Message from the Chairperson

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

I’m currently in Kentucky, attending to estate matters in the wake of the recent death of my dear 99-year-old mother. Many of you have experienced these tasks with loss of parents or family, and you know that it is a bittersweet experience, but a necessary one for most. Having loving parents with extended longevity is becoming more common, and while we are blessed with their presence, it’s sobering to appreciate the increasing frailties of old age and to be reminded of our own impending mortality. An AAP colleague who recently lost his 91-year-old father, mourning the loss of a beloved parent, yet thankful for having had him so long, said simply, “It’s never long enough.”

My sister and I have been here sorting through the lifetime of photographs, clothing, various keepsakes and memories…so many memories. We were indeed fortunate to grow up in a loving family of five children, with both parents with us until we were well into adulthood. As we deal with the challenges of being co-executors of her estate, as well as sorting through photos of people of past generations (who were those people?) I am reminded of the need to get my own house and keepsakes in order.

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I am further reminded of the need for oversight and institutional memory at the AAP. Our Section has done some noteworthy collaboration with other sections in recent years and I hope that products of our accomplishments will be regularly updated and not forgotten or relegated simply to the commendable library of oral history.

Increased collaboration with other AAP Sections has been a priority for the Section on Senior Members in recent years. The collaboration with the Section on Administrative and Practice Medicine led to extremely useful online tools on retirement planning and to a remarkably well attended combined section education program at the 2010 NCE. The 2009 joint endeavor of our section with the SMURFS (Section on Medical Students, Residents, and Fellows) led to production of tools on Immunization to be used in pediatric residency training programs around the country. (I’m not sure at this point whether the CD sent to every pediatric residency program director 2 years ago is still even in use, archived, or relegated to circular files across the country.) Our joint efforts enabled inclusion of an historic perspective provided by those of us who remember having seen measles, H. flu meningitis, mumps, and even polio for our younger colleagues.

The ongoing collaboration with SOYP (Section on Young Physicians), promises even more opportunities. As you know, we were invited by SOYP to join their teleconference with the president elect candidates of the Academy. The details of that call with summary of the questions and answers discussed are available on our website and promise excellent and thoughtful leadership by either of the two candidates (both of whom, by the way, are members of our own Section!). One of the outcomes of planning that call with Dr. Kelsey Logan, chair of the...
SOYP, was the invitation to write our regular SOSM column in the Young Physician’s Bulletin on the topic of WHY I JOINED THE AAP. I invited Kelsey to contribute an article of the same title to this issue of the Senior Bulletin, in keeping with editor Dr. Maron’s intent to have a scheduled rotation of contributed articles or columns from other sections. In my opinion, the AAP could benefit from more collaborative efforts between and among sections, committees, and councils. Efforts such as the educational materials on immunization targeted to pediatric residency programs should be incorporated in the Committee on Infections Diseases and other relevant entities of the AAP.

That brings me to the subject of my column in the Section on Young Physicians (SOYP) Bulletin, which also appears on our SOSM website. I hope it will motivate some of you to write an article for the Senior Bulletin on your reasons for becoming an AAP member. Clearly, reasons change with time, and this should make interesting reading! I’m including an excerpt from my article here, for your interest.

When I was a young mother in the 1970’s, new to San Francisco, my now grown children were students at our local elementary school, I volunteered to provide a school health education program for the students at Commodore Sloat School. I was teaching grade schoolers about health when I was contacted by a senior pediatrician who was president of the northern CA AAP Chapter I, Dr. Martin Gershman. He and other chapter members were involved with a school health education program through the American Heart Association. He became one of my mentors, indoctrinating me with information about health education and legislative advocacy, introducing me to local and state key players in child health care politics, and teaching me how to make a difference, not just with the child who was my immediate patient, but for populations of children, with the backing of the AAP.

I could make a long list of reasons why I joined the AAP; but along the way, I made lifelong friends with pediatric peers and look forward to seeing them again socially and at national or regional AAP meetings, as well as at local chapter functions and committee meetings, or in other social contexts. Pediatrics and the world in general have changed exponentially in the past 40 years, but lasting friendships and connections bonded when young are special. Most people don’t realize that the AAP fosters friendships!

Learning the ropes of establishing a career and to establish contacts within the network of practice groups, hospitals, health plans, and other organizational affiliations necessary to get started as a pediatrician. As with any effort, the gain from membership affiliation is directly proportionate to what you put into the organization.

So, I look forward each fall to the reunion of old and new friends at the NCE and to learning—often from my former students and residents who are now long established clinicians, researchers, and teachers. I am once again reminded of the legacies which we all contribute, the memories which we share, and the challenges which we, as the “elders” and our younger colleagues face as members of the American Academy of Pediatrics.

Did You Know . . . ?
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
String theory is a complex, difficult to understand attempt to explain our physical world. Its proponents suggest the possible existence of multiple universes. It is not necessary to look beyond our current lives to believe in multiple universes; in fact, the evidence is all around us.

