Message from the Chairperson

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

ADVANCE DIRECTIVES, IMMUNIZATIONS, PERSONAL RESPONSIBILITY, AND...DEATH PANELS?

It’s a surprising observation in a medical staff meeting to request a show of hands for those who have living wills or advance directives. Only about 20% of physicians in general have indicated such instructions in writing. Pediatricians score a bit better at 35%. While pediatricians occasionally have experiences with counseling parents about withdrawal of life support or do not resuscitate directives for their incurably, terminally ill child, the one in three pediatricians who has applied those considerations to their personal life is exceptional. Apart from having signed such documents when my husband and I had our wills updated several years ago and each of the few times I’ve been hospitalized, I’ve had personal experience more recently in helping family members to update their advance directives. We discussed the sense of personal control, which this gives the individual who, while of sound mind, is able to provide their personal wishes and instructions to their physi...
cian or health care surrogate. I hope that more than 35% of the members of our Section already have such directives, and that our physicians are well aware of our wishes in advance of a terminal illness, serious injury, or unexpected, devastating event. This is the opportunity to stipulate your own directions. It’s not necessary to have an attorney draft such a document these days. One can Google search Advanced Directive or Living Will and scroll to your state of residence. The document is easily downloaded, modified to individual instruction, and signed before witnesses or a notary public.

Most life threatening events like motor vehicle accidents, cancer, heart attacks or strokes, or even getting shot don’t happen at convenient times when we can cogently ponder over whether we want life support for an indefinite period. Indicating our personal instructions ahead of time seems preferable to most instead of burdening a spouse or other loved one with such stressful decisions. So, when President Obama’s health plan proposal included a clause which would facilitate reimbursement for physicians willing to sit down with their patients and discuss their individual advance directives, I was amazed at how many protesters immediately saw this as a means for doctors to “pull the plug on Grandma”, and furthermore, to be “incentivized” for it. After all the uproar, the plug was pulled on that clause in the health plan proposal. Sadly, the general public must have a very low opinion of doctors and of our profession!

On the matter of personal responsibility for one’s health, it’s worth noting that immunizations are not just for children. In the past five years two of my close friends

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have had incapacitating sequel and disabling complications from shingles. Many health insurance plans do not cover the cost of Zostavax, the shingles vaccine, but this is a preventable illness with potentially very costly outcomes. Consider paying for it out of pocket, if your insurance doesn’t cover it. Studies indicate that people over age 55 are woefully under immunized and woefully vulnerable. Shingles is worth preventing, as is pertussis or any of the childhood illnesses which we may have had more than a half century ago. Please check the January 9, 1009 issue of MMWR or go online to the CDC Adult Immunization Schedule link cdcc.gov/vaccines/recs/schedules/adult-schedule.htm and discuss with your personal physician getting those recommended vaccines in addition to your flu shot this fall.

Update on Section Executive Committee Activities: We have drafted a resolution requesting discounted registration fees for all AAP CME programs for senior AAP members age 65 and older in good standing for presentation at the Annual Leadership Forum next March. While the AAP discounts registration fees already for the NCE, this is not the case with most other AAP continuing medical education programs, including the PREP courses. Our membership survey supports consideration that more senior members would attend these valuable courses, if registration fees were discounted.

Executive committee members will soon begin contacting those 27 AAP members in good standing who are nonagenarians. Actually, the AAP lists our eldest member as age 108! It’s clear that there’s a lot of living to be done after retirement from full time practice, and these interviews should yield some interesting reading for future issues of the Bulletin.

At our annual executive committee meeting during the NCE in Washington, we’ve invited Mr. Brad Hutchins from the AAP Development Department to update us on innovative considerations for section dues structure, which should lead to an increase in philanthropic giving for Friends of Children and other entities, as well as section membership benefits. Every member of the executive committee plus other members of this Section will make brief informational presentations at the District Breakfasts. We have several projects underway attempting to recruit more members, more female members, and more members in the age 55-70 age group.

And, a final reminder to attend the Annual Advocacy Award presentation on Monday October 19 at 1:30pm in Room 156 of the Washington Convention Center. The Award presentation and comments will immediately be followed by the annual Section Education Program (3.5 CME hours), featuring an outstanding faculty and topics which should be of great interest. There will be a reception following the program and all are invited to stay to enjoy meeting our faculty and to catch up with friends and colleagues.

I hope to see you there!

Lucy S. Crain, MD

The AAP Section for Senior Members would like to thank
Mead Johnson Nutrition
for their support of the Child Advocacy Award.
When President Obama took office in January, 2009, he confidently predicted that health care reform legislation would be passed by August, ready for his signature. The anticipated benefits of this legislation to be hurried along by a cooperative bipartisan Congress, he believed, would be clearly understood and supported by an electorate which, during the Presidential campaign of 2008, loudly proclaimed the need for the promised reforms. Voters, including physicians, said that they had had enough of the rising insurance premiums, employers dropping health insurance coverage for their employees, growing limitations on “covered” benefits and increased co-payments. They were ready for a change.

Three committees in the House of Representatives and two in the Senate were tasked to produce the reform legislation which had been, in part, discussed over the past 80 years. These efforts by Presidents Franklin Roosevelt, Harry Truman, Richard Nixon and Bill Clinton crashed on the rocks of opposition by insurance companies, medical organizations and fears of “socialized medicine.” Only Lyndon Johnson was successful in 1964-5 with the passage of Medicare and Medicaid, enabling the elderly and the very poor to obtain basic health care.

President Obama recognized that the effort to pass a broad reform would arouse strong opposition from many quarters and planned to pre-empt as much of the negative response as possible. Working with Karen Ignagni, chief executive of the trade group, America’s Health Insurance Plans, he obtained assurances that the mega health insurers and managed care organizations would support health care reform if all Americans were mandated to have insurance. The group was also agreeable to using community premium rates and covering pre-existing conditions under the new plan.

Negotiations with the Pharma group representing large drug manufacturers were also positive, as they agreed to reduce drug costs by $80 billion under the reform measure.

On August 8, 2009 at a Colorado Springs, Colorado meeting with Colorado physicians on health care reform, Dr. J. James Rohack, President of the American Medical Association, revealed his concerns about the freedom of physicians to care for their patients, and stated that doctors often get blocked or stalled by insurance company employees who argue about the medical necessity of an x-ray or scan. “The AMA supports the reform plan,” said the Texas cardiologist. He favors “America’s Affordable Health Choices Act,” as the new legislation is entitled, as it would create a unified form and set of rules for private and public insurers regarding which tests are covered. Rohack believes that this would cut down on the haggling about what tests are medically necessary.

With the support of insurance companies, medical groups, drug manufacturers and a majority in Congress, the passage of the reform bill seemed assured.

But not so fast. A campaign of opposition has been mounted, and with a response and fury and at this point (August 10, 2009) a measure of success that suggests that the health care legislation is in danger.

The precarious financial state of the nation and the unemployment rate of 9.4% have produced a general state of anxiety and loss of confidence that makes the understanding and acceptance of a change of this magnitude in our health care system frightening to many.

Although the President has been able to retain his personal popularity, a recent poll revealed only a 41% approval rate on his handling of the health care reform.

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The original goals of reform, i.e., covering the uninsured, containing the unsustainable rising costs of health care and improving quality of care, have been largely pushed aside by a loss of civility and accuracy in the discussions at local town hall meetings. The violence that has occurred at some of these meetings and the acceptance of startlingly false statements about the bill, including “killing grandma to save money” lends support to worries regarding the level of anxiety in parts of our nation.

Since we can’t predict whether major health care reform will pass (though some health bill probably will), the long term effect on children’s health remains uncertain.

The reform measures from the House could impact current programs, including CHIP and Medicaid. The recession has already produced reductions in size and benefits as well as physician reimbursement, and children are going without care.

My crystal ball is very cloudy, and I am making no predictions. The American people have waited too long already as we anticipate the next step forward. Are we ready? We shall see?

Please e-mail me at donroschiff@comcast.net with your questions, comments and ideas.

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**Public Versus Private Health-Care Insurance**

*By James L. Reynolds, MD, FAAP, FACC*

Progress has been made in our thinking about reforming health care. First, all are agreed that such reform absolutely must be cost conscious. The President himself and his chief financial officer, Mr. Peter Orszag, say cost containment is crucial to the country’s fisc; serious massive deficits threaten default. Tax receipts have notably declined, while spending is exponentially increasing. So health-reform must be done economically, with as little federal spending as possible. Most states are in financial difficulty, so there is no financial help from that level.

Second, there is general agreement that every American should be insured. Whether such insurance is a “right”; how basic this insurance should be; whether illegal immigrants constitute “Americans”; whether the true number of Americans uninsured equals 45.3 million, or really perhaps 7-8million (3%-15% of the population); and whether those insured at public expense have an understood return obligation to live healthy lives, i.e., absent addictive drugs, obesity, smoking, etc., in order to decrease the medical-insurance expense of tax payers are topics best avoided.

The main sticking point or cause for dissention is whether a public health-insurance plan should be included as an option. Those favoring a public plan say it will:

1. provide competition for private plans, which will bring premium cost down;
2. save money because of much lower administrative costs;
3. not have a cost-enhancing profit motive;
4. be more economical than private plans because of its large scale; and
5. be a much better negotiator in lowering remuneration of drug and medical-service providers, thus lowering cost.

