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

A TRIBUTE TO A GREAT TEACHER, MENTOR, AND FRIEND

Avrum Katcher, MD, FAAP
1925 - 2010

Those who knew Avrum Katcher at various stages of his life were impressed with different attributes, interests, and commitments. However, anyone who ever knew him at any stage of his life immediately realized his great joy in teaching and sharing the joy of learning, which was a life-long pursuit. Av chaired the Senior Section of the American Academy of Pediatrics for two terms (2004-2008). When I succeeded him as chair of the Section for Senior Members (SFSM) in 2008, I immediately realized that I could never fill his shoes in terms of sharing current updates and literature reviews with our executive committee and the section membership to the extent which he had demonstrated. He graciously accepted my frequent requests for help in fulfilling many of the ambitious tasks which our Senior Executive committee planned. When asked to submit an article on any of the topics about which he alerted us via e-mail, he readily complied and then contributed even more. He continued to

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send fact-filled e-mails at least once a week to the executive committee, even a day or two before he died June 4 of a massive stroke.

One of his passions was mentoring younger pediatricians, and he was adamantly committed to collaboration with the AAP Young Physicians Section. I recently had the privilege of reading several of his personal vignettes about life-long learning, which comprised an article for the Section on Young Physicians newsletter. An excerpt from his submission follows:

“Two people who also taught me a great deal were our first-born daughter, Ruth, and my wife, Estelle. When Ruth was born at the U of Pennsylvania hospital, the OB invited me to be in the delivery room. Within a minute or two after delivery, she watched her mother, and me closely, smiled, paid rapt attention, and did other things that at the time I did not know that newborn infants could do. The next day and the day after I came down to HUP (Hunterdon –U Penn) to see Estelle and Ruth, and both times found Ruth nursing on the breast. As I watched Estelle, I realized that she knew distinctly more about handling and breast-feeding this newborn that this great pediatrician had ever learned in training or in practice. So I watched, and learned, and I’ve been watching, listening and learning ever since, to the profit of my skills.”

I first learned of Av’s sudden death in a sad and shocking e-mail last weekend while I was attending a family wedding in Kentucky. The e-mail was from one of my former pediatric residents at the University of California, San Francisco, long in pediatric practice in New Jersey. The message reminded me that I had introduced him to Dr. Katcher some 25 years ago, when he completed residency in California and moved across the country to establish his practice in New Jersey. Imagine the delight
with which Av bestowed his mentoring skills to my former resident and helped introduce him to the pediatric community there! Av remembered that experience when I first joined the Senior Executive Committee years later. In fact, there was very little that he seemed to forget.

When our Senior Executive Committee voiced the need to make recommendations for retirement planning available to practicing pediatricians far in advance of their 65th birthdays and to include in that planning more information about activities after retirement, Av had already been exploring with several members of the Section on Administrative and Practice Medicine the need to disseminate more information on physician wellness and retirement to the AAP membership. SFSM members were delegated to work with SOAPM on the development and production of an excellent online Retirement Handbook (on both the SFSM and SOAPM websites). His support of communication with our Section membership via the ever popular website and Senior Bulletin was readily evident, and his remarkable abilities to collaborate with various groups was evidenced again and again in the annual section education programs at the NCE.

This year’s program is actually the outcome of a long awaited SFSM/SOAPM collaborative section education program, which was - in its infancy- another of Av Katcher’s brilliant ideas. He loved the agenda which our Section Education Committee devised with our colleagues on SOAPM, interspersing issues of wellness and survival of personal crises, with topics of medical economics, electronic medical records, and coding for medical homes. We will miss him especially this October 2 at the NCE, when the joint SFSM/SOAPM section education program is dedicated in his honor. And we will long continue to benefit from his legacy.

Lucy Crain, MD, MPH, FAAP

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

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

Winter Bulletin - Electronic Articles DUE to Arthur Maron MD, MPA, FAAP
December 1
Available on-line only by January 7, 2011
Overview
In this joint section program for SOAPM and SFSM, the day will be divided into 2 parts. The first half of the program will address the issue of preparing for retirement or reduction of time in practice. Speakers will address this in light of the current economic challenges. Speakers will also examine this from the perspective of the practice's financial climate, helping participants understand the need for balancing the interests of senior and junior partners. Physician wellness will also be a topic discussed. Speakers will address specifically how pediatricians and their practices have responded to personal crises (health and otherwise) to ensure the optimal health of the individual while also maintaining a stable and financially healthy practice. The 2nd half of the program will address more traditional practice management issues, beginning with the dialogue between members and the AAP Board of Directors. Coding experts will then tackle the issue of coding and payment for the activities now associated with the medical home model - a hot topic for any practice facing pay for performance issues. Finally, the program will also address the increasing role of technology and the impact this may have on the private health care system overall.

Objectives
Participants will gain a better understanding of what practices should consider to prepare for effective transitions as senior partners and pediatricians begin to reduce practice time or prepare to retire. In addition, other practice issues will also be addressed, including coding for medical home activities and how increased inclusion of technology-based measures and services will impact how practices interact with payers.

Agenda
8:00 am-8:10 am  Introductions and Dedication to Avrum Katcher, MD, FAAP
Lucy Crain, MD, MPH, FAAP & Robert Squires, MD, FAAP

8:10 am-9:00 am  Planning for Retirement in an Uncertain Economy
William Feaster, MD, FAAP
Objectives: To address immediate and long term goals, as well as timing, for transitioning from full-time practice.

9:00 am-10:00 am  Surviving Crises
Ellen Buerk, MD, FAAP, Mary Brown, MD, FAAP & Jill Stoller, MD, FAAP
Objectives: Speaking from personal experience, sharing strategies and resources in effectively dealing with personal health and other unanticipated crises.

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10:00 am-11:00 am Maintaining Balance: Physician Wellness
Hanna Sherman, MD, FAAP

Objectives: To identify methods to prepare the practice and themselves for responses to personal crises and how to maintain physician wellness.

11:00 am-11:15 am Break

11:15 am-12:15 pm Senior and Junior Partners: Economic Considerations
Herschel Lessin, MD, FAAP

Objectives: To identify potential challenges and benefits for themselves and their practice when considering retirement or reduced hours.

12:15 pm-1:15 pm Vanchiere Award Luncheon (SOAPM) (ticketed event)
SFSM Awards Lunch (for members & guests, no ticket required)

1:15 pm-2:15 pm AAP Board of Directors - What Are Your Practice Concerns?

2:15 pm - 3:15 pm Making It Practical: Coding for Medical Home Activities
Joel Bradley, MD, FAAP, & Margie Andreae, MD, FAAP

Objectives: To learn effective ways to code for activities associated with the medical home model.

3:15 pm -4:15 pm Technology and the Future of Managed Care
Chris Lehmann, MD, director of Information Technology for the AAP

Objectives: Update of anticipated further inclusion of technologic advances in quality assurance, electronic records, and to share managed care perspective on accessible health insurance and care for large populations.

4:15 pm Final Remarks and Conclusion
Lucy Crain, MD, MPH, FAAP, & Robert Squires, MD, FAAP

Biosketches of Joint SFSM and SOAPM Education Program

William Feaster MD, FAAP
Dr. Feaster is a pediatric anesthesiologist and administrator at Lucile Packard Childrens Hospital at Stanford University. He is the past officer of CA Chapter 1 of the AAP and co-chair of the Ch 1 Senior Physicians (Vintage Docs) Committee.

Mary Brown, MD, FAAP
Dr. Brown is a pediatrician in private practice in Bend, Oregon and current member of the AAP Board of Directors. Mary is a veteran of the Vietnam War and a breast cancer survivor. She will share how she and her family and her pediatric practice survived their crisis of unexpected illness and treatment.

