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

RECERTIFICATION WORRIES

Thanks to two 3 day conferences in the past week, I’ve accrued a significant number of my annual CME units required for California medical license renewal. Apart from CME hours and learning all sorts of things, such conferences are great opportunities to see old friends and to network. At both conferences, I was confronted by colleagues and senior pediatric peers who-like myself-were “grandparented” in with lifetime certification upon meeting qualifications of the American Board of Pediatrics prior to May 1988. Senior pediatricans are really worried about the security of their lifetime ABP certification.

You’ll find more information about this topic from our editor in this issue of the Bulletin. Also, you’ll find information in the June AAP News, and on the ABP website (www.abp.org). AAP president, Dr. Dave Tayloe also writes on this topic in AAP News this month. While there is reassurance that lifetime certification will continue to be valid, Dr. James Brown, vice president for public relations of the ABP, writes in the June issue of AAP News: “The value of my permanent certification, which was earned

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in 1974, does not carry the same significance it once did.” Encouraging participation in the ABP Maintenance of Certification program and stating that more pay for performance programs and other entities are already requiring “evidence of physicians’ continuous participation in MOC programs”, Dr. Brown further reminds readers that there are “incentives” for permanent certificate holders to begin MOC this year. Those details can be found on the ABP website.

Our own SFSM executive committee member, Dr. Buz Harlor is quoted with a counter opinion, hoping that board re-certification will not be inevitable for renewal of state licensure: “Most states require CME credit to maintain licensure, and that should be sufficient.” It should be reassuring to note that many sources of lifelong learning and evaluations of professional competence are required stipulations of hospital staff renewal, but the power of the ABP to grant certification and evidence of maintenance of certification in pediatrics is certain and carries much weight.

Much has changed in pediatric practice and in medicine in general in the intervening three decades since cessation of awarding lifetime certification by the ABP. Recertification has been required for new ABP diplomates since 1988, consistent with other medical specialties (ABMS). Initially, diplomats seeking recertification took open book examinations. This was a popular format and encouraged collegial study groups, fostered ongoing learning, and promoted competency compliance. However, secondary to concerns about cheating and abuses of that informal system, in 2003 the ABP did away with the open book test option. The AAP Board of Directors challenged the ABP concerns, noting the advantages of group study and convenience of book exams for busy pediatricians, even demonstrating the relia-
ability of secure identification systems (such as those used by the CIA and FBI) at an ABP Board of Directors meeting. Nonetheless, the ABP proceeded with the approved test site requirement and open book tests are a thing of the past for pediatricians participating in recertification. The ABP then began requiring monitored testing in approved test centers every 7 years to maintain certification or “recertification”. There are new plans in process for a more structured MOC system and you are encouraged to check the ABP website for details.

So, what’s a pediatrician grandmother/grandfather to do? The first option is to take the recertification exam as soon as possible and to participate in the other MOC requirements as stipulated on the ABP website. However, individual situations differ. A second option would be, as Buz Harlor stated, to hope that CME credit and ongoing participation in other established lifelong learning and quality assurance programs will suffice to satisfy both medical licensure and any health insurance or pay for performance requirements which emerge. Some may decide that they’re really going to retire within the next couple of years. Others may opt to recertify only in their subspecialty. Check the detailed information on the ABP website, take the practice exam at MOC@ABPeds.org (Click General Pediatrics Knowledge for Self-Assessment) and decide, knowing that there are distinct advantages to electing participation in MOC before 2010, if you select that option. There’s no doubt that most pediatric residency programs and community clinics, dependent to large extent on retired or semi-retired workforce, would be grossly understaffed without life time certificate holders, some or many of whom will elect not to participate in MOC, despite its perceived benefits.

Contrary to Dr. Brown’s comments, I’d like to think that my lifetime certification by the American Board of Pediatrics still has value and significance and that I and the other approximately 25,000 lifetime certificate holder/diplomates of the ABP will continue to have the voluntary option to participate or not in the MOC program. One thing is certain, the lifetime certificate does not expire. If you have other specific concerns, Dr. Brown graciously offered his e-mail address: jbrown@ABPeds.org for your questions. As for members of the AAP Section for Senior Members, we will continue, as a benefit of Section Membership, to post updated information and links to the ABP website on our SFSM website and in the Senior Bulletin to assist our members in making decisions which are best for their interests and their own professional situations.

Speaking of CME, remember to attend the Section’s education program and presentation of the Section Advocacy Award at the NCE on Monday afternoon, October 19. See the announcement in the Bulletin and on our website. It’s another outstanding program with extraordinary faculty. See you in Washington this fall!

Lucy S. Crain, MD
As we settle in for a hot summer, we can predict that the intensity of the effort to produce meaningful health care reform will increase with the temperature. The President has unequivocally and repeatedly stated that creating a comprehensive reform program which would bring health insurance to all U.S. children and most adults while controlling costs is required if we are to achieve budgetary balance and reduce the national debt.

Influenced by the Clinton (’93-'94) failure to pass health care reform legislation by utilizing a top-down approach, the President has avoided this error by assigning the effort to write a bill to the Congress. Three House and two Senate committees are now the responsible groups.

Leadership in the effort to produce consensus on the content of the measures appears to be coming from the Senate, where Ted Kennedy of Massachusetts chairs the Health, Labor and Pensions Committee, and Max Baucus of Montana chairs the Finance Committee. Mr. Kennedy has been a leader in the health reform movement for decades and hopes to guide passage of the legislation in spite of his own health problems. Mr. Baucus admits that health care reform is the “most difficult legislative challenge of his life” and appears to relish it.

Though there may be two separate bills arising in the Senate, there is said to be agreement on key elements including (1) the requirement that all individuals purchase health insurance, but with premium subsidies for those of modest means and (2) the creation of an insurance exchange to facilitate the purchase of affordable coverage by selecting a private federally approved health plan. Additional features would include the expansion of Medicaid to adults with an income level of 100% of the poverty level and an expansion of the Children's Health Insurance Program (CHIP) to families with incomes at 250% of the poverty level or less.

Children's health care reform advocates remain wary of reforms which may not reflect the special needs of children and the importance of early detection and treatment of abnormalities of physical, emotional and social development. Meeting these needs remains a major responsibility of pediatric primary care. A special emphasis on the value and necessity of incorporating an EPSDT approach to a children’s benefit package has been and will continue to be an ongoing part of all AAP discussions with health care reform planners.

President Obama clearly does not believe that a single payer plan is presently feasible. Without his support, though some Democrats may introduce a single payer bill, this idea will not go very far.

Senator Baucus has proposed the creation of a public insurance plan that would compete against private insurers. The Chairmen of the other four Congressional committees working on health care reform have supported the idea. Republican leaders in the Finance Committee have vigorously stated their opposition. Representatives of the health insurance corporations who appeared agreeable earlier to reversing their longstanding unwillingness to provide insurance to those with pre-existing conditions or to provide it only with a much higher premium have recently accepted the necessity of covering everyone, well or ill, if insurance was mandated for all. However, upon hearing of the proposal for a public insurance plan, they quickly predicated their support for coverage for all citizens on a requirement that no new public insurance plan be added to the competitive mix.

