors” by Frank K. Wood.

Both titles (approximately $12 each) and myriad others are available at your local bookstore or online.

Good websites, to bookmark and refer to often are:

AARP – Computers and Technology (http://www.aarp.org/learntech/computers/), a wonderful reference library, advisor on buying and upgrading computers, and a fun place to visit for recreational reading about technology, SeniorNet (http://www.seniornet.org or 1-800-747-6848), a volunteer run non-profit organization of senior citizen PC users. Their free website provides information on SeniorNet community learning centers, courses, and online tutorials.

Take a “test drive” and make some basic decisions:
Here are some points to consider when you take your “big box store” (Staples, Circuit City, Best Buy, Walmart, MicroCenter, etc.) test drive to get acquainted before your first or next computer purchase.

What brand/type of computer and operating system do I want?

<table>
<thead>
<tr>
<th>Apple</th>
<th>PC (Windows)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advantages: Limited choices but enthusiastic users report high reliability and good technical support; easy-to-use software especially with digital audio, photography, and video; limited virus/spyware threats</td>
<td>Advantages: A commodity available in many flavors at very competitive prices; large amount of software and peripheral hardware available; very expandable as needs change/grow; lots of tools easing use/accessibility — enlarging type, making keyboarding easier, providing special audible and visual cues, etc.</td>
</tr>
</tbody>
</table>
What components do I want/need in my PC?

- Desktop vs. laptop (lower cost, more features/$ vs. convenience and mobility re: travel)
- Processor and RAM memory (the more RAM memory, the better)
- Storage capacity: size of hard drive (your filing cabinet; more if high photo/music storage)
- Archiving and backup devices – e.g. CD ROM (routine transfer/storage of software and files), or DVD
- Keyboard and pointing devices (mouse and others – ergonomics and accessibility are the keys)
- Printer and/or Scanner (how often will you use the printer to print digital pictures, e.g. photo-quality printer vs. basic color ink-jet printing)

Multimedia Features

- Monitor (CRT monitors - low cost/high quality/bulky on the desk vs. thinner, lighter LCD panel displays of higher cost that take up less desk space)
- DVD reader and writer to view and write for high capacity/high quality archiving of data, including pictures/music, etc.
- Audio Quality/speakers (concert hall at home?)
- Digital camera (pays for itself in film developing cost savings over time if willing to share photos by e-mail or web)
- Web connectivity:
  - Dial-up modem (usually built-in)
  - Broad band connection (Centrino processor option for laptop to save battery, plus built in wireless connection vs. Ethernet connector)
- Software
  - Business/Productivity (Word Processing, Spreadsheets, Presentation Software, etc.)
  - Financial (Quicken or Money – manage personal finance for taxes, bill payment, online banking, brokerage/investing)
  - Photo/Video – there's a little bit of Cecil B. DeMille in all of us!
  - Computer protection against invasion of privacy (firewall), “bad software applications (antivirus, anti-spam, antispy)
- Other useful gadgets, e.g. Flash Drive to easily transfer data from one PC to another!

How much computer do I really need? What will I pay for it?

<table>
<thead>
<tr>
<th>Computer Type</th>
<th>Speed (Ghz)</th>
<th>RAM MB</th>
<th>Storage GB</th>
<th>Disc Writers</th>
<th>Monitor</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Budget (fills basic needs including e-mail, photo editing, word-processing, and web browsing)</td>
<td>Celeron / AMD</td>
<td>256-512 MB</td>
<td>40-80 GB</td>
<td>CD-RW</td>
<td>CRT/LCD 15-17”</td>
<td>$400 to $800</td>
</tr>
</tbody>
</table>
Computer Savvy for Seniors

<table>
<thead>
<tr>
<th>Computer Type</th>
<th>Speed (Ghz)</th>
<th>RAM MB</th>
<th>Storage GB</th>
<th>Disc Writers</th>
<th>Monitor</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workhorse (basic + games, graphic intensive applications, e.g. PowerPoint with pictures, video editing/video cam)</td>
<td>AMD / Pentium 4</td>
<td>&gt;512 MB</td>
<td>&gt;80 GB</td>
<td>CD-RW / DVD-RW combo drives</td>
<td>CRT/LCD 19” or &gt;</td>
<td>$1000 and &gt;</td>
</tr>
</tbody>
</table>

Note – RAM = computer memory; CD = compact disc storage device; DVD = digital video device, RW = read/write capability for disc writer. (adapted from Consumer Reports, June 2005)

The bottom line, almost any current PC with a printer and Internet connectivity will handle most mainstream requirements. The good news is that means that a generic, budget Windows PC is usually adequate to begin. PCs last a long time; however, plan to upgrade/replace every 3-5 years of so to be able to take advantage of new advances in technology. Old PCs have lots of uses, including use by young grandchildren.