Those favoring only private health-insurance plans strongly dispute the above assertions:

1. There are now some 1,300 or more private health-insurance plans, thus more than an adequate number for unfettered competition... if private-insurance providers were allowed by the federal government to actually compete.
Free competition requires, through the commerce clause of the Constitution, federal legislative removal of state restrictions on selling insurance across state lines. Currently, health-insurance premiums in some states now cost more than twice as much as in other states because of state-imposed legislative mandates on insurers. Mandates require insurers to provide in their basic policies, items such as chiropractic care, in vitro fertilization, acupuncture, hair transplant, sex-change operations, etc. Free competition across state lines would bring premium cost down and provide people with more options.

Removing two major mandated requirements, “guaranteed issue” and “community rating” would also encourage not only competition, but consumer choice and fairness. Guaranteed issue forces an insurer to issue to someone previously uninsured a policy at the time of illness—with this provision, why would anyone reasonably buy insurance before becoming ill? Community rating, forces insurers to charge an equal premium to everyone, regardless of age or health status. It’s certainly an imposition on the young, and on those who, as the federal government encourages, have a healthy lifestyle: e.g., avoiding addictive drugs, excess alcohol, smoking, and obesity; exercising regularly; and having regular medical checkups. Individuals should have the option to choose how basic or “gold plated” a policy they need based on their age and health circumstances. The basic concept of insurance is for payment of large bills incurred by serious illness, not that it pay for the first dollar of minor medical expenses. Tailoring insurance to individual need is the task of underwriting, an administrative expense.

There should be a federal requirement of full, plainly explained, and honest information about policy provisions, expenses, services, etc., with severe financial penalty for sharp practice, obfuscation, and dishonesty. There is no disagreement about the need for full disclosure.

2. That a public program will save money and operate efficiently and apolitically seems to be on its face an oxymoron. Thrift is hardly a federal attribute:

Federally run Amtrak is chronically over budget, with rail service increasingly problematic, and train wrecks increasing. Amtrak has lost $23 billion in today’s dollars just since 1990—the government runs Amtrak and prevents it from terminating egregiously unprofitable routes.

The Post Office is continually in debt; the postage rate now increases more than once yearly, with more increases already announced, and service is declining.

Medicare will soon be financially bankrupt, and is paying 30% more than necessary for drugs, devices, and physiotherapy because of fraud. A report by the inspector general for the DHHS states, “roughly 70%” of Medicare “payments for fiscal year 2008” should “not have been approved”, while Medicare officials “estimated the error rate at less than 10%, citing its own contractor, AdvancedMed”, but Medicare officials acknowledge” that the agency’s “own rules” are “vague”. Medicare is so easily defrauded exactly because it does not have the administrative cost of oversight preventing fraud; Medicare just willy-nilly pays whatever bills have valid claims numbers. President Obama’s public plan is modeled on Medicare.

The VA hospitals are over budget, and medical-practice abuses abound in the system—the most flagrant and recent (in Philadelphia) being implantation of radon seeds for prostate cancer not in the prostate, but in a large majority of cases, in the rectum and bladder. The VA’s inspector general in 2008 found that only 43% of VA centers have standard operating procedures in place and have properly trained their staffs for using endoscopic equipment. About 10,000 former VA patients were recently warned to get blood tests for HIV and hepatitis because of improperly sterilized equipment. The U.S.
experience with governmental management of anything is not encouraging. If you like the way public housing is managed, you will like a public health-care plan.

Almost all economically advanced countries have abandoned their publicly-run airlines, telephone companies, etc., to private industry in order to achieve lower administrative costs and consumer prices: About 37% of health-care costs for the uninsured went unpaid last year—a total of $42.7 billion. This cost translates to the average U.S. family having to pay an extra $1,017 in premiums last year to compensate for the uninsured.

 Unrealized is that what private medical insurers, such as Aetna or Signa or UnitedHealth Care sell to big employers is not medical insurance, per se, but medical-insurance administrative services: Very large employers pay insurance claims directly from their own funds; they are to this extent self-insured. How can a Medicare-like public-insurance plan possibly have the administrative efficiency of one of these large private medical insurers? It’s acknowledge, also, that Medicare transfers a great deal of its cost to hospitals, uninsured patients, private insurers, and thereby their policy holders (vide supra).

3. As to absence of a profit need making a public vs. a private plan more economical, one need only point to the many nonprofit private-insurance plans that abound, e.g., many Blue Cross-Blue Shield plans. But there is no evidence that they are more efficient and cost saving than for-profit plans. The need to make a profit is a strong stimulus to be more economical and efficient.

The profit motive—the return-on-investment incentive—impels private insurers to screen for waste and fraud, in contrast to Medicare that has no such imperative.

Further, investment incentive encourages private insurers to screen providers for quality performance. Medicare and Medicaid are forbidden by law from excluding substandard providers unless criminally convicted.

4. The economy of scale argument in favor of a public plan is spurious. Aetna services 18 million subscribers, UnitedHealth 25-30 million, and WellPoint more than 35 million subscribers, which is more than Canada’s monopolistic public plan services—Canada’s population is 33.6 million! UnitedHealth services more subscribers than most European countries! There is a definite limit to an economy of scale once a plan services several million people. That the government by ukase can force lower prices is undeniable, but unjust.)

5. A public plan can “negotiate” lower cost for drugs, medical devices, and physician reimbursement than private plans, and can lower premium cost, but only if the government continually infuses new and increasing taxpayer money into its plan and sets onerous and unfair regulations under which private plans have to operate. Private plans will be unable to compete with such a governmental monopsony (only one buyer) on an unequal playing field. A public plan will inevitably come to dominate any market in which it competes. On a level playing field, privately run plans will be more efficient, less expensive, result in more consumer choice, and proffer better medicine than a public plan.

But if the government, with its monopsony power, can reduce premium cost, what’s wrong with that? Would not that be a good? Several unfavorable things, unintended consequences, will result.

First, a free market sets prices that result in the rational allocation of scarce resources—in this case, medical care.
Second, absent profits produced by a competitive market, our pharmaceutical companies, denigrated by some as “Big Pharma”, will disintegrate and be unable to conduct the research and development that have provided a steady flow of innovative and beneficial drugs we—and the rest of the world—have relied on for better health. Some 2,900 drugs are currently under research by U.S. pharmaceutical companies.

Third, it’s predictable that having to work as a government employee at a low wage will be less attractive to those who would otherwise have become doctors and other medical professionals. There already exists a government-acknowledged shortage of internists brought about, at least partly, by their low Medicare reimbursement. The federal government, as it pushes a medical-home concept, currently suggests mending this government-created shortage by paying internists more for their cognitive services.

Fourth, for both patients and physicians government medicine will become increasingly unpopular as current recommendations of the Medicare Payment Advisory Committee (MedPAC) or some such board, become not recommendations but binding diktats: Choice will narrow, waiting for medical attention will increase—the current budget director, Peter Orszag, told Congress last year when he headed the Congressional Budget Office, that spending can be “moderated” if “diffusion of existing costly services were slowed.” [my emphasis]—and medical-care rationing, inevitably, will ensue.

Fifth, public plans are apt to make arbitrary, global, one-size-fits-all decisions that interpose unforeseen restrictions on physician practice and doctor-patient relationships. Witness the current Medicare plan announced (7/1/09) by the Obama administration to boost the reimbursement (+ 6%-8%) of primary-care doctors—presumably to belatedly correct the low reimbursement previously set by Medicare for this group—while arbitrarily and indiscriminately reducing fees to cardiologists generally (-11%), but specifically cutting their echocardiography fee (-42%) and cardiac catheterization fee (-24%), and slashing the imaging-service fees of radiologists (-20%)—the public has an opportunity to comment until Aug.31. To the detriment of medicine and unmindful of the consequences of its actions, state central planning encroaches further.

Sixth, other developed countries are moving away from state-run plans because of mounting costs and dissatisfaction. In the U.K. the present Labour Government has introduced choice in surgery by allowing patients to choose among facilities, often now including private ones. In Canada private-practice is now being allowed. In Sweden the government has turned over medical services to the private sector. The Netherlands now has a private system. Why do we in the U.S. want to experiment with a public plan when the nations that invented and unfavorably experienced it are progressively abandoning it?

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**On The Other Hand...**

**Counterpoint to the preceding article**

*By James Reynolds*

The preceding article comparing the merits of private versus public-based health insurance is thoughtful and leads one to the conclusion that private health care insurance is the way to go. Those of us who have spent over twenty-five years wrestling with “managed care” in the guise of HMOs,
IPAs, and PPOs, are entitled to a healthy skepticism that adding tens of millions of new subscribers to that system will make it all better. To his credit, Dr. Reynolds readily acknowledged in a personal correspondence, that the HMO paradigm had already been proven to be a disaster and that concept was long-ago rejected. Really? Virtually every patient and every physician today is saddled with care management parameters, pre-authorization, in-network vs. out-of-network services, irrational policies for vaccine administration, and multiple other frustrations to the delivery of health care.

My experience in the employ of the private health insurance industry taught me the mantra: Enroll the youngest, healthiest patients (by cherry-picking), direct them to the lowest-cost health providers, and hope that their demise is not lingering. Private health insurance companies are, by definition, captive to the bottom line of profitability.

Dr. Reynolds then asserts that health care could be more efficiently and effectively delivered by the private sector if only there was less government regulation and policies were not state-limited and basic services mandated. Deregulation of the private health care industry? Our experience with deregulation of Wall Street and the home mortgage lenders and the banks would be an instructive precedent.