There is the universe which consists of the legal status of the Affordable Care Act (ACA). This measure, which has been declared variously constitutional and unconstitutional by multiple courts, district and appellate, is headed for an ultimate decision by the U.S. Supreme Court in 2012. The Obama administration set the stage for a ruling next year by declining to press for an appeal in a lower court of appeals in Atlanta. At issue for the Court is whether congress can use its power to “regulate commerce” to require that all Americans who have taxable income certify by 2014 that they have health insurance or pay a penalty (tax).

In the universe that examines the benefits of the ACA which have already been recognized is the significant increase in the numbers of young adults who are in the 19-25 year age group and have been able to be insured under insurance carried by their parents. This group previously had to be removed from their parents’ insurance when they were 18-21 or left college. The Centers for Disease Control and Prevention estimates that in the first quarter of 2011 there were 900,000 fewer uninsured adults in the 19-25 year bracket than in 2010. This leaves the 25-34 year old group as the least insured. There have been no cost studies of this provision of the ACA, but insurance industry spokesmen have suggested that this increased premiums by 1-3%.

To no one’s surprise, the next parallel universe is that of the rising cost of health care. The Kaiser Family Foundation Study reveals that major health insurance companies have been charging sharply higher premiums this year, with an average annual premium for family coverage reaching $15,073 in 2011, 9% higher than 2010. Some consumer advocates have suggested that these higher prices, which came after several years of 3-5% increases, may be due to the anticipated increases in costs and the new rules in 2012 which would require a justification for any increase of more than 10%.

The universe entitled Obama administration proposals, as outlined in his new budget proposal deficit reduction plan, would cut $72 billion from Medicaid over the next decade. This is part of an effort to cut $3 trillion from the deficit in the next 10 years and would revise the formula for calculating Medicaid payments to states, saving $15 billion over 10 years.

Another newly recognized and peculiar universe (committee) that must be watched closely is the Senate-House “Super Committee of 12.” These well known and less well known Senators and Representatives have been tasked with the goal of identifying $1.5 trillion in budget savings and bringing forth a report by November, 2011. Whether this group can carry out the task is questionable, but the savings that they recommend may be influential for future consideration.

Academy staffers and leaders have been meeting with staff of the Super Committee in an effort to prevent slashing of children’s programs. The Academy has also been working with the Senate Appropriations Committee and report that programs of special interest to children and pediatricians did not receive severe budget cuts. Suggested funding levels actually were increased for immunizations and home visiting programs and held steady for emergency medical services and children’s hospital graduate medical education. A worry is the recommended reduction of $50 million in the Title V maternal and child health block grants.

The last universe to examine here is the one Continued on Page 5
that might be labeled “Governing by Crises.” After resolving the short fight over the funding of FEMA, the next hot date appears to be November 18 when the temporary spending bill runs out. Although Congress can pass legislation which authorizes spending coverage the rest of the year, the forces which want to raise a threat of a government shutdown if huge discretionary budget cuts are not agreed to appear to find that these repeated crises may be their best effective tool.

The cost of these cuts in the well being and health of children is apparent, as two of their targets consist of severe cuts in a nutrition program for low income women and children and deep cuts in regulation of air pollution. Children, sensitive in both of these areas, will surely suffer if this comes to pass.

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

2012 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

2012 Winter Bulletin - Electronic
December 1 articles due to Arthur Maron MD, MPA, FAAP
January 6, 2012 online

2012 Spring Bulletin
February 1 articles due to Arthur Maron MD, MPA, FAAP
March 1 mailboxes

2012 Summer Bulletin
June 1 articles due to Arthur Maron MD, MPA, FAAP
July 2 mailboxes

2012 Fall Bulletin
August 15 articles due to Arthur Maron MD, MPA, FAAP
September 15 mailboxes
On September 11, 2001, we were awakened to our vulnerability. We were viciously targeted as a place for mass murder. Our nation was at war.

September 11, 2001 began as a beautiful Indian summer day with bright sun and a cooling breeze. At 8:45 AM our world changed forever, as the beautiful summer day turned into a day filled with smokey clouds and cries of fear, shock and mass destruction. The sun disappeared as the result of the most cowardly and premeditated attack on American soil in our history. American Airlines flight #11 having left Boston's Logan Airport shortly before headed for Los Angeles crashed into the North Tower of the World Trade Center instantly killing all 92 people aboard, and setting the tower aflame.

Moments later, at 9:05 AM, another plane, United Airlines Flight #175 originating from Logan, en route to Los Angeles flew directly into the South Tower with 65 passengers, all of whom were instantly murdered. Seventy-seven innocent people died without knowledge of the events in NYC, when an American Airlines flight from Washington DC to Los Angeles was also hijacked and crashed into the Pentagon at 9:43 AM. A fourth hijacked plane, United Airlines flight #93 from Newark to San Francisco with 45 people aboard never reached its target, the White House. A few brave and fearless people altered the final course of that flight by attacking the hijackers causing the plane to crash in a Pennsylvania field killing all aboard. First responders in New York City had the course of history set out for them that morning. All are heroes who gave their lives and good health to save others attempting to save those still alive and trapped in the wreckage. The first responders who died valiantly that day included: Firemen 337; Port Authority Police 37; NYPD 23; NYS Tax Investigators 5; NYS Court Officers 3; FBI Agent l; Secret Service Agent l; FDNY Fire Marshall l; and Federal Fish and Wild Life Agent l.

