Message from the Chairperson

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

As we begin the new year with many tasks ahead, I’d like to share the following resolution, which the Section on Senior Members will present for vote and, hopefully, approval at the Annual Leadership Forum (ALF) this March. Members of the Section Executive Committee are well aware of the difficulties with personal health, travel, and other infirmities had by many of our Section members. Not the least of these “infirmities” is financial strain, living on fixed incomes, with retirement plans which were designed when costs of living were fractions of today’s reality. When Executive Committee member Stan Singer proposed a travel plan for Section members, feedback from a section membership survey confirmed that only a fraction of our members consider significant travel a likely option, due to the above reasons. The Executive Committee, concerned with these data, proposed the following resolution, which I plan to present on behalf of our Section at the Annual Leadership Forum in March. I ask that you read it over and encourage your Chapter and District Leadership to support this resolution, which has primary purpose of encouraging membership retention among our most faithful and most senior members of the American Academy of Pediatrics.
Resolution #15T
2012 Annual Leadership Forum

TITLE:
Membership dues forgiveness for longtime AAP members

SUBMITTED BY:
Section on Senior Members

DATE:

Whereas, There are fellows of the Academy who have contributed their time, talent and money to the AAP for thirty, forty and even fifty years or more, and

Whereas, There is a strong sense among the AAP membership that the service of these faithful fellows should be rewarded, and

Whereas, Both President-Elect candidates expressed support for the idea during a recent teleconference. Therefore, let it be

RESOLVED, The American Academy of Pediatrics provide lifetime complementary membership for fellows age 85 and older who have been members in good standing of the AAP for 30 years or more.

REFER TO:
2012 Annual Leadership Forum

AUTHOR/CONTACT
PERSON: Michael O’Halloran
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Supporting background for the resolution will be presented at the ALF, but you should note that there is a complete description of AAP membership categories on our website. The Department of Membership of the AAP reported to our Executive Committee in Boston this October that 334 FAAPs elected
“emeritus” membership this year, as of October 2011, and 96 elected to change their membership to “retired”. No accurate data were provided regarding how many members are lost to death or inability to continue membership because of the cost of dues. Simply looking at the advantages of Emeritus or Retired membership categories, it sounds like an inviting deal for eligible members! On the other hand, we know that the “Baby Boomer” generation is beginning to age out, and that without some innovative adjustments of the dues schedule and more concerted efforts at membership retention, those older members electing to become emeritus members, pay reduced dues, and opt out of being eligible to hold AAP offices will only increase.

So, our resolution is a modest proposal in the larger scope of overall AAP seniors. The Section on Senior Members has only 59 members who are age 85 or older (from a total section membership of about 600). Why do eligible seniors opt to not join the Senior Section? We’ve invitedFAAPs age 55 and older in good standing to join the Section with dues waived (in lieu of donation to Friends of Children or another AAP philanthropic entity) their first year. We provide a terrific website full of information crucially important for seniors, a quarterly Senior Bulletin, and a top notch annual Section Education Program at the NCE. We can help retain senior members if they are members of our Section! The executive committee was told by Membership at our October meeting that AAP leadership is considering increasing the age of eligibility for emeritus membership to age 67 or even older to attempt to stem this tide of older membership attrition. The executive committee of SOSM opposed this recommendation and recommended instead that the entire AAP dues structure and membership composition trends be studied for more fair and judicious recommendations.

Finally, it is with sadness that I report the death on November 29, 2011 of Dr. David Annunziato of Amityville, New York. He was former chair of the Section on Senior Members, past New York District chairman, esteemed colleague, mentor, and friend. Even during his prolonged illness, Dr. Annunziato died at age 90 after a long illness. He remained actively involved in AAP efforts, mostly from his home office the last few years of his life. He continued to have strong, informed opinions about a variety of pediatric topics and submitted a resolution to the 2011 ALE. We extend deepest sympathy to his wife Ruth, their two children and a granddaughter. David leaves a widespread legacy appreciated by his many pediatric students and residents, his pediatric colleagues, and his many patients and their families. He truly made a difference in so many lives and in so many ways.

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**Did You Know . . . ?**

A neat shortcut is available to allow you to get to our Section on Senior Members web site really fast.

Try it, you’ll like it!

Happy browsing.

www.aap.org/seniors

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As a pediatrician who’s now somewhat older
I’ve found a true professional home
Where my thoughts could be ever bolder
Of course it’s AAP’s own Senior Section
And now I’m so very thankful
That’s where I’ve made a firm connection!

Al Scherzer, MD
Stony Brook University School, of Medicine
Call for Nominations for Senior Executive Committee Positions: SECOND NOTICE

The Section on Senior Members (along with all other AAP Sections and Councils) will have a ballot on-line for open executive committee positions.

If you are interested in running for a position on the Senior Section Executive Committee, please contact either George Cohen, MD at gjcohen@verizon.net or Jackie Noonan, MD at jnoonian@uky.edu.

The ballot will be posted beginning March 1 and will close on March 31, 2012. You will receive a notice from the AAP that it is time to vote as the election draws near.

SECTION PROGRAM

AAP Section on Senior Members
Sunday, October 21, 2012 • 1:00 to 5:00 PM
as part of the AAP NCE, New Orleans, LA

Description/Objectives: The challenges and opportunities, both professional and personal, for Pediatricians in their senior years are innumerable but not always immediately apparent or available without deliberate planning and preparation. Many find it necessary to reenter the work force because of lost income from failed investments. Others, more fortunate, continue to serve their communities on a voluntary basis. In whatever capacity pediatricians continue to serve, they are challenged to maintain their professional acumen as well as their mental agility. After attending this section program, members will (1) become familiar with the necessary steps to reenter the pediatric workforce after a period of separation, (2) be further prepared to evaluate opportunities to volunteer their professional services in the community and (3) learn of proven steps and programs to maintain and promote mental capacity and well being.

