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

RECOMBOBULATE!

Perhaps you’ve seen it… There’s a sign in the Milwaukee Airport just beyond the security checkpoint identifying the “Recombobulation Area, according to intrepid columnist and entertainer Garrison Keillor.”. He explains that it’s where you, stuff your laptop back into its case, and put your shoes, belt, sweater, and coat back on, and attempt to regain some semblance of dignity. Keillor admonishes that America needs to pull itself together and recombobulate! I think it’s a good idea. In fact, if Congress, the Senate, and the President would recombobulate and work together truly reforming the funding of health care in the United States, we should expect solutions instead of endless, vicious partisan attacks, television and radio commercials, cries to “just toss it and start all over again”, false assurances about the merits of one health insurance plan above all others, and the endless political pork loading into a bill which should just be about bettering the health of our nation.

We live in complex, uncertain times when differing opinions and agendas on so many issues create roadblocks to ready answers. The public
has little trust in politicians or doctors. The economy seems in the dump. Health care and health insurance costs are prohibitively expensive and rising. Health insurance companies with huge advertising budgets have all but buried the Obama Administration’s ambitious hopes of a ready resolution of escalating health care costs. Yesterday, I watched part of a journalist’s interview with a health insurance administrator, who contended that “86% of the costs of U.S. health care are charges by physicians”. That’s just not true. The costs of health care in this country have been driven to a large extent by the explosion of costs of health insurance, ever increasing costs of pharmaceuticals, procedures, and medical equipment. Funding for preventive services is never adequate, even though prevention is the most cost-effective component of health care. Those of us who are more experienced (aka older) find ourselves wondering if there really is any change in which a majority can believe! Recombobulation has the appeal of tying our shoelaces, buttoning our jackets, and zipping our laptop back into place and, in the process having assured TSA of our own non-threatening personas emerging intact, picking up the pieces and going forward, perhaps having become better for the process.

Change is everywhere, in our retirement plans and investment portfolios, and in our professional certification, as indicated in at least two of the articles in this issue of our Bulletin. Our trust in the lifetime certification had by the majority of members of the Senior Section is challenged by the recent decision of the American Board of Pediatrics to-if not require- at least to strongly recommend participation in the Maintenance of Certification (MOC) Program, in addition to compliance with continuing medical education credit hours adequate for active state licensure. Older FAAPs are threatened by this for a variety of reasons, not the least of which is just
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taxing another expensive examination. If we plan to continue even with limited clinical practice, the ABP suggests that having the lifetime certification may not be enough at some unknown time in the future to satisfy insurance companies for payment of services or for the ever increasing requirements for consumer satisfaction and quality assurance. Our Section Executive Committee and other entities appealed to the ABP to extend the deadline for more onerous requirements for MOC for at least another year, and the deadline was extended by the ABP from December 31, 2009 until June 30, 2010. So, if you haven’t done so already and, if you wish to recomobulate, bite the bullet and take the exam for MOC, time’s running out for the short track. Go to www.abp.org and you’ll find much information on which to base your own decision regarding MOC. Happily, being a member of this Section or of the AAP in its various categories of membership for fellows does not require participation in MOC. However, the ABP’s assertion that MOC is the “new standard of specialty board certification” is a major change in policy which we cannot ignore if we plan to be involved in clinical practice for another 5-10 years or more.

Another reminder: Our Senior Section election this March will be conducted by electronic ballot. You have already received a postcard announcement of this change from the more costly paper ballot. Instructions for requesting a paper ballot will be printed on the card. We plan to carefully track voter participation and hope to increase our percentage of participation for the spring 2010 elections. Your vote counts, so please cast your ballot. If, for some reason, you cannot vote online this March, contact Tracey Coletta at AAP Headquarters to request a paper ballot (tcoletta@aap.org or 1-800-433-9016 ext 4926). We’d like to hear from you and invite your feedback to articles, the online winter edition of the Senior Bulletin.

Recomobulate in a positive direction for 2010 and please stay healthy!

To Be or Not to Be: A Snapshot of a Historical Moment

By Donald Schiff, MD, FAAP

Health care reform, the question upon which our Congress, the media, health care pundits and many citizens have spent the past year, appears to have become the victim, once again, of the complexity of the issue and the concurrent economic crisis, and may not survive.

In the President’s State of the Union address, the necessity of mobilizing our nation to the prime task of improving the economy and reducing the unemployment rate as quickly as possible understandably took priority, and the subject of health reform was not introduced until 37 minutes into the speech.

Although most Americans understand the priority that economic recovery must be given, the economic burden which our present unreformed health care system imposes is clearly not yet appreciated. Our present annual expenditure of 2.5 trillion dollars is out of control.

For families which are not insured or are underinsured, the first awareness of their untenable position frequently arises at a time of a medical crisis. The lack of sufficient insurance during such an event has been reported to be the most common cause of a family to declare bankruptcy.

As a nation, we have long recognized the twin problems of a lack of insurance leading to a neglect of preventive care and the absence of

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the regular utilization of a medical home. This defect in our current health care has led to the use of the ED as the expensive and readily available frequent source of “primary care.”

Although no unitary health care reform bill has passed the Congress, a number of desirable reforms were incorporated into both the Senate and House proposals. These included the availability of insurance in spite of pre-existing conditions, the removal of caps on medical care cost, the coverage of young adults under a parent’s policy to age 26 and the expansion of the Medicaid and CHIP programs to reduce the number of uninsured. Small businesses also would receive tax benefits or subsidies to aid insuring lower income employees.

The cost of adding 30+ million to the ranks of the insured and the improvement in benefits in their insurance would logically suggest that the proposed Senate bill would increase health care costs. The Congressional Budget Office, the non partisan official source of evaluation of the cost of proposed legislation, has recently determined that the utilization of these reforms would lead to a reduced deficit over the next two decades.

The surprising result in the recent Massachusetts Senatorial race has had a sea-change effect on the momentum to pass health care reform. Additionally, polling on the views of Americans on the health care proposals find support in less than 40% of those polled. Now Congressional leaders of health care reform have declared that they feel no need for immediate action, as they have the remainder of the year to pass the legislation.