Acknowledging the political clout of the health care insurance industry, there is a strong likelihood that their interests will be addressed. But it is hoped that adequate, universal, evidence-based care parameters can be implemented. We Americans deserve and expect a health care delivery system which is efficient as well as effective.

Readers with additional opinions are encouraged to join the debate.

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**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/TH-E-AAP1, or send an e-mail to membership@aap.org.
Letter to the Editor:

As a long time member of the Section for Senior Members of the AAP, I wish to share that I have just completed my term as the President of the County Medical Society. I was the first pediatrician to occupy this office.

It was an eye-opening experience dealing continually with County and State legislators. Their lack of knowledge concerning legislation they were dealing with was mind-boggling.

I specifically want to share with you, with acknowledgement to David Letterman, a list of the Top Ten things that bother me most about practicing medicine in 2009.

10. Many of the drugs in my armamentarium are excluded (not preferred) in the HMO formularies.
8. Being pressured to rush through too many patient encounters at the expense of getting to know them, their lifestyles, their hobbies, their aspirations, etc.
7. The two-tiered medical system in the USA with 25 million underinsured, and 46 million non-insured including 9 million children.
6. Lack of or poor communication between patient and physician, government and physician, and physician and physician.
5. The art of medicine is being replaced by the science of medicine instead of sharing the spotlight.
4. Vaccines and mercury are taking the blame for the increase in prevalence of autism and autistic spectrum diseases – an example of false science.
3. Loss of prestige both for the individual physician as well as for the practice of medicine. In general, no longer is medicine the top choice of high school seniors.
2. Private insurers run roughshod over patients, ancillary health care workers, and physicians with no agency in Albany to provide oversight.
1. Our health care system is broken, and we have no substantial replacement for it on the horizon.

Very truly yours,

Gerald Ente, MD, FAAP, FICP

For more information or to join the section . . .
visit our website at: www.aap.org/sections/seniormembers/
The health-care reform envisioned by President Obama and the House will almost certainly cause an increase in seniors’ Medicare premiums. This would have happened de minimus anyway, but with ObamaCare premiums will rise substantially in order to offset the $1-$2 trillion cost of the new entitlement. Medicare services will predictably decline. The focus now in Washington is on saving money to fund ObamaCare by cutting Medicare services: subjecting such services and drugs to an efficacy panel review, extending the age for Medicare enrollment, doing away with the Medicare Advantage program in which 20% of seniors are currently enrolled, subjecting Medicare services to a financial limit on the basis of a cost-per-year-of-life-saved criterion, possibly means-testing Medicare, lowering reimbursement for home and nursing-home care, etc. Obama himself has stated he hopes that at least $550 billion dollars can be saved by making Medicare cuts and changes. Former Medicare chief, Gail Walinsky, has stated that the only way to get immediate insurance for the uninsured is by cutting Medicare services. Under ObamaCare insuring the currently uninsured will be at the expense of the nation’s elders: robbing Peter to pay Paul. This scenario is not to say that Medicare does not need major revision: It would work more cheaply, efficiently, and innovatively if it were under private rather than governmental aegis—just as would almost any endeavor possibly excepting war—but Medicare reform is currently not on Congress’s agenda.

The Brobdingnagian budget deficit—currently 13% of GDP—which is growing exponentially as Congress spends not only on “Stimulus”, buying automobile companies, banks, and mortgages, but also buying “clunkers” and private jets for congressmen. This deficit and a major deficit increase due to proposed ObamaCare has finally gotten the public’s and our legislators’ attention. Resistance to this major growing entitlement has focused attention on how to do this as cheaply and efficiently as possible.

Paying for health care for the uninsured can be done best by using private medical insurance. Just think of any government-run program that is under budget and runs more cheaply than the Congressional Budget Office estimated at its outset. The only one that comes to my mind is the Medicare Advantage program. The CBO estimated it would cost much more than it did; it actually came out under budget! But although a government program, it is run by private insurers and drug companies essentially free of government interference except for continuing threats to put it out of business. ObamaCare is modeled on Medicare, but the fraud in Medicare and Medicaid is colossal. Safeway Stores has recently demonstrated how private enterprise can successfully cut drug and medical-insurance cost while retaining employee satisfaction with their care and making them healthier. The lower premium cost Safeway offers for participation in preventive care is the lure. Wal-Mart charges employees only $4.00 for any generic drug prescription.

Mr. Obama demonizes the private insurance market and wants the government, via a “public” plan, to “keep them honest”. He’s actually talking about the relatively small individual insurance market segment with 15 million insured, not the 90+ % of the insurance market that is government subsidized through businesses tax credits. The tax-unsubsidized small individual market is unstable—most policy holders are insured for less than 24 months as they move between jobs, thus making maintenance of a large risk pool of insured difficult, thereby increasing policy cost. Sensibly, if individuals could deduct their insurance cost, the individual market would be less vulnerable to undesirable restrictions, more risk-predictable for insurers, and less expensive for policyhold-

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What we need to do to insure the uninsured in the nation's precarious financial situation and avoid reductions in needed Medicare services inevitably promised by ObamaCare is:

**First**: Determine who legitimately is uninsured, i.e., is poor enough—*circa* $50,000 of income for a family of four/year, perhaps—to be unable to afford basic insurance and a citizen. The rest—perhaps as many as 38 million of the purported pre-recession 45-46 million—should be excluded from the entitlement.

**Second**: Entitle the poor to a private health savings account (HAS) of their choice, but with a government-mandated provision to spend up to the deductible amount, and a requisite out-of-pocket nugatory co-payment, in order to obtain medical care—co-payments for children should not be required: this is desirable because children can't be individually responsible—fortunately, medical care of children is relatively quite cheap. The poor would thus be empowered to choose their own care and, being personally responsible for a co-payment, would be inclined to use their insurance wisely, economically, thus increasing competition among care providers.

**Third**: Remove state restrictions on purchasing medical insurance across state lines. Such restrictions result in insurance costing two or three times as much in some states as in others. Congress could do this under the commerce clause of the constitution. This would result in the demise of multitudinous non-essential state mandates from insurance companies and would nationalize competition among insurers—there currently are 1,300 private medical insurers in the U.S.

**Fourth**: Require congress not to interfere with private medical insurers except to assure that they deal honestly, forthrightly, fairly with the public, and provide what their policies stipulate. The federal government should not dictate private-policy mandates, should not, e.g., require “community rating” (CR)—in fairness the young should not pay the same premium as the old—or “guaranteed issue” (GI)—insurance should be purchased before, not at the time of, illness—See no. 10 below. States having GI have by far the highest insurance premiums. Only five states now have it: ME, MA, NJ, NY, & VT. Two, NH & KY, have repealed GI due to insurance companies fleeing their states. CR is most unfair to young, healthy, low-risk people. Three states have both GI and CR: NY, NJ, & MA; unsurprisingly they have the highest individual insurance premiums among the 50 states, averaging two or three times higher than in the other 47 states.

**Fifth**: Require the poor to choose a primary care provider, a “medical home”, but be able to change their home should they so desire, and that they first seek care there, except for true emergencies as certified by an emergency physician. A small financial penalty should be exacted if this requirement is infringed. The decrease in emergency-department visits would result in a substantial saving.

**Sixth**: Adjudicate malpractice cases by state independent panels of medical experts with awards based on actual medical expenses and cap additional awards. Lawyers, who by contingency fees get 30% of malpractice awards, and jurors and judges without the medical expertise to judge malpractice, would thus be excluded from the process. We spend an unconscionable amount—estimated at up to 25% of medical spending—each year in the form of malpractice awards and the practice of defensive medicine.

**Seventh**: Repeal ERISA (Employee Retirement Income Security Act). No longer give businesses tax deductions for the purchase of employee medical insurance. Rather, give individuals tax credits or deductions instead. This is only fair.
Tying medical insurance to jobs is irrational, counterproductive, and originated from government mismanagement during WW II. U. S. business relieved of the responsibility for providing employee medical insurance would be more competitive vis-à-vis international firms, employees’ medical insurance would be portable, and their wages would rise. Individuals, their moral hazard decreased, would deal directly with their insurers and physicians. Individual responsibility for one’s medical care would encourage “shopping” for the best care at the best price. Individuals would be empowered. Physicians would be more responsive since patients could more easily switch doctors. The federal government should make it easier for groups, societies, associations, business federations, labor unions, Kiwanis Clubs, etc. to form risk pools to buy cheaper government-mandate-free insurance. The price of care would decline. About 177 million people (62% of adults under 65) currently get their health insurance through their jobs.

Eighth: The federal government, via a business tax advantage or rebate, should encourage private medical insurers to reduce premiums for those insured who get annual physicals, lose weight if obese, reduce hypertension, reduce cholesterol, don’t smoke, exercise, etc. A model is the Safeway Corporation’s great success with such a program for its employees. Lower-premium-induced prevention would result in more healthy Americans and would reduce medical cost by avoiding or ameliorating the major expense of delayed disease discovery and chronic disease. It’s disability rather than age that causes a major increase in medical-care cost.

Ninth: Congress should facilitate and encourage Americans to participate in HSAs by offering additional tax deduction for such medical insurance. Congress should raise the limit on contributions to HSAs. HSAs would foster saving for future medical care, paying lower premiums for high-deductible, lower-cost medical insurance, using insurance for its basic intention, i.e., paying for very costly, not-easily-affordable care rather than paying for first-dollar and easily affordable care.

