Message from the Chairperson

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

COMMENCEMENT
It’s the season of proms and commencements again, with speakers across the country advising young graduates that commencement means both the conclusion and the beginning of different phases of their lives. With less than 6 months remaining of my chairmanship of this section, I’m keenly aware of both the things that we’ve accomplished as a section and all the things which are yet undone, including plans to work with the SOYP (Section on Young Physicians) and SMURFs (Section on Medical Students, Residents, and Fellows) and the Council on Adoption and Foster Care on collaborative issues ranging from immunization updates to foster grandparenting. I’m confident that my successor as chairman, Dr. Arthur Maron, will bring many of these plus new initiatives to fruition as he assumes leadership of the section at the conclusion of the 2012 NCE.

SPRING SECTION
EXEC COMMITTEE MEETING
At the spring section executive meeting April 22 in Nashville, Tennessee, we inaugurated implementation of our plan to visit local children’s hospitals. We had a very informative visit to Vanderbilt Children's Medical Center, guided

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Copyright© 2012 American Academy of Pediatrics Section on Senior Members
by Dr. Meg Rush, acting Chairman of the Department of Pediatrics and Dr. Eddie Hamilton, Past President of the Tennessee AAP Chapter. You’ll find the visit description on our website and further on in this issue of the newsletter. The visit was so well received, that we hope to replicate it at other sites in conjunction with future Section meetings. Our intent in planning these visits is to encourage ourselves, as the most senior members of the AAP to assume some aspect of the role of ambassadors to the remarkable collection of children’s hospitals across this country and to encourage our counterparts in AAP Chapter senior pediatric committees to do likewise. Serving as informational resources and liaisons to chapter membership about the outstanding children’s hospitals in our own areas is a ready made opportunity to bridge some collegial gaps and to promote better understanding of these multi-specialty institutions which more and more are staffed by hospitalists and increasingly becoming foreign turf to primary care pediatricians. We need to address that with better understanding of our mutual roles in child health care, and I would like to encourage all chapters to challenge their senior committees to become informational ambassadors with their local or regional children’s hospitals and to submit articles to our Senior Bulletin and website, as well as to their chapter and district newsletters to describe their findings.

Our business meeting included review of our Section strategic plan, the topics for the 2012 and 2013 Section Education programs, and announcement of election results. There was much discussion of the recommendations by the Committee on Membership on proposed changes to eligibility for the Emeritus membership category, which we transmitted to the Board of Directors and the AAP Committee on Membership. I will ask Dr. Aronson to post our recommendations for
Emeritus membership on our section website for your further information, and you can find them in the minutes from our spring meeting. At this date, I have not received notice of the BOD’s recommendations for any changes to that membership category. We deliberated on the list of nominees for the annual SOSM Child Advocacy Award. As usual, all were outstanding and deserving of recognition, and our selected awardee, Dr. Gerald Gilchrist, will be honored at the Section luncheon during the NCE. I invite all of you to attend.

We discussed considerations for re-establishing a liaison with Generations United and the continuation of our staff serving as our informational liaison to the Grandparenting Coalition. With nearly a million US children now cared for predominantly or exclusively by their grandparents, this is an issue deserving of the attention and support of all AAP members and especially of our senior membership. Immunization issues and the need to develop a reliable system of registries, when only a fraction of states have these in place are becoming priority concerns again. These concerns are heightened by escalating numbers of deaths from preventable childhood illnesses including measles and pertussis, due to falling immunization rates and growing numbers of parents exercising personal belief exemptions to enable their children to attend school without required immunizations.

Dr. Maron will succeed me as SOSM chairman after the NCE, Dr. Jerry Aronson is elected as a member, and Drs. Singer and Shira re-elected as members of the Section Executive Committee. Dr. O’Halloran chose not to run for office, but volunteered to work with Dr. Aronson as assistant webmaster for our section.

ALF
The ALF was developed several years ago to succeed the Annual Chapter Forum, recognizing the need for representation of sections, committees, and councils at the annual leadership forum.