Moderator: Jim Shira, MD, FAAP

1:00 Transitions for Pediatricians: Reentering or Changing Practice
Elizabeth Grace, MD

2:00 Volunteer Opportunities for the Retired Physician: The Houston Experience
Peter V. Weston, MD

3:00 Break

3:15 Maintaining Mental Agility Throughout Life
Hilary McClafferty, MD, FAAP

4:15 Section Award Presentation

5:00 Section Reception

Award sponsored by Mead Johnson Nutrition
Don Berwick, pediatrician and national expert in the drive to improve health care, resigned on December 1, 2011 from his position as the official in charge of Medicare and Medicaid.

In a revealing article by Robert Pear in the New York Times, Dr. Berwick, with difficulty, attempted to stay away from the political schism currently severely impairing our national government. He received an interim appointment in April, 2010 to be the administrator of the Centers for Medicare and Medicaid Services. This came about as a result of the Senate’s (threatened filibuster by Republicans) refusal to confirm him by the usual process. This limited appointment was due to end on December 31, 2011.

“I came with an agenda,” Dr. Berwick stated. “I wanted to be a force for improvement, to try and change the agency which provides health insurance for one out of three Americans.”

Dr. Berwick believes that 20-30% of health care spending is “waste” that yields no benefit to patients. He listed five reasons for the high level of “waste”: (1) overtreatment of patients, (2) the failure to coordinate care, (3) the administrative complexity of the health care system, (4) burdensome rules, and (5) fraud.

When asked why Americans are still so deeply divided over health care reform (Affordable Care Act), he ascribed it due to the complexity of the law, but interestingly avoided the critical issues of cost, constitutionality and philosophical differences, as well as the widespread errors in interpretation of its features (death panels).

Dr. Berwick’s positive farewell remarks state that “we are a nation headed for more healing and much more healing and much safer care. There is a moon shot here, but somehow we have not put together the story in a way that is compelling.”

Secretary of Health and Human Services Kathleen Sebelius has announced that her department will award nearly $220 million to 13 states to help set up health insurance exchanges, the new marketplace for insurance plans. The 13 states which will receive the awards include seven which are suing to overturn the landmark law. They are Alabama, Arizona, Idaho, Iowa, Maine, Michigan and Nebraska. Accepting the money does not commit a state to follow through and establish a state exchange. Assuming that the ACA survives a Supreme Court decision in 2012, states which do not set up their individual state exchanges will have their omission filled by a federal exchange. The exchanges will function as a source of information and to provide help to those individuals and small businesses which are seeking to change their insurance programs or for those without insurance to make a choice based upon cost and benefits. It will also serve to help the newly eligible under Medicaid to enroll in that plan.

The Supreme Court has accepted the task of deciding the constitutionality of the Affordable Care Act. Hearings will begin in the spring of 2012, with a decision expected in the summer or fall of 2012. After various lower courts came to widely differing opinions on the question of constitutionality, with a majority giving positive opinions that the act is within the boundaries of the Constitution. The Court is allowing five hours of oral arguments instead of the usual one hour. A surprise from the Court was an unexpected allotment of time given to review of Medicaid with reference to the Federal-State relationship. Where this will lead is somewhat perplexing.

As with all legislation, the ACA is a framework which requires definition through rules and regulations to enable it to become functional.

To move forward on the decision to identify Continued on Page 6
what can be defined as essential health benefits for children, HHS elected to hold listening sessions in 12 locations throughout the United States. In Denver (where I testified), the presentation was made to the Regional Medical Coordinator and an Assistant Secretary of Health. My emphasis was on the importance of including a comprehensive program of benefits such as those covered by the EPSDT. This appeared to be well understood and hopefully will be incorporated in the final regulations.

Because the Select Committee on Deficit Reduction (the Supercommittee) was unable to reach agreement on how to reduce the national debt by $1.2 trillion over the next 10 years, an automatic trigger has been activated and is scheduled to take place in 2013. This scenario would require a reduction of spending in the Medicare and Defense Department programs equaling $1.2 trillion. However, bills to modify this previous agreement have already been introduced in the Congress, and although Medicaid was originally spared any significant reduction, the possibility of a completely new version of budget reduction is very likely putting Medicaid at risk for the next few years.

In an effort to help Congress and their staffs understand the importance of Medicaid to children and to foster the concept of “first do no harm,” educational programs co-sponsored by the Academy and more than 30 other members of the coalition of child advocacy groups are being given in Washington with a good response.

Finally, the good news. The Georgetown Center for Children and Families released a report that found that in spite of the rise in both unemployment and child poverty in the past few years, the uninsured rate for U.S. children (ages 0-17 years) has fallen from 9.3% to 8% nationally. Onward!!

Please e-mail your thoughts and suggestions to me at donroschiff@comcast.net.
In Memorium

DAVID ANNUNZIATO, MD, FAAP
1921 - 2011

We were all pained and saddened to learn of the recent death of David Annunziato after a long and debilitating illness. David was a legendary icon to us in the Section on Senior Members. He was there from the inception of the section, almost single-handedly writing a valuable Chapter Guide for Senior Committees. After serving with distinction on our Executive Committee, David was elected Chair and continued to excel in that role. David never missed a section meeting or function, until limited by medical disability in recent years.

But the story of David Annunziato extends far beyond the Section on Senior Members. After practicing pediatrics — “the old-fashioned way” — and becoming a fixture on Long Island, NY, David progressed to hospital administration and education at what is now known as Nassau University Medical Center. I am told he was still found recently touring the halls and stairwells of his home-away-from-home, with his oxygen tank in tow.