Tenth: Require every adult citizen to have health insurance: If everyone has a “right” to healthcare, everyone should be required to buy insurance if not too poor. The poor would qualify for a government health-care HSA as stated above (no. 2). Using unregulated private rather than government insurance would allow choice; insurance could be tailored to need and circumstance rather than having to endure the one-size-fits-all and bureaucratic regulation that government insurance entails. The non-poor young, e.g., would be able to purchase the cheaper insurance they need, and would do especially well with HSAs. The government should assist by making it easier for people to comparison-shop for their private health-care insurance by requiring full public disclosure and explanation of insurance offered to the public.

With the ten changes advocated above, Medicare services would not be cut. One would hope, however, that Medicare will itself be sensibly reformed so it will not go broke in a few years ahead.

Cicero’s advice given 2,064 years ago, in 55 B.C., eerily applies today: “The budget should be balanced, the Treasury should be refilled, public debt should be reduced, the arrogance of officialdom should be tempered and controlled, and the assistance to foreign lands should be curtailed lest Rome become bankrupt. People must again learn to work, instead of living on public assistance.” One can but recall the fate of Rome in 376 A.D., heedless of Cicero’s prescient advice.
And Some Thoughts from Bob Grayson

I am continually impressed and amazed by the disparity in the dollars billed to Medicare by physicians and hospitals as compared to the dollars actually approved and paid. My internist, ophthalmologist and others really do receive an inadequate amount for their services so that they have to perform additional—arguably unnecessary—procedures to make a little (or a lot) more income. Hey say the reason for the two levels of charges is so that non-insured can be billed for the larger amount. I wonder if the economists and bean counters working in Congress on our health bills use the dollars billed rather than the dollars allowed in estimating our health costs. I hope some good comes of the promised health reform. I favor a combination of government insurance and a private insurance system, with a choice between the two, and with a total elimination of HMO plans. Let the battle begin, and in a few years we will be able to evaluate which is best for this country.

Song
By John Donne
Submitted by Avrum L. Katcher, MD, FAAP

Go and catch a falling star
Get with child mandrake root,
Tell me where all past years are,
Or who cleft the devil's foot.
Teach me to hear mermaids singing,
Or to keep off envy's stinging,
And find
What wind
Serves t'advance an honest mind.

If thou be'st born to strange sights,
Things invisible to see,
Ride ten thousand days and nights
Till age snow white hairs on thee;
Thou, when thou return'st, wilt tell me
All strange wonders that befell thee,
And swear
Nowhere
Lives a woman true, and fair.

If thou find'st one, let me know;
Such a pilgrimage were sweet—
Yet do not; I would not go
Thou at next door we might meet.
Though she were true when you met her,
And last till you write your letter,
Yet she
Will be
False ere I come, to two or three.
As I was recently dealing with a family matter with somewhat similar circumstances, the story of the following event came to my mind. It took place when I was in solo practice in Germantown, Philadelphia, in the mid 1950s, a year or so after I had returned home from two years of service as an Army Medic, the first year and a half in Korea followed by 6 months at Ft. Bragg. Before Stel and I met.

One of the patients for whom I cared was a child of about 2 or 3 years of age, probably a boy. I knew the parents were separated and shared custody. The father came to see me one day, to talk about this. They had formerly lived across the Delaware River, in the New Hope, Pennsylvania area—can’t remember just where. When the parents separated, and divorced, it was agreed that there would be some shared custody: the father had the child either every weekend or every other weekend—can’t remember details. Father and child (when he was with his father) moved in to the grandparents’ home.

Father explained that the mother now was not happy about the arrangement, and wanted sole custody of the child. Her lawyer had requested a review by the judge, over in New Hope. The father wanted me to appear in court and testify that the child had a good home with his Dad and grandparents. I agreed, but said I’d need to see the entire family at the grandparents’ home, so that I could speak in court with some authority. Arrangements were made; I came to the home and observed for several hours. All went well, I interviewed them all. It seemed clear that this was a loving family situation. Had no trouble in visualizing what to say in court.

A few weeks later, a date was set, and I appeared. Mother had not only a lawyer but a doctor to testify on her behalf as well. My turn came; I was sworn in, and gave a careful report about what seemed to be a loving family situation, with no evidence of any trouble.

Judge gave a ruling immediately. He said that there was no information that would lead him to change the prior order about custody, and the existing rules should be maintained. But then he added an additional set of comments. Can’t remember just what the wording was, but it went something like this: “I wish to say to both parents, that it is of great importance that they realize that eventually the problems described here will be brought for review to a court much higher, and more important, than any available in this jurisdiction, or in the State of Pennsylvania, or indeed anywhere on this planet. And when this happens you will be brought before that court, and find yourselves having to account for your behavior to the highest degree. I strongly advise you to cease this strife and consider how you will explain yourselves before that Judge.”

This story is presented to you experienced readers in the hope that it may provide some food for thought and a review of how much “progress” has been made in the past fifty years.

A Recollection from Fifty Years Ago

By Avrum L. Katcher, MD, FAAP
Murphy’s Law Revisited

1. Law of Mechanical Repair – If you take something apart to repair it several times, eventually you will have enough parts for two of the same item.

1a. Law of Mechanical Repair - After your hands become coated with grease, your nose will begin to itch and you’ll have the urge to urinate.

2. Law of Gravity - Any tool, when dropped, will roll to the least accessible corner.

3. Law of Probability - The probability of being watched is directly proportional to the stupidity of your act.

4. Law of Random Numbers - If you dial a wrong number, you never get a busy signal and someone always answers.

5. Law of the Alibi - If you tell the boss you were late for work because you had a flat tire, the very next morning you will have a flat tire.

6. Law of Imminent Variation - If you change traffic lanes, the one you were in will always move faster than the one you are in now.

7. Law of the Bath - When the body is fully immersed in water, the telephone will ring.

8. Law of Close Encounters - The probability of meeting someone you know increases dramatically when you are with someone you don't want to be seen with.

9. Law of Inverse Result - When you try to prove to someone that a machine won’t work, it will.

10. Law of Biomechanics - The severity of the itch is inversely proportional to the ability to reach it.

11. Law of the Theater - At any event, the people whose seats are furthest from the aisle arrive last.

12. The Starbucks Law - As soon as you sit down to a cup of hot coffee, your boss will ask you to do something which will last until the coffee is cold.

13. Murphy’s Law of Lockers - If there are only two people in a locker room, they will have adjacent lockers.

14. Law of Physical Surfaces - The probability of an open-faced jelly sandwich landing face down is directly proportional to the value and delicacy of the carpet.

15. Law of Logical Argument - Anything is possible if you don’t know what you are talking about.

16. Brown’s Law of Physical Appearance - If the clothes fit, they’re the wrong color.

17. Oliver’s Law of Rhetoric - A closed mouth admits no feet.

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18. Wilson's Law of Commercial Marketing - As soon as you find a product that you really like, they will stop making it

19. Law of Doctors’ Visits - If you don’t feel well, make an appointment to go to the doctor; by the time you get there, you’ll feel better.

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**Proud to be a Pediatrician**

*By Stanford A. Singer MD, FAAP*

I was filling in the blanks on an application and came to the familiar space labeled “occupation”. Without hesitating, I wrote “pediatrician”. I know that I could have written “physician” or “medical doctor”. Why not write “pediatrician”? To me, it’s a great source of pride.

At this point in my career it’s easier to see the fruits of my labor than it was when I was younger.

There are presently a number of young physicians practicing in my community who tell me that one of the reasons they chose a career in medicine was some influence I had on them while they were my patients. I don’t remember being involved in any sort of recruiting campaign. Nonetheless, I inadvertently served as a role model.

Frequently, when I’m out in public, a waiter or store clerk will recognize me and remind me that they were once a patient in my office. It’s a pleasure to chat with them and find out what they’ve accomplished in their lives, although I still see myself as quite young and often wonder how these kids grew up so fast.

One of the delights of my life is seeing “grand-patients”. These are children of parents who were once my patients. Every one of these encounters is filled with stories and memories of what I did or said at the time these young parents were under my care. It’s obvious to me now that, as their pediatrician, I not only cared for their health, but provided some long lasting influence. It’s also very gratifying to see the trust and confidence reflected in their stories.

Recently, one of my nurses had a chance meeting with a woman whose grown children were once my patients. Tragically, she lost a young son in a drowning accident. She said that she would have never gotten through that terrible experience without my help. My counsel as the family’s pediatrician was an essential element in their healing process.

I know that all of you have similar tales to tell. We seniors can appreciate the impact we have had on our communities. We have a part in the traditions and legends of many families. We understand that we have had lasting influence on some children who later became leaders in business, government, education, and philanthropy.

We’ve spent part of every day preventing Polio, Tetanus, and Meningitis and understand that this does not have the dramatic impact of an emergency room cardiac resuscitation. We know that taking a call from anxious parents in the middle of the night is not as glamorous as open heart surgery. We realize that counseling parents about infant nutrition will never be the subject of a successful TV series. Yet, we all have experienced great satisfaction in the practice of pediatrics.

The mission statement of the American Academy of Pediatrics focuses on advocating for children and not applauding and promoting pediatricians. I think I know why. We’re the guys and gals in the white hats. We prefer modesty to boasting. We are the group who always writes in our policy statements “consult your health care

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The American Academy of Pediatrics • Historical Archives Advisory Committee

Who Was Hezikiah Beardsley and Why Was the Connecticut Chapter of the AAP Named After Him?