Are you ready to take the plunge? See you next time!!

Follow the Rules When Rolling!

by Joel M. Blau, CFP — President
MEDIQUIS Asset Advisors, Inc.
“Results. One client at a time.”

Plain and simple, there are several reasons why rolling over your IRA funds makes sense. You may be dissatisfied with the investment return from the IRA or are interested in pursuing other investment opportunities. One unique reason might be the need for immediate cash. If you withdraw funds from an IRA, but redeposit the funds back into an IRA within 60 days, there are no current income tax ramifications. When all of the requirements are met, IRA rollovers are tax-free and exempt from the usual 10% penalty on early withdrawals before age 59.

However, it is important to keep in mind that there are several potential pitfalls with IRA to IRA rollovers:

1. Missing the 60-day rollover period. The rollover must be completed within 60 days after the date you receive a distribution from the old IRA. For years, the IRS has ruled the 60-day requirement could not be waived even when the delay was not the taxpayer's fault. Recently, the IRS has indicated that it's more willing to grant an exception or waiver under extenuating circumstances, but it is still best to play it safe and stay within the 60-day rollover period.

2. Failure to roll over the same assets that were distributed. To qualify for a tax-free rollover, the cash or other assets withdrawn from the old IRA must be transferred within 60 days. You are not allowed to substitute other property. For example, in a recent Tax Court case, an individual withdrew cash from his IRA and used the money to invest in common stocks. He then transferred the stocks to a new IRA within the required 60-day rollover period. The Tax Court ruled that the transfer was taxable, since there was a change in the distributed assets.

3. Rolling over to the wrong IRA. The tax advantaged rollover is valid only if you make a timely rollover to an IRA that you personally own. If you mistakenly transfer the rollover funds to your spouse's IRA, or some other account, the transfer is fully taxable.

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Follow the Rules When Rolling

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4. Initiating more than one rollover during the year. You are allowed to roll over funds from one IRA to another IRA only once a year. The one-year period begins on the date you receive the distribution, not the date on which you roll over the funds into the IRA. The one-year rollover rule applies separately to each IRA that you own.

5. Rolling over a “mandatory distribution”. The law requires you to begin minimum distributions from an IRA by April 1st of the year in which you reach age 70½. You can not avoid the minimum distribution rule by rolling over the distribution to another IRA. Mandatory distributions may be avoided if the retirement plan assets are not held within an IRA, but are kept within the plan, and you have not yet retired. This exception, however, is not available for distributions made within an IRA.

6. Rolling over IRA assets to a Roth IRA. In general, the rollover from a regular IRA to a Roth IRA is completely taxable, but the funds will be able to be withdrawn tax free if they are withdrawn after the mandatory five-year holding period.

Be sure to consult with your tax and financial advisors to ensure that you are maintaining all tax advantages, prior to making any changes with your current retirement accounts.

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

(DISCLAIMER-Readers are advised that information contained in this article is of proprietary origin, and no approval or recommendation by the AAP is implied or intended. –The Editors)

Securities offered through Joel Blau, a registered representative of Waterstone Financial Group, Member NASD/SIPC.
Waterstone Financial Group and MEDIQUIS Asset Advisors, Inc. are independently owned and operated.

Hearing Loss from Noise

by Avrum Katcher, MD, FAAP

This article has been modified from Your Guide to BETTER HEARING a publication of the Better Hearing Institute
515 King Street • Suite 420,
Alexandria, VA 22314