Heroes lost in the towers numbered in the thousands, many of whose remains will never be found. For many months thereafter, mass efforts were dedicated to searching for any signs of life or excavating remains for burial and return to mourning families. These men and women breathed in air that was laden with asbestos, chemical fumes, finite particles of glass, steel, plastics and wood among others. Those 2500 contaminants flowing through the air were inhaled into the lungs and absorbed into the skin of the first responders. The clean-up lasted for months, with the First Responders inadequately protected as the EPA gave the downtown air the green light, and former New Jersey Governor, Christine Todd Whitman, said “I am glad to reassure the people of NY that the air is safe to breathe”. I can remember that evil appearing, fast moving, dark, dense, lethal cloud. That cloud was composed of pulverized, aerosolized concrete, steel, asbestos, electronics, plastic, and human remains. It consisted of more than 2500 contaminants. Workers, Police Officers, Firemen and many others from around the Country came to NYC to help in this massive effort. They were all subjected to this deadly air that was still full of the toxins that eventually took toll on all. Some died soon thereafter, while others suffer to this day the effects of exposure to the poisons of 9/11.

Aside from the immediate psychological trauma and later PTSD suffered by these workers, the first medical disease they exhibited was a new kind of cough, not typical asthma and not infectious bronchitis, but a cough that lingered and resulted in over a 4 week period of disability which was

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named the WTC or 9/11 cough. Not too long after that we began noticing peculiar diseases occurring in the people who worked at the Ground Zero site, aka ‘the pile’. Symptoms included weakness, exhaustion, insomnia, headache and other physical aches and pains, along with depression, cough and skin rashes of all sorts. Some of these people were noted to have sweat oozing out of their pores, which was blue, black and gray. Slivers of glass were also included in the sweat. Diseases do not match up with previously known risk factors. Patients were the wrong age or the wrong gender. Many of the first responders became disabled and took early retirement. Within five years after 9/11 there were 21 deaths and 75 diagnoses of various cancers and sarcoidosis among these workers. As time past and the number of people with illnesses increased, it became obvious that governmental financial aid would be needed in monitoring the health and treating the diseases of these first responders. Benefits for the medical care of the first responders became a political football. In 2006, NYS Governor George Pataki signed legislation to include death benefits for ground zero workers whose cause of death is either respiratory or cancer. Federal legislation, HR847, The James Zagroda 9/11 Health Compensation Act of 2010 was written to “amend the Public Health Service Act to extend and improve protections and services to individuals directly impacted by the terrorists attack in NYC on 9/11/01.” This was introduced in February 2009 and passed at the end of 2010. Meanwhile NYC and NYS repeatedly stated that these respiratory diseases and various cancers were not directly caused by ground zero exposure. In the US Senate, the Republicans filibustered against providing this coverage. On December 9, 2010, the Republicans maintained that they would continue to block such bills as long as there was an issue of extending tax cuts for families earning more than $250,000. (does this sound familiar?)

Detective James Zagroda was the first NYPD officer whose death was attributed to exposure to toxic chemicals at Ground Zero. He joined the police department in 1992, was a healthy non-smoker, and did not have a history of asthma or any respiratory condition. He spent 450 hours at the “site” working on recovery efforts. Weeks later he developed a persistent cough, developed shortness of breath and was unable to walk more than 100 feet without gasping for air. Zagroda, who died at the age of 34, was first autopsied by the Ocean County NJ Medical Examiner who reported “it is felt with a reasonable degree of certainty that the cause of death in this case was directly related to the 9/11 incident”. He described “unidentified foreign materials” in Zagroda’s lungs. The Armed Forces Institute of Pathology identified these substances as calcium phosphate, talc, cellulose and methacrylate plastic. The NYC Medical Examiners office performed a second autopsy which concluded that Detective Zagroda’s death was not related to the time he spent at ground zero. Two NYC medical examiners stated empirically beyond any doubt, that the foreign matter in his lungs did not get there as a result of inhaling dust at the site. They stated that the foreign substances were the result of “injecting prescription drugs”. Zagroda’s family requested a third examination, this time by the chief forensic pathologist of the NY State Police (he was formerly a medical examiner in NYC). Citing the presence of glass fibers in the lungs which could not be inhaled by self-injecting as well as other hard evidence, he concluded that James Zagroda died as a direct result of his efforts at the 9/11 cleanup site. When I first reviewed what came out of these lung washings and the peculiar sweat of these patients as well as their most peculiar diseases, I predicted that in the future their body defenses would be compromised. Their immune systems would turn against them or

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become dysfunctional and the results in years to come would be immune diseases or a multitude of unusual cancers which would occur in frequent numbers for those first responders who worked at ground zero. Unfortunately this prediction has come to be.