The “largest monster in the room” is that of the funding mechanism for the reform programs. The estimated cost of the needed reforms is judged to be $1-2 trillion over the next ten years. The $100-200 billion in new dollars annually is a relatively modest increase over the $2 trillion
which are already spent on health care each year but accentuates the need to find adequate funding sources.

The administration’s explanations that health care reform can be funded by savings in Medicare, Medicaid, electronic medical records and control of abuse and fraud appear unlikely to produce the required dollars.

Numerous options that would contribute additional funding include “sin” taxes on tobacco, alcohol, soft drinks and other sugar containing foods. An even more controversial tax would be a tax on the health insurance contribution currently paid by employers, but which is not presently taxed. Another option would be to use the Massachusetts model of play or pay based upon the employer and individual mandate. This would require employers to either fund health insurance for their workers or pay a tax to help cover the uninsured. An entirely different approach was put forth by “Zeke” Emanuel in his recent book Health Care Guaranteed. The funding under his plan would use a VAT (value added tax) as the only source necessary to fund all U.S. health care.

If the Congress can agree upon who will be covered under the plan and how to finance it, the next urgent question to be answered will be the benefit package, with particular attention to addressing the special needs of children. Additionally, a simplified administration to avoid the current complexity of the present day insurance process is essential.

Our passion to improve health care for all children can only be achieved if proper funding for the entire new program, including reimbursement for pediatricians and other caregivers, is an integral established by legislation.

In spite of the desire of the administration, the Congress and most citizens to change the untenable, complex arrangement in place, there is no assurance that we will see any significant major improvement. The debate over reform will surely bring forth the characterization that reform means a socialized governmental take-over of medical care. Whether this accusation will be believed by U.S. voters will play a large role in determining the outcome of the battle ahead.

Please contact me at donroschiff@comcast.net with your thoughts and suggestions.

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**Did You Know?**

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

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

Our toll free number is 888-227-1772.
May 1, 2009

To the Editor:

I have some comments regarding the interesting and timely article by Dr. Schiff in the Spring 2009 Bulletin.

He speaks of the removal of “severe constraints” placed upon stem cell research. The “constraints” were on EMBRYONIC stem cell research. Also, I’m not sure the present administration was aware when the restraints on embryonic stem cell research were removed of a report from Israel. (JAMA. 2009; 301 (11): 1118) A boy with ataxia telangiectasia was treated at a Moscow clinic with fetal stem cells when he was 9, 10, and 12 years old. At a medical center in Israel, he was found to have tumors in the brain and spinal cord. Tests of the tumor tissue revealed that the growth was derived from fetal cells.

Also addressed in the article is health care reform. Dr. Schiff reports the failure to reform health care in spite of a healthy economy in the mid-nineties. He suggests that the present financial downturn will result in our nation accepting a major health care system revision. Wouldn't addressing the serious economic downturn be the first priority? My suggestion to solve the health care problems of the unemployed is to give them help to get work rather than adjusting the health care system to deal with increasing unemployment.

There are issues that affect all or most Americans. The government needs to keep us safe. It is addressing the terrible downturn in the economy. Let’s not forget $4.00 a gallon gasoline. In the same issue of the Bulletin, Dr. Reynolds reduces the number of medically-uninsured from 47 million to a realistic 8 million. With all of the other problems our country is dealing with, should we reform the greatest health care system in the world to address a problem of 2.5% of the U.S. population? Perhaps new ideas and programs that focus on this group of truly uninsured are more appropriate.

Joseph A.C. Girone, MD, FAAP
Telford, PA

Update your Personal Profile

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

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

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

“Half a loaf is better than none”, runs the adage. But if the size, shape, and cost of the full loaf are unknown, what’s “half a loaf”? Is it smart to negotiate from a compromise position—from half a loaf—without an understanding of what the full loaf looks like? Shouldn’t “the whole loaf” be on the table?

“Single payer” is health care's full loaf. Best we define that full loaf before we decide what to compromise away. Here’s my list.

Everybody in, nobody out.
Universal for all Americans
Everybody pays in, according to ability to pay
Free choice of physician
Physician paid by government, not hired by government
Quality of care incentives
Emphasis on primary care and prevention
Not tied to employer or employment
“Portable” throughout the USA
Costs controlled by voters, not by “market”
Benefit package set by voters, not by “market”
No profit-taking investors
No incentive for competing health plans to provide less care for the dollar
Almost no financial paper-work for you or your doctor
A confidential electronic medical record that travels with you
Freedom to purchase added private “sesame seed sprinkles” to top the full loaf.

Negotiations are accelerating. Single payer is the gold standard and the full loaf. Other nations have it. If you were to be satisfied by “half a loaf” for Americans, which of the above would you take off the table?

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For more information or to join the section . . .
visit our website at: www.aap.org/sections/seniormembers/
The Genesis and Chronology of the Section for Senior Members

By Robert Grayson, MD, FAAP

In the beginning, it was just an idea for Bill Daniel and Bob Grayson, at the time when both were leaving their primary pediatric medical activities, between 1986 to 1988, Bill from academia and Bob from private practice - The questions in both their minds “were we prepared for retirement, financially, psychologically, and administratively?”

There had been nothing in our training, nothing in our Executive Board activities, and nothing in what the Academy offered to its members to help with these non-medical questions. As a service to members, the two retirees organized several three hour round tables entitled “You Are Never Too Young to Think Retirement” at the next several Annual Meetings. Over 100 interested folks attended these, encouraging more of the same. The program consisted of presentations by knowledgeable experts in the fields of Social Security and Medicare, health and disability insurance, financial planning and the arrangements for, and the emotional aspects of, leaving practice. These well attended programs stimulated Board and membership interest.

At the Boston 1999 Annual Meeting, Bill and Bob met with Dr. Kenneth Slaw, who staffed the Division of Sections at the AAP at that time. He suggested that they apply for permission of the Board to form a Section for Seniors.

At that time, the Board was trying to limit the formation of new multi-interest sections rather than those limited to a particular medical subspecialty. The Section on School Health had just been formed after much discussion, setting a precedent for forming a Senior Section. The application process for new sections consisted of securing in writing a required number of potential members in each District, and then applying to the Council on Sections for status as an Interim Forum. After a presentation by Grayson, approval for the Interim Forum was given at the San Diego Council of Sections meeting in November 1991, and Board approval followed shortly afterward. We were named “The Interim Forum for Senior Members.” The Executive Board appointed the following initial Steering Committee; Robert Grayson, Chair, William Daniel, Herbert Winograd, Doris Howell, Allan Coleman, and Murray Pendleton.

The proposed mission of the Forum was to represent the older (over 55 years) members of the AAP to the Board, to provide legislative activity for AAP policy, to provide health and financial information for senior members, to mentor young pediatricians in training, and to assist in planning for a healthy, successful and happy retirement.