In mid-March, I represented SOSM at the Annual Leadership Forum(ALF) and the pre-ALF session for chairs of AAP Sections Committees and Councils. The discussion across disciplines was robust, with far too much complaining from a number of pediatricians about the cost of dues and membership in specialty societies. In my personal opinion, it has always appeared unseemly that physicians making significantly above the average income in America should continue to WHINE about this issue. Clearly, every pediatrician has professional expenses, which constantly escalate, and costs of membership in the AAP as well as subspecialty societies is a chronic burden. On the other hand, teachers, tradesmen, and other workers in this country support families, pay dues to their membership organizations, labor unions, and have other job related expenses which far exceed the fraction of physician’s salaries for comparable expenditures. It is the price of doing business, and we need to remember what a privilege we have to be pediatricians and pediatric sub-specialists in this country. Potentially productive outcomes of this discussion was the resolve to examine graduated membership packages for subspecialists and to support chapters in fostering relationships with local medical centers and children’s hospitals. (Our assumed ambassadorial role seems to be right on target with this!) An informative presentation on the new AAP leadership information on the AAP member website (http://www2.aap.org/moc/leader/default.cfm) was given and can be found on the “about AAP”) tab. Another positive suggestion was that of “branding” by the AAP, recognizing that being a fellow of the American Academy of Pediatrics is a privilege and should be treated as such.

The forum convened with a number of talks including a promising report about the current fiscal health of the Academy. The two candidates for president elect, Dr. Michael Klein, a
pediatric surgeon from Detroit, and Dr. James Perrin, a developmental pediatrician from Boston, were announced and addressed the assembled forum. Both are impressive individuals, and I encourage you to read their statements in AAP NEWS and online.

A major function of the ALF is to provide a house of delegates for the AAP and to enable leadership to vote on member submitted resolutions. All of the resolutions are listed on the AAP member website. I’m pleased to announce that Resolution #52 Membership Dues Waiver for Longtime AAP Members was referred to the consent calendar and passed unanimously. This resolution, submitted by our section, was previously posted on our website and states that members age 85 and older with 30 or more years of AAP membership in good standing will have complimentary membership. In a time when the AAP is understandably worried about the “aging out” of a growing population of baby boomers, this was a welcome success.

Resolution #62 Terminating AAP Sponsorships by Coca Cola was pulled by request from the consent calendar and debated at length. Major objections were voiced about the pop up ads for Coca Cola products (including bottled water and other drinks in addition to Coke) which were so readily evident on the AAP website. Pediatricians from Atlanta praised the importance of the Coca Cola Corporation in their community and reminded us of the importance of this industry’s sponsorship of the reception at the NCE and other functions. Pediatric bioethicists countered that the acceptance of corporate sponsorship by professional membership organizations has long been seen as a conflict of interest and encouraged the AAP to re-examine our conflict of interest policies for the best interests of practicing pediatricians and chapter leadership, as well as for the ethical perception of the American Academy of Pediatrics as an institutional entity. (The AAP conflict of interest policy is found on the AAP web page under “corporate relationships” and was updated in May 2010.) Others decried the concerns about litigation and remembered the long past protracted case of Nestle v. AAP. Finally, after more than an hour of debate, a friendly amendment was offered, removing Coca Cola from sponsorship of HealthyChildren.org “as soon as possible”, causing the amended resolution to pass. This should motivate our Board of Directors to re-visit the perceived (and/or real) conflicts of interest with our membership organization and industry.
Reinventing Yourself: Senior Pediatricians
Looking Ahead to New Challenges and Careers

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 workforce 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

12:00 Lunch, Business Meeting & Senior Section Child Advocacy Award
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 Question & Answer
My editor says, “Time’s up – your piece is due today.” The long-awaited decision from the Supreme Court on the constitutionality of the Affordable Care Act (ACA) has not been made public, and thus my commentary is clearly not based upon the final decision but is designed to examine the facts that we have available on June 11, 2012.

What was assumed prior to the oral testimony before the Supreme Court was that based upon the commerce clause of the Constitution and prior deference that the Court has given to the congress, the Court was likely to declare the ACA constitutional. However, a number of the justices soon turned that assumption on its head by the aggressive negativity of their questions to the Solicitor General.

The opinion which is eagerly awaited may be broad, which would declare the entire bill unconstitutional, or may be “narrow,” declaring the individual mandate that would require all citizens to have health insurance or pay a fine unconstitutional.

Most observers believe that if the mandate is struck down, the remainder of the law will, of necessity, also fall, since removing the mandate destroys the heart of the financing mechanism upon which major components of the bill are based. The loss of funding would prevent incorporating the very popular requirement that insurance would not be denied due to a pre-existing condition. The loss of funding from the individual mandate would also likely deny the provisions of the ACA which prevent insurance companies from placing caps on individual policies, which currently causes some families to find that their insurance runs out after or during major health expenditures when it is most needed. Another feature likely to disappear is the action of the insurance companies that drop patients’ insurance if they have costly health problems in spite of having already paid for insurance for many years.

Now for “the other hand.” A number of health policy analysts, anticipating a negative Supreme Court decision, have looked carefully at the changes already put in place by the early implementation of the ACA and believe that the ACA has already and will continue to positively influence the health insurance plans available to the public.