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**Hands Across Generations . . . Growing the AAP**

*By Kelsey Logan, MD, MPH, FAAP*

Section on Young Physicians Chair

Some of you may know that the Section on Young Physicians (SOYP) and the SOSM recently co-hosted a successful president-elect candidate call with Drs. Brown and McInerny. Dr. Crain and I were able to pose questions to the candidates that applied to senior and young pediatricians, and we appreciate input for questions from the SOSM. It was a new spin on interviewing candidates, and we had much fun doing it!

As we prepared for and followed up on this call, Dr. Crain and I found we have many of the same goals for our sections and need new outlets to achieve them: promote the health of children, create opportunities for pediatrician growth, recognize value for AAP membership, and promote member AAP involvement/investment. We in the SOYP have been experiencing the same frustrations everyone else in the AAP has...dropping membership, complaint about cost, and questions about the ‘value of the AAP’.

Specifically, barriers to membership and involvement include an apparent lack of effective communication and the perceived barriers of large dues and not enough time. These are big issues, and none of us should be recreating work when we can band together. A new working relationship between the SOYP and the SOSM really complements a natural fit, as the AAP needs what this can provide: mentorship, inspiration, and camaraderie. We will be working on this in the upcoming months.

On the candidate call, Dr. Brown mentioned she would like to see our sections work together to contribute to the AAP. Both candidates felt our sections have important perspectives that would help us all increase efficacy of the organization. Here’s a quick overview of how our section is designed, based on our strategic plan:

- Educate our membership on important issues to young pediatricians (MOC, advocacy, leadership training),
- Encourage communication with members via email, chapter reports, newsletters, and direct contact,
- Develop programs on MOC, mentoring, social media, and
- Encourage YP involvement and representation in chapter leadership, national leadership, and speaking engagements.

What I am asking of you is to support the SOYP and the SOSM in our efforts to collaborate on a variety of projects or adventures. We value your input in how we can help the AAP be a better organization and how we can be better pediatricians. We need your advice on mentoring (and may ask you to mentor or be mentored!), how the AAP can connect with young and senior members in a meaningful way, and how we can work together to contribute substance to the organization we love.

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Over the past few months, I have enjoyed being challenged by senior members to raise more money, get more members to vote, etc.!

Friendly competition, in addition to collaboration, is something the SOYP needs. Challenges are welcome! If you know a YP, I challenge you to ask about AAP involvement. Most of us got involved in the AAP because of direct contact or mentoring from an older, wiser pediatrician. That needs to continue. While we have to have an organizational approach to involvement, person-to-person contact has to continue as the foundation of recruitment. This helps young members see how much the AAP means and does. In a world of email and text bombardment, face-to-face or phone contact means more and is not often ignored.

Lastly, Dr. Crain recently contributed a wonderful piece to our newsletter on why she is an AAP member. You inspire and educate us, and we need your stories. Please feel free to contact me or Dr. Crain with ideas on how we can make collaboration stronger. The YPs look forward to working with you.

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Did You Know?

The Academy Travel Office is here to serve your travel needs Monday thru Friday from 8:00 am till 4:30 pm 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.

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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/seniors
Letters to the Editor

To the editor:

Reading Dr. Annunziato’s article on the Joslin/Tolstoi debate in the summer edition of the Senior Bulletin. I was reminded of the lecture that stands out mostly clearly in my mind from my medical school days of 60 years ago. It was the pediatric rotation in the spring of our third year, which puts it in 1950. Dr. Lawson Wilkins, professor of pediatric endocrinology at Johns Hopkins, would be talking on diabetes and brought a guest speaker with him.

I do not recall her name, but she was a woman in her mid-forties, beginning to get a little gray hair, but appearing quite healthy. She related her story to us. She had developed diabetes at the age of eleven. Insulin had not been isolated at that time. Her family obtained the best care available at that time; she was put on a diet in which the major part of the calories were from fat, and not very palatable. But she continued on a rather rapid down-hill course, and the family was very concerned that she did not have long to live. (I do not recall that she mentioned the use of alcohol for calories; perhaps that was not considered for children.)

Her father was in the newspaper business – writer, reporter, publisher – I forget which. But through the newspapers, he read about the work on insulin by Banting and Best in Toronto, and contacted them. They were willing to make available to him what little insulin they had obtained. He made a little wooden chest with insulation to contain ice; carried this on the train from Baltimore to Toronto, and in Banting’s lab obtained sufficient insulin to supply his daughter for about 3 days. He promptly got on the train back to Baltimore, and even in the 3 days that she received it, improvement was noted. He got on the train again, went back to Toronto and obtained the next available quantity of insulin for a few more days.