The President, in the State of the Union address, again appealed to lawmakers to take another look at the proposed legislation, and after temperatures cool down a bit, see if they can overcome their differences and close the gaps in the proposals. Many believe that it is critical to convince individual holdouts from both political parties to come together to pass a bipartisan bill. Present trends suggest that this is most unlikely, particularly in an election year.

In spite of the current uncertainties, the American Academy of Pediatrics continues to work with its coalition partners to powerfully promote the well being of children by supporting the AAP basic principles, namely: (1) health insurance coverage for all children, (2) appropriate comprehensive health benefits, and (3) financial support for pediatrics, including proper reimbursement for quality pediatric care.

To be or not to be – we shall see?

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

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**Pardon These Puns**

**Here are some prize-winners from the International Pun Contest:**

1. A vulture boards an airplane, carrying two dead raccoons. The stewardess looks at him and says, “I’m sorry, sir, only one carrion allowed per passenger.”

2. Two fish swim into a concrete wall. The one turns to the other and says, “Dam!”.

3. Two Eskimos sitting in a kayak were chilly, so

they lit a fire in the craft. Unsurprisingly it sank, proving once again that you can’t have your kayak and heat it too.

4. Two hydrogen atoms meet. One says “I’ve lost my electron,” The other says, “Are you sure?” The first replies “Yes, I’m positive.”

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5. Did you hear about the Buddhist who refused Novocain during a root canal? His goal was (to) transcend dental medication.

6. A group of chess enthusiasts checked into a hotel and were standing in the lobby discussing their recent tournament victories. After about an hour, the manager came out of the office and asked them to disperse. “But why,” they asked, as they moved off. “Because”, he said, “I can't stand chess-nuts boasting in an open foyer.”

7. A woman has twins and gives them up for adoption. One of them goes to a family in Egypt and is named “Ahmal.” The other goes to a family in Spain; they name him “Juan.” Years later, Juan sends a picture of himself to his birth mother. Upon receiving the picture, she tells her husband that she wishes she also had a picture of Ahmal. Her husband responds, “They're twins! If you've seen Juan, you've seen Ahmal.”

8. These friars were behind on their belfry payments, so they opened up a small florist shop to raise funds. Since everyone liked to buy flowers from the men of God, a rival florist across town thought the competition was unfair. He asked the good fathers to close down, but they would not. He went back and begged the friars to close. They ignored him. So, the rival florist hired Hugh MacTaggart, the roughest and most vicious thug in town to “persuade” them to close. Hugh beat up the friars and trashed their store, saying he'd be back if they didn't close up shop. Terrified, they did so, thereby proving that only Hugh can prevent florist friars.

9. Mahatma Gandhi, as you know, walked barefoot most of the time, which produced an impressive set of calluses on his feet. He also ate very little, which made him rather frail and with his odd diet, he suffered from bad breath. This made him (Oh, man, this is so bad, it's good)..... A super calloused fragile mystic hexed by halitosis. (bet you start humming it).

10. And finally, there was the person who sent ten different puns to his friends, with the hope that at least one of the puns would make them laugh. No pun in ten did.

Second Class Pediatrician?

By Alfred L. Scherzer, MD, MSPH, EdD, FAAP
Professor of Clinical Pediatrics and Preventive Medicine
Stony Brook University, School of Medicine

After more than forty years of quality practice, teaching, academic affiliations, and international activity I feel like a second class pediatrician. It happened a few months ago. Reading through the AAP Newsletter I came upon a presidential editorial indicating that all American Board of Pediatrics diplomates will now be required to complete a four-step procedure, including a cognitive examination in order to maintain certification. This would include those of us who are seniors with what we understood to have permanent, lifetime certification, along with later diplomates in the timed category who would normally be expected to recertify. It took me quite a while to grasp what seems to be a very sudden change in ABP policy. Not long ago, we were assured that there were no future plans to change the status of the permanent certificate. Now, very suddenly, there is a deadline of June 2010 to take the cognitive examination to be followed later by completion of the other steps. Failing to do so within this time period would incur even more extensive requirements.

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So, what happened to permanent, lifetime certification? And why is it necessary now for seniors to go through this process of maintenance of certification (MOC)? I think we all understand and agree on the importance of lifetime learning, of keeping up-to-date in our field, and maintaining skills. Aside from our own individual professional motivation, state licensure certainly demands it with minimum CME requirements. But, surely, fruitful experiences over many years by seniors like you and I should also be realistically recognized and given appropriate consideration. The MOC process now in place seems to totally disregard the value and relevance of the clinical knowledge and skills that have come with years of practice by us senior pediatricians, and our certificate appears relegated to second class status. It is not a pleasant prospect.

As seniors who have contributed so much to the field of pediatrics I think we should make known our concerns, both to the American Academy of Pediatrics and to the American Board of Pediatrics. The permanent certificate has important meaning and value to us, and its continued recognition without qualification is essential as we proceed to relinquish our activities or continue on in a variety of professional capacities. Let no one denigrate it to second class status by simply ignoring it as the new MOC procedure unfolds.

Here are some of my thoughts to remedy this situation. First of all, I suggest that re-affirmation of the lifetime certificate and its significance be publicly acknowledged by the ABP, rather than simply being ignored as at present. Second, those with permanent certificates should have an alternate pathway to MOC. This should include licensure and an acceptable CV, appropriate evidence of CME, and certification of clinical competency by any variety of means including through hospitals, health centers, other related agencies, and academic affiliations. This would clearly enable assurance of continued professional status and competency.