A substantive statement by the nation’s largest health care insurer, United Health Care, announced today that they will keep in place several key provisions required under the ACA whether it survives the Supreme Court decision or not. The company intends to provide preventive health care services without co-pay or other out-of-pocket charges, allow parents to keep their under 26 year old children on their plan, and maintain a streamlined appeals process. They will also observe the ACA prohibitions on putting lifetime limits on insurance payouts and rescinding coverage after a patient becomes ill. Whether competitive insurance companies will follow the lead of United Health Care remains to be determined.

An additional area of concern highlighted by the limited content in the ACA is the need to attempt to control health care costs and become more efficient in our use of health care. The formation of accountable care organizations are a response to this need. The pediatric and the adult medical home also have the potential for significant cost savings.

Growing efforts to reduce the inefficient use of the emergency room is limited by both the lack of insurance of 50 million Americans who often use the E.R. as their primary care provider, and by the absence of caregivers after hours and on weekends for most of our urban population.

Another “on the other hand” remains the question of the effect of the “almost upon us” 2012 election for Congress and the Presidency. The
party positions are quite clear. If Obama is reelected and the ACA remains intact, we would immediately move toward implementation of the bill. This will require each state to develop their state or regional insurance exchanges or allow the federal government to develop one instead. Each state will also be required to develop its own list of minimum essential benefits which must be included in any insurance policy which will be sold in that state. With less than two years before the exchanges are scheduled to be operative, the tasks are formidable.

If Governor Romney is elected, he has clearly stated that his position is to repeal the ACA at once. Whether that will be possible will depend upon the Congress and which party controls each house. The history of the way Congress has used the filibuster during the past three years suggests that a continuation of the contentious nature of the relationship between the parties will lead to serious dysfunction regardless of which party wins the election.

Please e-mail me with your thoughts and suggestions at donroschiff@comcast.net.

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**Movie Reviews**

*By Lucy S. Crain, MD, MPH, FAAP*

**THE BEST EXOTIC MARIGOLD HOTEL** (for the Elderly and Beautiful) begins with a couple (Bill Nighy and Penelope Wilson) visiting a less than satisfactory potential retirement apartment in London with a glib, young realtor. Brief introductions follow of the other five major British actors in this delightfully entertaining and often all too real depiction of challenges of growing older. Financial crises, a desire to return to India to find his lost love (a retired judge played poignantly by Tom Wilkinson), adjusting to the death of her husband (Judi Dench) on whom she had been overly dependent for most of her life, looking for companionship, and looking for an inexpensive hip replacement (the incomparable Maggie Smith) bring this phenomenal cast of 60 and 70 year old gifted actors together in Jaipur. Directed by John Madden, known for *Shakespeare in Love* and other outstanding movies, this is a must see for all ages, but especially for seniors.

**MONSIEUR LAZHAR** is another must see for pediatricians of all ages. Initial playground scenes at a Montreal middle school evoke a happy, nurturing atmosphere. This suddenly changes with the stark discovery by a 7th grader of the body of his teacher, who has committed suicide in the classroom. Bachir Lazhar (acted by Fellag), an Algerian immigrant in need of employment, applies for a teaching position shortly after the teacher’s death. The need is urgent and his credentials—fortunately for the traumatized children in his class—are not adequately checked. M. Lazhar initially has difficulties adapting too many of the strict school rules, but soon becomes attuned to the students’ emotional needs as well as his goals for their academic success. We learn of his own tragic life, information which is spared from his students who benefit from his compassion, caring, and intuitive presence. Winner of a foreign film Oscar and six Genies (Canadian Oscars), this is a film which causes viewers to continue thinking about its psychological implications and the remarkable performances of the children, as well as that of the leading character. French with English subtitles, based on a play by Evelyne de la Cheneliere, written and directed by Philippe Falardeau.
Vanderbilt Children’s Hospital Tour

By Lucy S. Crain, MD, MPH, FAAP

Exploratory letter 12/2011

The AAP SOSM executive committee proposes to initiate a series of visits to Children's Hospitals around the country, in conjunction with our annual spring business meeting. Our group of 12-16 members hope to informally tour Children’s Hospitals, led by hospital pediatric staff and local chapter AAP members and note the local and regional services provided by each institution. Our further intent is to describe the facility and services in our quarterly Senior Bulletin and online publications for our Section membership of nearly 700 of the most experienced and senior members of the Academy as well as for the AAP membership at large. Since Vanderbilt Children’s is the inaugural site for this series of annual tours, your helpful suggestions will be appreciated. The role of Dr. Iris Snider of Athens, Tennessee, will be crucially important to the success of this endeavor, but also hope we can rely on the help of the Tennessee Chapter and local Nashville pediatricians to make this plan successful.