David was elected as Chairman of District II (New York State) of the AAP and served two terms on the national Board of Directors. I personally had the good fortune to be perennially seated next to David — I was from District III — and we shared innumerable side-bars during Board deliberations. Abounding with energy, David has recently worked on expanding the historical archives of the AAP and served on a task force to coordinate that effort.

All of us who worked with, and for, David marveled at his enthusiasm, his love for the AAP, his total professionalism and his ability to lead with endearing humility. David and his loving wife, Ruth, could always be found in the midst of any AAP gathering — Ruth snapping photos, David holding court.

David has enriched us all and we are deeply appreciative to have had him for a mentor, a colleague and a friend.

Arthur Maron, MD, FAAP
MENTORS: Senior Section October 15, 2011

Mrs. Lanvoit, 4th grade teacher—she was old in 1950. I’m sure she has a special place in heaven. Gave me a future.

My husband, J. Daniel Raulerson, MD, nephrologist, Inventor—he is old too but still working hard. My benefactor and best friend married to me for 50 years August 12.

Dr. Childers, Professor of English, University of Florida, now deceased. He taught me that Don Juan rhymes with true one. Advisor when I was a doctoral candidate—wrote a letter for me.

Roberta Dees, PhD, University of Florida, we were partners in crime when I taught in Community College. Taught me calculus over the phone when I went back to school at age 30 to do pre-med. Retired, lives in Charlotte, battling breast cancer.

Dr. Robert Cade, Professor University of Florida, College of Medicine, Scholar, inventor of Gatorade. Renaissance man also in heaven—driving a studebaker. Because of him I was accepted to University of Florida Med School at age 33.

Judy Baucher, MD, my Chief Resident—Recently retired from practice at Cincinnati Children’s Hospital, Emergency medicine. Now mentoring medical students, and residents working with the Arts in Cincinnati told me to go home when I was an intern.

Gerold Schiebler, MD, retired as Chairman, Dept of Pediatrics University of Florida and now lives at Amelia Island and takes the Greyhound Bus to Gainesville to tell Rick Bucharilli how to run his department. Working with a child’s Medical Home and advocating for the well-being of all children—his legacy.

Janet Silverstein, MD, now chairman

Lucy Crain, MD, MPH, FAAP (right) presents the 2011 Senior Child Advocacy Award to Marsha Raulerson, Med, MD, FAAP (left)

Endocrinology University of Florida, active AAP. A model for excellence.

Jay Whitworth, MD, now deceased. University of Florida, Jacksonville. My attending when I was a resident rotating at University Hospital, Jacksonville—my first experience with confronting child abuse. Later I had the privilege of working with him again with SWAN using telemedicine to provide physical exams to victims of child abuse. His addiction to tobacco probably caused his untimely death.

Carden Johnston, MD, was President of the AAP Alabama Chapter, when I moved to Alabama. He is now retired and lives in Birmingham. He remains very active with AAP. Launched my involvement with Alabama Chapter AAP.

Ed Rushton, MD, started my work with CATCH. I met him over the phone when I was an intern. Regina Benjamin, MD, present Surgeon General. Helped me navigate the Good-Old-Boys club of organized medicine. I can't catch up with her now.

Tommy Vaughan, MD Professor of Child

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Psychiatry UAB. He is working with me using telemedicine to bring psychiatric services to children in rural Alabama. What a kind gentle person he is!

Olson Huff, MD, Chairman, COFGA. My latest mentor and dear friend. I admire all the work he does in his retirement.


POETRY AND MEDICINE

BURNING FAITH

By Michael Wynn, DO

The things you did in the war. There is no explanation
For youth. Now 88, your right hand shakes, your voice is soft,
And your balance shot.
Blackbirds defending their nest harass a hawk
Passing overhead. You know that game.
Just trying to make your run and get home in one piece.
A bright March morning. The sights were off –
You were sure of it.
That bone white church had no right
Being on the west side of the Rhine.
You saw everything from the cockpit
And now, your recliner.
One bell from the clock. It’s the Sunday
Before Lent, your favorite.
You’ll be early to church like you were then.
Even if the pews are empty
You’re content
To sit and think – pray a little.
A steady hand when you reach
For the hymnal. Bach, page 34
O eternal fire, O love,
You will collect your souls…
You look outside during the sermon –
Watch the birds.
Children running out, eyes wider
Than their screams,
A few of them with ash only on their foreheads.
Careers for Pediatricians in Industry
A Largely Unknown Alternative

From the Provisional Section on Advances in Therapeutics Section of the AAP

Similar to the multiple career paths available to practicing physicians, there are many diverse and gratifying options for pediatricians outside of the traditional practice setting. To keep this article focused, we will discuss only careers in the pharmaceutical or biotechnology industry, but pediatricians should know there are many other options such as in health insurance and regulatory agencies (e.g., FDA). Perhaps the easiest way to grasp the spectrum of career choices in industry is to understand the drug development process. Typically, discovery chemists and biologists (basic science researchers) begin the process by selecting a receptor target, chemical, large molecule or antigens (e.g., vaccines) that have the potential to impact a disease state and are often advised during this process by physicians on the clinical aspects of the compound and program.