I am certain that my colleagues feel as I do that we, as well as the Board, are concerned to verify that all pediatricians meet the highest standards and that a lifetime of learning is a goal for all of us. We seniors want no less. But we also expect to have more appropriate recognition of the value of the permanent certification process. I would urge everyone to express their opinions and concerns, and to come forward with any other suggestions for a process that does not leave others feeling like second class pediatricians.
categories: Patient Care, Medical Knowledge, Practice-Based Learning and Improvement, Interpersonal and Communication Skills, Professionalism and Systems-based Practice. Residency program directors had to redesign resident curricula as well as resident evaluation into these 6 competencies. The boards proceeded in a like manner, and crafted Maintenance of Certification as a means of better assessing physician competence beyond simply measuring medical knowledge. The process has been an evolutionary one, starting with the need to “recertify” by taking an open book exam, to a more elaborate and complex process with 4 separate parts, each geared to capture 1 or 2 of the competencies. Just to reference yet another Hollywood movie, “Rollerball”, the rules seemed to change in the middle of the game, and then eventually there were no rules.

Well it’s not really “Rollerball”, though some may acknowledge the analogy. Changes began in 1988 with the move requiring Diplomates of the American Board of Pediatrics to re-certify by taking an examination and with the elimination of the oral exam, the last one having been administered in April 1989 in Nashville, Tennessee. The oral exam was a valuable tool to assess how applicants processed information. This was not simply medical knowledge, but its application. Initial certification required 2 days of multiple choice questions, some of which included photos and imaging studies. The recertification process was open book, on the computer or in a class room. But in 2003 the ABP moved to a secure exam for re-certification. The Board noted its role was to assure the public about the physician, not to provide the physician with an educational opportunity. Some who took the recertifying exam when it was open book noted that the process was a valuable one, allowing them to learn as they looked things up. In 2008, the initial certifying exam became just a single day and 7 hours of testing.

So now we have MOC, an elaborate 4 part process that hopes to better assess physician competence. And there is no dearth of articles, columns and letters encouraging all to participate. And there is also the potential admonition that licensing boards might be requiring MOC, Maintenance of Certification, for MOL, Maintenance of Licensure. Although I’ve been asked to write this column, I need to acknowledge that I am perhaps somewhat unique. Although I have a permanent certificate, I chose in 1980 to take the re-certifying exam. My motivation was that I had gone from private practice to an academic center. I was intimidated by the scholarly atmosphere. I wanted to be certain I was up to speed, and taking the exam was my way of putting pressure on myself. On that occasion, there were 3 of us in the room. I hadn’t brought any materials with me (I hadn’t realized one could), but the other 2 candidates did. I then recertified in 1992 and again in 2000, that time at home on my computer. I have since taken the certifying exam in Pediatric Emergency Medicine in 1998 and re-certified in 2005. Recently I took the exam in Child Abuse Pediatrics.

Am I a better pediatrician for all these exams? Have I learned more? Is the public safer? I still am busy seeing patients and teaching residents. Is there any rationale to having a retired physician or soon to be participate in MOC? Is it fair to infer that those who participate in MOC are somehow better pediatricians? What’s the evidence that this process is accomplishing anything?

When I ran for AAP President in 2003, I was repeatedly challenged about the ABPs decision to move from an open-book to a secure exam. I tried to explain how the ABP reached the decision, and how all certifying boards had reached a similar decision. There was a good deal of skepticism among AAP Fellows, many of whom felt the ABP was motivated more by monetary gain than by a true concern about the public.

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So how would I personally respond to all the concerns about MOC and lifetime certificate holders? I would not be intimidated by licensing boards or implications about a “lesser” pediatrician. I would ask myself about whether I thought participation in MOC would benefit my patients or me. Am I already taking a number of courses, reading, soliciting feedback and staying up to date? How easy would it be for me to apply all that I am already doing to MOC? Is it onerous? My experience with MOC was that it is not that easy to navigate the ABP site, and the site was problematic prior to January 2010. It appears improved since then but there may be additional ways to streamline MOC so it’s not so confusing.

And rather than being made a “second class” citizen, I would proudly proclaim: Certified by the American Board of Pediatrics: Lifetime Certificate.

I would be deceitful not to acknowledge that I have signed up for MOC. It was at the urging of the ABP and reminders from Linda Seals of their staff who in fact signed me up. She is a most helpful person at the ABP. I have Part 1 (my California license), I’ve signed up for Part 2 through the AAP (PREP for PEM: a self-assessment); I will have to take the general pediatric exam, and I have no idea how I will address Part 4 since I work in an academic setting. But I totally understand why none of you may choose to do so. Too complicated, and seemingly not based on any evidence that the process improves the care of the children we see! As they say on the radio, “Stay tuned for another exciting episode!”

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**Autobiography of Arnold Anderson, MD**

**A Nongenerian Member of the Section for Senior Members**

I was a privileged child by virtue of my parents’ love, intelligence and frugality. Because of the depression, I chose to earn my own way by doing all kinds of jobs and finally in college operating my own second hand textbook jobbing business and in medical school my primitive furniture wholesale business.

From medical school through my Mayo fellowship I always enjoyed extra curricular medical learning experiences, such as working on my own interests in research labs, as a physician and surgical assistant in private hospitals, as a pathologist’s assistant. The most significant of these were my continuous three-year instead of the usual three-month involvement with the Rochester Child Development Institute as a student and board member and also through my being tutored as a Mayo fellow by Mr. Harry Harkness, Mayo Clinic’s long-term chief administrative officer, in group practice management. Six years later after starting our group practice in St. Louis Park was going broke and Mr. Harkness provided us the necessary consultation for reorganization. That clinic now has more than 600 physicians and is the Park Nicollet Clinic.

From my internship at San Diego and through my first years of practice, I had 10 very significant pediatric mentors. All in private practice, three Academy founders, four Academy presidents. All taught me that child development was the “sheet anchor of pediatric practice.” They modeled excellence in practice and the importance of teaching, community service, and research, for professional development and gratification. I was fortunate in being able to design my practice on their model.

My wife, Rusk, (who graduated from college summa cum laude with a major in creative writing) was my most significant teacher. She taught me how to express myself. She edited all my earliest speeches and edited the papers.

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chapters I wrote and manuals I edited. By observing her manage our family, I learned the answers to most people problems at the clinic and hospital.