VANDERBILT CHILDREN’S MEDICAL CENTER TOUR

In conjunction with the spring meeting of the SOSM Executive Committee in Nashville, Tennessee on April 20, our group enjoyed its first children’s hospital tour. We were guided by Dr. Meg Rush, Acting Chairperson of the Department of Pediatrics and Dr. Eddie Hamilton Past President of the Tennessee AAP Chapter and a member of the Vanderbilt pediatric clinical faculty. Their detailed familiarity provided us with a remarkably successful visit to this 243 bed children’s hospital in mid-Tennessee. Drs. Rush and Hamilton met our group in the child-friendly lobby of the free standing Children’s hospital and we then walked outside to a lovely garden area with fish pool, all designed with children and families in mind. The bright colors throughout the hospital underscored that this is a place that understands children.

The Monroe Carrell, Jr. Children’s Hospital at Vanderbilt opened in 2004 and serves all levels of acuity from preventive well child care to neonatal and pediatric intensive care, pediatric surgery, and emergency care for children. The 8 story hospital has 83 Neonatal ICU beds, 36 PICU beds, a level 1 pediatric trauma unit with 25 emergency department beds and additional triage and observation beds, and 16 pediatric operating rooms. We were especially impressed with placement of pre-op and procedural rooms as well as anesthesia providing facility for ECMO and some pediatric surgical procedures in the NICU and PICU units. Family centered care is encouraged, with a dedicated number of family rooms and inviting areas within patient rooms for parents to rest and stay with their children.

Vanderbilt Children’s is well recognized for its research and teaching, as well as its expertise in behavioral development, pediatrics, children with special health care needs, vaccine research and development, genetics, pediatric epidemiology, childhood cancers, and Centers of Excellence for treatment of diabetes and congenital heart disease. There are 3 cardiothoracic surgeons, 9 pediatric general surgeons, 3 ear nose and throat surgeons, and 3 pediatric ophthalmologists on full time staff. The pediatric housestaff has 67 residents in the categorical pediatrics track and 10-14 med-peds residents, as well as 2 pediatric neurology residents.

Dr. Hamilton observed that past town-gown differences had been resolved with good incorporation of active roles for community pediatricians in the clinical and teaching faculty, both within private pediatric practices and in clinic-

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Vanderbilt Children's Hospital Tour Continued from Page 8

Dr. Rush observed that the increased role of pediatric hospitalists (of whom there are 8 FTEs at Vanderbilt) has had impact on this relationship, although many local private pediatricians still round on their hospitalized patients.

In 2011, the Children's Hospital had nearly 120,000 pediatric visits from its home county (Davidson) and 20,500 from other states. It was noted that pediatric patients came from 48 states and the District of Columbia. About half of the patients have Tenn Care (Medicaid) coverage. Two other Nashville hospitals also have level 3 nurseries, and occupancy rates are high in all. Carrell Children's at Vanderbilt is one of 3 pediatric hospitals in the Children's Hospital Alliance of Tennessee. The other two are located at Knoxville and Memphis (LaBonheur). State funding is available to cover perinatal transport. (It was noted that the well known St. Jude's Children's Hospital in Memphis, specializes in pediatric oncology and does not provide perinatal services, so is not a member of this alliance.)

TNAAP is very actively involved in child health advocacy and routinely partners with the Children's Hospital Alliance of Tennessee in these endeavors. Its location in the state capitol helps with scheduling on site legislative testimony and helps to promote the partnership of the academic and private practice community. The Department of Pediatrics at Vanderbilt funds TNAAP chapter membership fees for its pediatric residents, as do 95% of residency programs around the country.

Practice Management Online (PMO) is Moving!

The American Academy of Pediatrics is pleased to announce the content of Practice Management Online (PMO), the online home for the best pediatric practice management information, tools, and resources for pediatricians and their office staff, will be migrated from its current web page (http://practice.aap.org) to www.aap.org effective June 28, 2012.

The PMO content will be housed in the Practice Support page at: http://www.aap.org/en-us/professional-resources/practice-support/Pages/Practice-Support.aspx

The updated Practice Support page will provide a platform for practice management resources that will be integrated with all other AAPWeb content. This new format will help staff to disseminate new information and resources on coding, financing and payment, practice management, quality improvement, health information technology, etc. on a much timelier basis.

To make the transition easier for users, the main categories (“buttons”) from PMO will be moved to the new site, and content will be organized similarly to PMO. If you have trouble finding what you are looking for, a Search Box allows you to search only the Practice Support-related content within the larger www.aap.org site. If you have any questions or require assistance once the new site is launched, please feel free to contact Jose Lopez, Manager, Practice Management, at jlopez@aap.org.