Steering committee meetings were held several times in 1992 with attention focused on sub-committee appointments in the following areas; Legislative activity, newsletter editing, program planning, membership recruitment, financial and retirement planning, professional liability and chapter liaison. In addition to the members of the steering committee, Don Schiff, Jim Caffee, Reed Boles, Jim Reynolds, Dan Shapiro, and Murray Pendleton headed sub-committees. Allan Coleman was the newsletter editor for the first two years, and then these duties were taken over by Bob Grayson as he learned desktop publishing. Membership of the Forum reached over 1000 on the first membership drive. Interesting to note that many of the above named are still active with the Section.

Our first formal Interim Forum meeting was in October 1992 at the San Francisco Annual Meeting. It was well attended by over 100 pediatricians. Topics discussed included Social Security, Medicare and financial planning.

In February 1993, the Executive Board approved of our promotion to a Provisional Section, the last step before recognition as a permanent Section.

The second annual program was presented at
the Washington Annual Meeting October 30, 1993. It was an important event, attended by over 200 guests, and featured two keynote addresses by the former Surgeon General, Everett Koop, and the current Surgeon General Joycelyn Elders. This was one of the high spots of the entire Annual Meeting. Both discussed the health care reform bills (the Clinton proposals) which were working their way through Congress at that time.

The format and content of the Senior Bulletin changed as Bob Grayson assumed editorship with November 1993 edition. The general newspaper format initiated at that time continues up to the present.

Full Section status was approved at the Executive Board meeting in February 1994. All subcommittees continued as before.

In the interest of brevity, the remainder of this chronology will continue as summaries of principal activities in each of the succeeding terms of our Section Chairs.

Herb Winograd took office in October 1995 and served for the next six years, The Bulletin increased to three issues per year and expanded to about twenty pages per issue. The annual educational program was reduced to a half-day affair at the time of the NCE, with a brief business meeting and social event included. Attendance at the annual programs was small in proportion to the size of the membership. Cost of registration and hotel and travel expenses continued to be a factor. Requests to the Board to allow senior members in the community in which the meeting was held to attend without registration fee did not succeed. However, later in Herb's term the NCE registration fee for emeritus members was reduced. Nevertheless, section membership decreased, but various inducements stabilized the membership at about 700.

The Bulletin increased to four issues per year and increased in size to 25 to 30 pages. It became the prime method of communication within the Section, especially with small attendance at annual programs. It should be mentioned that Ken Slaw continued to be a major source of support, as the staff assigned to our section changed several times. Kathy Ozmeral, and Jackie Burke have been especially capable staffers.

David Annuzziato succeeded Herb Winograd as Section Chair in December 2000. David’s big effort went to increasing the number of Chapter Senior Committees. He collaborated in the production of a workbook for Chapter Presidents on how to form Senior Committees. During his term, a welcome breakfast for AAP members attending the NCE for the first time was initiated. Senior Section members acted as hosts at each breakfast table and answered questions about AAP activities. At Don Schiff’s initiative, an Annual Legislative Advocacy Award to a member of the Section who was chosen each year by the Section Executive Committee. Robert Black of California was the first honoree. David’s term was marked also by his interest in and activity with the AAP History and Archive Committee. Many seniors were active in obtaining oral histories of well-known pediatricians and for making archival contributions to the Academy. Legislative activity was especially involved with the S-chip program.

The December 2002 issue of the Bulletin was the last under Bob Grayson’s editorship. It was edited by Joan Hodgman and Avrum Katcher for the next two years.

Avrum Katcher followed David as Section Chair in October 2004. His first task was to select a new editor for the Bulletin. Joan Hodgman and Arthur Maron volunteered to assume that role as co-editors. A list serv was established and an AAP web site was created by Jerry Aronson as webmaster as other sources of information for seniors Avrum’s term showed stable member-
ship, continued excellent programs and an increased AAP involvement, enabled by the new Annual Leadership Conference at which Chapter Presidents, Committee Chairs, Section Chairs, District Chairs and staff members met for a three day conference.

His six years as Chair were busy times for Avrum. Most of the current membership has followed the happenings in the Section in the Bulletin and on the website. It should be noted here that Avrum has been a consistent contributor to the Bulletin from the earliest days. His wide scope of interest, his admirable literary style, his thoughtful and erudite book reviews, his intelligent commentary on world events have made the editors chores more enjoyable. Many hours were spent just enjoying his articles before including them in the many issues of the Bulletin from all our editors, “Thanks, Avrum.” One last word of appreciation to the list of program chairs; Herb Winograd, Doris Howell, Jim Reynolds, Jackie Noonan, and Lucy Crain and George Cohen. They have arranged many stimulating, educational and enjoyable meetings, which regrettfully could not reach all of our members. Thanks, also, to the many contributors to the organizing efforts of the Section, and to the Bulletin which has been the glue which has held us together.

Your editor, Arthur Maron, had asked me to trace the genesis of the section. I have reviewed it, especially briefly, for the years since 2000. These years are easily recalled by most of the Seniors reading this. I will let David and Avrum elaborate further on these recent years. It is now Lucy Crain’s time to carry the Senior torch and make Section history.

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**Update on American Board of Pediatrics (ABP) Maintenance of Certification (MOC) Program**

*By Arthur Maron, MD, MPA, FAAP*

For the information of our readers who may not be fully aware of the August 2008 definition and description of the ABP Maintenance of Certification (MOC) program, a comprehensive summary can be accessed at the American Board of Pediatrics web site at [www.abp.org](http://www.abp.org).

Those members who hold a permanent certification from the American Board of Pediatrics, awarded prior to the newer “time-limited” certifications, will remain certified.

Permanent certificate holders are encouraged however, to fulfill the requirements of the Maintenance of Certification Program. There are four elements which must be satisfied to successfully complete the MOC program, including the passing of a proctored written examination which measures current pediatric knowledge.

The full rationale and implications of the MOC program can be reviewed on the ABP web site, particularly by those Section for Senior Members who are still in pediatric practice and/or have a relationship with fiscal intermediaries and similar agencies.

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**Computer Virus Followup**

Subsequent to the article in the last issue warning of computer dysfunction to be blamed on the C-Nile Virus, we had a communication from an astute reader who offered the additional thought that those of us who did not believe in this whole thing were actually suffering from the D-Nile Virus. (Editor)
Here we have not merely a measure of a man but a measure of three men of distinction—Williams, Coles and Roma—two of whom were physicians (Williams and Coles) and a photographer, Roma. They unite in their efforts as though they were a championship team in any given sport.