After editing the Academy Adoption Manual, she challenged our family to adopt our tenth child, a baby girl who was otherwise not to have a home. It has been a wonderful family experience.

My teaching experiences included presentations at county medical societies in Minnesota and Wisconsin, at Continuing Medical Education (CME) programs, at state, regional and international meetings, as a visiting professor in universities in the United States and abroad, and as an active member of the clinical faculty at the University of Minnesota. My research has been in infectious disease, nutrition, behavioral pediatrics and practice management. I have written or been co-author of 37 articles or book chapters. I gave reports at several Ross Conferences, participated in AMA, Children's Bureau, NIH projects and committees, White House and international nutrition conferences, and have been a member of four Academy Section Committees and Chairman of two.

My public service has been participation in several governors’ and mayors’ conferences (chairman of some), school board member, and consulting pediatrician for special schools, community service agencies, YMCA, Boy Scouts, Boys Club, American Indian Movement, etc.

The distinguished alumnus awards from St. Olaf College, the University of Minnesota, and the Mayo Clinic were among the awards I received. Essential to my professional career was the continuous help and support I received from countless people, all more experienced and knowledgeable than I.

“Scholarship, which includes research and innovation and teaching, based on the data base of your own practice is essential to be the best pediatrician you can be. That includes full time practitioners as well as academicians. Other essentials are caring for the poor and being a community pediatric activist.”

Editor's Note: We invite all age 90+ members to send in their thoughts and insights.

A Day in the Life of a Young Physician

By Melissa Hostetter, MD, FAAP

Member of the Section for Young Physicians

We were recently talking about the differences in how medicine is practiced differently these days than 30, 20 or even 10 yrs ago. We thought it would be interesting to get a look at how practice and pediatricians lives are different now and how they may be similar. There are likely things we can learn from each other about the art and practice of medicine and the balance of our daily lives. Here is my “Day in the Life.”

I am a general pediatrician in my 5th year of private practice in a small group practice of 4 general pediatricians in a rural area of Virginia. I am the wife of a family practice physician who has been in a group practice for about 9 years that is owned by the local university. I am also the mother of three children ages 11, 6 and 3 year old. I am lucky enough to have found a practice where I can work part time, 3 days a week. My husband is very involved in our kid’s lives and chose while I was in residency and we were expecting our second child to work part time, also 3 days a week. We have both of our

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parents within 30 minutes of where we live and my Mom is our daycare provider 3 days a week. My husband’s father helps with the yard work. This is my back drop for my “Day in the life”.

My Monday started at 6 am getting up to go to the hospital to round on one newborn in the nursery and two children on the ward, a typical winter call day. I said good-bye to my kids as my husband was getting them breakfast and getting lunches ready for school. My Mom would be there by 7:30 to watch our youngest after my husband left for work. Monday is the only day that both my husband and I work. At the hospital, I sent the healthy newborn home. Of the two children downstairs, we had one 6 year old with an asthma exacerbation who was ready to go home. I spoke with the family about discharge plans and medications at home. I logged on to our EMR and checked the schedules for the week and called our schedulers to set up the follow up apt. I sent prescriptions electronically from our EMR to the pharmacy for his home medications. The other child on the floor was a 19 month with a history of intermittent neutropenia, recent PE tubes and a week of fever, vomiting and diarrhea. She was starting to feel somewhat better without fever but we decided to watch her throughout the day to see if she was able to eat without emesis. After writing my notes in the hospital (the hospital is still not on an EMR or electronic orders, though it is coming), I drove over to my office, about 5 miles from the hospital. Upon arriving at my office, I already had a patient waiting. I turned on my desktop computer and notebook computer and brought up our office EMR. I had the usual mix of well child checks, sick visits and ADHD follow up apt.

As it was my Dad’s 60th birthday, I had blocked my schedule before noon in order to take him out to lunch. Arriving back a little before 2 pm (when our afternoon schedule starts), I began working on my notes from the morning. I checked my e-mail and responded to a parents question over e-mail. Our phone nurse messaged me about a few phone calls and refill requests. I spoke with the nurse on the pediatric floor about our one patient; she had had some additional emesis. I spoke with the mother on the phone and we decided to continue to observe for the afternoon. She had pulled out her IV the night before and we decided to leave it out for a few more hours and see how she would do. I reviewed my one partners’ “inbox” in the EMR, whose day off it was, for important labs or phone calls.

The afternoon patients began to arrive. My notebook “froze up” a couple of times and it seemed that everyone was having problems with their notebooks. As it turns out all the notebooks had lost their connection to the internet but the desktops seemed to be functioning. With a little investigation our physician manager (also our tech guru) discovered that the wireless router had gone out. We placed wires in each of the exam rooms so we could plug into the internet when we went into the room. We were able to replace the router and got connected again. In between we continued to try to see as many patients as possible.

I got my last patient out the door at around 5:45. I decided not to finish my notes at that time but to head over to the hospital and see if our one patient was ready to be discharged. She had done well in the afternoon and parents were ready to go home. I reviewed my schedule and gave the Mom an appt. I messaged our front desk staff to schedule the appt.

I got home at about 7:30; my husband was in the process of putting our two boys to bed. Our daughter was taking a bath. I had some leftover pasta and sauce for dinner. My Mom had made the dinner. After eating dinner, I got on to our lap top at home, logged on to our EMR website and worked on completing my notes and billing for the day. I took a few phone calls over the evening, the usual concerns about fever and cough. A little after midnight I got a more inter-
This volume is a most fascinating description of the relatively short period of time, within which President Franklin Delano Roosevelt worked to turn around the United States from the Great Depression, perhaps the worst we have ever seen or endured. No one can deny that times in our country have been difficult and that a majority of our population has endured difficulties of immense nature. But when Roosevelt entered the Presidency, it was at a time, in March, 1933, when not a hundred or so, but thousands of banks has bankrupted and closed their doors, 25% of the employables were without work, the farmers were rebelling against times they could not control, and so many were without food that they fought scraps found in garbage dumps. Rotten meat was claimed. In some schools as many as 90% of the children were underweight. Herbert Hoover, who preceded Roosevelt as President, unwittingly and unwillingly gave his name to the camps that the unemployed created under bridges: “Hoovervilles.”