By Howard A. Pearson, MD, FAAP

The Hezekiah Beardsley Connecticut Chapter of the American Academy of Pediatrics is the only one of 59 state or regional chapters of the AAP that bears the name of a person. There was a Hezekiah Beardsley Pediatric Club in Connecticut as early as 1935 that later became the Hezekiah Beardsley Pediatric Section of the Connecticut Medical Society. When the Connecticut Chapter of the AAP was founded in 1948, the Hezekiah Beardsley eponym of the pre-existing associations was retained.

Hezekiah Beardsley was born in Stratford, Connecticut in 1748. He had no formal medical education, for indeed there were no schools of medicine in Connecticut until the Medical Institution at Yale College opened in 1813. He became a pharmacist and physician, probably through apprenticeships, and practiced both professions in Southington and Hartford between 1778 and 1782. In 1782 he moved to New Haven where he practiced medicine and opened an apothecary shop on Chapel Street between Church and Orange Streets. He died of consumption in 1790 and was buried on the New Haven Green. Later his headstone was moved to the Grove Street Cemetery. Portraits of Hezikiah and his wife painted by Beardsley Limmer, a local artist, hang in the Yale University Art Gallery.

Addendum:

Shortly after I wrote this piece, I received a letter from a former patient who is now the mother of three children. I quote from the letter: “Your name came up in a conversation I had with my mom the other day and I decided to write you a letter to let you know that I still remember your kindness to this day... I never forget those who’ve had a good influence on my life, and I want you to know you are one of the special people in my heart and I will never forget you.”

What more needs to be said?
Beardsley was one of thirteen physicians who founded the Medical Society of New Haven County in 1784. One of the stated purposes of the Society was “collecting and preserving useful papers relative to the practice of medicine.” Only four years later in 1788, the Society published *Cases and Observations: by the Medical Society of New Haven County in the State of Connecticut*. This volume, copies of which are preserved in the historical library of the Yale School of Medicine, was the first published transactions of a county medical society in America.

The most renowned of 26 reports in the Transactions was contributed by Hezekiah Beardsley. He described a male infant, son of a Southington farmer, who had the onset of “constant puking in the first week of life.” The child continued to immediately vomit almost everything that he was fed. Beardsley first examined the child in Southington when he was two years of age and noted that he was “lean with a pale countenance and wrinkled skin like that of old people.” Beardsley, on the basis of his clinical observations and examinations, diagnosed the child as having a “scirrosity in the pylorus.” The child died when he was five years old. Beardsley, who had moved to New Haven, did not hear of the death until two days later. He went immediately to Southington to perform an autopsy, arriving just before the burial service. He wrote:

“The later period, the almost intolerable stench, and the impatience of the people who had collected for the funeral prevented so thorough an examination of the body as might otherwise have been made...The stomach was unusually large, the coats were about the thickness of a hog’s bladder. The pylorus was invested with a hard, compact substance or scirrosity which completely obstructed the passage into the duodenum, to admit with greatest difficulty the finest fluid.”

Beardsley’s report was reprinted in its entirety in the 1903 Archive of Pediatrics by Sir William Osler who considered himself a pediatric practitioner and, in fact, was a founding member of the American Pediatric Society in 1888. Dr. Osler wrote that Beardsley had “completely and accurately” described the condition of hypertrophic pyloric stenosis of infancy. Although subsequent historical research has uncovered earlier possible cases from England, Beardsley’s report is notable for its clinical and pathological correlations and, of course, for its uniquely American origin.

### 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.
Steven Wright is the erudite scientist who once said: “I woke up one morning and all of my stuff had been stolen... and replaced by exact duplicates!” His mind tends to see things a bit differently than the rest of us mortals. Here are some of his gems:

1. I’d kill for a Nobel Peace Prize.
2. Borrow money from pessimists - they don’t expect it back.
3. Half the people you know are below average.
4. 99% of lawyers give the rest a bad name.
5. 42.7% of all statistics are made up on the spot.
6. A conscience is what hurts when all your other parts feel so good.
7. A clear conscience is usually the sign of a bad memory.
8. If you want the rainbow, you gotta put up with the rain.
9. All those who believe in psychic kinesis, raise my hand.
10. The early bird may get the worm, but the second mouse gets the cheese.
11. I almost had a psychic girlfriend, but she left me before we met.
12. OK, so what’s the speed of dark?
13. How do you tell when you’re out of invisible ink?
14. If everything seems to be going well, you have obviously overlooked something.
15. Depression is merely anger without enthusiasm.
16. When everything is coming your way, you’re in the wrong lane.
17. Ambition is a poor excuse for not having enough sense to be lazy.
18. Hard work pays off in the future, laziness pays off now.
19. I intend to live forever; so far, so good.
20. If Barbie is so popular, why do you have to buy her friends?
21. Eagles may soar, but weasels don’t get sucked into jet engines.
22. What happens if you get scared half to death twice?
23. My mechanic told me, “I couldn’t repair your brakes, so I made your horn louder.”
24. Why do psychics have to ask you for your name?
25. If at first you don’t succeed, destroy all evidence that you tried.
26. A conclusion is the place where you got tired of thinking.
27. Experience is something you don’t get until just after you need it.
28. The hardness of the butter is proportional to the softness of the bread.
29. To steal ideas from one person is plagiarism; to steal from many is research.
30. The problem with the gene pool is that there is no lifeguard.
31. The sooner you fall behind, the more time you’ll have to catch up.
32. The colder the x-ray table, the more of your body is required to be on it.
33. Everyone has a photographic memory; some just don’t have film.
34. If your car could travel at the speed of light, would your headlights work?
35. What is an insomniac, agnostic, dyslexic? A person who stays up all night wondering is there is a DOG.
36. I put instant coffee in my microwave and went back in time.
Unprecedented Global Aging Examined in New Census Bureau Report Commissioned by the National Institute on Aging

Re-printed from the National Institute of Health (NIH) News

The average age of the world’s population is increasing at an unprecedented rate. The number of people worldwide age 65 and older is estimated at 506 million as of midyear 2008; by 2040, that number will hit 1.3 billion. Thus, in just over 30 years, the proportion of older people will double from 7 percent to 14 percent of the total world population, according to a new report, “An Aging World: 2008.”

The report examines the demographic and socioeconomic trends accompanying this phenomenon. It was commissioned by the National Institute on Aging (NIA), part of the National Institutes of Health, and produced by the U.S. Census Bureau. It was released today by the Census Bureau.

“The world’s population of people over age 65 is growing rapidly, and with it will come a number of challenges and opportunities,” said NIA Director Richard J. Hodes, M.D. “NIA and our partners at Census are committed to providing the best data possible so that we can better understand the course of population aging and its implications.”


“Aging is affecting every country in every part of the world,” said Richard Suzman, Ph.D., director of NIA’s Division of Behavioral and Social Research. “While there are important differences between developed and developing countries, global aging is changing the social and economic nature of the planet and presenting difficult challenges. The fact that, within 10 years, for the first time in human history there will be more people aged 65 and older than children under 5 in the world underlines the extent of this change.”

Highlights of the report include:

— While developed nations have relatively high proportions of people aged 65 and older, the most rapid increases in the older population are in the developing world. The current rate of growth of the older population in developing countries is more than double that in developed countries, and is also double that of the total world population.

— As of 2008, 62 percent (313 million) of the world’s people aged 65 and older lived in developing countries. By 2040, today’s developing countries are likely to be home to more than 1 billion people aged 65 and over, 76 percent of the projected world total.

— The oldest old, people aged 80 and older, are the fastest growing portion of the total population in many countries. Globally, the oldest old population is projected to increase 233 percent between 2008 and 2040, compared with 160 percent for the population aged 65 and over and 33 percent for the total population of all ages.

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Things are spiraling out of control. I think I have become lost in a world of electronic madness.

One of my sons informed me this week that my cell phone has become obsolete and I must head down to the cell phone store and get a phone that is contemporary with the time.

I pointed out that the fancy razor/slimline phone with camera built in that he made me trade my perfectly good flip-top Motorola cell phone for two years ago still works perfectly fine. Well, except for the camera thing. Never could figure that out. Even the few times I actually did take pictures I couldn’t figure what to do with them and gave up.

That is except when I would push the wrong button and take a video of the ceiling or my feet.

Seems the issue is that I am unable to text with the tiny little 3 character buttons. “Hi, son,” would come out looking like, “Gh Qmo.” My grandkids have even spoken to my wife about Poppa’s crazy text messages. Give me a break. Whatever happened to actually talking on a phone? Isn’t that what they were invented for?

They want me to get one of those phones that you can turn upside down and sideways and has a typewriter keyboard with keys about one-eighth the size of my pinky finger.

Note from an Electronically-Challenged Senior

The report was prepared by Kevin Kinsella and Wan He of the International Programs Center in the Population Division of the Census Bureau. Research for and productions of the report were supported under an interagency agreement with the NIA’s Behavioral and Social Research Division.


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>.

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One of my four sons is a realtor whose real occupation is fly fishing. “Way to go, son.” Or in my text language, “Xbz um Io, rmo.”

We were floating the Yakima River in his guide-quality drift boat south of Ellensburg, Washington. We were miles from anything remotely resembling civilization. Rock canyon walls were on either side of us. Bear with me as I try to explain this strange thing.