Jose F. Lopez
Manager, Practice Management
American Academy of Pediatrics
847/434-4089
I Was Always Taught to Respect My Elders,
But It's Getting Harder and Harder to Find Them

Someone asked the other day,
What was your favorite fast food when you were growing up?
We didn't have fast food when I was growing up, I informed him.
All the food was slow.

C’mon, seriously. Where did you eat?
It was a place called at home, I explained!
Mom cooked every day and when Dad got home
from work, we sat down together at the dining room table,
and if I didn’t like what she put on my plate
I was allowed to sit there until I did like it.

By this time, the kid was laughing so hard I was afraid
he was going to suffer serious internal damage,
so I didn’t tell him the part about
how I had to have permission to leave the table.
But here are some other things I would have told him
about my childhood if I figured his system could have handled it:
Some parents NEVER owned their own house,
ever wore Levis, never set foot on a golf course,
ever traveled out of the country or had a credit card.
In their later years they had something called a revolving charge card.
The card was good only at Sears Roebuck. Or maybe it was Sears & Roebuck.
Either way, there is no Roebuck anymore. Maybe he died.

My parents never drove me to soccer practice.
This was mostly because we never had heard of soccer.
I had a bicycle that weighed probably 50 pounds, and only had one speed, (slow)
We didn’t have a television in our house until I was 19.
It was, of course, black and white, and
the station went off the air at midnight,
after playing the national anthem and a poem about God;
it came back on the air at about 6 a.m. and
there was usually a locally produced news and farm show on, featuring local people.

I was 21 before I tasted my first pizza, it was called ‘pizza pie’ or “Ah Beetz” and I grew up with it,
maybe because I grew up in an Italian neighborhood.

When I bit into it, I burned the roof of my mouth and the cheese slid off, swung down, plastered
itself against my chin and burned that, too. It’s still the best pizza I ever had.

I never had a telephone in my room.
The only phone in the house was in the living room and
it was on a party line. Before you could dial,
you had to listen and make sure some people

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you didn't know weren't already using the line. 
Pizzas were not delivered to our home but milk was. I also remember the peddlers coming 
around with their vegetable and meat trucks; shouting so that people would come outside to 
see what was there for sale and that probably set the tone for our dinner that day.

All newspapers were delivered by boys and all boys delivered newspapers — 
my brother delivered a newspaper, six days a week. 
It cost 7 cents a paper, of which he got to keep 2 cents. 
He had to get up at 6AM every morning.
On Saturday, he had to collect the 42 cents from his customers.
His favorite customers were the ones who gave him 50 cents and 
told him to keep the change. His least favorite customers 
were the ones who seemed to never be home on collection day.
Movie stars kissed with their mouths shut.
At least, they did in the movies. There were no movie ratings 
because all movies were responsibly produced for everyone 
to enjoy viewing, without profanity or violence or most anything offensive.

If you grew up in a generation before there was fast food, 
you may want to share some of these memories with your 
children or grandchildren, if they aren't busy texting.

Growing up isn’t what it used to be, is it?
My Dad was cleaning out my grandmother’s house and 
held me an old Royal Crown Cola bottle. 
In the bottle top was a stopper with a bunch of holes in it.
I knew immediately what it was, but my daughter had no idea. 
She thought they had tried to make it a salt shaker or something.
I knew it as the bottle that sat on the end of the ironing board 
to ‘sprinkle’ clothes with because we didn’t have steam irons.
How many of these do you remember?

Head light dimmer switches on the car floor. 
Ignition switches on the dashboard. 
Heaters mounted on the inside of the fire wall. 
Real ice boxes. 
Pant leg clips for bicycles without chain guards. 
Soldering irons heated on a gas burner. 
Using hand signals before changing lanes or turning

And how many of the following do you remember?

1. Blackjack chewing gum 
2. Wax Coke-shaped bottles with colored sugar water 
3. Candy cigarettes
I Was Always Taught to Respect My Elders . . . Continued from Page 11

4. Soda pop machines that dispensed glass bottles
5. Coffee shops or diners with tableside juke boxes
6. Home milk delivery in glass bottles with cardboard stoppers
7. Party lines on the telephone
8. Newsreels and cartoons before the movie — and double-features
9. P.E. Flyers
10. Butch wax
11. TV test patterns that came on at night after the last show and were there until TV shows started again in the morning. There were only 3 channels... and a motorized rotary antenna on the roof.
12. Peashooters
13. Howdy Doody
14. 45 RPM records
15. S & H greenstamps
16. AM radio consoles
17. Metal ice trays with lever
18. Mimeograph paper
19. Blue flashbulb
20. Packards and Studebakers
21. Roller skate keys
22. Cork popguns
23. Drive-ins
24. Pump operated insect sprays
25. Wash tub wringers and corrugated washboards

Maybe it's time to stop lying about your age and start bragging about it.