William Carlos Williams was known as a pediatrician but actually practiced general medicine at a time when almost all physicians did everything. They made house calls carrying a black bag, performed various surgical procedures, and assumed responsibility for all their actions — much like a one-person health care system. Williams was born in 1883, graduated from the University of Pennsylvania Medical School in 1906, and practiced medicine in Rutherford, New Jersey from 1910 to 1951. His patients knew little of his writings. But Williams was a poet of rare distinction, one of the half-dozen or so which our country has produced. In addition to his wonderful poetry, he wrote novels, short stories and essays. He was associated with many of the writers, artists and talented people of his day. Artists such as Charles Demuth, Edward Hopper were close friends. His son has related to me that after a full day and evening in the practice of medicine, he would retreat to his small writing room atop his home/office, to write. Williams carried with him cards upon which he would jot down notes which would be useful later in his writings. More information about Williams is found on the internet at Wikipedia.

Robert Coles, born in 1929, graduated medical school at Columbia University, practiced child psychiatry, and is now on the faculty of Harvard University. His list of writings enormous. His association with Williams began when he was a college student; Williams invited Coles to accompany him on house calls, encouraging him to enter medical school. One result, many years later, was this book. In addition, Coles compiled the many stories Williams wrote about doctors, patients and the practice of medicine, found in his “The Doctor Stories”, published by New Directions Press.

Thomas Roma has published many books on photography, has taught in a number of eminent colleges and universities, and is now a professor of photography at Columbia University. His artistry in this book is magnificent. It is my regret that the many wonderful photographs cannot be well-reproduced in the Bulletin.

This volume arose from the association between Williams and Coles. I heartily encourage you to obtain your own copy and enjoy the photographs and the ever-so-thoughtful comments by Williams and Coles. They are an opening to Williams, the physician, at a time so different from today and to Williams, the poet and author, who managed to excel in two disparate fields in a manner rarely seen in our times.

In those days, as Coles writes, some patients did ... come to see the doctor at his office, but he would also go to a good number ... for their convenience or necessity. His practice was among the poor, who were quite sick, disabled, without transportation. And Williams said, “Hell, it’s the doctor’s job to help his patient when he can, wherever they are.” He regarded his patients as his teachers. “They have their say to me.” He incorporated behavior in his world view. “They never did, those big shots in Washington during the 1930s, ask a lot of kids like those {pointing to a group of boys and girls} to talk about what’s there, waiting to be
heard and seen, handed over to others, through printed words, pictures ... where was the urban version of the FSA, aiming its sights at ordinary city kids? I guess we’ve gotten lost a little”. In a poem on Poverty, Williams wrote

“It’s the anarchy of poverty delights me, the old yellows wooden house indented among the new brick tenements .... the dress of the children.

Reflecting every stage and custom of necessity —-
Chimines, roofs, fences of wood and metal in an unfenced age and enclosing next to nothing at all ...”

He was devoted both to his medicine and his writings.

“Sometimes I envy others, fear them a little too, if they write well.
For when I cannot write I’m a sick man and want to die. The cause is plain ...”

Coles explains, Williams did his work with a fountain pen and some paper...His working life was enacted in a home, and then in his car as he drove...A house call brings two worlds together...The job of the visiting doc is to ease the tension, bridge the two worlds, learn a lot, apply what’s learned to the everyday practicality of living. The patient’s whole body [and mind] are signaling trouble — through sweat, pain, alarm, and outright fear, and the doc has to figure out what, why”. At another time, “We meet, greet, hope to heal, and grow a bit during these times...now and then helping and being helped, no small thing: helper and helped trying to pull it off, force an illness into a full retreat, win one for a full recovery.” Williams saw every patient as an opportunity both for him and the patient to learn and grow. On another occasion, he wrote, “Sure I’m using my medical knowledge on those house calls, but I’m also joining a family, a gathering of humans who are using their heads, thinking deep — a doc come visiting because of bad news but someone whose arrival might {and soon} deliver good news.” As Coles would express these thoughts, “The riddles that philosophers and psychologists pose are those that house calls pose for patients and their visiting docs alike. The doctor and the patient behold one another out of need, out of interest, out of their shared humanity.”

I do recommend this book, and also for you as a physician the volume called, “The Doctor Stories”, pulled together from Williams’ short stories by Coles. Some of you may have seen one of them, “The Use of Force”, published recently in this Bulletin. Williams would have, and I feel that Coles now does, agree with the comment by Dr. John Kitzhaber, who wrote, “The purpose of the health care system is to produce health, not simply to finance and deliver health care.”

Avrum L. Katcher, MD, FAAP

A Country Doctor
By Sarah Orne Jewett

This is a review of a book published in 1184 by an author whose father and grandfather were primary care practitioners in Maine. Jewett first began to write at 16 years of age, and her first publication was a short story for Atlantic Monthly when she was 19. She eventually published nine volumes of short stories and three novels including A Country Doctor. This book is a “bildungsroman” about the life of a woman, who was adopted and raised by a local physician until, as an adult, she entered practice with him.

The story encompasses much of the general reaction to women who sought a career outside of husband, home and family in the days

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when it appeared. This has also been recounted in non-fiction, realistic detail, by Dr. Mary Putnam Jacobi, whose husband was Dr. Abraham Jacobi, a name we all know because of his vital influence on pediatrics in the United States. Dr. Mary Jacobi was the first woman to graduate with a degree from the École de Médecine in Paris. She wrote extensively on the position of women who entered medicine. There were some 2000 women in medicine by 1880, and the number tripled by the 1920’s, but then the rate at which women entered medicine in this country fell sharply, a trend not reversed until after the middle of the century. Jewett writes at a time when women were entering medicine, to a degree, usually studying at one of the six medical schools for women. Later, towards the end of the Nineteenth Century, she was one of the active group of women who convinced the John Hopkins University to admit women to the medical college it was about to start—to a degree! Ten percent of each entering class would be “allowed” to be women.

Jewett was closely attached to her father, an eminent general practitioner in their part of the state, and for a time she considered entry into medicine, but preferred her writing. She did learn a great deal about medical practice and disease, as it was known at the time; this appears clearly in this novel as she describes the adventures of her protagonist, Nan Prince, who attachment to her adoptive father/physician resulted in progressive absorption of what was know at the time of the practice of medicine.

A crucial scene in the novel occurs when Nan, who had learned a great deal while seeing patients with her adoptive father, and sometimes in his place, decided to reset a dislocated shoulder, and did so with great success, in the presence not only of several acquaintances, but also a young man who was close to asking her to marry him. As she realized what she had accomplished on her own, she crystallized her determination to take up medicine as her career. She is described as amazed to recognize her unmistakable command of the situation. This was equivalent to saying no marriage to the young man. At that time, as mentioned, women’s career was in the home.

In the place-Maine in the later potion of the nineteenth century—a woman who took up a career was often segregated from marriage, parenthood and much social intercourse. Dr. Mary Jacobi was one of the rare exceptions. Jewett writes carefully of the reaction of women in the small community to Nan’s ambition and plans. It takes us not only back in time, but illuminates a culture of the position of women. It should be noted that the typical “bildungsroman” is about a man. This story places its aspiring female doctor at the center, and follows her from an orphan toddler to a fully trained physician ready to enter her career as a physician. Nan realizes that she is, as Jewett writes, “to make the best use possible of the gifts God had certainly not made a mistake in giving her. ‘If He meant I should be a doctor,’ the girl told herself, ‘the best thing I can do is to try to be a good one.’ “ Her adoptive father, the physician, said she ‘should be fitted by nature with a power of insight, a gift for [his] business, for knowing that is the right thing to do, and the right time and way to do it… must have this God-given power to [him] of using and discovering the resources of medicine.”