After significant preclinical testing, a promising candidate compound may enter the clinical trial stages of testing in humans. A pediatrician ushering this product through these various stages would be working in fields such as clinical development or patient safety. These physicians would use their clinical knowledge in addition to a host of other skills to design and implement clinical studies to test a drug's safety and efficacy. If the FDA or other global regulatory agency approves the product in question, a pediatrician working in Medical Affairs or Scientific Affairs now takes over as the medical expert on that product. Some pediatricians working in this area might be based at the company headquarters and oversee postmarketing safety studies, interact with key physicians working in the therapeutic area or educate the community physicians on the medical aspects of the product. Other pediatricians, often called medical science liaisons, might be field-based and act as the medical “ambassador” for the product to physicians, researchers and insurance companies in a designated geographic area. While there are certainly other areas within industry for physicians, clinical development, safety and medical affairs are some of the more common roles. Pediatricians in industry can work with drugs or biologics for adult use and are the experts for their use in pediatric patients. The timing is excellent for pediatricians in industry as every drug developed in the clinical space must be considered for use in children.

Regardless of the position, there are numerous advantages to working within industry compared to working in a clinical setting. Intellectually, an industry career is incredibly stimulating and offers opportunities to acquire new skills. Your work might allow you to become more proficient in public speaking or enhance your knowledge of biostatistics and epidemiology. You may have the opportunity to specialize in certain therapeutic areas or hone select skills like clinical trial design and medical writing. You will likely travel to national or international scientific meetings and have the opportunity to interact with leaders in the field. In addition, working in industry provides you a career path in which your growth in the company or therapeutic area is only limited by your interest, effort, and the skills and knowledge you acquire. Rather than treating individual patients, many of us working in industry feel that our work is improving the health and well-being of millions of children around the world through the discovery, development and translation of new medicines, devices and vaccines into practice.

While salaries in both clinical practice and industry are variable and beyond the scope of this article, there are a variety of human resource perks that may not be available in the practice setting (without raising the blood pressure of your

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partners). For example, many companies offer sick days (for your own recovery from illness, sick children, doctor’s visits, etc.), flexible work schedules, telecommuting options, tuition reimbursement plans, continuing education plans, and onsite gyms and daycares. In short, many companies are excellent employers and may treat you better than you treat yourself in the practice setting.

Despite the numerous positive aspects of a career in industry, there are some limitations. First, and probably foremost for many, is the lack of patient contact. Depending on your personality and interests, this issue may or may not be a negative for working in industry. Many industry pediatricians find creative and impactful ways to remain clinically active if so desired. Working in a large (or for that matter even a small) company can also result in a decent-sized serving of corporate politics and reporting structure. However, this experience may not be all that unfamiliar to those in academia or a group practice. Pediatricians in industry often find themselves “constantly connected” and working long hours. While the emergencies and urgencies are certainly different, the time and effort committed to the job is probably similar to our clinical counterparts with perhaps a bit more flexibility. Fortunately, we both have had positive experiences in regards to each of these limitations.

Ultimately, a career in industry can be an incredibly rewarding alternative to clinical practice. The options and growth opportunities are quite diverse for the pediatrician interested in bringing new medicines, devices and vaccines to patients. Unfortunately, these important career alternatives are largely unknown to many practicing physicians. We hope that the new Provisional Section on Advances in Therapeutics and Technology (P-SATT) will help to increase awareness of these options as well as improve education and collaboration among physicians to bring medical advances to children.

Sincerely,

Charles A. Thompson, MD FAAP
Chair
Provisional Section on Advances in Therapeutics and Technology
charles.a.thompson@pfizer.com

Seth Toback, MD FAAP
Newsletter Editor and ListServ Moderator
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About The Provisional Section on Advances in Therapeutics and Technology (P-SATT)

P-SATT was launched in July 2010 with a mission to advance pediatric health and well-being through collaboration, communication and education on the discovery and development of therapeutics and technology and their successful translation into practice. P-SATT’s diverse membership includes pediatricians working in industry, the Food and Drug Administration, clinical practice and other organizations.

If you would like to know more about our section or careers in industry, please feel free to contact either of us via the email addresses below. AAP members may join P-SATT by clicking this link, http://www.aap.org/moc/memberservices/sectionform.cfm, logging in as an AAP member, checking the box for “Advances in Therapeutics and Technology,” and completing the remainder of the form.
The Tragic Death of American Medicine –
IS IT TOO LATE FOR HEALTH CARE REFORM

By Lawrence D. Frenkel, MD, FAAP
Chair, Senior Section, New Jersey Chapter, AAP

During the past half century, powerful social and economic forces have changed the character of many facets of American life. Unfortunately, many of these changes detract from cherished expectations regarding our own health care and that delivered to others. These forces include: 1) the general loss of respect for authority, with the resulting distrust and hostility, 2) the broad application of “for profit” business practices to many aspects of American life previously thought to be in the realm of public good or social responsibility, and 3) increasing political intervention (including a multitude of state and federal “unfunded mandates” and regulations generated by legislative and executive branches) into aspects of health care previously thought to be private or otherwise sacrosanct from political influence.

Sadly, the United States is slowly losing its long held, well deserved, and generally uncontested reputation as offering the best health care, biomedical research, and medical education in the world. Although these detrimental forces have affected all three areas, the major negative effects are reflected in the deterioration of physician-patient relationships and the quality of care delivered in and out of the hospital.

The tremendous growth of the role of both governmental and non-governmental payers has had a tremendous influence on many aspects of health care delivery during the past 30 years. Certainly Medicare and Medicaid have had a positive and revolutionary effect on the quality of and access to care for the elderly and poor. However, under the guise of controlling costs, a variety of HMOs, PPOs, etc. were created. The reasoning behind their creation was an intellectual fraud. Increasing health care costs were never correctable by these new entities which only added further wasteful, onerous, and costly administrative burdens to the health care system. The problem of rapidly increasing health care costs in the United States was a reflection of at least five phenomena generally outside the focus of these new entities: the growth of life-saving but expensive pharmaceuticals and technology in patient care; the expectation that absolutely every medical option should be pursued regardless of prognosis or cost; the practice of “defensive medicine” to protect health care providers from often frivolous malpractice suits, unhealthy lifestyles rampant in American life; and wasteful duplication of glitzy, but very costly hospital services (such as cardiac surgery and neonatal intensive care units) in small cities unable to support even one such service.