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
Book Review

Devil In The Grove

By Gilbert King

I have just turned the last page of this exceptional telling of an event that occurred over 60 years ago in Groveland, Florida. As I was a fledgling pediatrician at that time in a Northern city, I was aware of some of the injustices inflicted on African Americans in the deep South during the post war years and before, but I could not have imagined the monstrous cruelty and inhumanity that was apparently the norm in Central Florida at that time.

The book, which is a true account of the case of four African American young men, two of whom were returned World War II veterans, and all unquestionably innocent. The four young men were accused of raping a teenage white wife. The book chronicles the trials, convictions, and the ultimate appeals to the Supreme Court. The brutal, unbelievable cruelty, and murderous intent and actions of law officers, elected officials and the indifference of the racist, and politically-motivated governor are a frightening expose of an embarrassing time not so very long ago in the memory of many Seniors.

It is a portrait of a crusader for equal, humane treatment for persons of all races that was the life work of their advocate, Thurgood Marshall, who spent many hours fighting before the Supreme Court, eventually himself rewarded with a seat thereon, where he could truly support the constitutional rights of all men and women.

In the trite words of those who write the book jacket review, this is a “page turner”, albeit a most disturbing one. In the appropriate words of the same jacket, it truly was a “dawn of a new America”.

Read the book and plan to do little else while the frightening story unfolds.

Herbert L. Winograd, MD, FAAP
Developmental Disabilities: An Update for Health Professionals is an annual interdisciplinary, multi-professional conference at the University of California, San Francisco designed to provide a practical and useful update for primary care and subspecialty health care professionals who care for children, youth, and adults with complex health care needs and developmental disabilities.

Over just the past two years, thanks in large part to support from the Special Hope Foundation, this conference has included more than 500 participants in the educational offerings on topics concerning developmental disabilities in adults and children. The 2012 topics, as for the previous ten years, addressed current and new perspectives, research findings, and clinical guidelines on autism spectrum disorders and other developmental disabilities to learn from the various disciplines represented and to provide much appreciated feedback and questions to speakers. Of the 270 attendees, there were 66 physicians, 117 nurse clinicians and allied health professionals, and 58 caregiver attendees plus 58 faculty, trainees, and students whose registration was complimentary. The number of caregivers at the 2012 conference was the largest yet in this category.

History & Overview: In 2001, representatives from the Wellness Program of the California Department of Developmental Services (DDS), were concerned with the growing numbers of individuals with autism spectrum disorders and the lack of working knowledge of screening, diagnosis, and treatment resources among primary health care professionals in California. DDS met with Dr Robert Baron, chief of the UCSF Office of Continuing Medical Education (OCME) and Dr. Lucy Crain, then chief of the UCSF Pediatric Disabilities & Down Syndrome Clinic to propose that UCSF host a collaborative CME conference on autism screening and identification. With the addition in 2003 of adult nurse practitioner Geraldine Collins-Bride as co-chair, that proposal was expanded to include the breadth of developmental disabilities across the life course and has continued with remarkable success (despite the inability of DDS to continue to assist with the conference due to ongoing State budgetary constraints). This annual, fully accredited interdisciplinary conference is unique on the West Coast and began in 2002 with the inclusion of the Healthy People 2010 Goals and emphasis on Medical Homes, family focus, and transition to adult health services. The conference also includes other priority topics, as directed by MCH, DDS, our Planning and Advisory Committee, Continuing Medical Education guidelines, our attendees, and our colleagues in the California LEND and Developmental Behavioral Pediatrics Programs. Educational evaluations and outcomes are carefully measured to assure compliance with the State of California Health Professional Accreditation requirements.

For more information on the 2012 course https://www.cme.ucsf.edu/cme/CourseDetail.aspx?coursenumber=MOC12001
A special needs travel situation can be a factor influencing people's willingness or interest in traveling to the point that they just feel better staying at home or in a place where they have a significant comfort level. This is not necessarily the best thing for them or their loved ones. It is frequently a very positive thing to travel for fun or to see loved ones. Traveling when you are on oxygen, in a wheelchair, have a urinary problem (urine incontinence or needing to self catheterize yourself or wear a urinary diversion container bag) are examples of problems many of us have to deal with as we become handicapped, aged, or just have problems like this that we have lived with for most of our lives. People with colostomy bags are also in need of some direction.