Her father made many train trips to Toronto

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John Raffensperger, MD, FAAP

To the editor:

In these days when medicine depends so much on technology, your readers might be interested in a new book, “Two Scottish Tales of Medical Compassion” that was just released by Cosimo Classics. The first story, “Rab and his Friends” at first glance seems to be a dog story, but in reality is a description of a mastectomy performed in 1830 before anesthesia or antisepsis. The surgeon, James Syme, became the chief surgeon at the Edinburgh School of Medicine and the father in law of Joseph Lister who discovered antisepsis. The author, John Brown, a student at the time of the operation became a much beloved Edinburgh physician and the author of many essays and short stories. He was the physician to Mrs. Samuel Clemens when Mark Twain visited Edinburgh. William Osler reviewed “Rab and His Friends” while he was still a student; it was his first book review. The second story, “A Doctor of the Old School”, tells of a family physician who made his rounds in the Highlands of Scotland by horseback during the latter part of the 19th century. It is a heartwarming, delightful story of “personalized”, medicine practiced from the heart. I was so taken by these two stories, that I put them together along with a brief history of the Edinburgh School of Medicine to show the connections between how medicine was taught there and the stories. I spent years, finding a publisher because these two stories should again be brought to the public and especially the medical profession. Any physician who reads “Two Scottish Tales of Medical Compassion” will hasten to make a gift of the book to every medical student of his acquaintance. The book can be obtained direct from the publisher, Cosimobooks or from Amazon.

John Raffensperger, MD, FAAP
during that year, obtaining increasing amounts of insulin as it became available. During that year or two, methods were developed to produce insulin in amounts that it could be generally available to diabetics. In telling us about this 30 years later, she certainly made it clear to us students what Best and Banting’s work had meant to diabetics. So now, 90 years after they did their early work on insulin, I still feel that I had a very real contact with one of their first patients.

**Letters to the Editor Continued from Page 10**

The AAP Section for Senior Members would like to thank Mead Johnson Nutrition for their support of the Child Advocacy Award.

**Tomorrow’s Children Endowment Funds Urgent Needs**

Thanks to the contributions of donors to Tomorrow’s Children Endowment (TCE), the American Academy of Pediatrics (AAP) has been able to fund programs that address some of the most urgent and pressing need affecting children’s health today and in the future.

The TCE was established in 2001, growing from $90,000 to its current value of $1.8 million as of July 31, 2011. There are another $6 million of known pledges and planned gifts, such as bequests legacies, insurance, charitable trusts, and charitable gift annuities that will be added to the endowment in the future.

The first project that TCE funded was for Hurricane Katrina Disaster Response. Additional funding was used to establish a Disaster Response webpage on AAP.org. Other past projects have included funding an Immunization Alliance, a coalition of organizations to preserve the health of the nation’s children through immunizations, and funding Disaster Preparedness Courses that have been presented now in several countries.

Recently, TCE provided $75,000 to help launch AAP’s Obesity Initiative. This initiative will help pediatricians, parents, communities, and children to address the rising epidemic of overweight and obese children. Overweight threatens not only children’s current health but their future adult health. Overweight and obese children are at greater risk for diabetes, hypertension, hypercholesterolemia, heart disease, pancreatitis, gallstones, and other physical and mental health issues.

Past and current donors to TCE have created a legacy that continues to provide resources to help the AAP now and in the future to meet its mission of obtaining optimal physical and mental health and well being of ALL children. Everyone is welcome to contribute to the endowment; all endowment gifts no matter the size are important to the future health and well-being of children.

For more information about making a gift for Tomorrow’s Children, please contact Joseph Like, CFRE, at 847-434-4740 or jlike@aap.org.
Volunteer with Health Volunteers Overseas

By Danielle Stonehirsch

A private, nonprofit organization, Health Volunteers Overseas was founded in 1986 to improve global health through education of local health care providers. In 25 years of service, HVO’s training has transformed lives – of the health care providers, their colleagues and patients, and of the HVO volunteers themselves. HVO designs and implements clinical and didactic education programs in child health, primary care, trauma and rehabilitation, essential surgical care, oral health, blood disorders and cancer, infectious disease, nursing education and wound management. In more than 25 resource-poor countries, HVO volunteers train, mentor and provide critical professional support to health care providers who care for the neediest populations in the most difficult of circumstances.

HVO programs are staffed by short-term volunteers – fully licensed and trained health care professionals committed to sharing their knowledge and skills. There are also opportunities for senior residents accompanied by a consultant mentor. The average assignment is 4 weeks, although some programs do offer shorter assignment options. Volunteers pay for their own travel expenses and usually a minimal fee for housing, normally at a guest house close to the hospital.

HVO currently has pediatric programs in four countries: Bhutan, Nicaragua, St. Lucia, and Uganda. Each of these programs is kept running by a team of staff and volunteers, both locally and abroad. Each program has a North American director responsible for approving and preparing all candidates.