His “Blackberry” rang. It was blue and I asked him why it wasn’t called a Blueberry. He shook his head with that “dealing with an elder” despair look I get a lot these days. It was another realtor who called to say that the sellers he represented had agreed to my son’s client’s changes and he had the signed documents in hand.

My son told him to FAX the papers to his office and he would get them signed and faxed back to close the deal that morning. A minute later the phone rang and he hit a few buttons and looked over the FAX, now on the Yakima River with us.

He then called his clients and told them he was faxing the papers to them to sign and asked them to FAX them back to his office. While he was waiting, he hooked into a fat rainbow and was just releasing this 22-inch beauty as his phone rang again with the signed FAX from his clients.

He called the other realtor and told him he was sending the signed papers back by FAX. The deal was closed. He smiled and just said, “You are a little behind the times, Dad.” I guess I am.

I thought about the sixty million dollar a year business I ran with 1800 employees, all without a Blackberry that played music, took videos, pictures and communicated with Facebook and Twitter.

I signed up under duress for Twitter and Facebook, so my seven kids, their spouses, 13 grandkids and 2 great grand kids could communicate with me in the modern way. I figured I could handle something as simple as Twitter with only 140 characters of space.

That was before one of my grandkids hooked me up for Tweeter, Tweetree, Twirl, Twitterfon, Tweetie and Twitterific Tweetdeck, Twitpix and something that sends every message to my cell phone and every other program within the texting world.

My phone was beeping every three minutes with the details of everything except the bowel movements of the entire next generation. I am not ready to live like this. I keep my cell phone in the garage in my golf bag.

The kids bought me a GPS for my last birthday because they say I get lost every now and then going over to the grocery store or library. I keep that in a box under my tool bench with the Bluetooth (its red) phone I am supposed to use when I drive. I wore it once and was standing in line at Barnes and Nobles talking to my wife as everyone in the nearest 50 yards was glaring at me. Seems I have to take my hearing aid out to use it and got a little loud.

I mean the GPS looked pretty smart on my dash board, but the lady inside was the most annoying, rudest person I had run into in a long time. Every 10 minutes, she would sarcastically say, “Re-calc-ulating.” You would think that she could be nicer. It was like she could barely tolerate me. She would let go with a deep sigh and then tell me to make a U-turn at the next light. Then when I would make a right turn instead, it was not good.

When I get really lost now, I call my wife and tell her the name of the cross streets and while she is starting to develop the same tone as Gypsy, the GPS lady, at least she loves me.

To be perfectly frank, I am still trying to learn...
how to use the cordless phones in our house. We have had them for 4 years, but I still haven’t figured out how I can lose three phones all at once and have to run around digging under chair cushions and checking bathrooms and the dirty laundry baskets when the phone rings.

The world is just getting too complex for me. They even mess me up every time I go to the grocery store. You would think they could settle on something themselves but this sudden “paper or plastic?” every time I check out just knocks me for a loop.

I bought some of those cloth re-usable bags to avoid looking confused but never remember to take them in with me.

Now I toss it back to them. When they ask me, “paper or plastic?” I just say, “Doesn’t matter to me. I am bi-sacksual.” Then it’s their turn to stare at me with a blank look.

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**The Circumlocution Office**

*Submitted by Avrum L. Katcher, MD, FAAP*

The possible relevance to our current version of United States bureaucracy came to mind just the other evening, when I was reading a novel by Charles Dickens, *Little Dorrit*, first published in 1857, and found, in typical Dickensian language, vastly funny, but also penetrating to the bone, a critique of how the political system of our own country has been working, and perhaps in some ways, worsening progressively. Written more than a hundred and fifty years ago, here is a satiric description of the governing beaurocracy of Britain at that time, the which, if you read with only a modicum of attention, you will find applicable to ever so many features of our own political system, national, state and local. Jim, I hate to say it, but Dickens had a point. The following quote commences on page 100, opening Chapter 10:

“Containing the Whole Science of Government The Circumlocution Office was (as everybody knows without being told) the most important Department under Government. No public business of any kind could possibly be done at any time without the acquiescence of the Circumlocution Office. Its finger was in the largest public pie, and in the smallest public tart. It was equally impossible to do the plainest right, and undo the plainest wrong without the express authority of the Circumlocution Office. If another Gunpowder Plot had been discovered half an hour before the lighting of the match, nobody would have been justified in saving the parliament until there had been half a score of boards, half a bushel of minutes, several stacks of official memoranda, and a family-vault full of ungrammatical correspondence, on the part of Circumlocution Office. This glorious establishment had been early in the field, when the one sublime principle involving the difficult art of governing a country, was first distinctly revealed to statesmen. It had been foremost to study that bright revelation and to carry its shining influence through the whole of the official proceedings. Whatever was required to be done, the Circumlocution Office was beforehand with all the public departments in the art of perceiving—HOW NOT TO DO IT. Through this delicate perception, through the tact with which it invariably seized it, and through the genius with which it always acted on it, the Circumlocution Office had risen to overtop all the public departments; and the public condition had risen to be—what it was. It is true that how not to do it was the great study and object of all public departments and professional politicians all round the Circumlocution Office. It is true that every new premier and every new government, coming in because they had upheld a certain thing as necessary to be done, were no sooner come in than

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they applied their utmost facilities to discovering How not to do it. It is true that from the moment when a general election was over, every returned man who had been raving on hustings because it hadn’t been done, and who had been asking the friends of the honorable gentleman in the opposite interest on pain of impeachment to tell him why it hadn’t been done, and who had been asserting that it must be done, and who had been pledging himself that it should be done, began to devise, How it was not to be done. It is true that the debates of both Houses [of Parliament] the whole session through, uniformly tended to the protracted deliberation, how not to do it....All this is true, but the Circumlocution Office went beyond it. Because the Circumlocution Office went on mechanically, every day, keeping this wonderful, all-sufficient wheel of statesmanship, how not to do it, in motion.”

It would be possible for some pages from the book to be applied to any number of local governments here in New Jersey, where I live. It would also be possible—but enough of that. Look round you, at your own local government, your professional organizations of all sorts...need I say more?

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**In Perfect Health**

*By Charlie Anderson*

In order to understand this story, it helps to know a little about me. I am 74 years old, very active, still working two days a week, and have hobbies of skiing, golf, and hiking. In the past 5 years I have had a knee replacement, back surgery for spinal stenosis, laser treatment of my eyes to prevent glaucoma, and surgery on my hand for carpal tunnel. I take ibuprofen for my aching body and joints, which raises my blood pressure, and I take Hydrodiuril to lower the blood pressure. My cholesterol is well controlled with Crestor and I go to the Spa most mornings to stretch and work out.

I buy fresh eggs from a neighbor who raises chickens, sheep, and grandchildren, all of whom run around the yard together. He is 78 years old, 5 ft. 3 in. tall, and 250 lbs. He has Type II Diabetes, several missing teeth, and a bum hip so he can walk only a few yards at a time. He used to be a shepherd, spent his summers in the mountains tending sheep, and has had a good life in spite of having only a third grade education.

I stopped by for eggs one morning, and after giving me the eggs, he reached up into a tree and picked two apricots. We each ate one, and as I spit out the seed I saw him swallow his seed. He looked at me with a puzzled expression. “You don’t eat the seed?” “No,” I said laughingly. He went on: “You know, it cures cancer! I had cancer of the prostate 10 years ago, and I just went to my doctor for a check up. He did an exam, and blood test, and told me: ‘You are in perfect health! Cancer: Zero, Cholesterol: Zero!’” He gave me a big grin, “I am in Perfect Health.”

Later that day as I was musing about my own problems of aging, a friend came up to me and asked: “Charlie, I haven’t seen you in a long while. How are you?” I couldn’t help but smile as I answered: “I’m in Perfect Health.”
You realize that you're getting old when...

- A 30-year mortgage sounds like a pretty clever scam.
- You no longer consider staying under the speed limit a challenge.
- Your supply of brain cells is finally down to a manageable size.
- People no longer view you as a hypochondriac.
- In a hostage situation, you are likely to be released first.
- You know all the answers, but nobody asks you the questions.
- The little old gray-haired lady you help across the street is your wife.
- You turn out the light for economic reasons.
- Your children begin to look middle-aged.
- You have too much room in the house and not enough room in the medicine cabinet.
- You can live without sex, but not without glasses.
- Your back goes out more than you do.
- You quit trying to hold your stomach in, no matter who walks into the room.
- Your arms are almost too short to read the newspaper.
- “Getting a little action” means you don't need to take a laxative.
- You are cautioned to slow down by the doctor instead of by the police.
- Your secrets are safe with your friends because they can't remember them either.
- It takes longer to rest than it did to get tired.
- You're asleep, but others worry you're dead.
- You give up all your bad habits and you still don't feel good.
- You sing along with the elevator music.
- You enjoy hearing about other people's operations.
- People call at 9:00 p.m. and ask, “Did I wake you?”
- You answer questions with, “Because I said so!”
- Your childhood toys are now in a museum.
- You can't remember the last time you laid on the floor to watch TV.
- Your ears are hairier than your head.
- You and your teeth don't sleep together.