I found these approaches to be uncanny in similarity to what William Carlos Williams told the young doctor-to-be, Robert Coles, in the book they jointly authored on Williams’ house calls and office visit. There, as noted in another essay, he describes so clearly his interactions with patients, families, the jointure of their approach to help whatever it was that was making a patient sick. It was people working together. And that is clear in Jewett’s record of the formation of a physician 30 to 50 years before the Williams/Coles book was written. The Doctor Stories of Williams, as pulled together by Coles, make this even clearer. Jewett

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understood what Williams later would say, “Even when the patients knew me well, and trusted me a lot, I could sense their fear, their skepticism. And why not? I could sense my own worries, my own doubts.”

And Nan learned from her adopted father and mentor, “Every student of medicine, should be fitted by nature with a power of insight, a gift for [his] business, for knowing what is the right thing to do, and the right time and way to do it.”

Let it be said that these two writers, the physician and poet William, Carlos Williams, and the writer/daughter of a physician father and grandfather, Sarah Orne Jewett, shared feelings about patients, doctors and the relationships that their encounters develop. If you have the time, read both books, and understand better who and what you are.


Avrum L. Katcher, MD, FAAP

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"Good, Better, Best": Resident Education, Then and Now

By Carol D. Berkowitz MD, FAAP

At one of the celebratory events surrounding the 75th anniversary of the American Board of Pediatrics, Kevin Weiss, MD, MPH, President and CEO of the American Board of Medical Specialties, remarked that doctors arise in the morning and start out each day striving to be “great physicians”. To be fair, the remark was made in the context of a session devoted to quality improvement, but nonetheless, I was struck by how far that concept was from where I had been as a pediatrician and educator during my career.

First, I struggled with the notion of “greatness”. Most of the residents with whom I worked wanted to make it through the day without killing anyone! Perhaps that’s an overstatement, but certainly they were striving to succeed without harming anyone or missing any readily apparent diagnoses. Next, I recalled a classic essay by Linda Nochlin, published in 1971 and entitled, “Why are there no great women artists?” Rather than responding, “Yes, there are!” and listing little-recognized individuals, Linda Nochlin redefined the question into “What leads to greatness in art?” Her response was mentoring. Women artists were “hobbyists”, painters whose talents were not nurtured by art academies or experienced instructors.

When individuals, such as Rosa Bonheur, succeeded, it was because of individual attention they received through personal or family mentoring.

Mentoring is, in fact, required for program accreditation by the ACGME, just one of multiple requirements. But, the Accreditation Council on Graduate Medical Education (ACGME) doesn’t require that residents become great physicians; just competent ones. And programs now must structure their curriculum to assure that residents are competent in six domains, affectionately referred to as the six competencies: Patient Care, Medical Knowledge, Practice-Based Learning and Improvement, Interpersonal and Communication Skills, Professionalism, and System-based Practice.

To some extent, the process of defining and expanding upon the competencies has taken on a life of its own and, in so doing, has increased the workload and documentation required for program directors, programs, and institutions. For every education experience, there is an expectation that some, if not all, of the competencies will be addressed. Pages of documentation are generated in anticipation of...
a review by the Residency Review Committee for Pediatrics (RRC) and a site visitor. Residents are prompted on the competencies and on the goals and objectives of each segment of the curriculum. The Program Information Form (PIF) is over 100 pages, filled with descriptions about how the competencies are addressed. Yet, at the end, the uniqueness of each program seems lost in the sea of competency verification.

The move toward resident education being dictated by the need to meet the competencies is in direct contrast to the impetus for innovation and creativity espoused by the R3P Project (Residency Review and Redesign in Pediatrics) and funded by the American Board of Pediatrics Foundation. The conclusion of this project was that there was a need for less uniformity in resident education to better meet the needs of the children and the future direction in which healthcare is going. But resident education had allowed for flexibility and creativity until the burden of documentation and data collection became a distraction.

So, in our effort to document competence, have we aborted the march to greatness? By mandating documentation of Individual Learning Plans (ILPs), reminiscent of IEP, Individual Education Plans for students with educational challenges, have we moved from the art of learning to the act of noting what one has to learn? Can we teach someone the “love of learning”, or should we instill that love by making the educational process so rich and exciting that enjoyment and satisfaction just flows naturally?

I am reminded of a video shown at the ACGME by Dr. David Leach. It was of Parker J. Palmer, PhD, author, activist and educator. In the video Dr. Palmer speaks of asking a student how you can tell a good teacher. The student replies that it’s easier to spot a bad teacher – they speak, but the words appear over their head like a bubble in a newspaper cartoon.

Is there any way to know if all the changes imposed by the RRC and ACGME have improved resident education or the quality of pediatricians entering the workforce? Are newly-trained physicians better prepared to care for children than those trained in the past?

I don’t know the answer but I am fairly certain that we will never be able to measure whether or not we have improved the educational process through the multiple changes. We may be able to now document that each resident was observed doing a history and physical during their training and provided feedback, but the impact of that experience on their performance in the future, will, I believe, remain impossible to measure.

I think the majority of physicians want to do the best they can. Many believe they are, and are surprised when they learn that their performance is below that of their peers in certain measurable aspects of patient care or disease management. Our goal then should be to instill in residents a willingness to self-assess, accept feedback and engage in programs that offer them information about how they are doing in a constructive and meaningful way. In the final analysis, it really isn’t about being a great physician. It is about providing excellent healthcare to those under our care.

Editor’s Note: These comments by Carol Berkowitz are thought-provoking and challenging. Carol speaks with a modicum of authority, having served as my immediate successor as Chair of the Residency Review Committee for Pediatrics. Her hypothesis – that we can sometimes be negatively impacted by too much of a good thing – might be applied to many issues of our time. The safety net of Social Security has become a danger to the solvency of our nation. The concept of special-interest groups influencing Congress has grown into a money-driven stranglehold on our Congressmen. The miracle of cyber communication now has grown into a potential menace for our children. Perhaps the dictum of David Leach, MD, Executive Director of the ACGME, that, “What is measured, tends to improve”, needs to be revisited. (AM)
Medical Information for Caregivers
Now Available on NIH SeniorHealth Site

If you’re caring for an older friend or family member, you’ve probably had questions about Medicare, the federal health insurance program for adults 65 and older and people under age 65 with disabilities. While you may know that Medicare helps pay for medical and prescription drug costs, you may want to become more familiar with the Medicare benefits and resources available to your friend or loved one. An easy-to-read overview, “Medicare Basics for Caregivers,” is now available at NIHSeniorHealth.gov, the Web site for older adults from the National Institutes of Health. This brief, yet comprehensive introduction to Medicare gives caregivers the basics and helps them find answers to their questions.