Roosevelt took office on 4 March, 1933, when I was 8 years old. He decided in a number of ways on a new course from his predecessor. That course was set in the first hundred days after he took office, whence the term The Hundred Days, which is still used about the early times that our chief executive officer functions. By inauguration day, every state in the union had declared a bank holiday in an effort to prevent all banks from failing.
The men—and women!—who were appointed to Roosevelt’s cabinet were of widely varying backgrounds and points of view. What is most important is that they were willing to give their best, and willing to think about what was needed and what would most help their President to do his job. He, on his part, did not have a great reservoir of knowledge or understanding, but he did have an open mind, and a willingness to consider what was best, and, above all, the ability to listen to what his cabinet taught him, what was recommended. If something did not work, he—and they—were willing to change the plan and try again. And, in addition, the Senate and the House of Representatives were also willing to work with the President. The vicious negative attitudes which, all too often, characterize the approach of the lawmakers of today were largely muted at that time, probably because everyone recognized that if change did not come soon, the nation might not survive. Women and girls worked for 6 cents an hour. Time magazine reported that “Our hospitals were filled with women who had worked themselves into a state of collapse for a pittance.” Our health care system today is in deep trouble, but it does not appear that our solons are willing to take the approach of the first Hundred Days.

In Roosevelt’s second inaugural address, after winning re-election by a larger margin than the first time, he commented that during the four year interval his fellow citizens had changed their approach to what was needed. “They had come to appreciate,” he said, that “We all go up or else we all go down, as one people.” He added that the federal government had become “the instrument of our united purpose.” How many of you who read this short essay believe that such an attitude could possibly be found today among our people?

What did this man do to accomplish so much? His background helps. Old well-to-do family with widespread connections with others of similar background. He seems to have been something of a natural-born politician, even though he was contemptuous of others, regarded them as stupid and did not want to bother with them. But then he became sick with poliomyelitis, which left him seriously weakened in his legs, and his attitudes change. He was willing to listen to others, try out new ideas. He married Eleanor Roosevelt, also from a distinguished background, and herself a person of character. She became willing to tolerate his tendency to take up with other women. He hid his disability, life in a wheelchair, even though it was no secret. By now his political views became tied to his strong religious faith. He was said to believe that the betterment of life and people was a part of God’s work.

During his campaign in 1932, he began to reveal some of the beliefs that were later to support his work. In one radio address he promised to champion “the forgotten man at the bottom of the economic period.” When he was nominated to run for president, he told the delegates who selected him, “I pledge you, I pledge myself, to a new deal for the American People.” But when he delivered his inaugural address, he said first, “This is a day of national consecration,” using language which revealed his personal religious attitude. The audience of at least 100,000 persons was silent, careworn, worried. Roosevelt went on to say that he would speak to all citizens, “with a candor and a decision which the present situation of our Nation impels.” Then came one of the most distinguished statements ever uttered by a President, it was his “firm belief that the only thing we have to fear is fear itself.” He emphasized the importance of putting people to work. And he called for stricter supervision of banking, credit, and investments, in other words, an end to speculation with other people’s money. He attacked the banking industry, the practices of unscrupulous money changers, whose behavior was rejected by the hearts and minds of men. He used religious quotes again, in referring to the money changers who had fled from the temple.
A recent survey of Americans found that the issue uppermost in their concern is our stalled and sick economy with its accompanying high unemployment rate, slowed productivity, burgeoning debt, prospective higher taxes, declining dollar, and looming threat of inflation.

Therapeutically, three macroeconomic theories have been advanced for this situation: 1. governmental fiscal stimulus—a conventional Keynesian approach—i.e., increased deficit-financed spending; 2. increased tax-financed spending; and 3. deficit-financed tax cuts.

We are well into the deficit-spending approach of the current administration. It hasn’t worked well: The large deficit-financed current spending stimulus ($168 billion in the Bush era and $775 billion in that of the Obama administration) was supposed to produce less than an 8% unemployment rate by October of this year, but it currently is 10%. Admittedly, job losses are, however slowly, diminishing; there has been a slight increase in gross domestic product; and some stimulus funds have been repaid. But the recession recovery is less than robust.

Some, who believe that spending trumps tax-reduction policy, say that perhaps the size of the stimulus has been inadequate: A second deficit-financed stimulus is now needed. President Obama’s economic team has reported in January, 2009—before the president was even in office—that $1 of governmental spending increases gross domestic product (GDP) by $1.57, while $1 of tax cuts yields a GDP increase of only 99 cents, therefore, it’s better to spend more than to tax less in restarting the economy. Maybe more of the same medicine already prof fered is needed.

However, a number of recent studies suggest otherwise. In 2002 a study by Olivier Blanchard and Roberto Perotti reported that “increases in taxes and increases in government spending have a strong negative effect on private investment spending. This effect is difficult to reconcile with Keynesian theory.” (Mr. Blanchard is currently the chief economist at the International Monetary Fund {IMF}, and Mr. Perotti is a professor at Boccini University in Milan, Italy.)
Two 2008 studies also favor this latter approach. One is by Andrew Mountford (University of London) and Harald Uhlig (University of Chicago), who evaluated the three restorative methods advocated by economists, i.e., deficit-financed spending, deficit-financed tax cuts, and tax-financed spending. They reported that “deficit-financed tax cuts work best among these three scenarios to improve G.D.P.”

The other study is by Christina D. Romer and her husband, David H. Romer, working at the University of California, Berkeley. They also concluded that stimulus spending has an effect less powerful than the more powerful economic effect of tax policy: Tax cuts historically raise G.D.P. by about $3, thus three times the amount found in January by the Obama economic team, and almost twice the multiplier effect caused by governmental stimulus spending according to the Obama economic team’s January report.