Jill Stoller, MD, FAAP
Dr. Stoller the managing partner of Chestnut Ridge Pediatric Associates, Woodcliff Lake, New Jersey. Dr. Stoller graduated with distinction from Cornell University in 1982 and received her MD degree
from Mount Sinai School of Medicine in 1986 where she was awarded the Howard Rappaport award for excellence in Pediatrics and was inducted into AOA Honor Society. She completed her pediatric residency at The Albert Einstein College of Medicine in 1989 and then continued there for a fellowship in Ambulatory Pediatrics from 1989-1990. Dr. Stoller was board certified in pediatrics in 1989 and recertified in 2004. From 1990-1996, Dr. Stoller was Assistant Clinical Professor of Pediatrics at The Albert Einstein College of Medicine. For two years she served as the chief of pediatric inpatient service at Bronx Municipal Hospital Center. From 1992-1996 she was the medical director of the Pediatric Consultation Service, a primary care clinic for HIV-affected children.

Dr. Stoller has been a member of SOAPM since 2004 and has served on the Executive Committee since 2006. Dr. Stoller is Co-Chairperson of the Practice Management Committee of the American Academy of Pediatrics NJ chapter. She has served on the AAP-NJ’s Pediatric Council for the past five years. Dr. Stoller has served as the medical director of a grass-roots not-for-profit organization, Our Chance International. In this role she organized and led three medical missions to Ghana, West Africa. She is also a member of the school board in Upper Saddle River, NJ where she resides with her husband and two children.

**Hanna B. Sherman, MD, FAAP**

Dr. Sherman is an organizational consultant and educator who works with organizations and leaders nationally to foster authenticity and service in work. She helps leaders integrate insights from diverse wisdom traditions with their own inner truths, leading to deeper understandings of professionalism, leadership, and organizational change. A consultant with Relationship Centered Health Care, she leads efforts nationally in relationship-centered culture change in healthcare. With Penny Williamson, she co-leads Courage to Lead, a leadership development and professional renewal retreat series. Hanna is a member of the founding cohorts of cross-professional facilitator training with Parker Palmer and the Center for Courage and Renewal, and of the healthcare leadership institute Leading Organizations to Health. She serves as course director on professional renewal for the American Academy on Communication in Healthcare and chairs the American Academy of Pediatrics’ special interest group on physician wellness. Hanna speaks and writes regularly on leadership development, professionalism, and humanism in medicine.

**Herschel Lessin, MD, FAAP**

Dr. Lessin has been an active member of SOAPM for many years. He is in full time practice as a senior partner in the Children's Medical Group, a 23 pediatrician group with 8 offices in the NYS Hudson Valley. He has served as SOAPM nomination chairman and is an Ex Officio Member of the executive committee in his role as SOAPM liaison to COPAM. He is a senior consultant at the Verden Group, and is a nationally recognized speaker on Practice Management, having given, seminars at serveral NCE’s, SOAPM section meetings, Future of Pediatrics meetings as well as regional meetings of many organizations. He is an active contributor to the SOAPM listserv and a lead author on serveral new upcoming AAP policy statements on immunizations. Dr. Lessin received his BS Summa Cum Laude from Union College and his MD from Stanford University School of Medicine. He completed his residency in pediatrics at Yale and has provided medical for children ever since.
Joel Bradley, MD, FAAP
Dr. Bradley has been an active member of the Committee on Coding and Nomenclature (COCN) since 1995, where he has represented the American Academy of Pediatrics on the American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC), the RUC Practice Expense Advisory Committee (PEAC), and the CPT Advisory Committee. Most recently, Joel became the first primary care pediatrician appointed to the CPT Editorial Panel, where he is also the Chair of the newly developed CPT Vaccine Coding Caucus.

Through his work at the RUC and CPT, he has played a crucial role in the development and appropriate valuation of several codes essential to pediatrics, including: pediatric immunization administration, neonatal and pediatric critical care and low birth weight services, pediatric critical care transport, and developmental testing. Joel has also taken the lead in the Academy’s current pursuit of CPT codes for non-face-to-face services.

Furthermore, Joel provides the backbone of coding education for the Academy. In addition to being the editor for AAP coding publications (Coding for Pediatrics, the three Quick Reference Guides To Pediatric Coding and Documentation, and the Pediatric Coding Companion newsletter), he is an accomplished speaker, providing outstanding coding presentations for NCE and the Coding Workshops.

As a general Pediatrician with the Premier Medical Group in Clarksville, TN and medical director of the Cumberland Pediatric Foundation in Nashville, TN. He enjoys teaching coding and practice management, and working nationally and in his state Chapter’s Managed Care Council to improve the reimbursement for pediatricians.

Joel and Betsy Bradley live in Clarksville, TN and are the parents of three children.

Margie Andreae, MD, FAAP
Dr. Andreae is a member of the Committee on Coding and Nomenclature and SOAPM. She is on the Editorial Review Board for Pediatrics in Review and is the Editor-in-Chief of the American Academy of Pediatrics Coding Publications Editorial Advisory Board providing oversight for the annual Coding for Pediatrics manual and the monthly Pediatric Coding Newsletter. She is active in the AAP Michigan Chapter and has served as the Chapter Treasurer.

Dr. Andreae is an Associate Professor and Associate Director for Clinical Services, Division of General Pediatrics, and Associate Chair for Billing and Finance in the Department of Pediatrics and Communicable Diseases, University of Michigan Medical School. She co-administers the nine University of Michigan pediatric primary care health centers giving leadership and direction on all aspects of practice management and quality of care issues. She maintains an active general pediatric practice and mentors post-graduate trainees choosing careers in primary care pediatrics.

Dr. Andreae serves in an advisory role both locally and nationally regarding compensation programs and billing and coding practices. She has given invited presentations on faculty compensation and physician billing. Her work in this area is published in peer reviewed journals.
The passage of the Health Care Reform bill, the Patient Protection and Affordable Care Act (ACA) is clearly a giant step forward in enabling American Children to receive affordable quality, comprehensive health care.

The AAP has consistently worked to ensure that their fundamental priorities for children and pediatricians become a part of the reform bill. I have listed the top three principles and offer a comparison between these basics and the components of the ACA bill.

**Principles**

1. Health care for all children
2. Comprehensive age appropriate benefits in a medical home
3. Appropriate payment rates and workforce improvements to allow real access to covered services

Although ACA does not give every child health insurance, major increases in the number of insured children will be achieved by expansion of both Medicaid and CHIP eligibility and financing through 2015. Additional major expansions will occur with the provision that enables young adults under 26 years to be covered under a parent’s policy.

A ban on any pre-existing conditions exclusions will enable those currently uncovered children with asthma and diabetes to attain protection. The prohibition of annual caps on health insurance coverage will benefit many, as will the feature under the new law that a child’s insurance cannot be rescinded if she becomes ill.

Age appropriate benefits are defined as the “Bright Futures Services” and are to be incorporated into all new insurance plans without any cost sharing. Bright Futures provides guidelines for all components of the scheduled well child visits from birth through adolescence.

The medical home concept pioneered by the AAP in the late 1960’s has now been accepted by medical professionals, families and health care management organizations as a standard for the delivery of quality health care services. The new law gives states the opportunity to expand current medical home initiatives.

ACA provides for an unprecedented investment of $8.3 billion of federal funds to bring parity to Medicaid and Medicare funds for primary care doctors. The increased payments apply to evaluation and management codes for services provided by pediatricians, internists and family physicians. Although the reform act calls for an incremental increase in payments over a three year period, some states may choose to push up rates earlier to avoid a very steep increase each year. The AAP is working with some states to promote this change.

Additional steps to increase the workforce through scholarship loans and loan repayment plans to encourage a larger number of pediatric subspecialists, pediatric surgical specialists and providers of mental and behavioral health is also part of the ACA.

As with all legislation, we begin with a framework which must be fleshed out by the development of rules which direct the actual operation of the plan. AAP staff and committee members are actively consulting with congressional staff to provide expert opinion as we move toward implementation of ACA.