Dr. Alia Antoon, Chief of Pediatrics at Shriner’s Hospital for Children in Boston and Assistant Clinical Professor of Medicine at Harvard Medical School, has volunteered with HVO’s pediatric programs three times in the last eight years, and is scheduled to visit Bhutan for a month this fall. She has already fulfilled assignments in Nicaragua, Cambodia, and Uganda. Her first assignment was in Siem Reap, Cambodia, at the Angkor Hospital for Children. HVO no longer has an official pediatric program there, but does still occasionally send subspecialists, including specialists in hematology, nephrology, and GI. AHC is a fifty bed hospital whose mission is to provide a center for the further education and clinical training of medical professionals while delivering high quality health care to the children of Cambodia. In

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addition, the hospital serves as a regional training center for outlying facilities. Each morning, Dr. Antoon attended teaching rounds, observed and discussed patient diagnosis and management with trainees, and gave a lecture. In addition to her experiences at the hospital, she was also able to visit two health centers and make home visits. She was also able participate in a tangible step towards progress: “One of the other works I was involved with was helping the Director of Medical Education, Dr. Rathi Guhadasan, with the curriculum development...I reviewed the full two year curriculum and found it very comprehensive and challenging and thought it met all the criteria for a good pediatric training program. I approved it and I think it also can become a benchmark for other pediatric training programs in Cambodia.”

At Mulago Hospital in Kampala, Uganda, Dr. Antoon participated in rounds and gave lectures on pediatric endocrinology: “I scheduled...the pediatric endocrine lectures for the post-graduates starting the second week daily between 1:00 and 2:00 p.m., covering the matter with a baseline knowledge of the area of interest. For example, pituitary, adrenal, thyroid, sexual maturation, etc. The sessions were interactive and practical, and I tried to help the residents utilize whatever is available to them to reach the accurate diagnosis.” Mulago takes both general pediatricians and sub-specialists. Volunteers participate in a teaching program on pediatric topics of need and interest, designed jointly with the department faculty. Volunteers attend Pediatric Department conferences and grand rounds, participate in hospital rounds, and teach postgraduate and medical students. About once a week, volunteers attend a specialty clinic of interest.

Dr. Antoon will be headed to Bhutan in October for her next assignment. The National Referral Hospital in Thimpu, Bhutan accepts volunteers for assignments of one month, and general pediatricians are preferred. Each volunteer is asked to prepare in advance and give at least two presentations during their assignment. The general pediatric floor admits patients under 12-years-old and diagnoses are made on a clinical basis.

The HVO program in Nicaragua focuses on training in four main areas: neonatology, general pediatrics, pediatric burn management, and community outreach/public health. Volunteers work in two hospitals: Hospital Infantil Manuel Jesus Rivera and Hospital Fernando Velez Paiz. Both are government run and mostly free for patients. Volunteers are involved in training through lecturing and presentations as well as by conducting rounds. They will also provide hands-on demonstrations.

In St. Lucia, pediatricians volunteer at St. Jude Hospital by providing pediatric care through activities such as covering the delivery room for complications, examining babies on discharge, working on the pediatric ward, and covering the clinic and emergency room. The program goals are to teach and train St. Lucian pediatric house staff in areas including, but not limited to asthma, nephritic syndrome, chronic developmental disorders, cardiology, infections disease, and neonatology.

Uganda, St. Lucia, Nicaragua, and Bhutan are beautiful and exciting countries which each provide different and rewarding experiences for individuals looking to do their part in making a difference in global healthcare. By teaching professionals at these program sites how to improve their healthcare practices, you can have a great impact with effects lasting long after you have returned home. If you are interested in a volunteer assignment, check out HVO's website (www.hvousa.org) or contact Danielle Stonehirsch at d.stonehirsch@hvousa.org for more information.
A Report from Bill Kueffner, Ninety-One Years Young

On March 14, 1920, in St. Paul, Minnesota, Helen and Bill Kueffner became the proud parents of a baby boy, William Robert Kueffner. The family lived in St. Paul, where the senior William worked as an attorney, and spent summers at a family cottage in Marine on St. Croix. Bill attended Creighton High School where he was a good student and a strong member of the swim team. He also was a Boy Scout and earned the honor of Eagle Scout. He went on to Carleton College (Class of 1941) on a full scholarship. Over the summer he worked at Glacier National Park Hotel. During his time off, Bill would go hiking in the park’s mountains, often with the hotel photographer who was diabetic. Not yet trained in medicine, Bill enjoys remembering how the photographer would eat raisins when he “needed a boost.” At one point he had considered studying engineering, but after two years at Carleton, he transferred to the University of Minnesota where he went into a premed program. With schedules compressed because of the war, Bill graduated from their medical school in 1943. The entire medical school was enrolled in the ASTP – Army Student Training Program. The Army would pay for their education, but they would become medical officers.

After graduating, Bill started his internship at City Hospital in Washington, D.C., until he was sent to Camp Upton Army Hospital on Long Island for Army medical training. There he met an occupational therapist named Elizabeth. They married at St. Patrick’s Rectory in New York City. Shortly thereafter, Bill was sent to Italy as a Battalion Surgeon, rising to the rank of Captain in the 10th Mountain Division. He replaced a doctor who had walked the wrong way into enemy lines and had been captured. Bill looked after the soldiers in the 2nd Battalion in the Apennine mountains of Central Italy. The wounded brought in by the medics were treated or sent back to a M.A.S.H. He celebrated VE day at a battalion aide station he had set up on beautiful Lake Garda, across the water from the villa where Mussolini and his mistress were captured. After that, the 10th Mountain Division was rumored to be the lead attack in the invasion of Japan until the surrender after Hiroshima changed those orders.