Notably, Mrs. Romer is now the chairwoman of Mr. Obama’s Council of Economic Advisers. Ironically, there appears to be disagreement among the president’s economic advisers, but there is growing evidence that reduced taxation is the best fiscal measure with which to combat recession.

The type of tax reduction is vitally important. One recalls the ineffective lump-sum individual tax rebates done in the spring of 2008. They did little to influence individuals to spend and businesses did not produce noticeably more. Effective tax reduction should be of a type that encourages private-investment spending, such as an investment tax credit, decreasing the very high corporate tax—one of the highest in the world—and extending tax cuts that are about to expire; tax reductions should be long term; short-term rebates are relatively non-productive: Investment risk requires predictable and stable taxation.

(This article is based on “Tax Cuts Might Accomplish What Spending hasn’t by N. Gregory Mankiw, The New Your Times, Dec. 13, 2009.)

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**Why God Made Moms:**

*Answers given by 2nd grade school children to the following questions:

**Why did God make mothers?**

1. She’s the only one who knows where the scotch tape is.
2. Mostly to clean the house.
3. To help us out of there when we were getting born.

**How did God make mothers?**

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

**What ingredients are mothers made of?**

1. God makes mothers out of clouds and angel hair and everything nice in the world and one dab of mean.
2. They had to get their start from men’s bones. Then they mostly use string, I think.
**Why God Made Moms:** Continued from Page 14

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

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

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

Why did your mom marry your dad?
1. My dad makes the best spaghetti in the world. And my mom eats a lot.
2. She got too old to do anything else with him.
3. My grandma says that mom didn't have her thinking cap on.

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

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

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

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

If you could change one thing about your mom, what would it be?
1. She has this weird thing about me keeping my room clean. I’d get rid of that.
2. I’d make my mom smarter. Then she would know it was my sister who did it not me.
3. I would like for her to get rid of those invisible eyes on the back of her head.
The relevant pages are reproduced at the end of this commentary for the convenience of our readers. They concern a portion of Mark Twain’s book, Huckleberry Finn. This classical novel, which recounts how this only partly grown boy of 13, living in a pre-Civil War environment, is befriended, and enters into a relationship with a slave who has run away from his “master.” Huck and Jim, the slave, embark on a peripatetic, trip on the Mississippi, which is filled with adventure and, of course, grave danger. Should Jim’s identity be learned by the authorities as they go, he will be restored to his prior state at once. But, how does Huck help him to find a life of freedom, and should Huck do this, because to take such action runs completely counter to Huck’s background, his cosmos, his own position in the southern world of that time.

I read Huckleberry Finn for the second time just a couple of years ago. It took another author to help me appreciate the crucial nature of the step that Huck took, and the internal battle that occurred when he reached a decision that the moral nature of what he had to do, had produced such internal turmoil that he had a major decision to make. And what happened was his recognition that despite his awareness of possible outcomes, he had to do something, take an action, acknowledge what might—or might not—come of it, and proceed.

The book which brought all this to my attentive understanding is The Philosophical Baby by Alison Gopnik a professor of psychology at the University of California at Berkeley. This was published in 2009 by Farrar Strauss and Giroux, New York. The firm has graciously allowed us to reprint the crucial few pages which bring the matter into focus. I am indebted to Dr. Gopnik, not merely for permission to reprint, but also for having written a very thorough discussion of, as she puts it, “What Children’s Minds Tell Us About Truth, Love, and the Meaning of Life.” The book by Gopnik complements an extensive volume on morals and justice, by Michael Sandel of Harvard, which I hope to write about at some point.

Making rules gives us a powerful mechanism for changing what we do and adjusting to new circumstances, but our basic empathic assumptions about good and harm govern those changes and protecting us from moral relativism. In much the same way, the basic assumptions of learning allow us to make radical changes in our theories of the world, but they protect us from knowledge relativism. We choose theories that lead to good predictions, or rules that lead to good outcomes. This allows us to produce radically new kinds of theories and rules without saying that anything goes.

In both cases, of course, there’s lots of room for argument. Figuring out what’s a good outcome is no easier than figuring out what’s a good prediction. Harm and help aren’t straightforward. People may want things that are bad for them in the long run, or they may seem content because they don’t realize that a better life is even possible. But, at the core, we rely on general principles even in very young babies. We may not agree whether a particular rule will make things better or whether a particular theory will explain things better. But at least we can agree that it should.
Even two-year olds have an immediate intuitive, emotional, empathic understanding of help and harm, rooted in intimate interactions. They also understand that they should follow rules, but that rules can be changed. These two abilities in concert give us a very human capacity for moral innovation. Morality, like everything else that is human, is deeply rooted in our evolutionary history, but the most important feature of that evolutionary history is that it allows us to reflect on our own actions and to change them.

One of the greatest moral stories in all of literature is about the way that empathy changes rules. And it’s a story about a child. Huckelberry Finn is only thirteen when he runs away from his abusive father and joins Jim, a runaway slave, on a raft on the Mississippi. Huck knows the rules about slavery, rules that have all the force of tradition, authority, law, and religion behind them. He knows that the rules say that protecting a runaway slave is an egregious theft. He knows that people who break the rules are condemned to hell. But he also knows Jim and he knows him intimately, face-to-face, with the intimacy of early childhood. In fact, Jim, unlike his real father, has been Huck’s caretaker. At the crucial juncture of the novel Huck has to decide whether to give Jim up to the authorities.

So I was full of trouble, full as I could be, and didn’t know what to do. At last I had an idea; and I said I’ll go and write the letter—and then see if I can pray. Why, it was astonishing the way I felt as light as a feather right straight off, and my troubles all gone. So I got a piece of paper, and a pencil, all glad and excited, and sat down and wrote:

Miss Watson your runaway nigger Jim is down here two mile below Pikesville, and Mr. Phelps has got him and he will give him up for the reward if you send.