Vital decisions which are to be made in the next few weeks will determine the level of funding for Medicaid through the Federal Medical Assistance Percentage (FMAP). Various factions in both parties in the congress have suddenly taken an austere position on the budget. The passage of enhanced FMAP funds is essential to the financial well being of state Medicaid
programs. This unexpected turn of events has taken the governors of most states by surprise. In response to the potential loss of Medicaid funds, the governors have collectively sent a forceful letter to congressional leaders explaining the critical level of their budgetary deficits and the danger of not supporting Medicaid programs with supplementary funding.

Opposition to the health reform bill persists. The attorneys general of over a dozen states have together brought a lawsuit to have ACA declared unconstitutional. Other groups have claimed that the voluntary basis of a state’s participation in the Medicaid program has been removed by the new legislation. Although most legal experts don’t believe that these claims are valid, the cases may well end up before the Supreme Court for a final decision.

It appears to me that the greatest problem that we will need to deal with is the question of continuing support of the financing of the reform plan. Whether money will be truly saved will only begin to be known 4-5 years after implementation. But there is no doubt that the health of America’s children will be enormously protected by the passage of this legislation.
In Memorium

AVRUM LABE KATCHER, MD, FAAP
1925 - 2010

As the Senior Bulletin Editor who has succeeded Avrum Katcher and struggled to meet his lofty achievements, it is my sad task to publish the final group of four offerings submitted by him before his sudden demise. Our collegiality spanned over forty years, and he never ceased to be my mentor, always professional, always an inspiration, and never failing in his wisdom. I was very young when I succeeded him as Chairman of the New Jersey Chapter of the AAP, and I immediately invited him to attend our Executive Committee meetings to lend his thoughts and experience. “Oh, no.” Av responded. “I’ve had my chance. Now it’s your turn and I’m staying out of your way”. His good judgement and wisdom were ever-present.

Avrum will hold the enviable title as the most prolific, well-respected, and multi-faceted contributor to this Bulletin. His passing will leave a gaping void. It is some consolation that his legacy will be permanently archived on these pages.

Rest well, Av.
Dr. Rushton has prepared a detailed and fascinating discussion of the health of Royalty of many European countries, going back in some instances a thousand years or more. His focus is on disorders of health related to genetic inheritance. It is a great pleasure to read this thoughtful volume, not only because of the quality of Alan's work (I use his first name because we have worked together since he came to Hunterdon Medical Center to be our third pediatrician, and to use his outstanding background in medical genetics to enhance the quality of work we are able to provide), but also because he has prepared an excellent well-written detailed essay.

In many instances it is not possible to ascertain with clarity what that inheritance may be in families where there is no accurate information available for decades and centuries ago. However, helped by the detailed notes taken by those attendant upon the Royal families, Rushton has created a remarkable evaluation the events of long ago, in many instances based upon the descriptions of the symptoms of illness, which have been recorded by those who provided care. More recently, of course, knowledge of genetic disorders has expanded rapidly and as a result confirmed case reports may be compared with the records left us from earlier times.

Two genetic disorders have been selected by the author for intensive scrutiny: hemophilia and variegate porphyria. The former has been identified by the Royal physicians, and preliminary DNA evidence of the latter has been observed in living relatives of the British Royal family. In addition, Rushton has been able to trace very suggestive symptoms of variegate porphyria in King George III. Description of hemophilia was made by physicians towards the end of the 1700s. It was soon clear that it was marked by easy bruising and hemorrhage and involved males much more frequently than females. Although an anonymous German author published a description in 1793, the first one in North America was by Philadelphia physician Johns C. Otto in 1803. Rushton notes that the eighth child of Queen Victoria, born in 1853, was the first Royal offspring to have hemophilia. He traces the spread of knowledge through many of the royal houses during the course of that century. And he has put together a very careful study to show the most likely explanation for the appearance of this condition, first in the British family and then elsewhere in European Royalty. Rushton's analysis is well thought out, well put together, and a very reasonable approach to this question.

A principal portion of this volume is devoted to study of variegate porphyria as it appeared in many of the Royal families of Europe. Rushton does an excellent job of describing the appearance of this disorder, its spread, and the consequences thereof. He skillfully documents the illness of British King George III who may very well have suffered from porphyria during the days of the American Revolution when he was the head of the Royal house in England. A detailed description of the disorder which afflicted him is provided, although not including a motion picture made of it, The Madness of King George, starring Nigel Hawthorne, Helen Mirren, Ian Holm, Amanda Donohoe, Rupert Graves and Rupert Everett.

The origins of Royal variegate porphyria are traced with care, and with detailed consideration of what might have led to the

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extensive appearance in so many Royal families. Included therein is a splendid description of the genetic spread and the impact on the sufferer. Indeed, this volume is a brilliant essay on the medical qualities influencing the appearance of variegate porphyria. It should be noted that the carefully drawn charts, displaying the family trees, showing who acquired genetic symptoms and when are quite small and details difficult to identify.

It has been a pleasure to review this volume, and I recommend it without hesitation to anyone interested to learn more about the interaction of the genetic makeup leading to medical disorders, with the impact upon human satisfaction. Alan has done a wonderful job.

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**A Quote from**

**President Franklin Delano Roosevelt**

**January 6, 1941**

President Roosevelt, in an address to Congress on 6 January 1941, in a speech in which he introduced the notion of the four freedoms, is quoted as saying:

“...we look forward to a world founded upon four essential human freedoms. The first is freedom of speech and expression—everywhere in the world. The second is freedom of every person to worship God in his own way—everywhere in the world. The third is freedom from want, which, translated into world terms, means economic understandings which will secure to every nation a healthy peacetime life for its inhabitants—everywhere in the world. The fourth is freedom from fear, which, translated into world terms, means a world-wide reduction of armaments to such a point and in such a thorough fashion that no nation will be in a position to commit an act of physical aggression against any neighbor—anywhere in the world. That is no vision of a distant millennium, it is a definite basis for a world attainable in our own time and generation...Freedom means the supremacy of human rights everywhere.”

How relevant this is today.

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

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**The AAP Section for Senior Members**

would like to thank

**Mead Johnson Nutrition**

for their support of the Child Advocacy Award.
This exciting and extraordinarily stimulating book is replete with observations and information for physicians, nurses and other health workers, designed to help them avoid disastrous errors and to enhance the quality of hospital care they provide. The principal author, Dr. Pronovost, is a professor at Johns Hopkins School of Medicine, working in Anesthesiology, Critical Care medicine, Surgery, Health Policy and Management.

The story opens with a detailed report on the unnecessary death of an 18 month old girl whose life was lost because of medical error and neglect while a patient at Hopkins. Some years later, the father of the senior author of this book (a medical student at Hopkins at the time) died at the age of 50 also due to medical error and poor quality of care. Years later Dr. Pronovost became involved with methods to improve patient safety, and on meeting the family of the girl mentioned above, the surviving members of each family began to work together: Sorrel King, whose little girl had died, and Dr. Pronovost, whose father had died prematurely. This book is the story of what they did to reduce unnecessary deaths and injury. It is a remarkable achievement, and should be studied by every medical student and physician, and every nurse, technician and other professional persons who work in a hospital.

One story after another demonstrate how the authors adapted, from diverse sources, most notably from the senior leadership at Hopkins, methods to prevent other deaths like these. For a start, the “top leaders decided that, instead of burying” the death of the little King girl, “they wanted to talk about it and learn from it.” It became clear that this event “allowed for a change of culture to occur” with extraordinary effort to recognize institutional arrogance, a belief that Johns Hopkins could do no wrong, that “we are the world’s greatest institution and so we don’t make mistakes.” All of this was led by the President, the Dean, and others of note in administration.