Pediatricians should be aware of the dangers of excessive noise. There is a relationship between loudness and the duration of a sound, in terms of danger to hearing. At the ends of the scale, a whisper, which is usually about 30 Decibels, offers no danger. At the other end, a gunshot or a jet engine at takeoff is 140 Decibels, and offers IMMEDIATE risk to hearing. A lawn mower at 90 Decibels produces a risk of hearing damage in 8 hours. A jackhammer, at 105 Decibels, in 1 hour. And what is most important to all of us, a BABY’S CRY, WHICH IS 115 DECIBELS, PRODUCES A RISK OF HEARING DAMAGE IN 15 MINUTES. Notice that the scale is logarithmic, not arithmetic. As a person with a typical “presbycusis,” or sensorineural high tone hearing loss associated with age, I wear hearing aids, which help, to a degree. But how I wish I’d have known the above 56 years ago. For those of you who read this, there may be little preventive action you may take. But one thing you can do is to warn your younger colleagues, help them take action to prevent damage, and encourage audiologic testing for you and them on some systematic basis.
True Stories from Doctors
Submitted by George Cohen

A man comes into the ER and yells, “My wife's going to have her baby in the cab!” I grabbed my stuff, rushed out to the cab, lifted the lady’s dress, and began to take off her underwear. Suddenly I noticed that there were several cabs - and I was in the wrong one.

Dr. Mark MacDonald, San Antonio, TX

At the beginning of my shift I placed a stethoscope on an elderly and slightly deaf female patient’s anterior chest wall. “Big breaths,” I instructed. “Yes, they used to be,” remorsed the patient.

Dr. Richard Byrnes, Seattle, WA

One day I had to be the bearer of bad news when I told a wife that her husband had died of a massive myocardial infarct. Not more than five minutes later, I heard her reporting to the rest of the family that he had died of a “massive internal fart.”

Dr. Susan Steinberg, Manitoba, Canada

I was performing a complete physical, including the visual acuity test. I placed the patient twenty feet from the chart and began, “Cover your right eye with your hand.” He read the 20/20 line perfectly. “Now your left.” Again, a flawless read. “Now both,” I requested. There was silence. He couldn’t even read the large E on the top line. I turned and discovered that he had done exactly what I had asked; he was standing there with both his eyes covered. I was laughing too hard to finish the exam.

Dr. Matthew Theodropoulos, Worcester, MA

During a patient’s two-week follow-up appointment with his cardiologist, he informed me, his doctor, that he was having trouble with one of his medications. “Which one?” I asked. “The patch. The nurse told me to but on a new one every six hours and now I’m running out of places to put it!” I had him quickly undress and discovered what I hoped I wouldn’t see . . . Yes, the man had over fifty patches on his body! Now, the instructions include removal of the old patch before applying a new one.

Dr. Rebecca St. Clair, Norfolk, VA

While acquainting myself with a new elderly patient, I asked, “How long have you been bedridden?” After a look of complete confusion she answered... “Why, not for about twenty years - when my husband was alive.”

Dr. Steven Swanson, Corvallis, OR

I was caring for a woman from Kentucky and asked, “So how's your breakfast this morning?” “It’s very good, except for the Kentucky Jelly. I can't seem to get used to the taste” the patient replied. I then asked to see the jelly and the woman produced a foil packet labeled “KY Jelly.”

Dr. Leonard Kransdorf, Detroit, MI

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A nurse was on duty in the Emergency Room, when a young woman with purple hair styled into a punk rocker Mohawk, sporting a variety of tattoos, and wearing strange clothing, entered. It was quickly determined that the patient had acute appendicitis, so she was scheduled for immediate surgery. When she was completely disrobed on the operating table, the staff noticed that her pubic hair had been dyed green, and above it there was a tattoo that read, “Keep off the grass.” Once the surgery was completed, the surgeon wrote a short note on the patient’s dressing, which said, “Sorry, had to mow the lawn.”

and finally...

A new, young MD doing his residency in OB was quite embarrassed performing female pelvic exams. To cover his embarrassment he had unconsciously formed a habit of whistling softly. The middle-aged lady upon whom he was performing this exam suddenly burst out laughing and further embarrassed him. He looked up from his work and sheepishly said, “I’m sorry. Was I tickling you?” She replied, “No doctor, but the song you were whistling was, “I wish I was an Oscar Meyer Wiener”.

(Dr. wouldn’t give his name)

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**Book Review #1**
by Avrum L. Katcher, MD, FAAP

**A Brief History of The Smile**
by Angus Trumble
Basic Books, NY, 2004

One has such a pleasure to pick up a volume written in entertaining fashion, explaining about a matter of interest, and free of cant and hard-core politicking. This is such a book. Trumble, raised and educated in Australia, is now Curator of Paintings and Sculpture at the prestigious Yale Center for British Art, New Haven, CT. Estelle and I have visited their collection on several occasions. Housed in a magnificent building designed by the distinguished Philadelphia architect, Louis Kahn, it is a wonderful showplace for the landscapes, portraits, drawings and many other features of the Yale collection.