Back in the States, Bill and Elizabeth’s first son, Bruce, was born in October, 1945. The young family moved to Brighton in Boston where Bill gained pediatric training at Boston Children’s Hospital and Harvard Medical School. It was a wonderful opportunity to meet renowned doctors, pioneers in pediatrics, such as Dr. Gross, Dr. Green, Dr. James Gambol, Dr. Lewis Diamond, Dr. Sydney Farber, and Dr. Charles Janeway.

Why did Bill decide to go into pediatrics? “I liked children and I had been encouraged by Dr. Lewis Sweet during my internship in Washington,” he said. In June, 1946, Bill and Elizabeth moved to New York City and Bill studied at Cornell Medical School at New York Hospital. They lived in a fifth floor walk-up on East 75th Street.

They later moved to Fairfield, Connecticut, closer to Elizabeth’s parents, where Bill started his practice in 1949. That same year their second son, John, was born. As a young pediatrician, Bill volunteered his services as team doctor for the Roger Ludlowe High School football squad. He was amazed how, despite their injuries, the players always wanted to get back on the field. Over the years, the practice grew and moved from a second floor office over Clampett’s Drug Store to a house in downtown Fairfield.

In 1951, Bill’s wife Elizabeth was diagnosed with breast cancer at the age of 32. She died the following year. With two young sons and a fledgling practice, Bill was a busy man. He met Nancy during a ski weekend with friends and they were married in 1953. In the years to follow, the family grew from four to eight: sons Paul, Eric, Carl, and Chris were born.

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A doctor from the old school, or at least one from an earlier time, Bill made house calls all over town carrying his familiar doctor's bag, which is now part of the collection at the Fairfield Historical Society Museum. As a result, he still knows Fairfield's streets as well as any firefighter. Patients also came to the house on Old Academy Road to be checked or examined - that is, if they hadn't been cured over the phone while he sat at the table during family meals.

One family, short on funds, offered Bill a weekly supply of eggs in return for his pediatric services. Unfortunately, the hens stopped laying. So the family presented Bill with a donkey instead. Christened Sybil, the donkey was warily accepted, but enjoyed by a sleigh full of Kueffner boys on the next available snow day.

In 1957, Bill and his partner, Frank Scholan, moved their office to a 200-year-old building that served as a Tide Mill, and later a restaurant, overlooking the harbor in Southport, Connecticut. With intriguing waterfowl outside the windows, the waiting room was equipped with fascinating push-button, pinging distractions for children—old typewriters, telephones, cash registers, and airplane controls that Bill obtained from the Salvation Army. When the building came up for sale in 1974, Bill took a deep breath and bought it from the Wackman Boys Club. With retirement in mind, he and Nancy had their sons build a compact, but airy apartment on the third floor, where Bill lives today.

Bill has long been active in both Fairfield and in the local medical community. He served on Fairfield's Board of Health for a number of years. He has been a member of the staff at Bridgeport, St. Vincent's, and Norwalk Hospitals. He headed the pediatric department at Bridgeport Hospital for several years. He also worked at Yale Medical School, and was the Connecticut State Chairman of the American Academy of Pediatrics.

Finally, in 1985, Bill retired, but he didn't slow down. Fulfilling a long-held goal, he volunteered at the Albert Schweitzer Hospital in Haiti, contributing fully his career-long experience and expertise. He and Nancy made several subsequent trips to Haiti where they both volunteered their services. Between visits, he helped raise funds, and he located sources of medicine and supplies for the hospital. He continues to be very active in supporting the hospital today.

Bill never loses his enthusiasm to be involved with people and projects—from his dedicated efforts in Haiti to attracting purple martins to the Tide Mill martin house, from helping research and shepherd the design and construction of handicap ramps at the Pequot Yacht Club and at the Fairfield Beach Club, to tending to his plants in his greenhouse. While managing to stay quite active in the community, Bill spent the last several years caring for Nancy, who developed Alzheimer's and died in 2007.

These days, it's hard for Bill to go anywhere without someone saying “Hi, Dr. Kueffner, I was one of your patients.” Often there are generations of patients —children and their parents. Arthritis and glaucoma don’t slow him down. To him, these are inconveniences, not impediments, and not enough to prevent him from being the first on the dance floor at the Pequot Yacht Club, where he has sailed for more than 50 years.

What is Bill’s advice to young pediatricians? Bill said, “One should choose pediatrics because one wants to help children and their parents. Making money is not the goal. If that’s what you’re after, go into finance! The reward in our profession comes from the satisfaction after an accurate diagnosis and successful cure and a smiling patient.” And what is most important? “We should take the time to listen,” says Bill.
Customer Service?

By Joseph A.C. Girone, MD, FAAP

You have called customer service for a variety of purchases and insurance plans. After the “on hold” time, you are familiar with the message, “This call will be recorded for quality assurance and training purposes.”