What then is described in this volume is first, how change was created at Hopkins, and how the distinction between changing behavior and changing the results of care could be identified, both important but with far greater emphasis on the latter. One key event was the adaptation, from the world of commercial airlines, the recognition that one way to ensure that every step of safety must be recognized, that a checklist is created to show every member of the medical or surgical team that each step has been carried out, and that the performance of this routine be documented, recorded and verified by every person involved. That means that surgeons no longer decree in solitary grandeur what will be; instead, each nurse, resident, and every other member of the team joins to record that what has taken place is what should have taken place. And, finally, that each team, and each unit of the institution, keep records to be able to show that the results of care at that unit have improved until they have reached a zenith.

This remarkable volume is replete with anecdotes, which display how this was accomplished. Some of it comes from the influence of senior administrators. Some from changes of culture. Some from adaptation of novel methods. Much from the personality and activity of the senior author. Without in any way criticizing him, it is amusing to see how often his sentences, particularly in the paragraphs which tell a story, open with “I…” This man is

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not personally known to me, but he must be a medical locomotive to have done what he has done. And the same for the mother of that little girl whose death triggered so much and who worked with the author for many years.

Dr. Peter Pronovost worked with persons from many backgrounds. In addition to those in hospitals, he enthusiastically encountered and swept up as partners, political figures at state and national levels, medical administrators who were able to influence entire states to adapt in hospitals life-saving methods, and individual professional persons who recognized how they, working with their associates, would reduce the frequency of sickness, injury and death. Perhaps most of all, if every patient of every health care worker, in the office, in the hospital, or just living and caring for her and his health, could consider what may be learned within these pages, there would be, I believe, the potential for a stunning improvement in our national health statistics coupled with a decrease in our national health expenditures.

These pages are being written during the week when the Congress seems to be passing the most significant health care legislation since Medicare. Yet, the methods described in this book may well accomplish more.

Avrum L. Katcher, MD, FAAP

Please accept my apology for not having included in my review a reference to a Commentary by the author, Peter Pronovost, MD and his associate, Ruth Faden. This appeared in JAMA for 16 August, 1009, Vol. 302, No. 8, page 890. The authors set a brief but very useful Priority for patient safety, with reference to Ethics, Accountability and Public Engagement. It serves as a background for this volume and an entry level discussion as well. I do hope that all readers of our Bulletin will make themselves familiar with Pronovost’s book and consider it on a regular basis whenever they send a patient, or enter themselves into either brief of full-time inpatient care.
Clinical Vignettes: Lessons Learned from Practicing Pediatrics

By Avrum L. Katcher, MD, FAAP

What We Don't Know: How the Mother of Two Children and I Learned Together

A mother had been a patient of mine for several years, bringing two boys, now five and seven, to the office for regular care. There were no unusual health problems, and the family seemed to be a good example of an upper middle class well-functioning family of four.

One day in midwinter she came to the office for a scheduled health evaluation of both boys. All seemed to be going well. The only surprise was that the boy's mother was suntanned. “Have you been away?” I inquired. “Yes,” she replied, my husband and I went to one of the Caribbean Islands for two weeks. My mother came over to care for the boys. “How did it go?” I inquired, thinking mostly of the grandmother left here with the children. “Oh,” she said, “I was reminded all over again why I married my husband.” After they left, I thought what a wonderful family this was.

About a month later, I found her name on my appointment list. The mother came in alone. She looked wan. “What can I do for you?” She said, “Do you remember when I was here last with the boys for their checkup? Less than a week later my husband left work with a large suitcase. I asked where he'd be. He said, 'I won't be back. He's going to live with Jenny and file for a divorce.' Jenny was his office secretary.

Wow! That had been a totally unexpected shock for her, and was for me. Although I had never met the boys' father, I had never suspected in any way that this was other than the well-functioning family I had known for some years. Was there something that I had missed in several years of care? I never found out. She and the boys moved away and I never heard from them again. But it was a lesson to me, about what to consider when providing health care.

House Call: Learning from the Mother of a Patient, and the Pediatrician with Whom I Shared Office Space

Another pediatrician and his son shared office space at one time with me. This pediatrician had been at one time the President of the American Academy of Pediatrics, and was highly respected. We shared night and weekend call, seeing each other's patients. We had a rather high quality, well to do practice. One Sunday I was called to the home of one of the patients for a crying toddler. On examination, the girl had an ear infection. The mother and I discussed the situation: I phoned in a prescription and as I was packing my bag she asked if I'd care for a cup of coffee.

As we drank our coffee, I said to her, “Mrs. J, you obviously have great admiration for my partner. Please tell me more about why you think so highly of him. I could learn something.” The mother then said this: “Dr. Katcher, you should know when I take my daughter to see your partner, the way he speaks to me, and treats me, makes me feel that I am the most wonderful mother in the world!”

I realized that I was missing a key part of what I attended to in practice. So there you are: Another way in which I learned from a child's mother.

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Learning from the Patient, Years Later:

One of the great sources of satisfaction for me was to be the solo pediatrician in our town and county. With the passage of time, our practice has grown to over a dozen pediatricians and several nurse practitioners but for my first half dozen years there, I was alone. To this day, if I am in town, or floating 'round, someone will stop me to say, “Dr. Katcher, do you remember me? You used to take care of my children” and tells me about how well they have grown, with spouse, grandchildren, etc. Few events in life are more thrilling and pleasing.

Such an encounter occurred a few years ago, when a robust man, with a big chest, stopped me on Main Street. Actually, he had been the patient. As soon as he told me his name I remembered all the details. Eight year old boy had been admitted with severe wheezing by his family physician, who then asked me to take over the case. It was agreed to give amongst other treatments intravenous medication; he was not taking fluids well and looked sick. Later that day the head nurse on the floor called me to say that the boy had pulled his IV out a total of three times in six hours. “Please come back.” I should add that at that time there was no full time pediatric hospitalist at our hospital.

Left the office (which then was in the same building as the in patient floor) and went right over to see my patient. He was actually no worse but he certainly should continue with his IV. Spoke with his parents, who agreed to allow me some private time with the boy. So I sat down on his bed—he and I together, and talked with him about the whys and wherefores of what was going on, and what the staff hoped to do. He made it clear if I put on the IV again he’d pull it out again as soon as possible. I said to him, in effect, “You know what you’re doing is like committing suicide. Do you know what the word suicide means?” He nodded his head. “Your mother and father love you very much. It would hurt them very badly if you did that. The nurses love you. That is why they called me back. Well, we are not going to let you do that. I am going to sit here on the bed with you. If you try to do anything that will keep you from getting better, I’ll stop you. I’ll stay here all night, and then someone else will come in. Do you understand me?” He looked at me very closely, said nothing. But after a while I asked him if he’d promise to do what he should do to help him get better, and he nodded his head favorably.

And he kept his promise. I had never spoken with a child like that before. And that was the man of 40 years or so who spoke with me on the street, 32 years later.

Stories like this are without end. We all have experienced them.

This article was also published in the Spring 2010 edition of the AAP Young Physicians newsletter.
The History of Pierre Fredet and Pyloric Stenosis

By John R. Raffensperger, MD, FAAP

Making the clinical diagnosis of hypertrophic pyloric stenosis provides a pleasant glow of satisfaction to every pediatrician. The operation, pyloromyotomy, one of the miracles of the twentieth century, is simple and cures the patient for life. We are indebted to Harald Hirschprung and Pierre Fredet for making this miracle happen.

In 1888, Harald Hirschprung, the head physician of the Queen Louise Children’s Hospital in Copenhagen, described the clinical course and pathology of two babies who died with congenital hypertrophy of the pyloric muscle. In view of the eventual surgical treatment, he made an important observation; “the mucosa showed six ledge-like parallel columnae protruding along the entire length of the canal. These ledges form a rosette which projected into the cavity.” The obstruction did not involve the mucosa, but was entirely due to the pyloric muscle. Many physicians attributed the muscle hypertrophy to spasm and treated these babies with gastric lavage, electrical stimulation, diet and drugs. Surgery was the treatment of last resort. Gastroenterostomy, with a more than fifty percent mortality was the most commonly performed operation until 1907. Various forms of pyloroplasty, including stretching the muscle with dilators passed through the stomach, provided better results, but even with these operations, the mortality rate varied from sixteen to forty percent.