But this volume, by a man who must be a polymath, will bring smiles to the face of any reader. Trumble reviews smiles and laughter, as well as other manifestations of related emotion, in seven concise chapters totaling less than 200 pages. He has absorbed his neuroanatomy, muscular anatomy, physiology, brain function and selected aspects of human and animal behavior. He is able to relate these subjects to the smile without being ponderous, overbearing or formal. His chapter headings give the game away: “The Serious and the Smirk, Decorum, Lewdness, Desire, Mirth, Wisdom and Deceit as well as a fine summary.”

His review of the fabled *La Gioconda*, or as we would say, the *Mona Lisa*, rings all the changes from Leonardo’s sixteenth century biographer, Vasari, through John Ruskin, Bernard Berenson, to Sigmund Freud, …culminating in a most thoughtful suggestion that the original name of the painting was derived from the name of the lady’s husband, who was a man named Francesco del Giocondo. She was born in 1479 and was married at age 16. The woman who became Francesco’s wife was named Lisa Gherardesca. *La Gioconda* is the feminine form of her married name. Trumble suggests that the original name was just word play, a pun, on the family name, “Giocondo.” It is descended from the Latin *iucundus*, meaning happy, glad, joyful. Whence, the smile. And all of this in seven pages.

Under the chapter heading of Lewdness, of course he commences with the seventeenth century Dutch painting, and after some wandering around, manages to bring to attention the lewd figures, typically grinning, often found in the British Romanesque church architecture of the eleventh and twelfth centuries. We learn about the origins of the slang term

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Sheela for a young woman of dubious virtue, common in the British armed services of a few generations ago and perhaps to this day. And in addition, the origin of the Cheshire cat (a breed that never existed) who so puzzled Alice, and who faded from their conversation gradually, with the grin being last to go.

This little volume may be heartily recommended to those who desire to relate human behavior, anatomy and physiology to the history of our culture, and to those who just wish to enjoy themselves while picking up some information with which to amuse their friends.

**Book Review #2**

*by Gordon Mella, MD, FAAP*

*Emeritus Member, Senior Section*

**“Mountains Beyond Mountains”**

*by Tracy Kidder*

*Random House Trade paperbacks, New York*

It isn’t often that you meet committed people. Concerned people, yes; they are fairly common and tend to be obnoxious with their pet causes. But Tracy Kidder met Paul Farmer, M.D. in Haiti and knew that he had found a man of rare commitment.

Dr. Farmer is a Harvard infectious disease specialist who went to Haiti, discovered a love for the people and found a way to make a difference in their lives. The first part of the book describes the health and social problems in Haiti and what a single, highly energetic, dedicated physician can do. The author, Tracy Kidder, is a classy writer and can really make the reader feel the love and compassion in Dr. Farmer.

Later in the story you learn more about Dr. Farmer’s personal life and how he has expanded his modus operandi to include a fight against disease on a global scale. Personally I was surprised to learn what a threat tuberculosis continues to be in the third world and also in the Russian penal system.

This book is easy to read, 104 pages in paperback, and it should be read by anyone connected to the health care field to help us set our sights a little higher.

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**Senior Moments**

*by Benjamin Silverman, MD, FAAP*

1. Two elderly women were eating breakfast in a restaurant one morning. Ethel noticed something funny about Mabel’s ear and she said, “Mabel, did you know you’ve got a suppository in your left ear?” Mabel answerd, “I have? A suppository?” She pulled it out & stared at it. Then she said, “Ethel, I’m glad you saw this thing. Now I think I know where my hearing aid is.”

2. When the husband finally died his wife put the usual death notice in the paper, but added that he died of gonorrhea. No sooner were the papers delivered when a good friend of the family phoned and complained bitterly, “You know very well that he died of diarreha, not gonorrhea. Replied the widow, “I nursed him night and day so of course I know he died of diarrhea, but I thought it would be better for posterity to remember him as a great lover rather than the big poop he always was.”

3. A funeral service is being held for a woman who has just passed away. At the end of the service, the pall bearers are carrying the casket out when they accidently bump into a wall, jarring the casket. They hear a faint moan! They open the casket and find that the woman is actually alive! She lives for ten more years, and then dies. Once again, a ceremony is held, and at the end of it, the pall bearers are again carrying out the casket. As they carry the casket towards the door, the husband cries out: “Watch that wall!”