HUCK FINN

I felt good and all washed clean of sin for the first time I had ever felt so in my life, and I knew I could pray now. I didn’t do it straight off, but laid the paper down and set there thinking — thinking how good it was all this happened so, and how near I come to being lost and going to hell And went on thinking. And got to thinking over our trip down the river, and I see Jim before me all the time in the day and in the night-time, sometimes moonlight, sometimes storms, and we a-floating along talking and singing and laughing. But somehow I couldn’t find no places to harden me against him, but only the other kind. I’d see him standing my watch on top of his’n, stead of calling me so I could go on sleeping and see him how glad he was When I come back out of the fog and I come to him again in the swamp, up there where the fiend was and such-like times; and would always call me honey and pet me and do everything he could think of for me, and how good he always was; and at last I struck the time I saved him by telling the man we had small-pox aboard, and he was so grateful, and said I was the best friend old Jim ever had in the world, and the ONLY one he’s got now; and then I happened to look around see that paper.

It was a close place. I took it up and held it in my hand. I was a-trembling, because I’d got to decide, forever, betwixt two things, and I knowing it. I studied a minute, sort of holding my breath, and then says to myself:

“All right then, I’ll GO to hell” — and tore it up.

The AAP Section for Senior Members would like to thank Mead Johnson Nutrition for their support of the Child Advocacy Award.
New Historical Perspective Feature in Pediatrics

It has been reported by David Annunziato, Section for Senior Members liaison to the Historical Archives Advisory Committee (HAAC), that a new Historical Perspectives feature will be appearing in *Pediatrics* on a quarterly basis, beginning in March. Literary contributions from any of you will be encouraged and welcomed. This is a short feature (2 pages of the journal, 1800 words of text or 1500 words with a large photo) intended to bring history to the journal’s readership. It is hoped that it will excite more interest in the HAAC Articles are sought that will excite popular interest, ideally by indicating relevance to child health today. A provocative photo, for example, might trigger an interesting reflection.

For more information and guidance, contact Jeff Baker, baker009@mc.duke.edu.

Wisdom of Conversion Lies in Tax Rates

*By Joel M. Blau, CFP® and Ronald J. Paprocki, JD, CFP, CHBC®
MEDIQUUS Asset Advisors, Inc.
“Results. One client at a time.”(sm)

The year 2010 will be pivotal for retirement planning, as it will be the first time taxpayers will be able to convert funds currently in regular IRAs to Roth IRAs, regardless of their income level. Many physicians would have liked nothing better than to take advantage of the tax-free buildup and tax-free withdrawals associated with a Roth IRA, but have been ineligible to do so because of the income restrictions imposed by the IRS. Stringent income rules also apply to the traditional deductible IRA, where the earnings grow on a tax-deferred basis, and the distributions are taxed as ordinary income. The tax law previously allowed deductible IRA owners to convert to a Roth IRA, but modified adjusted gross income (AGI) could not exceed the maximum allowable amount of $100,000, again making most physicians ineligible to convert.

However, good news arrived at the beginning of 2010. Recent tax law changes eliminated the conversion income limit, allowing individuals to convert a traditional IRA to a Roth IRA without any restrictive income ceiling. As an added benefit, those who choose to convert a traditional IRA to a Roth IRA in the year 2010 will be able to pay taxes on the taxable portion of the conversion over the subsequent two-year period. The tax law (Code Sec. 408A (d)(3)(A)) requires that half of the income tax be paid in 2011 and the remainder paid in 2012. Keep in mind that this provision applies only to conversions actually completed in 2010. For conversions that occur after 2010, all of the taxable portion of the conversion will be taxable in the year the conversion is made. Either way, you are allowed to pay the tax on the conversion from non-retirement assets, avoiding the need to deplete the retirement account.

The decision of whether to convert in 2010 should center on your thoughts relative to current and future income tax rates. If you expect your tax rate to be the same or higher when you eventually withdraw your money, it may actually make sense to pay the tax liability associated with the conversion in exchange for the opportunity for federal tax-free growth and future federal tax-free distributions. While a conversion to a Roth IRA requires you to include the assets you’re converting among your taxable income, it also enables you to avoid federal taxes on future IRA earnings and withdrawals, unless the tax law changes again. Obviously, the longer you expect your assets to remain within the Roth IRA, the more you can benefit.

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Wisdom of Conversion Lies in Tax Rates

Continued from Page 18

from its federal tax-free growth potential. Roth IRA distributions are tax free if they are deemed to be “qualified distributions” - meaning the account owner is age 59½ or older and has held assets in the Roth IRA for a minimum of five years.

If you are under that magic age of 59½, distributions from IRAs are subject to a 10% early withdrawal penalty. This penalty is waived for the purpose of the conversion. If you then decide, after the conversion, to withdraw funds from your Roth IRA and are under age 59½, you would still be subject to the 10% early withdrawal penalty.

On the other side of the age spectrum are the rules dealing with the required minimum distributions from a traditional IRA, which must begin by age 70½. Roth IRAs have no withdrawal requirements. Thus taxpayers can allow their money to stay in the Roth IRA much longer, with the hope of generating additional tax-free income.

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.

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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/THE-AAP1, or send an e-mail to membership@aap.org.
Ponderisms
Forwarded by James Bolton, MD, FAAP

I used to eat a lot of natural foods until I learned that most people die of natural causes.

There are two kinds of pedestrians: the quick and the dead.

Life is sexually transmitted.

Health is merely the slowest possible rate at which one can die.

The only difference between a rut and a grave is the depth.

Health nuts are going to feel stupid someday, lying in hospitals dying of nothing.

Have you noticed since everyone has a camcorder these days no one talks about seeing UFOs like they used to?

Whenever I feel blue, I start breathing again.

All of us could take a lesson from the weather. It pays no attention to criticism.

In the 60’s, people took acid to make the world weird. Now the world is weird and people take Prozac to make it normal.

How is it one careless match can start a forest fire, but it takes a whole box to start a campfire?

Who was the first person to look at a cow and say, ‘I think I’ll squeeze these dangly things and drink whatever comes out?’