The primary strategy that these non-governmental health care payers (or health insurance companies) have employed to control costs is increasing co-pays and deductibles while ratcheting down benefits for patients and reimbursements for already overburdened providers who are legally banned from any sort of collective negotiations with the payers. These mechanisms have recently been embraced by the governmental programs as well, further threatening the financial viability of our current primary care providers.

Insidious “administrative costs and paperwork” (demanded by payers and governmental regulators) now constitute untold unproductive person hours and more than 35% of the healthcare dollar! These costs include “profits” for the health insurance companies and their managers. Most health insurance companies

Continued on Page 13
are now “for profit”; the expectation is that they will make a profit and pass it on to the owners (stockholders) of the company. Unfortunately, the same excessive self-interest that fueled the recent collapses of the housing market, Wall Street, and banks also seems to motivate these health insurance companies that set profit goals on the basis of what the market will bear.

Equally distressing, however, is the almost imperceptible destruction of the relationships between physicians and their patients. Four factors are largely responsible for this unfortunate result. First is the almost universal lack of respect for and even hostility toward most authority figures, including physicians; this dates from the 1960s and the Vietnam era. Second are the frequent changes to employee health plans to reduce costs for the employer. This in turn, often causes an abrupt change of primary care providers for the employees and their family members, which destroys the benefits inherent in continuity of care for both the patient and the physician. In addition, the discontinuity adds to the cost of care. Third and equally disruptive for the physician-patient relationship is the use of the physician as a “gatekeeper” which changes the relationship from advocate to adversary. Fourth, as negative economic forces are increasingly brought to bear on physicians thus compelling them to see more patients, and give each patient less time, physician-patient relationships are often strained to the breaking point. This lack of time for each patient and the missing knowledge accrued from long-term doctor-patient relationships, increases the possibility of preventable medical errors.

The current state of American medicine is an unhappy one. Patients are appropriately growing more dissatisfied with and alienated from the whole system. The amount of burdensome regulatory and reimbursement paperwork is financially overwhelming small office practices, adding significant unreimbursed and unnecessary costs, and taking physician time away from health care delivery. Primary care providers are so financially and emotionally squeezed that many are leaving practice and medical students are shying away from primary care. The dearth of internists in many areas is making timely access to quality care more difficult for patients, regardless of income or insurance. So-called boutique practices are an expensive alternative in which a limited number of patients are seen in a timely manner in exchange for large up-front payments. Many of these practices do not accept third-party payment plans, including Medicaid and Medicare. This access limitation for older and poorer patients will become a crisis if these reimbursement levels are cut further and dramatically as currently proposed by the federal government.

Recently and perhaps predictably, the same ratcheting down of payments by both governmental and nongovernmental health insurers, which have been successfully thrust upon physicians for decades, are now being applied to hospitals. This has been reflected in an increased rate of hospital closures, especially in inner cities and urban areas where hospital cost shifting, staffing, and fundraising have always been more difficult. The increasing financial pressures on hospitals associated with cuts in direct patient care personnel (at the same time that “administrative” slots are expanding) is a likely contributor to the problem of inpatient medical errors. Both the increasing alienation between patients and the health care system and media emphasis on medical errors is reflected in increasing fear of hospital care and invasive outpatient procedures.

We must not allow the current structure of health care delivery to continue. It is not a case of throwing the health care baby out with the bath water, the baby has already drowned!

Continued on Page 14
Nor will the major problems be solved by the electronic medical record. The EMR could reduce some errors and should have some beneficial effects with regard to the portability of patient information (especially good immunization registries) but it does not improve physician-patient relationships (it may even further interfere with them as the physician interacts with the computer screen and not the patient). Pay for performance is a fad which has been shown, in the United Kingdom, to have had disappointing results and is viewed by physicians as the wrong solution for the wrong problem.

The best minds in our country must now apply themselves to a complete restructuring of our health care system as carefully and creatively as possible.

This deliberative but not hasty process must be kept as free as possible from self-interest and partisanship. The final plan will probably require a single payer system which Encompasses Medicare, Medicaid, veterans’ care and the federal employees’ program. There should be a concerted effort to limit unproductive administrative activities and free up the providers to do what they should do, provide patient care. The system should encourage the application of new technology which has been proven in a scientific manner to benefit patients. The ability of the system to discourage inappropriate litigation will make it possible to further decrease overutilization of technology and other procedures. It must discourage costly, inappropriate, intrusive and sometimes painful end-of-life medical excesses yet make death and dying as comfortable and natural as possible. The new health care system should establish financial incentives for both patients and providers that encourages effective preventive medicine and healthy life styles (i.e. providers should be adequately reimbursed for cognitive activity and preventive care, including patient lifestyle education). The system must develop mechanisms to prevent unnecessary and costly duplication of facilities and programs by mandating regionalization yet allowing each patient the choice of providers so as to maintain the quality fostered by good service and outcome based competition, but discourage wasteful and costly fads. Greedy and corrupt physicians must be systematically re-educated or weeded out.

The new health care system should be regulated by a process which would include most of the stakeholders (physicians and other providers, patients, pharmaceutical companies, medical schools, hospitals, state and federal agencies and legislators, etc.). It should be insulated from poorly thought out political quick fixes and costly fads. Some of the goals of the system would include a provider and patient-friendly environment, rational cost control, malpractice tort reform, monitoring and facilitating best practices, high quality care, reduction of medical errors, and support of medical education and research.