The topic was developed with the Centers for Medicare and Medicaid Services based on its booklet, “Medicare Basics: A Guide for Families and Friends of People with Medicare.” “Knowing how Medicare works can help a person make better financial decisions about care,” says Dr. Marie Bernard, deputy director of the National Institute on Aging. “A caregiver who is knowledgeable about Medicare can be an informed advocate for an older loved one who needs to access the benefits the program provides. The new ‘Medicare Basics for Caregivers’ topic on NIH SeniorHealth is an excellent source of concise, easy-to-understand information that will benefit both caregivers and their loved ones.”

Caregivers and others needing a general introduction to Medicare can visit http://nihseniorhealth.gov/medicare/toc.html to find out about medical and hospital benefits, enrollment, billing, prescription drug costs, home health care and much more.

Older Americans are increasingly turning to the Internet for health information. In fact, over 70 percent of online seniors look for health and medical information when they go on the Web. NIH SeniorHealth (www.nihseniorhealth.gov), which is based on the latest research on cognition and aging, is a joint effort of the National Institute on Aging (NIA) and the National Library of Medicine (NLM). The site features short, easy-to-read segments of information that can be accessed in a number of formats, including various large-print type sizes, open-captioned videos and an audio version. Additional topics coming soon to the site include dry eye, periodontal disease and long-term care.

CMS administers the Medicare program. For more information, visit the Web site at www.medicare.gov.

The NLM is the world’s largest library of the health sciences and collects, organizes and makes available biomedical science information to scientists, health professionals and the public. For more information, visit the Web site at www.nlm.nih.gov.

The NIA leads the federal effort supporting and conducting research on aging and the medical, social and behavioral issues of older people. For more information on research and aging, go to www.nia.nih.gov.

Have an Issue?

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

For more information or to join the section . . . visit our website at: www.aap.org/sections/seniormembers/.
Well, here we are – in the middle of my first year as Editor of the Bulletin of the Section for Senior Members. I am attempting to apply the knowledge gained from my predecessors – from the legendary Bob Grayson, Editor for ten years, to the legendary Joan Hodgman, whose demise cruelly aborted her stewardship of the Bulletin. I have attempted to make my arrival seamless, and hopefully our readers have not suffered from my presence. It has been suggested, however, that – in the interest of full disclosure – that I make public a little-known circumstance of my role as Editor.

The fact is that, although I am Editor of the Bulletin, I am unable to read it. Lest that surprise you, let me report that I do not read any books and hardly any printed material. Gave up driving about five years ago. I am fairly good at newspaper headlines. Movies and TV are marginally OK, but forget about subtitles in foreign films!

But, please be assured; in spite of vision challenges, I am not disabled! I have not missed an annual NCE in twenty-plus years, am completing six years on the Executive Committee of our Section, and enjoy my role as Executive Dean at Saba University School of Medicine, a Caribbean medical school. The vast majority of people with whom I come into contact have no idea that I have trouble seeing, and I like it that way. I enjoy a feeling of accomplishment every time I leave a professional meeting or finish a presentation without anyone being aware of my vision – or lack of it.

The official diagnosis—glaucoma. Basically, bilateral optic neuropathy of unknown etiology. Ten years ago, I had to convince my ophthalmologist that something was wrong. He laughed at me and assured me that my intraocular pressure was – and always had been – normal. He did visual fields to humor me, and then we both stopped smiling. It was “normotensive” glaucoma; it would progress inexorably to limit my vision and the management was to keep my normal intra-ocular pressure down to ultra-low levels in the hope that the deterioration wopuls be slowed. It is now ten years later, my vision is distinctly worse, but who can say how much worse it would have been without intervention?

Enter the “Knight in Shining Armor” astride a galloping white steed, to save me from disaster. Technology. Modern technology. Just when my computer skills were failing fast, ZoomText® came to the rescue. A remarkable vision aid, which enables me to read, albeit slowly, by reversing colors, magnifying and even reading text to me upon command. Other devices, such as a desktop reader which acts a bit like the computer program, which allows me to read ordinary documents and letters. To enhance my mobility, I have a portable version of the desktop reader and the most remarkable addition recently of a cell phone sized device which takes a picture of any text and converts it to verbal technology. I won’t dwell on other aids such as my voice-operated cell phone and the waiver by the phone company of 411 charges. My hardest-working and best-looking aid, of course, is my loving and devoted wife, Ruth, who fills in the many blanks between the technological marvels.

As with everything in life, there have been pluses and minuses. The ability to recall numbers and data has been enhanced. I’ve learned the telephone keypad and its relevant letters, but so have my texting grandchildren. I’ve mistaken a few men’s and women’s public bathrooms, but have yet to be arrested. I found that the audible computer-reading was a distraction at the Executive Committee meetings, but fixed that by bringing earphones last time. I keep up with the latest literature by use of audiobooks and even MP3 players. The answer to the various challenges has always been: accommodation. When I find that I cannot make it over the high hurdle, I run around it and keep going. I am gratified that my interests and activities continue unabated, and I revel in the joy of living and making a difference.

The next time we meet, stop and chat for a bit. But my facial recognition capability is not instantaneous, so identify yourself, please.
Many pediatricians are unaware that, in addition to the membership category of “Fellow”, “Specialty Fellow”, etc., there are two other categories of membership designed especially for retired pediatricians and senior pediatricians. The idea is to make it easy for us to stay connected to the AAP as a way for us to continue our lifelong interest in the welfare of children. And, not incidentally, our academy needs us. The two categories created to accomplish this are “Retired Fellow” and “Emeritus Fellow”. Both categories involve a decrease in dues and they both have some conditions, which need to be met to qualify.

The Retired Fellow category requires that a fellow (this includes specialty fellows and corresponding fellows) must be at least fifty five years old, must have been an AAP member for 5 years or more, and must no longer derive income from professional activities. The membership requirement of 5 years might not need to be consecutive depending on circumstances. Retired Fellows may not hold national AAP office but it is important to note that they do retain their right to vote for national officers. They may also hold office in AAP sections. Effective July 1, 2009, the dues for this category are $188, a considerable savings. This includes online access to our journal, Pediatrics, with all of its archives. Also included is AAP News, both print & online. A “print” subscription to Pediatrics can be had for an additional $60.

If you believe you are eligible to take advantage of either of these membership categories, you can download a form from the online AAP Member Center: click Member Benefits and Services located in the Member Community box along the left, then click AAP Membership Change of Category/Status Form. For questions, contact AAP Customer Service at 866-THE-AAP1, M-F 7:00-5:30pm central time. To check on your current AAP category/status go to the Member Center and click on My Account, located next to your name near the top of the page.

The following are lists of the privileges and benefits associated with belonging to either of these categories. This list can also be found online. First go to the AAP Member Center. Then click on Member Directory located in the Member Community box along the left. Then click on Academy information and finally click on the AAP Membership Categories document located near the bottom.