On the eighth of October, 1907, an infant with a history of vomiting and an eight hundred gram weight loss was admitted to the Hospital St. Louis-enfants in Paris. The baby had a distended stomach, a palpable pyloric mass and scant urine but “his face was good and he had a good cry.” The attending physicians, Henri Dufour and Dr. Pierre Fredet, a young surgeon, decided to operate on the baby before there was further malnutrition. An intern gave a chloroform anesthetic and Dr. Fredet made an upper midline incision through the abdominal wall. The pyloric muscle was hard, bloodless and looked like a uterine fibroid. After he cut and spread the muscle to the mucosa, Dr. Fredet sutured the muscle horizontally. He then made a similar incision on the posterior wall of his pylorus but was unable to completely close the muscle. There were two instructive intra-operative complications. Dr. Fredet was forced to empty the distended stomach with a trocar and all the small intestine eviscerated outside the abdomen because of “insufficient anesthesia.” Today, every surgeon empties the stomach with a catheter before surgery and Dr. Fredet developed a better anesthetic technique. The infant survived and a month later, on November fifteenth, 1907, he operated upon another infant who also survived.

The successful treatment of these two infants reflects Dr. Dufour's wisdom in obtaining a surgical consultation before the infant suffered further malnutrition and Dr. Fredet’s recognition that the obstruction did not involve the mucosa.

Over the next twenty years, Dr. Fredet surveyed the world's literature on pyloric stenosis and outlined clear indications for an early operation to avoid severe malnutrition. He analyzed gastric contents to demonstrate the elevated chloride that later explained the metabolic alkalosis seen in these babies. He recognized the value of giving sub-cutaneous saline with glucose, preoperative lavage of the stomach and the importance of keeping the baby warm. Over the long term, he demonstrated normal emptying of the stomach following pyloromyotomy and reported upon his first two patients, operated upon in 1907, when they were thirty two years old.

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Pierre Fredet's life from 1870 to 1946 is all the more remarkable because it spanned periods of great political unrest and three terrible wars between France and Germany. At medical school in Paris, he won competitive examinations to become an extern and then an intern. After a year of military service, he returned to Paris to pursue a career in surgery, learned antiseptic surgery with “inflexible rigor”, became a prossector in anatomy and carried out research in embryology. During the first Great War he served as a military surgeon and then spent most of his surgical career at the Hopital de la Charite and the Hopital de la Pitie. As a chief of service, he insisted upon rigid discipline in the operating room and classified the interns as “the pests and the useless”. When an intern showed improvement, Fredet's highest accolade was “Well! Not bad progress”. One of his colleagues said, “In pediatric surgery, Fredet is the greatest benefactor of our generation”.

In 1912, Conrad Ramstedt, in Germany performed a similar pyloroplasty but was unable to suture the muscle layer. He left the muscle open and the infant survived. This simple operation was quickly adopted by surgeons everywhere, especially in the United States. The essential step in the Ramstedt operation, the extra-mucosal pyloromyotomy is the same as that described by Pierre Fredet.

Today, the diagnosis is made with ultra-sonography and the operation is often performed by video-assisted laparoscopy with zero mortality and essentially no morbidity. We must salute surgeons such as Pierre Fredet who a little more than a hundred years ago opened the door to modern treatment of this once lethal disease. With no more guidance than his writings, a few drops of chloroform, a scalpel and a few hemostats, today's surgeons can successfully treat babies with pyloric stenosis—even when the electricity fails.

This communication is an abstract of PIERRE FREDET AND PYLOROMYOTOMY that appeared in the Journal of Pediatric Surgery, 44, #9 September 2009, pages 1842-1844. The references may be seen in the original article.

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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/
Dear Ladies and Gentlemen:

I am a 67-year-old general pediatrician practicing part-time, 2½ days a week, in our St. Marks/Wasatch Pediatrics office here in Salt Lake City. I also teach residents and medical students in Continuity Clinic at the University of Utah. I will retire from my office practice in July of 2010, not that far away, but I will continue to teach at the university, and will also probably volunteer at a few clinics here in the area. So . . . I felt it reasonable to recertify to “maintain currency,” even ‘tho it necessitated lots of time and stress, and at least $2000, to take the PREP Course in Portland, study for and take the test.

Yesterday I took the recertification exam as a Permanent Certificate Holder here in Salt Lake City. The Prometric Test Center did an amicable, professional job of administering the test, as I indicated in the survey at the end of the exam. There was, however, no similar feedback instrument to let you folks know of test-takers’ views of the whole ABP process. There should be, and in its absence, here are my thoughts for your use. As said below, I don’t yet know if I passed, so this is neither sour grapes nor bouquets of roses.

First, I read (after the test, not predicted in the preliminary materials from the ABP as it should have been) that it would take up to 60 days! to receive my test results. I called your office yesterday afternoon to ask why, and Louise White explained the after-test process to me. Even now, I still can’t see why it should take so long to score and return results to anxious, ego-threatened pediatricians. A computerized, multiple choice exam should be correctable on electronic receipt by the ABP, needing only a well-qualified clerk to do the work, not “a team of psychometricians, batching the exams at intervals. A friend taking the Dental School Aptitude Test at the same center knew of her results immediately after her exam was finished! So please work on that, while I sweat my results.

I feel the whole process of recertification of older pediatricians is quite sensible, after working with the issue for the past 6 months. Commercial aircraft crews are not “grandfathered” in their flight status, and take annual refresher courses to protect their passengers’ lives – so should we, painful as the process is, for our patients’ benefit. I think we all know that pediatric CME, for the most part, is still passively sitting in lectures, without even questions to gauge comprehension at the end, let alone performance measures to see if we really learned and might practice what we’ve learned. It is typically difficult to build new CME material into our daily practices. Thus your rationale is sound. The only flaw in the ABP system is that we’ve not been forced to recertify for the past years (I’ve never had to recertify since Pediatric Boards in 1975), so I had to work hard to prepare.

The PREP course in Portland in September was intense for docs not used to sitting still for a half hour, let alone 5 days straight, but it was very well-organized by Scott Miller and a woman whose name I’m sorry to have forgotten. The meals were real, not “continental”, and the lecturers were nearly all concise, presented material well-referenced, and thorough. They often highlighted “What’s gonna be on the test”, ‘tho only bold-face type, not red colored type, translated to the take home syllabus. The syllabus, with lectures and case presentations, served very well as a study guide this past few weeks in preparation for the exam.

The exam itself was fair and reasonable, in my stressed eyes, apparently designed and written based typically on presentation of a patient or problem, differential diagnosis, and first steps such as might be required of a general

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pediatrician in the office or hospital, before referral to a subspecialist or hospitalist. I felt most competent dealing with questions about conditions seen frequently in my practice, less so with renal, endocrine, diabetes, and genetics issues which we in practice refer quickly, even though we try to do an initial work-up. We often don't get initial bloodwork, knowing we'll forget something and the kid will require another stick. And with good texts, Up To Date or other internet resources, and easy telephone links to subspecialists, even a doc in Pinedale, Wyoming can get quick help nowadays.

So I hope I passed, and if I don't I'll feel it was because of long disuse of many of the topics and trying to relearn them in a short time, rather than innate inability. I feel my preparation and study time were very beneficial, at times fun and always interesting, and if I follow through with my side notes (like we really need a spirometer in our practice – not just a peak flow meter – thanks to Dr. Kelso), can incorporate this work into daily practice.

I appreciate your work, and hope these comments can serve a useful purpose for you.

Sincerely,
Tom Metcalf, MD, FAAP
Salt Lake City

To the Editor:

I am certain that many of the permanent, lifetime certificate holders like myself (in practice since 1970, boards 1972) are very frustrated and upset with the Board of Pediatrics who insist on making us all “Second Class Pediatricians”, as so aptly put per the article by Alfred Scherzer, MD in the recent issue. I have personally asked the NJ Chapter if they could publish a statistic showing the number of permanent certificate holders vs. the number of those who are going to yield to the intimidating tactics of the Board, (preferably eliminating those in academic pediatric settings, article by Carol Berkowitz, MD). I have been told this is not possible unless the Board does it.