Oxygen
Plane travel now means that we are in a cabin with an adjusted altitude of 5,000 to 10,000 feet. This creates a real problem for anyone with chronic lung disease or certain cardiac problems. Therefore, we need to know:

What are my oxygen requirements?
• Since airlines do not provide oxygen anymore, we need to work with a company that can provide us with portable oxygen concentrator (POC). This concentrator can be carried or pulled like a suitcase, and extra batteries can be supplied. These can provide a constant flow of oxygen, up to 3 L at 0.5 L increased increments. There is an approved list of these, which airlines use, but that may vary with the airlines. Bottles of compressed gas oxygen are now rarely available with airlines, and certainly not in this part of the United States, including Hawaii.
• Oxygen may also be necessary in times of layovers.

Will oxygen be available at your destination (i.e. hotel or someone’s home)?
• Liquid oxygen (LOX). This is a cryogenic product that is delivered by your home oxygen dealer in the form of liquid oxygen in a reservoir. There is LOX portable oxygen that comes in different sizes, holding a half to larger amounts of oxygen. This can provide up to eight hours plus for use. Liquid oxygen (LOX) is not used nor approved in most airlines.

Wheelchairs
Do not hesitate requesting a wheelchair if there is any questions about your ability to walk comfortable. You can use these on departure from any airport or other facility, and upon arrival. Wheelchairs are also available in stopovers enroute.

Waste Disposal
Waste disposal collection from catheters and/or bags such as reservoirs for stools and urinary bag collection devices should be emptied before departure, on stopovers, and upon arrival at your destination.

Traveling by Car
This, in a way, is the easiest way to travel because you can bring along your oxygen concentrator or other needed equipment from your local provider or equipment.

Traveling by Train
Some people feel this is also a relatively simple method of travel, but it is important to get help before getting on the train, at train stations enroute, and at your destination. Your own oxygen POC would be helpful here. Wheelchairs would also be helpful before traveling, during the time of transition between trains, and at your destination.

The most important thing to do with any method of travel is to check and recheck your carrier/air carrier (airplane, train) several times before the trip. Sometimes, a travel agent may be necessary for assistance in making arrangements as they can be most helpful when they discern what your needs are.
Spotlight on Joseph Telch, MD, FAAP
Nominated by the Ontario Chapter for the 2012 Child Advocacy Award

(Ed. Note) The Section on Senior Members (SOSM) invites nominations for our ANNUAL CHILD ADVOCACY AWARD, presented at the NCE. The SOSM Executive Committee reviewed a number of outstanding pediatricians this year. Although Dr. Telch was not selected as the 2012 recipient, of the Award, it was felt that his letter of nomination should be excerpted here as a tribute to his exemplary and inspirational record of achievement. AM

Dr. Joseph Telch trained in pediatrics at the Facultad de Medicina in Mexico City in 1969, and also received a diploma in Clinical Medicine of the Tropics at the prestigious University of London, England in 1974. In 1986 he was awarded a Masters Degree in Clinical Nutrition from the Hospital for Sick Children, Toronto, Ontario. He is married with two children, and has practiced as a beloved community pediatrician in Unionville, Ontario just north of Toronto for over 25 years. He has received many awards and recognition for his work including the Premio Federico Gomez award, which recognized Dr. Telch’s pioneering effort in establishing the first nutrition clinic for children with special needs at the Holland Bloorview Rehabilitation Centre in Toronto, Ontario, as well as the AAP Special Achievement Award in 2008. He remains as dedicated as ever in continuing to serve and advocate for the children of Ontario in his many current capacities.

As many in the AAP are well aware, the very existence of the AAP Ontario Chapter today is a direct result of the tenacity and energy put forth by Dr. Telch for the last decade. His efforts to promote advocacy on behalf of children also extend to other political arenas, such as the Ontario Medical Association Pediatrics Section, the Canadian Pediatric Society (CPS) and many others. At the CPS, Dr. Telch was instrumental in establishing both the Community Pediatrics section as well as the Oral Health section, showing a vision and leadership that now allows pediatricians to advocate for children in the community setting as well as promoting an underrepresented area of children’s health in Canada and the United States, oral and dental health. Dr. Telch has also been a passionate advocate for promoting nutritional well being of children with special needs, as evidenced by his accomplishment of creating the nutrition clinic at Holland Bloorview Rehabilitation Centre, the largest centre for children with special needs in Canada. He has served as consultant at this clinic, as well as a similar clinic at Erin Oaks Centre in Mississauga, Ontario. Thus, for over 25 years, Dr. Telch has not only been a passionate advocate for children in his own office practice but hundreds, if not thousands of special needs children for both nutritional and oral health needs. But perhaps what most stands out about Dr. Telch is his active mentoring of younger pediatricians, and is a fine example of how senior pediatricians can continue to influence and promote advocacy in their later years. I am confident that Dr. Telch will remain a passionate and effective advocate for Ontario’s children and youth for many years to come.