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**Words Worth Pondering:**

“No problem is so big or so complicated that it can’t be run away from!” (Linus of ‘Peanuts’ - Charles Schulz)

“In the torment of the insufficiency of everything attainable we come to understand that here in this life, all symphonies remain unfinished.” (Karl Rahner)

“Appearances are entirely what they appear to be — and behind them — there is nothing.” (Jean Paul Sartre)

“There is nothing more frightening than the sight of ignorance in action.” (Goethe)
Adult Preventive Healthcare for Pediatricians

From the MED-PEDS Section of the AAP

The Med-Peds (Internal Medicine-Pediatrics) Section of the American Academy of Pediatrics had another successful Pediatrician Health Day (PHD) exhibit at the NCE in Boston. The goal of the exhibit was to teach pediatricians about their own health care particularly related to health promotion, cancer screening, stress and burn out. We had over 200 pediatricians receive information from our booth including members from the senior section. There were 34 med-peds volunteers (10 students, 11 residents/fellows and 13 attending physicians) from 20 unique residency programs, private practices and medical schools that made this project successful.

For those that did not visit us we would like to share the information that was provided to participants. See you in 2012.

http://www2.aap.org/sections/med-peds/

Allen Friedland, MD, FACP, FAAP
Executive Committee, American Academy of Pediatrics Section on Med-Peds

Tommy Cross, MD, MPH, FACP, FAAP
Section Chairperson, Academy of Pediatrics Section on Med-Peds

Michael Donnelly, MD, FAAP
Executive Committee, Academy of Pediatrics Section on Med-Peds

Stress Self-Assessment Exercise

Choose the most appropriate answer for each of the following 10 statements:
A—almost always
B—often
C—seldom
D—almost never

Circle your answer for each of these:
1. Find yourself with insufficient time to do things you really enjoy?
   A  B  C  D

2. Wish you had more support/assistance?
   A  B  C  D

3. Lack sufficient time to complete your work most effectively?
   A  B  C  D

4. Have difficulty falling asleep because you have too much on your mind?
   A  B  C  D

5. Feel people simply expect too much from you?
   A  B  C  D

Continued on Page 16
6. Feel overwhelmed?
   A   B   C   D

7. Find yourself becoming forgetful or indecisive because you have too much on your mind?
   A   B   C   D

8. Consider yourself to be in a high-pressure situation?
   A   B   C   D

9. Feel you have too much responsibility for 1 person?
   A   B   C   D

10. Feel exhausted at the end of the day?
    A   B   C   D

Add up your Points to determine how much stress you have due to “overload”

- For every A, get 4 points
- For every B, get 3 points
- For every C, get 2 points
- For every D, get 1 point

What is your total score? ________________________________

A score of 25-40 indicates a high stress level, one that could be psychologically or physiologically debilitating due to “overload”.

Source: Girdin DA, EverlyGS, and Dusek DE, Controlling Stress and Tension, Allyn and Bacon, Needham Heights, MA, 1996.
**Adult Preventive Healthcare Checklist for Pediatricians**

<table>
<thead>
<tr>
<th>Screening/Treatment</th>
<th>How Often?</th>
<th>For whom?</th>
<th>Society</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Breast cancer (mammogram)</td>
<td>Every 1–2 years</td>
<td>Average risk women ≥ age 40</td>
<td>CDC, USPSTF, ACS, ACOG</td>
</tr>
<tr>
<td>□ Cervical cancer (PAP smear)</td>
<td>Every 1-3 years depends on media &amp; HPV testing &amp; previous results</td>
<td>Age 21 May stop at age 65 if not at high risk</td>
<td>ACS, ACOG</td>
</tr>
<tr>
<td>□ Colon cancer</td>
<td>Depends on test</td>
<td>All average risk men and women at age 50; USPSTF recommends against screening &gt;85</td>
<td>USPTF</td>
</tr>
<tr>
<td>□ Prostate cancer</td>
<td>Insufficient evidence to screen or case by case</td>
<td>Discussion at age 40 if several &lt;65 y.o. first degree relatives; age 45 if one first degree relative with cancer or African American; ≥50 y.o. &amp; more than 10 yr life expectancy</td>
<td>USPSTF, ACS, AUA</td>
</tr>
<tr>
<td>□ Aspirin</td>
<td>Daily</td>
<td>Consider men &gt;45 y.o. &amp; women &gt;55 y.o.</td>
<td>USPSTF</td>
</tr>
<tr>
<td>□ Flu vaccine</td>
<td>Yearly</td>
<td>All</td>
<td>CDC</td>
</tr>
<tr>
<td>□ Pneumococcal vaccine: 23 valent</td>
<td>Once usually</td>
<td>All adults ≥ 65 y.o. All adults 19-64 with medical conditions include: Smokers, chronic lung conditions like asthma, COPD, chronic cardiovascular conditions, diabetes</td>
<td>CDC</td>
</tr>
<tr>
<td>□ Shingles vaccine</td>
<td>Once</td>
<td>All adults ≥ 60 y.o. FDA: approved ≥50 y.o.</td>
<td>CDC</td>
</tr>
<tr>
<td>□ Tdap vaccine</td>
<td>Once</td>
<td>All adults 19 - 64 y.o.; Adults &gt;65 in contact with infants &lt;12 months not previously vaccinated with Tdap.</td>
<td>CDC</td>
</tr>
<tr>
<td>□ Abdominal aortic aneurysm</td>
<td>Once</td>
<td>Men 65 – 75 who have smoked</td>
<td>USPSTF</td>
</tr>
<tr>
<td>□ Blood pressure</td>
<td>Normal: recheck in 2 years Prehypertension: recheck in 1 year Stage 1: 2 months Stage 2: 1 month ≥180/110 treat now</td>
<td>Goal: &lt; 120/&lt;80 Prehypertension: 120-139/80-89 Stage 1: 140-159/90-99 Stage 2: ≥160/≥100</td>
<td>JNC 7, USPSTF</td>
</tr>
<tr>
<td>□ Diabetes screening</td>
<td>Every 3 years</td>
<td>Those with BP &gt;135/80 or those with other CV risks (age &gt;45, obesity, certain ethnicities)</td>
<td>USPSTF, ACP</td>
</tr>
<tr>
<td>□ Lipid screening</td>
<td>Every 5 years if average risk</td>
<td>All men and women ≥ 20 y.o. or men and women at increased risk ≥ age 20 Men ≥35; Women ≥ 45 if increased risk</td>
<td>NCEP, USPSTF</td>
</tr>
<tr>
<td>□ HIV testing</td>
<td>Once</td>
<td>Ages 13-64 y.o. unless high risk</td>
<td>CDC</td>
</tr>
<tr>
<td>□ Osteoporosis</td>
<td>Once</td>
<td>Women ≥ 65 y.o. Women ≥ 60 y.o., men ≥ 65 y.o. risk factors</td>
<td>NOF, ACP, USPSTF</td>
</tr>
<tr>
<td>□ Thyroid testing</td>
<td>Insufficient evidence</td>
<td></td>
<td>USPSTF</td>
</tr>
<tr>
<td>□ Hormone replacement therapy</td>
<td>Recommend against routine use</td>
<td></td>
<td>USPSTF</td>
</tr>
</tbody>
</table>