Why not conduct our own survey?

The Senior Bulletin could become a sounding board to let our voices be heard, so to speak. The poor economy and its impact on office visits, the inadequate reimbursements from the Insurance companies, and now the added impact of the MOC asterisk; it might be helpful to hear from those of us who disagree with the Board.

What better forum than our Senior Bulletin?

Thomas Baumlin, Jr., MD, FAAP

(As usual, comments and opinions are encouraged and welcomed from our loyal readers. Send your letters to: artmaron@aol.com AM).
Advocacy in Action
By Lucy S. Crain, MD, MPYH, FAAP

I was invited by the editor to write about my ongoing efforts in the production of the annual DEVELOPMENTAL DISABILITIES: UPDATE FOR HEALTH PROFESSIONALS continuing medical education (CME) conference at the University of California, San Francisco. The conference is an advocacy effort, in my opinion and that of more than 300 attendees in 2010, as it meets an unique (and otherwise not well addressed in this area) educational need for pediatricians, nurse clinicians, and other health care providers who care for children and adults with autism and other developmental disabilities.

The conference planning began in 2000 with outreach to UCSF by the California Department of Developmental Services (DDS) requesting an educational conference for health care providers in northern California, where there was no MCH funded or University Affiliated multidisciplinary training program for developmental pediatricians or other developmental specialists. State DDS was interested in promoting a single CME program focused exclusively on autism spectrum disorders. As I was founding director of the UCSF Pediatric Disabilities & Down Syndrome clinic and had full time clinical and academic responsibilities in general pediatrics, taking on the conference was very much a labor of love.

It was also an opportunity to advocate for better health care services for individual with developmental disabilities, including autism.

At the beginning, I made it clear that the conference must include more than autism and should cover the breadth of developmental disabilities across the lifespan. It was an ambitious undertaking with the only similar California precedent having been a single conference in southern California addressing autism and cerebral palsy. I was pleased that DDS concurred, and the partnership was established with that first course, underwritten by an educational grant from DDS and produced from the Office of Continuing Medical Education at UCSF. I developed the course content, working with a Community Advisory and Planning Committee, which included Wellness Project representatives from DDS, local agencies specializing in services for children and adults with DD, and –most importantly—parents and family members with relatives with DD and individuals with DD.

The program was most difficult to devise the first year, as we were so new to this endeavor, but I’ve learned a lot with each year’s experience. One thing which I learned immediately was the need to have a co-chairperson for the course. In clinical practice at UCSF, I had commonly “graduated” my patients with disabilities to an outstanding nurse practitioner in the General Medical Clinic, and adding her—Gerri Collins-Brode, RN, MSN, ANP—as co-collaborator has fostered a very productive working relationship, which is reflected in a true life-span approach to choices of faculty and topics within the broad field of developmental disabilities.

The partnership with educational grant underwriting by DDS concluded abruptly last spring (thanks to California’s economic shortfall), after the agenda and speakers were confirmed for the 9th annual conference this March. Thanks to some desperate last minute grant writing efforts, and to the generosity of MCH and HRSA, as well as innovative collaboration with the University of Southern California & University of California, Los Angeles LEND program and the Lucile Packard-Stanford DBPeds program, we were able to offer a conference, which exceeded our expectations in terms of attendance, outstanding faculty, and quality of content.

Whether there is an actual “epidemic” of Autism Spectrum Disorders is still debated. (I definitely

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see more children deserving the diagnosis than in years past.), there still are significant numbers of individuals with other intellectual disabilities (aka cognitive impairment, and previously known as mental retardation), cerebral palsy, epilepsy, and other neuro-developmental and behavioral-mental health pathology that demand ongoing education for health care professionals of all disciplines. We’ve offered some good debates on the Autism Epidemic issue, Early Identification and Intervention, and some others on “How Much ABA is Too Much?”, Psychopharmacology with Autism Spectrum Disorder, the Efficacy of Cognitive Behavioral Therapy in Developmental Disabilities and lots more. We’ve found our audience pleased with the breadth of perspectives offered by our conferences, with emphasis placed on putting research into practice, epidemiology, various behavioral and mental health interventions, as well as “cutting edge” presentations of current practice guidelines and new techniques in treating various developmental disabilities.

As we plan for the 10th annual conference for March 10 and 11, 2011, we already envision an additional focus on issues of cultural diversity, including advocating for the need to train more health care professionals, including developmental-behavioral pediatricians and clinical nurse specialists and psychologists and speech and language pathologist and and child psychiatrists and neurologists (etc) and their adult counterparts- from culturally diverse backgrounds to better address the true “epidemic” (in a good way) of cultural diversity that reflects the population we serve and of which we are part. I retired in 2002 from fulltime practice at UCSF, where I had long “supported my habit” of DBPediatrics with a busy general pediatrics faculty practice, but I’m enjoying the opportunities for teaching and advocating for a better prepared group of health care providers to better serve the needs of individuals with developmental disabilities through this annual educational conference. That’s part of the reason I describe myself as “recycled, not retired!”

Lucy S. Crain

PS: I previously wrote an ongoing column entitled Advocacy in Action and would invite any of the multitude of you who are similarly involved in advocacy and service efforts in your communities to contact our Senior Bulletin editor, Dr. Arthur Maron, to describe your own advocacy efforts.
It was 1964, when a young Stephen Maitinski was appointed a rotating intern at the then Meadowbrook hospital (now the Nassau University Medical Center) in East Meadow, New York. He followed that internship with residencies in pediatrics and psychiatry. Having completed those he was appointed assistant director of the Child Development Center (CDC) there. In 1971 he was appointed Director of that discipline. A perfect choice, he had also been the chief physiotherapist at Mount Sinai Hospital in New York City.

Having noted this, I write about this man. A warm, friendly, kind, considerate, extremely bright, and always smiling gentle person.

Dr. Maitinski, as a teenager, had been in a Nazi concentration camp during World War II.

Soon after I was appointed Director of Pediatric Ambulatory Services, which included overseeing the CDC, I became very close to him. Almost every Wednesday morning, after grand rounds, we would spend an hour or so together in his office. I loved and respected his philosophy of life. We mainly talked about children, their problems and how we might improve their lot. Many fruitful ideas came from those meetings, some of which were immediately adopted by our chairman.

Steve rarely spoke of his life in a concentration camp. One day, as he washed his hands, sleeves rolled up, he turned to me, pointed to the numbers tattooed on his left forearm and said, “I keep that so that I will never forget”. No further discussion followed.

About one month later, as he prepared our coffee, he noted that he made coffee for the “Commandant” every morning. Over the next few years, little by little, small parts of his life in a German concentration camp unfolded.

At age 14, Steve was detained and sent to the camp. He never mentioned its name or where it was located. I never asked. He had been a teenager in Czechoslovakia. The camp was of “moderate” size with three sections, one for women, one for men and one for children. He was in the latter area. Water was plentiful but food was scarce. About one month after arriving, the “Commandant” was walking through his section inspecting. He took out his watch and accidentally dropped it. Steve jumped out, picked it up and handed it to the “Commandant”. He received a pat on his head. Shortly after, two guards came and took him to the commandant’s headquarters. There he was told he was to be the commandant’s houseboy.

The headquarters building was a two story building with offices on the first floor and the commandant’s living area on the second floor. The latter was staffed by three men, a cook, a butler and a third who supervised and brought flowers everyday. Steve was assigned a “closet-sized” room and given strict instructions as to his duties, one of which was to have coffee ready for the commandant when he arose in the morning. He was never to speak unless spoken to. There were a dozen other chores he had to attend to every day. *One was to taste the commandant’s food prior to it being served to him.