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"The gin and tonic has saved more Englishmen's lives than all the doctors in the Empire"

— Winston Churchill

Once upon a time, the Empire of Peru stretched along the Pacific coast of South America and included what are now Ecuador, Peru, Bolivia and Chile. Rumors of its riches were rampant since the days of Columbus and were reinforced by the findings of Hernán Cortez in Mexico.

In the early 1500's, Francisco Pizarro, warrior and conquistador, in the name of the throne of Spain, took possession of Peru, hoping to find the hidden treasures of the Incas. He was a soldier, a conqueror whose sword was entrusted by the Spanish crown to bring civilization to the savage lands and to collect silver and gold as a token of appreciation from the natives. Conquistadors can not stay still; they are supposed to be constantly riding on their horses conquering new lands for the Crown. So, who would stay behind and mind the store? No problem, the King of Spain would send an administrator to manage the newly acquired possession. It would be an important position, so it had to have an important title. They found one: Viceroy!

The one in our story was Don Luis Gerónimo Cabrera de Bobadilla, Count of Chinchón, who arrived with his wife, Doña Francisca Henriquez de Ribera, who had the title of Countess of Chinchón but for short, she was known as “la Chinchona”. One day, the Countess fell ill with a very high fever. Dr. Juan de Vega, a Spanish physician at the court, did everything he could to cure her but to no avail. In desperation the Viceroy decided to ask for help and called for native shamans to come and attend to his wife. They did and, in between chanting and dancing, they prepared a concoction which was made by boiling the bark of a local tree in water. Miraculously, the fever subsided and that magical medicine got its first European name: Peruvian bark.

Aware of the potential of this cure, Bernabé de Cobo, a Jesuit missioner who accompanied the troops, sent it to Spain where it also got to be known as Jesuit powder. From there, it traveled to Italy and to England. By 1658, Peruvian bark was being sold in London and, in 1677, it was officially entered into the British Pharmacopoeia. European physicians credited this medicine with the successful treatment of fevers and specifically for malaria.

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In 1749, Jean-Baptiste Sénac, a French physician also described the properties of this drug on his “Traité de la Structure du Coeur, de son Action et de ses Maladies”. Much later, in 1914, Karl Freiderich Wenckebach reported a patient being treated for malaria who curiously, was also relieved of his recurrent attacks of heartpalpitations. It was Carolus Linneus (1707-1778), a prominent botanist and taxonomist, born in Sweden, who finally catalogued this tree as Chinchona to pay homage to the Countess. Language has the ability to change even while being spoken, and soon chinchona became quinqua, then quinquina, then quinina. According to Linneus’s classification, this tree belongs to the family of Rubiaceae, genus of chinchona, which contains no less than forty species. They are indigenous to the eastern slopes of the Amazonian Andes, on both sides of the Equator, where they grow at an elevation of 1500 to 3000 meters and up to 15-20 meters in height.

Natural quinine is still being used around the world. In Brazilian Herbal Medicine, it is considered good as a tonic for general fatigue, as a digestive stimulant, and useful for the treatment of fevers, malaria, amebic infections, diarrhea, dyspepsia, heart problems, lumbago, neuralgia, pneumonia, typhoid fever and even for varicose veins. In Europe, quinine is considered an antiprotozoan, antimalarian, antispasmodic, appetite stimulant and for disorders of the liver, spleen and gall bladder. It is also used to reduce palpitations, headaches, leg cramps and many more uses.

What is it in this bark that makes it work? In 1820 two French scientists, Pelletier and Caventou found the answer when they isolated an alkaloid and named it quinine. The world rapidly recognized the potential of this medicine, and before anyone could even dare think about it, seeds of the tree were smuggled out of South America by the British, who cultivated it in India and Ceylon, and by the Dutch, who created enormous plantations in Java. The cultivation of the Chinchona tree was so vast in Java that, by 1918, the bulk of the world’s supply of quinine was under the control of the Dutch. Then came World War II and when in 1942 the Japanese army occupied Java, the Allies had to go back to South America for their supply of the bark. The need not to be dependant on Mother Nature, demanded that science come up with a solution. In 1944, scientists were able to synthesize the alkaloid in the laboratory and a new drug was born: chloroquine, which is still being used as one of the most efficient treatments for malaria. Today, the chinchona tree is being cultivated in South America, India, Indonesia and Africa.