USPSTF= U.S. Preventive Services Task Force; CDC= Centers for Disease Control and Prevention; ACS= American Cancer Society; ACOG= American College of Obstetricians and Gynecologists; AUA= American Urological Association; JNC 7= Joint National Committee; ACP= American College of Physicians; NCEP= National Cholesterol Education Program; NOF= National Osteoporosis Foundation
The Section on Young Physicians had a very successful session at the NCE focused on mentoring. Through group discussion, we found that everyone would like to have a mentor or mentors and some of us have had varying success in finding the perfect mentor. I will admit, I am one of those people who have struggled to find the “perfect” mentor in my role as an academic general pediatrician.

The group spent a good amount of time defining the qualities we all look for in a mentor. Popular themes included: good listener, honest, teacher, guide, advisor and overall, someone who helps a mentee achieve specific goals.

What struck me as fascinating was the concept of having peer mentors. Most of the time we think of mentors as someone older, wiser and further along in their careers. People can use peer mentoring in a variety of ways including to collaborate on projects.

So I have realized that my quest to find that one “perfect” mentor is flawed. One person could not possibly be able to guide me through all aspects of my career or help me develop as a professional. I still have my overall mentor, the person who encourages me to develop my various ideas into scholarly projects and reminds me to say no when I am overcommitted. But I’ve sought out others to mentor me as well.

For instance, I have struggled with how to manage office staff, especially the ones who aren’t well trained. So I’ve turned to my friends who have had similar problems and we’ve brainstormed how to improve the situation in my office. Subsequently, I’ve had some change over in staff and I’ve had some success with instructing my new medical assistants.

In the next month or two, my office is implementing an electronic health record. I am both excited and fearful about how this will affect not only my practice but also the many residents I have rotating through my clinic. So I have found peer mentors who have been through this change and asked them what to expect and gotten many tips on how to make the transition less painful.

In return, I am helping these same peers as their institution converts from being a private hospital to a community teaching hospital. I’ve listened as they tell me about their struggles to juggle resident education with the demands of productivity. I am able to guide them and give them feedback about how to deal with these pressures.

And lastly, I’ve started seriously thinking about the promotion process at my institution. In academic medicine, being recognized for your scholarly work is important but the process is mystifying. One of my colleagues, who has been on faculty a couple of years longer than me, started explaining what exactly I need to be thinking about in preparation for applying for promotion. He was a wealth of information! I have asked various senior members of my department similar questions over the years and haven’t gotten answers that were pertinent to my career.

So my search for a mentor has greatly expanded. Slowly but surely, I am finding a cadre of people to help me as I progress in my career. Consider looking outside the box to peers in your quest to find a suitable mentor!
Reaching for a New High: The Salad Bowl Syndrome

By Niru Prasad, MD, FAAP

Have you ever heard of the “salad bowl” syndrome? If you are the parent of a teenager, and you notice your salad bowls missing from the kitchen, please check your teenager’s bedroom closets. You may find these bowls stacked up with stolen medication pills that have been taken from parents or grandparents. These may even be color-coded. In the past year, there has been an increasing trend of prescription drug abuse among our adolescents. As more prescription drugs fill our medicine cabinets, our kids have more of a chance to abuse them.

Last February, I had the opportunity to visit Cancun, Mexico. On the day I arrived at the resort, I was sitting in the lobby and observed an airport shuttle drop off a group of about 20 teenagers. They appeared to range in age from 16-18. Later that afternoon, while I was relaxing at the beach, I saw the same group of teenagers. I noticed that most of them were carrying their own “salad bowls” filled with what I thought was different colored candy. They were tossing the bowls around and passing them back and forth to one another. A few of them were also popping the “candy” in their beer bottles. My curiosity grew more and more since these kids were loud, laughing, giggling, and appeared to be getting very high. When I got closer to the kids, I was shocked to see that what I thought was candy was actually medication – all color-coded in their salad bowls.