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You realize that you’re getting old when . . . Continued from Page 26

• Your try to straighten out the wrinkles in your socks and discover you aren’t wearing any.
• Your top three favorite pastimes involve sleep.
• Medicare says you’re too old for their coverage.
• You can’t be tried by a jury of your peers because there are none.
• It takes two tries to get up from the couch.
• There’s nothing left to learn the hard way.
• Everyone is happy to give you a ride because they don’t want you behind the wheel.
• Your new easy chair has more options than your car.
• You sit in a rocking chair and can’t get it going.
• Your little black book only contains names ending in M.D.
• You wonder how you could be over the hill when you don’t remember being on top of it.
• A passing funeral procession pauses to see if you need a lift.
• Everything hurts, and what doesn’t hurt doesn’t work.
• Your knees buckle and your belt won’t.
• You don’t care where your wife goes, just so you don’t have to go along.
• The clothes you’ve put away until they come back in style have come back in style.
• The pharmacist has become your new best friend.
• Your idea of weight lifting is standing up.

It takes twice as long to look half as good.

“Getting lucky” means you find your car in the parking lot.

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/.
Having arrived at the magic four score and ten, I am responding to a long time resolution to put down my memories of these many years. This is not intended to be a biography but only my commentary on events of these years. I will attempt to divide it into three parts: my life, the practice of pediatrics, and world happenings.

My Life

I was born on March 12, 1919 in Passaic NJ, the first-born of my father, a dentist, and my mother, a secretary in a small insurance office. My mother was a victim of the influenza pandemic while pregnant with me. I have been told that she was very sick, that the pregnancy was threatened by the illness, and the only medication available at that time was whiskey prn. Perhaps an intrauterine habit was formed so that for most of my adult life I have enjoyed a vodka tonic before dinner (but only one).

The pre-teen years were generally uneventful except for the usual childhood illnesses. Whooping cough prevented me from being the ring bearer at my aunt's wedding. They were afraid I would start coughing and drop the ring, and perhaps lose it. Chicken pox was uneventful, but measles was not. I developed otitis media, followed by mastoiditis. I was critically sick, and in need of a very competent ENT surgeon from New York City (15 miles away) suggested by my paternal uncle, a generalist. The story I have been told is that the ENT specialist with his nurse came to Passaic, set up an operating room in the family kitchen, and performed successful surgery there under ether anesthesia, I am here writing this as an example of experience vs evidence-based medicine.

I attended public elementary and high school, with long walks to both schools, and received an excellent education. Most of my teachers were dedicated women who had chosen teaching as a desirable profession and enjoyed respected careers. I still remember many of them by name. I had shop (manual training) in the seventh and eighth grades, which encouraged my life long association with tools and building. My high school curriculum was "pre-college," including four years Latin, four years math, two years French, and four years of English. All very good but the most useful in the following years was the typing course, which I elected.

Childhood years were pleasant, happy times with several upgrades of our homes, but hard times were ahead. I have lived through two economic depressions, one major, several minor wars and other national crises. The economic downturn of the early 30's left lasting impressions, revived by the financial problems occurring as I write. I remember my mother worrying about paying the trades people. I remember seeing the free food lines formed in our nearby ball park, the hungry unemployed waiting for their noon meal. I recall the barter system, dental work by my father for haircuts, dry cleaning and other services. My parents lost the house of their dreams to foreclosure in 1936 and lived in rentals thereafter. I did not appreciate how hard it must have been to help me through four years at Princeton even with my scholarships and loans, and student employment at 25 cents per hour (if I remember correctly). I can sympathize with folks going through the same problems now.

I was fortunate to have met my future wife, Shirley, in 1939 at a Lehigh University fraternity party (I was visiting my best friend Si Margolis), and in spite of my uncertain financial and Army situation, we were married on November 6, 1942. We were fortunate and had a very successful marriage lasting 61 years until a devastating melanoma took Shirl in June 2003. We were blessed with two great kids, Bill and Jane, and two remarkable granddaughters from Jane and her Bob. I have lived to see Bill apply for social security and Medicare!

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WWII came next. Our medical school programs were accelerated, to 12 continuous academic months and residency to nine months. We were enlisted as privates in the Army Special Training Program to keep out of the draft and in medical school. We were sent to Camp Upton for processing. I passed the code test so well (I was a radio amateur at the time) that they wanted to send me to Fort Monmouth to the Signal Corps. I protested loudly and went back to P&S. I graduated in December 1943, and started a rotating internship. I profited by the experience gained in the rotations through medicine, surgery and specialties. I could have stayed on for another nine or eighteen months of residency, but chose to go on active duty in spite of the birth of our son in July 1944. I felt very strongly about what was going on in Europe and the Pacific. In retrospect, I feel that leaving Shirl with a baby and an unsettled living situation was not a wise or mature decision. But lucky again, it worked out OK. At the time, I regretted not being assigned to the European theater, but in retrospect again, my stateside service was most fortunate. I could be with Shirl and Bill most of that time.

Pediatric residency training followed, six months at the contagious disease hospital in New York City’s Willard Parker and two years at Duke Hospital. The NY experience gave me a once-in-a-lifetime opportunity in seeing and caring for 12 cases of small pox, and a broad exposure to the childhood infectious diseases, a major help in pediatric private practice. The Duke residency was unlike current rotations. Dean Davison, pediatric chair and medical school dean, felt strongly that all veterans should have a chance for training, so our pediatric department had many more residents than were needed. The Dean handled this by farming us out for rotations at Sydenham in Baltimore and Charity in New Orleans for infectious disease experience, to community hospitals and to precepts with private pediatricians in NC cities. I relieved the only pediatrician in Salisbury so that he could get some vacation time. Getting referrals from general practitioners was quite an experience. We were a more mature group than usual, and we profited by this type of rotations.

Jane, our second child, was born at Duke Hospital. Shirl’s post partum experience was unique. Since our rental duplex was not quite finished, and Bill, Shirl’s mother and I were living in a motel, Shirl and baby Jane remained in the newborn rooming-in section for 30 post partum days. Jane was moved into the nursery for an afternoon when I took Shirl out to a Duke football game. Compare that to recent discharge recommendations of 24 to 48 hours or less!

When the time came to hang out the shingle, we chose Miami Beach, Shirl’s home town. It was our locus for 37 years until retirement in 1986. I will save comment on the practice years until later in this story.

Since leaving the practice in 1986, my retirement has moved along as planned. We did not move away to a special retirement area. I feel strongly that people should stay in the community where they have been living. One’s friends, family, support systems, cultural activities, and familiar landmarks are all helpful in the aging process. I finished the last three years on the AAP National Board without the pressures of practice, traveled more leisurely with Shirl and initiated educational activities for which there had never been time heretofore. A highlight among the educational experiences has been the "school at home" courses produced by the Teaching Co, providing knowledge of things we never had time heretofore. The downsides of these retirement years have been several; loss of close friends due to death or moving from the area, Shirl's passing due to melanoma, my visual problem with recurrent retinal detachment, (leaving me with monocular vision), and the gradual hearing loss have been unfortunate. The latter increases the sense of isolation in

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spite of hearing aides and headphones. All told, I am very fortunate with health and physical capabilities. Fortunate too, in living in the same house for 50 years with bachelor son, Bill. In retrospect, it has been great to have lived long enough to have seen the successful careers of children and grandchildren.

The Practice of Medicine

As I sit here and watch the debate on health care reform and the future of the delivery of health care in our country, I realize how fortunate I have been to have chosen medicine, especially pediatrics, as a career. I have participated in so many exciting events; the smallpox epidemic in NYC in 1947, the elimination of smallpox as a threat in the 80’s, the production of the polio vaccines and the virtual elimination of polio since their introduction. I’ve witnessed the introduction of sulfas drugs, penicillin, and other antibiotics, the production of other vaccines against many infectious diseases, the improvement in cancer therapy, and the dramatic advances in surgery. I have shared these advances, and yet, these exciting health tools are unfortunately not available to all kids everywhere.

The highlight of my practice years and beyond, has been my involvement with organized pediatrics. Starting as a charter member of the Miami Pediatric Society in 1951, continuing through leadership in the Florida Pediatric Society, the Florida Chapter of the American Academy of Pediatrics, the Executive Board of the Academy itself, and ending in 2000 as editor of the Bulletin of the Senior Section of the Academy has been a great trip! Shirl and I made life-long friends, and contributed to the growth and activities of the Academy. Our involvement in policy and advocacy for the well-being of children brought much satisfaction to us both.

But all that glistens is not gold. I have seen the loss of professionalism within my chosen field. I watched the change of the practice of the healing ethic to the competitive world of business, the loss of the art of practice and the compassion for our patients, and the changes (not for the best) brought about by the formation of HMO’s, the entrepreneurial forms of our health care delivery, created by insurance companies and/or private groups. These corporate entities have been more concerned with financial profit than with the quality of care given. The HMO concept was established during the 70’s to provide health care to more people at a lower cost. Somewhere along the way, they turned into cash cows for corporate financial schemers especially at the expense of the health care recipients. It has come to the time when patients are called consumers or clients by bean-counting hospital administrators. Is this the profession that we idealists had envisioned?

At a meeting in the White House called by Hilary Clinton as she designed the Clinton Health Reform, I made the comment in her presence that HMO’s were like run-away locomotives hurtling down the track to ultimate collisions and massive damage to the system. Unfortunately, somewhat prophetic.

Another change in health care delivery was the introduction of the training and licensing of medical assistants and nurse practitioners. I opposed this at the time of my term on the AAP Board. Insurance companies and HMOs were looking for less expensive providers than trained physicians. The ultimate result has been walk-in clinics in drug stores, super markets, Doc in the Box operations and the licensing of these inadequately trained individuals for ever increasing practice opportunities.