Although I never tried it myself, I was told that quinine has a very, very bitter taste so it had to be mixed with something else to make it palatable. During its occupation of India, casualties because of malaria were hurting the British troops more than the enemy. Although a teaspoonful of sugar may have made the medicine go down, that idea did not go well with the tough soldiers. It had to be something more appealing, something that would make a soldier feel much-macho. As the story goes, somebody in London remembered the magic tonic which the British troops used when they were fighting in Holland against Spain. Why not use “Dutch Courage” to disguise the bitter taste of quinine? It would boost the soldier’s ability to fight and, at the same time, it would prevent malaria? That was really a bloody good idea...!!

During my childhood, “Gunga Din” (RKO-1939) was one of the movies that made a big impression on me, and I take pleasure in reminiscing those images again. I can see the handsome British officers, with the looks of Cary Grant and Douglas Fairbanks, Jr, under the scorching sun of India, sitting on the ruins of a destroyed garrison, waiting for the enemy attack while sipping away a cool, sweaty glass of “Dutch courage tonic” mixed with quinine water (with a slice of lime, just for looks).

I would hate to disagree with Sir Winston Churchill but, to tell the truth, if the therapeutic dose of quinine is 200-350 mg. three times a day, and considering that 6 oz of tonic water contains about 20 mg of quinine, my math tells me that a British soldier fighting in India, had to consume 10 to 20 glasses of gin and tonic three times a day. WOW!! That would make the soldiers more courageous but surely it would impair their vision, cause a lot of “friendly fire” and the survivors would return home with a very nice case of cirrhosis of the liver. It would not be because of the quinine...

Even if you do not have nocturnal leg cramps, give yourself the luxury to savor a glass of gin and tonic once in a while. But, do not kid yourself; you would be doing it for enjoyment and not for therapeutic reasons. Unless you think you have the looks of Cary Grant, in which case you may already have had too much to drink.

Cheers!!
Editors' Note: **This Uplifting Message is Contributed by Our President Elect**

by Eileen M. Ouellette, MD, JD, FAAP

The first day of school our professor introduced himself and challenged us to get to know someone we didn't already know. I stood up to look around when a gentle hand touched my shoulder. I turned around to find a wrinkled, little old lady beaming up at me with a smile that lit up her entire being. She said, “Hi handsome. My name is Rose. I’m eighty-seven years old. Can I give you a hug?”

I laughed and enthusiastically responded, “Of course you may!” and she gave me a giant squeeze.

“Why are you in college at such a young, innocent age?” I asked. She jokingly replied, “I’m here to meet a rich husband, get married, and have a couple of kids...” “No seriously,” I asked. I was curious what may have motivated her to be taking on this challenge at her age.

“I always dreamed of having a college education and now I’m getting one!” she told me. After class we walked to the student union building and shared a chocolate milkshake.

We became instant friends. Every day for the next three months we would leave class together and talk non-stop. I was always mesmerized listening to this “time machine” as she shared her wisdom and experience with me. Over the course of the year, Rose became a campus icon and she easily made friends wherever she went. She loved to dress up and she reveled in the attention bestowed upon her from the other students. She was living it up.

At the end of the semester we invited Rose to speak at our football banquet. I’ll never forget what she taught us. She was introduced and stepped up to the podium. As she began to deliver her prepared speech, she dropped her three by five cards on the floor. Frustrated and a little embarrassed she leaned into the microphone and simply said, “I’m sorry I’m so jittery.

I gave up beer for Lent and this whiskey is killing me! I’ll never get my speech back in order so let me just tell you what I know.”

As we laughed she cleared her throat and began, “We do not stop playing because we are old; we grow old because we stop playing. There are only four secrets to staying young, being happy, and achieving success. You have to laugh and find humor every day.

You’ve got to have a dream. When you lose your dreams, you die. We have so many people walking around who are dead and don’t even know it! There is a huge difference between growing older and growing up. If you are nineteen years old and lie in bed for one full year and don’t do one productive thing, you will turn twenty years old. If I am eighty-seven years old and stay in bed for a year and never do anything I will turn eighty-eight. Anybody can grow older. That doesn’t take any talent or ability. The idea is to grow up by always finding opportunity in change.