Sadly, experimentation with drugs and alcohol among teenagers is very common due to their growing curiosity, peer pressure, and visited correctional facilities for drug rehabilitation; I have arrived at certain conclusions regarding adolescent drug abuse that I would like to share with you.

Teenagers at risk for developing serous alcohol and drug problems include:

- Children with a family history of substance abuse
- Children who are depressed or have low self-esteem
- Children facing extreme peer pressure

Commonly abused drugs include:

- Alcohol
- Tobacco
- Marijuana
- Non-prescription drugs such as ephedrine, over the counter sleeping pills
- Benadryl
- Commonly prescribed medications for them or their family members such as Ritalin, Adderall, Xanax, Oxycontin, Codeine, Vicodin
- Inhalant abuse among children is also gaining popularity due to its ease of use through the nose. Inhalants are known by such street names as huffing and sniffing. The dangerous habit of getting high by inhaling fumes of common household detergents such as, ethanol, methanol,
helium balloons, etc. has been responsible for the immediate deaths of thousands of these children every year due to lung and brain damage.

• Crack is powerful addictive stimulant that is an inhalant form of cocaine. Although crack is used to get a quick high, prolonged use leads to drug dependence, aggressive behavior and malnutrition.

• Club drugs: this term refers to drugs being used by teens and young adults during all night parties known as “raves” or “trances”. Methamphetamines, LSD, and ecstasy are some of the party drugs that are gaining popularity since most of them are colorless and tasteless and can easily be added to beverages to increase euphoria.

• There has also been a significant increase in anabolic steroid use among our athletes.

• Recently, there have been, many reported deaths due to an overdose from a deadly mix of heroin and a potent painkiller called fentanyl. The heroin/fentanyl cocktail has alarmed law enforcement officials in major cities where authorities claim the cocktail mixture is being used to initially make users euphoric. The use and abuse of heroin laced with fentanyl is getting very serious. Fentanyl is a synthetically manufactured pain medication 50 to 100 times more potent than morphine. It is commonly prescribed to cancer patients. Heroin laced with fentanyl is also administered through a patch, oral lozenge called fentanyl lollipop or through injection.

Signs of early regular use include:
• Heavy use of perfume or aftershave to mask smell of smoke
• Alcohol on breath or use of breath freshener or gum
• Diminished interest in social activities held at school, church, or with family
• Morning-after fatigue
• Unusual thirst
• Midnight vomiting

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Reaching for a New High: The Salad Bowl Syndrome... Continued from Page 20

Signs of regular use or beginning drug dependency:
• Loss of appetite, craving for sweets
• Possession of drug paraphernalia such as rolling papers, pot pie, or cellophane “baggies” (usually indicative of marijuana use)
• Loss of eye contact during conversations
• Red eyes, frequent use of eye drops, dilation of pupils
• Burning incense and heavy use of perfume in the room
• Finding reasons not to be home after school
• Strange phone calls, vagueness about activities
• Major drop in school in school performance

What are the treatment plans?
• Parents can help through early education about drugs, keeping their own medication controlled, open communication, good role modeling and early recognition of the problem.
• Since the decision to get treatment is serious, parents should seek help from mental health professional and act accordingly.
• There are a few important factors to remember:
  1. It is very important to match the treatment settings, intervention, and services to each individual’s particular problems and needs.
  2. Effective treatment duration should be prolonged until recovery.
  3. Counseling individuals and group therapy are critical components of effective treatment.
  4. The person should have a strong motivation and positive attitude towards life and lastly, it is important to know that an addicted individual may require prolonged and multiple episodes of treatment to achieve long term abstinence and fully restored functioning.

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From a marketable government debt securities standpoint, investors are offered many choices. These bonds are termed “marketable” because they are widely traded in public markets, providing liquidity to investors. Existing and new marketable U.S. government bonds can be purchased through government securities dealers, usually for a small commission. New issues may also be purchased directly from the government without paying commissions through the Bureau of Public Debt’s Treasury Direct program, at www.treasurydirect.gov.

Marketable U.S. government securities include:

- Treasury Bills (T-Bills): T-Bills are short-term debt obligations with maturities of 13, 26, or 52 weeks. They are sold at a discount from face value with the difference between the purchase price and the face value (or the sales price if sold prior to maturity) being the “interest”. The interest, however, is not taxable until the bill is sold or matures.

- Treasury Notes: Treasury notes are medium-term debt obligations with maturities ranging from two to ten years. Notes have a fixed interest rate and pay interest on a semi-annual basis.

- Treasury Bonds: Treasury bonds are issued for terms of 30 years. Like Treasury notes, T-bonds have a fixed interest rate and pay interest on a semiannual basis.

- Treasury Inflated-Protected Securities (TIPS): TIPS are a relatively new type of government debt. With a fixed percentage yield, and paying interest every six months, TIPS are intended to provide protection from loss of purchasing power due to inflation. At issue, TIPS have a par value or principal amount. The value of the principal amount is then adjusted for changes, up or down, based on changes in the Consumer Price Index. Each interest payment is calculated by multiplying the adjusted principal amount by the fixed percentage rate. At maturity, the investor receives the greater of the inflation-adjusted principal amount or the face value at original issue. TIPS are issued with maturities of 5, 10, and 20 years.

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instruments are normally issued under author-
ity of an act of Congress and usually involve
some form of government guarantee or spon-
sorship. Most are traded in public markets, and
come in different forms and are issued by enti-
ties such as the Government National Mortgage
Association (GNMA), the Federal National
Mortgage Association (FNMA), or the Federal
Financing Bank (FFB). Interest income from
these securities may actually not be exempt
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that not all of these securities are backed by the
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be sure to determine that prior to investing.

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