That’s where I come in. I listen and evaluate the recordings and then give feedback to the customer representatives who answer the calls. I’m going to take you behind the scenes to eaves-drop on one of my feedback sessions with a customer representative. Here’s what I said to the rep after listening to the call.

My first suggestion is that you use your real name. I know your name and it wasn’t the name you gave to the customer on this call. I know reps give either fictitious names or the name of another rep just in case the problem isn’t solved satisfactorily or the customer isn’t pleased. Don’t do it.

When in training, you were taught to initiate the encounter with, “how can I help you today?” You asked, “So, what’s the problem now?” This response puts the caller on the defensive. The caller feels this question implies they have called in the past and they are a nuisance. Let’s be more touchy-feely with, “What can I do to help you?”

After the customer relates the reason for the call, a positive statement such as, “I understand your problem”, is appropriate. Your response, “So, what do you want me to do?” does not generate confidence in your ability to handle the problem.

The customer is asking for your assistance so your next statements, “Have you tried anything to solve the problem” and “Have you asked all of your family and friends for their opinion”, aren’t called for.

It’s best not to say anything personal about the customer. Your observation to the caller of “your voice is really annoying” just can’t happen again.

Comments about the problem, such as, “Hm, you’re in real trouble” only make the customer more anxious. “Let me see how I can help you”, is more reassuring.

When the caller began to cry, this was an opportunity for you to show compassion and reassurance rather than your response, “this is ridiculous. Get hold of yourself.”

Try to give the caller confidence in your ability to solve the problem. Your statements, “This sounds weird. Let me ask someone” and “I’m new and I’m not sure what to do” aren’t confidence builders. “I’m going to ask my supervisor who has more experience” is better.

I know some calls are frustrating, but you can’t say, “You’re breaking up. Call back.” and then hang up the phone. If you need a break, you can say, “You’re breaking up. What is your name and phone number and I will call you back.”

That’s it, a typical feedback session. Keep it in mind the next time your call is recorded.
As a complement to their investment portfolios, many retirees and those close to retirement are increasing their bond holdings in an effort to add diversification and reduce their overall risk exposure. Caution needs to be exercised, however, as many investors are under the misunderstanding that bonds cannot lose principal value.

From the moment a bond is purchased, it is subject to market fluctuation. A prime cause of the fluctuation is often attributable to overall changes in interest rates. As a general rule, bonds move inversely with interest rates. If interest rates go higher, bond prices decrease, and conversely, they go up in value as interest rates decrease. Other bond investment risks include “credit risk”, which rating agencies define as the ability of the issuer to pay back interest as well as principal. Beyond credit and market risk, there is also the risk that the issuer will “call” the bond prior to maturity at a pre-stated value.

Once you decide to add bonds to a portfolio, you must also determine how to structure the implementation. Bonds can be purchased on an individual basis, within a unit investment trust (UIT), or through a mutual fund. Constructing a portfolio of individual bonds offers more direct control over maturity, face value, bond type, credit range, and other bond characteristics. While this approach may be useful for matching future liabilities and pursuing other investment objectives, achieving broad diversification with a custom portfolio may prove a challenge. The portfolio may be less liquid, more expensive to trade, and require a higher degree of oversight than is feasible for the average investor.

In order to provide greater diversification and reduce the impact of individual defaults, many firms offer UITs. The portfolio manager assembles a variety of bonds with similar maturities that can be categorized as short-, intermediate- or long-term to form a UIT. Most UITs purchase bonds from 20 to 30 issuers, thus allowing the investor to spread his risk by buying a piece of all of the bonds within the portfolio. As the individual bonds within the trust mature, the proceeds are paid to the investor.

As an alternative to UITs, investors looking for additional bond diversification can buy shares in a mutual fund, which may have hundreds or even thousands of different bond issues. Since bonds are traded through a network of dealers and not a centralized exchange, bond funds have better access to multiple dealers than most individual investors. They also have the capacity for large-volume trades, which provides a cost advantage over smaller investors, particularly when trying to buy more bonds to increase diversification. Funds tend to offer better liquidity and broader diversification across issue type, maturity, credit quality, and geography, although shareholders do not control the selection of bonds in the portfolio. Shareholders can also access daily fund prices and know the average credit rating within the portfolio. Equally important, the fund managers are expected to monitor average yields at different maturities, qualities, and regions to gauge the relative riskiness of different issues.

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Keep in mind that when investing in a bond mutual fund, you are never guaranteed the repayment of your principal, even when bonds mature. From a liquidity standpoint, bond mutual fund shares can be sold at any time, at the value at the time, which may be more or less than your original investment.

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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**Leadership Openings for the Section for Senior Members**

In March 2012, an election ballot for leadership positions for the Section for Senior Members Executive Committee will be available for all section members.

The Chairperson position and three Executive Committee member positions are open.

If you are interested in learning more about a leadership position on the Section for Senior Members, please contact George Cohen, MD, FAAP at gicohen@verizon.net.