**Retired Fellow**

**Privileges:**
- Vote in National Elections
- Use of “FAAP” Designation
- Serve on Committees and hold office in committees
- Section Membership and hold office in Sections
- Chapter Membership
- Listing in AAP Online Membership Directory

**Benefits:**

Continued on Page 19
Membership Categories for Retired and Senior AAP Members Continued from Page 18

- Pediatrics Online only (Option to purchase print subscription for $60.)
- Online access to AAP News (Option to purchase print subscription for $10.)
- Access to Member Center, PediaLink.org™, and Practice Management Online
- SmartBrief, a daily e-newsletter (featuring pediatric content gleaned from various sources, including national and international media).
- A copy of select AAP-authored manuals and samples of patient education literature upon request. Retired Fellows receive a card or letter offering them a new copy of the manuals when new editions come out.
- Member pricing (discounted below that which is charged to non-members) on publications, subscriptions, and CME courses, live and online.
- Special reduced registration pricing for the annual National Conference & Exhibition.
- Member Benefit Affinity Programs:
  Pediatric Insurance Consultants (PIC), Inc
  Group Insurance Plans
  Members Liability Insurance Program
  GEICO Auto Insurance
  Bank of America WorldPoints credit card
  Car Rental Discounts thru Hertz and Avis
  Certificate Framing by Framing Success
  Health Care Notification Network
  MyPracticeBuilder
  ResX.com, internet-based travel booking service (accessed online by clicking the link at the bottom right in the AAP Member Center).

Emeritus Fellow

Privileges:
- Vote in National Elections
- Use of “FAAP” Designation
- Serve on Committees and hold office in committees

- Section Membership and hold office in Sections
- Chapter Membership
- Listing in AAP Online Membership Directory

Benefits:
- Pediatrics Online only (Option to purchase print subscription for $60.)
- AAP News subscription, both print and online
- Red Book™2009: Report of the Committee on Infectious Diseases in format of choice
- Access to Member Center, PediaLink.org™, and Practice Management Online
- SmartBrief, a daily e-newsletter (featuring pediatric content gleaned from various sources, including national and international media).
- A copy of select AAP-authored manuals and samples of patient education literature upon request. Emeritus Fellows receive a card or letter offering them a new copy of the manuals when new editions come out.
- Member pricing (discounted below that which is charged to non-members) on publications, subscriptions, and CME courses, live and online.
- Special reduced registration pricing for the annual National Conference & Exhibition.
- Member Benefit Affinity Programs:
  Pediatric Insurance Consultants (PIC), Inc
  Group Insurance Plans
  Members Liability Insurance Program
  GEICO Auto Insurance
  Bank of America WorldPoints credit card
  Car Rental Discounts thru Hertz and Avis
  Certificate Framing by Framing Success
  Health Care Notification Network
  MyPracticeBuilder
  ResX.com, internet-based travel booking service (accessed online by clicking the link at the bottom right in the AAP Member Center).
An Interesting Perspective

Written By Regina Brett, 90 years old, of The Plain Dealer, Cleveland, Ohio

“To celebrate growing older, I once wrote the 45 lessons life taught me. It is the most-requested column I’ve ever written.” My odometer rolled over to 90 in August, so here is the column once more:

1. Life isn’t fair, but it’s still good.
2. When in doubt, just take the next small step.
3. Life is too short to waste time hating anyone.
4. Your job won’t take care of you when you are sick. Your friends and parents will. Stay in touch.
5. Pay off your credit cards every month.
6. You don’t have to win every argument. Agree to disagree.
7. Cry with someone. It’s more healing than crying alone.
8. It’s OK to get angry with God. He can take it.
9. Save for retirement starting with your first paycheck.
10. When it comes to chocolate, resistance is futile.
11. Make peace with your past so it won’t screw up the present.
12. It’s OK to let your children see you cry.
13. Don’t compare your life to others. You have no idea what their journey is all about.
14. If a relationship has to be a secret, you shouldn’t be in it.
15. Everything can change in the blink of an eye. But don’t worry; God never blinks.
16. Take a deep breath. It calms the mind.
17. Get rid of anything that isn’t useful, beautiful or joyful.
18. Whatever doesn’t kill you really does make you stronger.
19. It’s never too late to have a happy childhood. But the second one is up to you and no one else.
20. When it comes to going after what you love in life, don’t take no for an answer.
21. Burn the candles, use the nice sheets, wear the fancy lingerie. Don’t save it for a special occasion. Today is special.
22. Over prepare, then go with the flow.
23. Be eccentric now. Don’t wait for old age to wear purple.
24. The most important sex organ is the brain.
25. No one is in charge of your happiness but you.
26. Frame every so-called disaster with these words “In five years, will this matter?”
27. Always choose life.
28. Forgive everyone everything.
29. What other people think of you is none of your business.
30. Time heals almost everything. Give time, time.
31. However good or bad a situation is, it will change.
32. Don’t take yourself so seriously. No one else does.
33. Believe in miracles.
34. God loves you because of who God is, not because of anything you did or didn’t do.
35. Don’t audit life. Show up and make the most of it now.
36. Growing old beats the alternative — dying young.
37. Your children get only one childhood.
38. All that truly matters in the end is that you loved.
39. Get outside every day. Miracles are waiting everywhere.
40. If we all threw our problems in a pile and saw everyone else’s, we’d grab ours back.
41. Envy is a waste of time. You already have all you need.
42. The best is yet to come.
43. No matter how you feel, get up, dress up and show up.
44. Yield.
45. Life isn’t tied with a bow, but it’s still a gift.
Investors seeking a tax deferral strategy, or those who wish to create an income stream during retirement which they cannot outlive, often look to tax-deferred fixed annuities since taxation on the interest is deferred until distributions are made. The tax benefits of fixed annuities, however, do come with restrictions: Payouts must begin after you reach age 59½ or earnings may be subject to a 10% federal income tax penalty.

Annuities were first created in response to investors looking for an alternative investment which offered guarantees for their principal and interest, as opposed to fluctuating investment vehicles such as stocks and bonds.

When purchasing an annuity, it is important to understand some definitions of terms as they relate to the policy. The “policy owner” is the individual who makes the investment, and has all of the rights of ownership, including terminating or transferring the annuity to another insurance company, and changing beneficiaries. The “beneficiary” is the individual who will receive any potential proceeds payable upon the death of the owner or the annuitant. The “annuitant” is the individual whose life is used to determine the amount of the payments made during the annuity payout periods.

To provide flexibility of payout options, insurance companies tie distributions to a variety of guaranteed time periods. Examples of payout options include:

**Lump-sum withdrawal:** An annuity owner can actually withdraw all of the accumulated funds within the policy without having to spread the payments over a certain amount of time. A complete lump-sum withdrawal is considered by the issuing company to be a surrender of the policy thus terminating any remaining annuity benefits.

**Partial withdrawals:** Many annuities allow partial withdrawals without a surrender charge or penalty in order to allow policy owners limited access to their accumulated funds without having to terminate the contract. The amount allowed to be withdrawn is generally limited to 10% to 15% of the annuity value, either on an annual, cumulative, or absolute total basis.