I had anticipated the prepaid form of practice. When I started my practice in 1949, I offered the entire newborn first year of care, including the two or three hospital visits for the new baby, a house visit at the age of two weeks and all office visits and immunizations for the entire first year for the sum of $100. This arrangement was pop-

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ular and helped build my practice. The problem, however, in many cases, was that full payment was not made by the end of the first year, and I had trouble collecting the balance. I discontinued this plan after several years and went on a fee-for-service basis. I would not advise this concept for inclusion in the health reform legislation as has been suggested.

As I watch the debate over the present attempt for reform of our health care system, I am more convinced than ever of a single-payer system. My personal experience with Medicare, (five eye and ENT procedures, and routine general health maintenance care) has been very satisfactory. Medicare is a great system for us seniors. In spite of early AMA opposition, most physicians would not do away with it. It is not socialized medicine! I wish we had legislated Pedicare for my years of practice. The inequality of fee reimbursement between procedural and cognitive services could have been avoided if the surgeons had not taken the lead when Blue Cross plans were created. They set procedural fees relatively high, and fees for the cognitive physicians too low. Medicare and insurance plans accepted this concept. Medical reform should correct this inequality.

The State of the World.

When recalling one’s life events, it seems appropriate to comment on the condition of our planet. These ninety years have been both amazing and cause for worry in an era of contrasts. As mentioned, I have seen wars and economic cycles. I saw a man land on the moon, an amazing scientific and engineering achievement, and yet cancer is still a major cause of death. I have seen the birth of the computer, the internet, twitter, Face Book and yet the loss of face-to-face personal communication. I have just finished watching a DVD of Ken Burn’s moving account of the Civil War, and am witnessing the administration of the first African-American President of the United States. And yet the minorities have not achieved full equality. I mention DVDs in remembering that I still have a few 78 records of Caruso from my family’s collection. Talk about progress!

I have mentioned only a few of the contrasts in these 90 years. One could go on to great length in listing events, both good and bad. My gnawing question is "why has it not been more good and less bad?" "Why so much resistance to the problem of climate change?" I certainly do not know the answer. Neither do the great minds of our time, scientific, political, religious, or philosophical. At best, I propose the following commentary.

Greed has been the common denominator, in my opinion. Whether it is greed for territory on the part of a country (the empire builders), greed for power on the part of dictators or politicians, greed for money by entrepreneurs, and ego greed (ambition) on the part of athletes, for example. Has this basic human trait been the driving force for good in some cases, but mostly for the bad? If greed is a basic human characteristic at a physiological and psychological level, it may be modified to some degree by behavior modification techniques. Substitution of other rewards rather than money might help in an individual’s case; eg. recognition or honors in an educational system or promotions rather than bonuses in business or institutional system. In terms of the larger societal entities, countries or nations, major financial institutions (AIG or the Madoff ponzi scheme for example) strong central control measures are necessary.

It is hard to reflect on the condition of our world after participating in its events for these ninety years. It is too complex to consider in less than a typical large hard cover book. But let me express a few ideas anyway. I have more questions than answers, along with think-tanks, commentators and bloggers. How can a society which contemplates a trip to Mars after its visit to the Earth’s moon, which invented the air-

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plane, the radio, the computer and the internet among other things, accept the inequality in wealth, nutrition, health and opportunity among its members? Why aren’t the scientific, industrial and agricultural advances universally available? Why can’t varying religious, ethnic and political groups live harmoniously with each other? Why? Why? Somehow, we must find an answer.

Reprise

All in all, it has been a very good life. I have enjoyed good health, so that even at 90, I am able to remain active in gardening (500 bromeliads, 60 rose bushes and a few fruit trees) and my hobbies. I enjoyed the practice of pediatrics and the exciting discoveries in that field and in science in general. I wish the world of haves and have-nots could change so that military combat would yield to settlement of differences by discussion. It must happen lest the energy of the atom destroy us all.

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**A Reference to RLS**

**Charles Dickens**

*Discovered by Avrum L. Katcher, MD, FAAP*

Was re-reading, after a lapse of many years, a novel, *Great Expectations* by Charles Dickens, published piecemeal, after Dickens’ fashion, in 1860-1861. It is the oldest reference to Restless Legs Syndrome that I have seen, even though at the time Dickens knew nothing of the medical nomenclature, for this at least. However, Wikipedia notes: “Earlier [professional] studies were done by Thomas Willis (1622–1675) and by Theodor Wittmaack.[55] Another early description of the disease and its symptoms was made by George Miller Beard (1839-1883).[55]”

The speaker quoted below on page 114 of the novel is a rather anxious lady with trouble sleeping. As you can see, Dickens had some insight into the complaint:

“[Said] Camilla, ‘I don’t wish to make a display of my feelings, but I have habitually thought of you more in the night than I am quite equal to.’

‘Then don’t think of me,’ retorted Miss Havisham.

‘Very easily said!’ remarked Camilla, amiably repressing a sob, while a hitch came into her upper lip, and her tears overflowed. ‘Raymond [her husband] is a witness what ginger and sal volatile I am obliged to take in the night. Raymond is a witness what nervous jerking I have in my legs. Choking and nervous jerkings, however, are nothing new to me when I think with anxiety of those I love.’”

Readers of the Bulletin who have time to read for pleasure might want to try *Great Expectations* which while not at all skimpy at 500 pages is chock-a-block full of astute observations of people in different walks of life, and how they deal with each other, and with the events that impinge on them.
The Worker, Retiree, and Employer Recovery Act of 2008, signed into law at the end of last year, has a dramatically positive impact on individuals subject to minimum distributions from their individual retirement accounts (IRAs). Previously, the Internal Revenue Service (IRS) had required that distributions be made from an IRA after the owner turned age 70½, and prescribed a method and table for determining the amount of the annual required minimum distribution (RMD). Once you reached that age, in order to avoid IRS penalties, you had to take the RMD each year by December 31st. If you did not, you would have been subject to a 50% penalty on the amount that you should have taken out but didn’t.

Under the newly passed Act, there is no required minimum distribution for calendar year 2009 from IRAs, retirement annuities, or employer-provided defined contribution retirement plans, including Keoghs, Individual 401(k)s and 403(b) plans. Distributions, however, will be required again in 2010, and beyond, assuming there are no other changes or modifications within the Act. The Committee Report for the Act makes it clear that the new relief applies both to otherwise required lifetime distributions to employees and IRA owners, as well as to after-death distributions to beneficiaries.

However, for purposes of applying the RMD rules after 2009, the required beginning date is determined without regard to the temporary waiver rule. The hope is that those taxpayers whose retirement fund values deteriorated substantially during 2008 and who can afford to wait can defer their withdrawals and allow their investments additional time to recover. In addition, the Act also is beneficial to those who have other investments to live on and would prefer not to pay taxes on IRA distributions they don’t need.

The Committee Report specifically states that the relief provision will not apply to a taxpayer who attained age 70½ in 2008 but chose to delay their first minimum distribution for 2008 until April 1, 2009. That individual still must take that first distribution by April 1, 2009 but will not have to take the regular required minimum distribution for 2009.

Regardless of age, distributions from qualified employer plans may not be required in certain circumstances, if you’re still employed. There are also no required minimum distributions from a Roth IRA, with the exception being a non-spouse beneficiary, or a spouse beneficiary who hasn’t rolled over the assets into their own account. In these situations where a RMD is typically required, those account holders will not be subject to the RMD rules for 2009. Roth 401(k) plans do have RMDs, which also are waived for 2009, but can be complexly avoided by rolling over the funds into a Roth IRA. Be sure to contact your tax advisor to determine which rules apply to your own specific situation.

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

Please consult your tax advisor regarding any questions you may have with respect to your personal tax liability. The opinions expressed in

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**Children's Science Exam**

*(with actual answers)*

**Q:** Name the four seasons.

*A:* Salt, pepper, mustard and vinegar.

**Q:** Explain one of the processes by which water can be made safe to drink.

*A:* Flirtation makes water safe to drink because it removes large pollutants like grit, sand, dead sheep and canoeists.

**Q:** How is dew formed?

*A:* The sun shines down on the leaves and makes them perspire.

**Q:** How can you keep milk from turning sour?

*A:* Keep it in the cow.

**Q:** What causes the tides in the oceans?

*A:* The tides are a fight between the Earth and the Moon. All water tends to flow towards the moon, because there is no water on the moon, and nature hates a vacuum. I forget where the sun joins in this fight.

**Q:** What happens to your body as you age?

*A:* When you get old, so do your bowels and you get intercontinental.

**Q:** What happens to a boy when he reaches puberty?

*A:* He says good-bye to his boyhood and looks forward to his adultery.

**Q:** Name a major disease associated with cigarettes.

*A:* Premature death.
Q: How are the main parts of the body categorized? (e.g., abdomen)
A: The body is consisted into three parts — the brainium, the borax and the abdominal cavity. The brainium contains the brain; the borax contains the heart and lungs, and the abdominal cavity contains the five bowels A, E, I, O, and U.

Q: What is the fibula?
A: A small lie.

Q: What does ‘varicose’ mean?
A: Nearby.

Q: Give the meaning of the term ‘Caesarian Section.’
A: The Caesarian Section is a district in Rome.

Q. What is the meaning of ‘benign’?
A. Benign is what you are after you be eight.