There were many pictures of the commandant’s wife, his children and the family, throughout the living area. There too, the commandant was quiet and reserved. In the office and throughout the camp however, he was loud, angry and vicious. Many people died every day, most from starvation, even though this was not a death camp.

As Steve noted, the commandant had a “voracious” sexual appetite. Almost each day he would choose a woman from the encampment to spend the evening with him. Steve, who spoke Yiddish, German, and

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impeccable English instructed these women as to what was expected of them. Each was to have a “thorough” bath, upon arrival, say nothing and never to resist, among other things. After an hour or two with the commandant they were fed the remnants of the evening meal and dismissed. Steve stressed the fact that no woman was under twenty years of age. That was a rule. The commandant had a few favorites who were brought back several times. If one became pregnant, she “disappeared”.

Once each week, the commandant had a party. Six officers from inside and some from outside the compound were invited, never more than six, and six or more of the Jewish women prisoners were brought in. After dinner, and socializing, they retired to the bedrooms and all departed by 10:00 p.m. Steve was confined to his “closet” during the parties.

After almost one year of this “luxurious” life, a doctor visiting the commandant, observed Steve while he was serving coffee. He suggested that Steve might have tuberculosis. He had a cough, was pale and was losing weight in spite of adequate food. Almost immediately, Steve was sent to live in a “shed” between the children’s and women’s section. He called it a “shed” because only six teens lived there. There were no water, no electricity, no toilet facilities, just four walls and six beds. There was water and an open latrine behind the shed where one was exposed to the elements and anyone in the area. As Steve noted, there was no modesty.

Everyone was stripped of that very soon after arriving at the camp. Frequently, all internees were stripped and exposed for hours. The guards used the women as they saw fit.

After about eight months of this existence, Steve was liberated by the American forces. He was sent to a hospital where he was diagnosed with malnutrition, tuberculosis, rheumatic heart disease, typhoid fever and diabetes. After an indefinite period of time, he was “adopted” by a German nurse who had cared for him in the hospital. She took him home, and nursed him back to health.

He later married that nurse. They came to America where he studied and became a Physiotherapist. After several years, they returned to Europe, and divorced.

Steve went to medical school. He met and married Vera and they had a daughter. When she was three, they returned to America and both Steve and Vera did pediatric residencies with us.

As noted, he supervised our Child Development Center for many years. They bought a house a few blocks from the hospital where Steve indulged in his two great hobbies: cooking and gardening.

Steve retired in 1994. He developed a small psychiatry practice and after several years, died.

He was one of the finest people I have every met. One further note, when the CDC was relocating to the main hospital in 1976, Steve noticed a large DellaRobbia in a scrap heap at the old facility. It was the size of the DellaRobbia, adorning the outside of L’hospital del Innocenti in Annunziato square on the outskirts of Florence, Italy. A piece was broken off. He had it repaired and hung it in his new office.

Because I admired it so often, when Steve retired, he offered it to me. I accepted it on condition that we donate it to the AAP in his name. They accepted it. A few years ago, Errol Alden notified me that it was being moved from the archives library to the main rotunda where it hangs today, in all its colorful glory. We never discovered where it came from.

It has been many years since Steve recounted these few events in his life. I hope I have described them as he presented them to me.
Letter To The Editor
Advocacy in Action

The Washington Chapter, AAP nominated William O. Robertson, MD, FAAP for the Senior Section Advocacy Award for his continuous advocacy for children and mentoring to many students and physicians. We laud all seniors who continue to advocate, but we wish to share with your readership the work Dr. Robertson has done and why he was deserving of our nomination.

Dr. Robertson is remarkable for his patient and long-term vision. He has been director of the Washington Poison Center and retired recently after fifty years of service. Among his achievements: mandated imprints on pills to distinguish them from each other; promotion of child proof containers; poison prevention education; prevention of medical errors by tenaciously advocating for an “anti-scribbling” bill that mandates legible prescriptions.

Dr. Robertson still attends chapter trustees meetings and gives advice when asked or needed. He still writes a monthly article for the Washington State Medical Association newsletter that discusses medical errors and litigation.

He has held numerous positions of leadership and always used those positions to advance child and patient safety. He is the whole package: academician, scholar, teacher and leader. His modes of advocacy have been legislative, policy formation, teaching, writing and volunteering. He is a remarkable role model.

Our chapter is in awe of Dr. Robertson’s accomplishments and the legacy of safety that we benefit from every day across our state and across the nation.

Sincerely,

Beth Harvey, MD, FAAP
WA Chapter President
The Senior Pediatric Society

By M. S. Disxon, Jr., MD, FAAP

The Senior Pediatric Society originated in January, 2000, when four older Pediatricians had lunch in a local Irish restaurant. The purpose of the meeting was to discuss the possibility of establishing a group of retired pediatricians who might enjoy having lunch together to talk about the “good old days of pediatrics.” It was decided unanimously to proceed, and the first meeting for lunch was held on February 17, 2000, at the Edgewater Yacht Club. Twenty-one older pediatricians were present, which was considerably above our expectations. Since then, our organization has grown and we now have 77 members. Usually 35 to 40 members attend each meeting. Our 49th meeting was held on our 10th anniversary on February 17, 2010, at Edgewater Yacht Club.

The structure of the organization has evolved over the years. Criteria for membership include the following:

1. A pediatrician with an MD or DO degree, or comparable degree for those from overseas.
2. Retired from practice, or approaching 65 years of age.
3. Living in the greater Cleveland area.
4. Attendance at one meeting.

We have a wide span of age with one of our members in her late thirties, who retired because of illness, and several in their 90’s.

Our luncheon meetings occur five times per year in various clubs where our members have memberships, and also in hospitals with a Pediatric Department where we used to work. We meet at noon and mingle for the first half hour, sit down for lunch, then follow the program outlined below:

1. Introduction of new members, who give a brief summary of their professional lives.
2. Introduction of guest; Originally guests were not encouraged, but recently our policy has changed, and now we welcome spouses and guests.
3. Recognition of members who have passed away since the previous meeting.
4. Recognition of honors received by our members since the previous meeting.
5. Secretary-Treasurer report.
6. Introduction of the speaker and program. The topics generally depict various aspects of the history of medicine, and the frequently presented by members of the Society. (If you are interested in receiving a complete list of past topics, please email tcoletta@aap.org.)

Our Senior Pediatric Society is administered by a Steering Committee which is comprised of six members. Their duty is to call the members 3-4 weeks before the meeting and ask if they will attend, and if so would they like a beef, chicken, or vegetarian lunch. Originally we thought a number of our members who are retired would like a telephone call from a former colleague, but now some prefer an email.

One of the members of the Steering Committee is the leader who arranges the meeting, selects the speakers, and presides at the meetings according to the schedule in the previous paragraph. Another Steering Committee member is the Secretary-Treasurer, who collect the money for the lunch, pays the bill, and writes the minutes of the meeting. The Steering Committee also meets

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in August to plan for the coming year, and the minutes of the meeting are read to our membership.

Our only source of income is the charge for lunch. We do not have dues. There have been a minimum of problems, but one occurs when a member registers for the meeting and then does not attend. Since we are usually charged for that lunch, we have to send a bill to the members for payment.

The Senior Pediatric Society has grown beyond our expectations. It has fulfilled its role as a forum for old colleagues to convene socially, and at the same time provides an educational component. We keep learning about current activities and achievements of our friends, and renew memories of those who are no longer with us.

*M. S. Dixon, Jr., MD, FAAP*
2224 Chestnut Hills
Cleveland Heights, OH 44106

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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.
I would like to welcome our young students and teachers here today, and to tell you that I feel both privileged and humbled to share my thoughts with you this morning. I am privileged to have an opportunity to speak to such a talented, engaged, and interested student body. The very fact that you are here today shows me that you are students (and teachers) who think about the future, and how you can shape your own destiny – and to me, it is a privilege to be able to speak with you. At the same time, I feel humbled by the experience; because I do not believe I am anything out of the ordinary. I am daughter, wife, mother, sister, friend, who also happens to be a doctor and active member of the community. So, while I hope I do have some insight you might find valuable, I am certain, if you look hard enough, you would find equally valuable role models in your own life.