If Jimmy cracks corn and no one cares, why is there a song about him?

Why does your OB-GYN leave the room when you get undressed if they are going to look up there anyway?

If quizzes are quizzical, what are tests?

Do illiterate people get the full effect of Alphabet Soup?

Does pushing the elevator button more than once make it arrive faster?

Why doesn’t glue stick to the inside of the bottle?

Do you ever wonder why you gave me your email address?
Patriot's Progress: A Living Military History of Kitsap County

By Submitted by Roger J. Meyer, MD, MPH, FAAP

Patriot's Progress: A Living Military History of Kitsap County is a robust, entertaining series of reports from members of this country’s seven uniformed services, sharing personal details of their military experiences in hazardous situations. The lead article is a short story from Len Forsman, Suquamish Tribal Chairman, about Chief Kitsap, Seattle's War Chief. Several Medal of Honor stories and a wide variety of personal reports give insights into the impact of the military missions on civilian life. One of the authors shared his story of surviving the sinking of the S.S. Yorktown. He recently passed away but his story remains with us. The literary work involved collaboration with seven museums and the seven uniformed service representatives.

All proceeds from sales of the book are being distributed to military charities, museum archive support and scholarships.

Additional information can be requested and orders for the book can be addressed to: Roger J. Meyer MD MPH FAAP COL (retired), 1220 NE 17th, Suite 11E, Portland, Oregon 97232

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.

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/
CREDO

I believe that all that you go through here must have some value; therefore there must be some reason. And there must be some “going on.” How exactly that happens I’ve never been able to decide. There is a future – that I’m sure of. But how, that I don’t know. And I came to feel that it didn’t really matter very much because whatever the future held you’d have to face it when you came to it, just as whatever life holds you have to face it in exactly the same way. And the important thing was that you never let down doing the best that you were able to do – it might be poor because you might not have much within you to give, or to help other people with, or to live your life with. But as long as you did the very best that you were able to do, then that was what you were put here to do, and that was what you were accomplishing by being here.

And so I have tried to follow that out – and not to worry about the future or what was going to happen. I think I am pretty much of a fatalist. You have to accept whatever comes and the only important thing is that you meet it with courage and with the best that you have to give.

ELEANOR ROOSEVELT

This CREDO of ELEANOR ROOSEVELT, which was discovered by Avrum & Estelle Katcher during their visit to the Roosevelt estate in New York, may offer some insights into the point of view of this wonderful woman, who rose to the pinnacle of achievement in spite of the challenges of her environment, including the proclivity of both her husband and mother-in-law to develop other relationships.
ATTENTION SENIOR MEMBERS!

2010 Senior Election – New Information
This is the first year the Section for Senior Members will have an on-line ballot. The section elections ballot will be live as of March 1. An email notification will be sent to all members. Voting ends at 11:59pm March 31st.

www.aap.org/elections

2010 SFSM Election Candidates

Chairperson
Lucy Crain, MD, MPH, FAAP
(Incumbent)
San Francisco, CA

Executive Committee Member
(Vote for 1)
☐ Esther Pinder, MD, FAAP
    Silver Springs, MD
☐ Iris Snider, MD, FAAP
    Athens, TN

If you don’t have internet access or you still wish to have a paper ballot you can request one by contacting Tracey Coletta at 847-434-4926 or tcoletta@aap.org

Find Us Fast?
A neat shortcut is available to allow you to get to our Section for Senior Members web site really fast. Try it, you’ll like it! Happy browsing.

www.aap.org/seniors
Let's Move

On February 9, First Lady Michelle Obama launched “Let's Move,” a national campaign to end childhood obesity. The AAP was proud to join this initiative and equally proud to have AAP President Judith Palfrey share the stage with the First Lady. Dr Palfrey stated that, “We face a medical and moral imperative to rescue our children's health,” and noted, “Because obesity is a complicated problem, it will require a sophisticated solution.”

As part of this initiative, the AAP has pledged to call upon every pediatrician to calculate BMI for every child over the age of two at every well-child visit. In addition, the AAP will urge all pediatricians to provide “prescriptions” for healthy, active living—including good nutrition and physical activity—at every well-child visit. To support our members, the AAP is making available model downloadable prescription forms in English and Spanish. To find these and other resources, visit www.aap.org/obesity/whitehouse.

Additional ongoing interventions recommended by the AAP to reduce the prevalence of childhood obesity include: encouraging mothers to breastfeed and supporting breastfeeding mothers to improve the duration of breastfeeding, helping families eat nutritious, well-balanced meals together and incorporate 5 fruits and vegetables into children's daily diet day, ensuring that every child has opportunities to be active for at least 60 minutes every day, advising that parents limit the time children spend in front of the television to less than 2 hours a day and no television for children under 2, and improving the quality of food and beverages served in schools and childcare. All of the recommendations in this campaign are consistent with existing AAP recommendations and Bright Futures guidelines.

This campaign represents a long-term commitment to our children's health. The AAP shares the First Lady's goal of overcoming obesity in this generation of children through our combined efforts. As Dr Palfrey stated in her remarks yesterday “We cannot expect a solution overnight, but we must take on this challenge. The health of our children—and the future of this country—is in our hands. Together, we can reverse the numbers and improve the health of our children.”

To learn more about this initiative and the resources available for pediatricians and to see news articles and highlights from the launch visit: www.aap.org/obesity/whitehouse.

2010 Senior Bulletin Schedule

We welcome contributions to the Bulletin on any topic of interest to the senior community. Articles for consideration should be sent to the Editor at artmaron@aol.com with copies to the Academy headquarters tcoletta@aap.org

Summer Bulletin -Mailed
June 1 Articles DUE to Arthur Maron MD, MPA, FAAP • July 6 Mailboxes

Fall Bulletin -Mailed
August 20 Articles DUE to Arthur Maron MD, MPA, FAAP • September 28 Mailboxes

Winter Bulletin -Electronic
December 1 Articles DUE to Arthur Maron MD, MPA, FAAP • January 7, 2011 Mailboxes