Have no regrets. The elderly usually don’t have regrets for what we did, but rather for things we did not do. The only people who fear death are those with regrets.”

At the year’s end Rose finished the college degree she had begun all those years ago.

One week after graduation Rose died peacefully in her sleep. Over two thousand college students attended her funeral in tribute to the wonderful woman who taught by example that it’s never too late to be all you can possibly be.

**REMEMBER, GROWING OLDER IS MANDATORY. GROWING UP IS OPTIONAL.**

We make a Living by what we get, We make a Life by what we give.
Why God Made Moms

Answers given by elementary school age children to the following questions

Why did God make mothers?
1. She's the only one who knows where the scotch tape is.
2. Mostly to clean the house.
3. To help us out of there when we were getting born.

How did God make mothers?
1. He used dirt, just like for the rest of us.
2. Magic plus super powers and a lot of stirring.
3. God made my mom just the same like he made me.
   He just used bigger parts.

What ingredients are mothers made of?
1. God makes mothers out of clouds and angel hair
   and everything nice in the world and one dab of mean.
2. They had to get their start from men's bones. Then
   they mostly use string, I think.

Why did God give you your mother and
not some other mom?
1. We're related.
2. God knew she likes me a lot more than other people's moms like me.

What kind of little girl was your mom?
1. My mom has always been my mom and none of
   that other stuff.
2. I don't know because I wasn't there, but my guess
   would be pretty bossy.
3. They say she used to be nice.

What did mom need to know about dad
before she married him?
1. His last name.
2. She had to know his background. Like is he a crook?
   Does he get drunk on beer?
3. Does he make at least $800 a year? Did he say NO
   to drugs and YES to chores?

Why did your mom marry your dad?
1. My dad makes the best spaghetti in the world. And
   my mom eats a lot.
2. She got too old to do anything else with him.

3. My grandma says that mom didn't have her thinking cap on.

Who's the boss at your house?
1. Mom doesn't want to be boss, but she has to
   because dad's such a goof ball.
2. Mom. You can tell by room inspection. She sees the stuff under the bed.
3. I guess Mom is, but only because she has a lot more to do than dad.

What's the difference between moms
and dads?
1. Moms work at work & work at home, & dads just go
to work at work.
2. Moms know how to talk to teachers without scar-
ing them.
3. Dads are taller & stronger, but moms have all the real power 'cause that's who you got to ask if you
   want to sleep over at your friend's.
4. Moms have magic, they make you feel better without medicine.

What does your mom do in her spare time?
1. Mothers don't do spare time.
2. To hear her tell it, she pays bills all day long.

What would it take to make your mom
perfect?
1. On the inside she's already perfect. Outside, I think
   some kind of plastic surgery.
2. Diet. You know, her hair. I'd diet, maybe blue.

If you could change one thing about your mom, what would it be?
1. She has this weird thing about me keeping my room clean. I'd get rid of that.
2. I'd make my mom smarter. Then she would know it was my sister who did it and not me.
3. I would like for her to get rid of those invisible eyes on her back.
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4. When I went to lunch today, I noticed an old lady sitting on a park bench sobbing her eyes out. I stopped and asked her what was wrong. She said, “I have a 22 year old husband at home. He makes love to me every morning and then gets up and makes me pancakes, sausage, fresh fruit and freshly ground coffee.” I said, “Well, then why are you crying?” She said, “He makes me homemade soup for lunch and my favorite brownies and then makes love to me for half the afternoon.” I said, “Well, why are you crying?” She said, “For dinner he makes me a gourmet meal with wine and my favorite dessert and then makes love to me until 2:00 a.m. I said, “Well, why in the world would you be crying?” She said, “I can't remember where I live!”
Planning for Your Bonus Years

After retiring at 65 most will have about 15 bonus years to enjoy. This session will provide ideas to help you plan for a nice and worthwhile future.

Date: 10/09/2005  Time: 1:30—5:30 pm


Schedule

1:30-1:45 Child Advocacy Award
1:45-2:30 Generations United
   Donna Butts, Executive Director
2:30-3:15 The Donovan Program
   Arlene Johnson, PhD
3:15-4:00 International Child Health
   Jane Schaller, MD, FAAP
4:00-4:30 Discussion
4:30-5:30 Section Business Meeting and Reception

Sponsored by the AAP Section for Seniors Members.
To find out more information, log onto www.aap.org/sections/seniormembers