When I was asked to address this wonderful group of students, I spoke with my own children (all of whom graduated from DCDS) and asked them how to prepare. They said, “Mom, you don’t need to prepare anything! You raised four kids who turned out well, and had a great career at the same time. Just tell them how you did it!” So, here I am sharing with you some very personal thoughts about taking hold of your future and being the best that you can be, and also about getting what you want out of life.

Things have really changed for women in science and engineering in the past few years. One sign of the change is in Barbie dolls. Not long ago you could buy a Barbie doll that said “Math is tough.”

Today you can buy Computer Engineer Barbie, with her pink laptop matching her pink glasses and watch.

I want to begin by telling you a little about myself.

I am a board certified pediatrician and emergency medicine physician, currently working at numerous local health institutions. I am also a housewife or homemaker, a mother of four and grandmother of seven – all boys.

There are two parts of my life – my family life and my professional career and as a general rule I try to keep both parts very separate from each other.

So, let me tell you first about my family life:

I was born and raised in the city of Patna. Patna is the state capital of Bihar in India. I come from a large family. I was 5th in a line of 8 siblings. I have three brothers and four sisters.

One of my earliest childhood memories is walking to school accompanied by my parents. Every day, we would pass by a blind school for orphans.

I was always struck by how these impoverished kids with no money and no parents could still enjoy themselves so freely despite not having vision. I remember asking my dad, “How can I help them?” His immediate reply was to help them by becoming a doctor. This set me on the path to be a doctor.

I hated studying math and physics. However, I comforted myself by thinking that soon I will be studying biology and chemistry which I loved. I got out of high school when I was 14. Somehow, I managed to get through the science curriculum and succeeded in entering a prestigious medical school.

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So far so good. My dad was a senior government official in the Indian government, similar to a cabinet member in Washington, DC. Sadly he passed away at the young age of 47, leaving behind my mother and his eight children. None of us were settled at that time. This was quite a setback. I got discouraged and wanted to quit my medical studies. However I received a very nice motivational letter from the principal of my school saying, “Niru, don’t give up. Your father wanted you to become a doctor and he is watching you from heaven.” This note changed my whole life and I am very proud to say that my mother with the help of our uncles raised all of us in the best way she could. We received merit scholarships and most of us became professionals – 3 engineers, 2 doctors and 1 computer scientist, and my other 2 sisters were perfectly happy getting married and raising children.

After graduation from medical school, I married my husband, who is also a doctor.

In 1965, we came to the US with only $8 each in our wallet out of which $4 was spent in buying coffee at Cairo airport another $6 were given to the porters at New York airport.

Both of us started our internship and residency at Wayne Medical School here in Detroit. I decided to do pediatrics from Children’s Hospital of Michigan. I still had this memory of those blind orphans and how to help them.

We didn't have much money, but we saved some during our residency and with it bought one of the first Mustangs.

Following my residency and fellowship I stayed home for 8 years raising our 4 children who by God’s grace all turned out to be professionals and well placed in life.

Today my children are married and have children of their own.

Once I entered the field of medicine again I decided to work in the emergency room since the flexibility of those hours enabled me to manage my family.

My husband, being an orthopedic surgeon, was busy in practice. My role was to stay at home when children came back from school. It was very hard for me to switch from pediatrics to emergency medicine but I knew that this was the best thing for my family at the time, so I hung in there.

Over time, I began writing my book, which I consider as my 5th child. It took me over 5 years to publish this book.

I collected several thousand dollars from sale of my book at major book stores and donated the proceeds from the sale to establish a memorial fund I named for my parents at the same blind school orphanage I used to walk by as a little girl.

Now, my books have been distributed all over the world and also to several children’s centers, community hospitals in United States. It has even been donated to a Mother Teresa home in Calcutta in India.

I have also written many health related articles that have been published in local newsletters, newspapers and journals. You can find these articles on my website, www.doctorniruprasad.com.

Currently, I also host a TV program on Bloomfield cable TV channel 15 called “Health Talk”. I invite experts from different fields of medicine and we talk about current topics, burning issues, preventive measures and advise regarding healthy living to all age groups. I also hosted a radio talk show on WPOM 1460 before I entered the world of TV. Who knows — one day perhaps Oprah and CNN may invite me on their shows.
I have received several awards over the years. They include:

- Blue Cross Blue Shield Caring for Children Angel Award 2003
- Heritage Hall of Fame 2005
- Blue Cross Blue Shield Claude Pepper Certificate of Merit 2006
- Michigan Association of Physicians of India Lifetime Humanitarian award 2007, and
- Humanitarian award from the Bharatiya Temple 2008

So, that’s who I am.

Now let’s spend the next few minutes talking about how you can achieve your goals.

1. **What are your professional goals?**

   I am assuming because you are all here this morning that you are at least somewhat interested in pursuing a professional career in the sciences. And whether you are interested in medicine, technology, engineering, or any combination or variation of these professions, you should know that these so-called “scientific” professions are dying for students like you to enter their field. Because scientific advancements are always evolving, it is very important for young people like yourselves to enter the profession and keep us old fogies up-to-date with recent advancements!

   So, for the sake of this morning, let’s identify your professional goal as entering a professional scientific field.

   But let’s set a few more goals this morning.

   Let’s set goal #2: Study math and science – study it hard, diligently, and faithfully, throughout high school.

   Well the thing about high school is there are a lot of distractions – there are sports, and clubs, and dating – and those things are all fine and good but let’s not let those distractions take our mind off of goal #1. So, how are we going to keep from being distracted?

   By setting goal #3: Stay focused.

   From the day you enter high school until graduation night, stay focused. And if you have achieved goal #2 (study hard) and goal #3 (stay focused), then that will inevitably lead you to goal #4.

   Goal #4: Go to college.

   Goal #5: Have sweet dreams of success.

2. **How do you achieve your goals?**

   Remember each and every one of you sitting in this room is very precious. You each have a bright future ahead of you, and the future of our country depends on students like you fulfilling their potential.

   I know this time of your life is not going to be easy. You have some real work ahead of you: high school credits, advance placement classes, SAT scores.

   Competition to get into a good college will be tough, and no matter how good you are, there will always be somebody better than you. So here are a few tips for keeping your head above water in the years to come:

   1. Keep your self-esteem high. You know your own worth, even if it seems others around you do not.
   2. Stop comparing yourself to other students. You have no idea what happens behind closed doors.
   3. Associate with students who like, respect, and support you.
   4. Get involved in activities you enjoy, not activ-
1. Parents also, sometimes, push their sons to play with legos and their daughters to play with Barbie dolls.

Knowing the above, here are some motivational tips for the young women in the audience:

1. Set your goals in life and stick to them.
2. Envision yourself as a doctor, engineer, computer scientist, etc. If you dream it, you can achieve it.
3. Find a role model or mentor with whom you can discuss your future.
4. Expect obstacles. Also expect to overcome them.
5. Study, study, study.

Mattel recently announced the new Barbie career – If Barbie can be a computer engineer, you can too!

And boys, I have not forgotten about you. Here are some general study skills for all of you:

1. Be ready to listen when you come to class, even if the subject is difficult to understand.
2. Do not hesitate to ask questions. This is tough stuff.
3. Take notes in class and re-write them after class, giving you time to think about what was taught.
5. Stay away from anybody who does not have a goal.
6. Stay focused on your goal.
7. Study long and hard.
8. Remember you, and you alone, are in charge of your destiny.
9. Develop your priorities and balance them in your life.
10. Instill the magic of belief in yourself.
11. Never let a failure in life disappoint you, because every failure will make you stronger.

And lastly, motivate from the heart. “Make the impossible, possible.”