**Life only annuity:** Regular payments are made for as long as the annuitant lives. Payments completely cease upon the annuitant’s death, and beneficiaries receive no benefits even if the annuity owner received less than their initial investment.

**Life with term certain:** In order to avoid the potential loss of principal associated with the life only option, a term certain option can be selected. If the annuitant dies before the specified time certain period, typically 10, 15 or 20 years, the annuity payments continue to be paid to the beneficiary for the remainder of the term. If the annuitant does not die within the term certain time period, payments will continue for as long as the annuitant lives.

**Joint and survivor:** This option allows for the regular annuity payments to be made over the lives of two individuals. At the death of either of the individuals, annuity payments will continue to be paid to the survivor. Depending on the specific annuity, the payments may be made at the same or at a reduced level.

**Period certain:** Annuitants who do not wish to tie their payouts to life expectancy can choose to have regular payments made over a certain set period of years. Once the payout period ends, no further lifetime benefits are available. If the annuitant dies before the end of the specified period, payments continue to be paid to the named beneficiary for the remainder of the pre-selected time period.
It is important to understand that fixed annuities are neither insured nor guaranteed by the FDIC, and that they may actually decline in value if surrendered prior to maturity due to related charges. The guarantees are based on the claims paying ability of the issuing insurance company.

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

Securities offered through Joel M. Blau, CFP® and Ronald J. Paprocki, JD, CFP®, registered representatives of Waterstone Financial Group, Member FINRA/SIPC. Waterstone Financial Group and MEDIQUUS Asset Advisors, Inc. are independently owned and operated.

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**Get Involved in Child Advocacy Efforts at AAP**

The Federal Advocacy Action Network (FAAN) is made up of all AAP members. It allows them to receive e-mail alerts when action is needed on Capitol Hill. FAAN members are asked to contact their members of Congress asking them to take action on specific child health issues. The AAP Department of Federal Affairs gives FAAN members the information and tools needed to persuade their legislators. Every AAP member is enrolled in the FAAN.

If AAP members want to do more federal advocacy than responding to the FAAN alerts, we encourage pediatricians to join the AAP Key Contact program. Key Contacts are AAP members who have agreed to take their advocacy to the next level by developing an ongoing relationship with their respective federal legislators. Key Contacts receive more sophisticated assignments from the AAP Department of Federal Affairs and are expected to report back their results. Contacts should be ready to respond at a moment's notice to requests for action and become a resource for their federal legislators at critical decision points. Being a Key Contact requires a very small time commitment but can yield big results.

To see the latest info from the FAAN or to sign up to be an AAP Key Contact, log on to the Member Center and click on “Federal Affairs” or for more information, please contact Erin Howard, Assistant Director, Public Affairs and Member Advocacy, (800) 336-5475, or ehoward@aap.org.
Alternative Medicine
By James Reynolds, MD, FAAP, our resident cynic

Q: I've heard that cardiovascular exercise can prolong life; is this true?
A: Your heart is only good for so many beats, and that's it... Don't waste them on exercise. Everything wears out eventually. Speeding up your heart will not make you live longer; that's like saying you can extend the life of your car by driving it faster. Want to live longer? Take a nap.

Q: Should I cut down on meat and eat more fruits and vegetables?
A: You must grasp logistical efficiencies. What does a cow eat? Hay and corn, and what are these? Vegetables. So a steak is nothing more than an efficient mechanism of delivering vegetables to your system. Need grain? Eat chicken, beef is also a good source of field grass (green leafy vegetable), and a pork chop can give you 100% of your recommended daily allowance of vegetable products.

Q: Should I reduce my alcohol intake?
A: No, not at all. Wine is made from fruit. Brandy is distilled wine, that means they take the water out of the fruity bit so you get even more of the goodness that way. Beer is also made out of grain. Bottoms up!

Q: How can I calculate my body/fat ratio?
A: Well, if you have a body and you have fat, your ratio is one to one. If you have two bodies your ratio is two to one, etc.

Q: What are some of the advantages of participating in a regular exercise program?
A: Can't think of a single one, sorry. My philosophy is: No Pain...Good!

Q: Aren't fried foods bad for you?
A: YOU'RE NOT LISTENING!!! ~ Foods re fried these days in vegetable oil. In fact, they're permeated in it. How could getting more vegetables be bad for you?

Q: Will sit-ups help prevent me from getting a little soft around the middle?
A: Definitely not! When you exercise a muscle, it gets bigger. You should only be doing sit-ups if you want a bigger stomach.

Q: Is chocolate bad for me?
A: Are you crazy? HELLO ~ Cocoa beans, another vegetable!!! It's the best feel-good food around!

Q: Is swimming good for your figure?
A: If swimming is good for your figure, explain whales to me.

Q: Is getting in-shape important for my lifestyle?
A: Hey! 'Round' is a shape!

Well, I hope this has cleared up any misconceptions you may have had about food and diets.

Continued on Page 24
AND...
For those of you who watch what you eat, here's the final word on nutrition and health. It's a relief to know the truth after all those conflicting nutritional studies.
1. The Japanese eat very little fat and suffer fewer heart attacks than Americans.
2. The Mexicans eat a lot of fat and suffer fewer heart attacks than Americans.
3. The Chinese drink very little red wine and suffer fewer heart attacks than Americans.
4. The Italians drink a lot of red wine and suffer fewer heart attacks than Americans.
5. The Germans drink a lot of beers and eat lots of sausages and fats and suffer fewer heart attacks than Americans.

CONCLUSION
Eat and drink what you like... Speaking English is apparently what kills you??

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2009 NCE Section for Senior Members Program
Controversies in Care: What You Don't Know May Harm You

October 19, 2009 • Washington, DC
1:30 PM - 6:30 PM

Presentation of the Section on Senior Child Advocacy Award*

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

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

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

*Section on Senior Child Advocacy Award sponsored by Mead Johnson Nutrition
2009 - 2010 Senior Bulletin Schedule

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

Fall Bulletin 2009
August 24, 2009 articles due to Arthur Maron, MD, MPA, FAAP
September 28, 2009 mailboxes

Winter Bulletin 2010
December 1, 2009 articles due to Arthur Maron, MD, MPA, FAAP
January 8, 2010 mailboxes

Spring Bulletin 2010
March 16, 2010 articles due to Arthur Maron, MD, MPA, FAAP
April 20, 2010 mailboxes

A STUNNING SENIOR MOMENT

A self-important college freshman walking along the beach took it upon himself to explain to a senior citizen resting on the steps why it was impossible for the older generation to understand his generation. “You grew up in a different world, actually an almost primitive one” the student said loud enough for others to hear. “The young people of today grew up with television, jet planes, space travel, man walking on the moon. We have nuclear energy, ships and cell phones, computers with light speed....and many more.”

After a brief silence, the senior citizen responded as follows.

“You’re right son. We didn’t have those things when we were young....so we invented them. So now, what are you doing for the next generation? The applause was amazing!”