H. Yamashiro
MD FRCP(C) FAAP
President, Pediatricians Alliance of Ontario/Ontario Chapter AAP
Chair, Pediatrics Section, Ontario Medical Association

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

The special membership program of the Section on Senior Members has now been in place for over a year and has been very successful. For a contribution of $25 or more to the Friends of Children's Fund, new Section members will receive their first year of membership dues free. Those members will then be billed for the usual $20 dues during each subsequent year. At that time, they can decide whether they want to continue section membership.

This innovative program has generated more than $3000.00 in contributions and has resulted in the addition of 60 new Section members.

Membership in the Section on Senior Members is open to Fellows in good standing who are 55 or older. The Section presently has a membership of over 700 and is a very diverse group. Members of the section are in many different stages of their careers with some actively practicing, some practicing part time, some involved in alternate careers, some completely retired, and many volunteering in rewarding and fascinating areas.

The Section attempts to meet the needs of its members with an excellent periodical newsletter, a very useful and up-to-date web site, and CME programmed for the particular demographic of its membership. Recent advocacy efforts have focused on lifetime certification by the American Board of Pediatrics. The Section is also undertaking a study of the issues of grandparents becoming primary care providers of their grandchildren. Upcoming scientific programs will focus on career changes, maintenance of mental acuity, and issues of medical ethics.

Donate to AAP Brick Program

The Academy invites you to be a part of its building. The plaza and entry way of the Elk Grove Village, Illinois, headquarters office recently was renovated. For a limited time, you can make a donation to the Friends of Children Fund and sponsor a brick to be placed in the walkway or walls near the main entrance. Dedicate a brick and express appreciation for a mentor, colleagues, family or friends.

To design your brick and make your donation visit http://aap.thatsmybrick.com or contact GraceGeslowski at ggeslowski@aap.org or call 888/700-5378.
Book Review

Reaction and Remedy
Paul Starr

The Healing of America
T.R. Reid

For those of us who are policy wonks or even followers of the debate on health care this spring promises to be an interesting if not frustrating time. Most pediatricians have supported health care reform according to surveys by the American Academy of Pediatrics research department. Many hope that the promised changes of increased access to care and more comprehensive coverage will improve the lives of children [and pediatricians].

For a course in health policy, one should begin with Paul Starr’s 1982 book, ‘Social Transformation of American Medicine’, a comprehensive history of the progression of health care throughout the history of the United States; the first part details the profession of medicine and the beginning of the hospital system while the second part covers the twentieth century introduction of health insurance and early health system reform efforts. Paul Starr’s second book, ‘Reaction and Remedy’ reiterates some of the discussion of twentieth century reforms with a discussion of the Clinton’s attempts to reform health care through the introduction of the Affordable Care Act, Obama’s health care legislation, with a fifteen year intermission between the two presidencies. His analysis of the downfall of the Clinton’s plan blames the defeat on the rabid partisanship [sounding familiar to the current political scene] that arose when the bill was introduced and less to the complexity of the legislation. Starr places less blame on the complexity of the legislation, possibly due to the fact that he was a principal advisor to President Clinton. The famed ‘Harry and Louise’ advertisements were more of a distraction than an influence on the overwhelmed public.

Without health reform during the 1990’s [except the Bush administration expansion of Medicare prescription drug coverage] a similar scenario emerged during the Obama administration of concerns for the economic viability of health care costs approaching 20% of GDP as well as the frustrations of physicians and hospitals and patients over costs and coverage. Starr documents what he calls the health policy trap in which an increasingly complex and expensive health ‘system’ keeps most people largely satisfied with their current health care. The new legislation largely leaves the employer based health insurance system intact ‘If you like your health plan, you can keep it’ clearly for political reasons and focuses on low income families and individuals. The book is strong on health policy and weaker on the political aspects of the debate which continues to unfold as the US Supreme Court considers the challenges brought by 26 states.

Traveling to a number of developed nations to seek multiple opinions of his injured shoulder becomes the backdrop for a tutorial in comparative health care economics by T R Reid, a Washington Post writer and commentator for National Public Radio. First published in 2009, the book was updated to include an afterword that in straightforward terms explains the Affordable Care Act [ACA]. Reid describes the health care systems of several other developed nations as quite different from each other, yet none of them follow the stereotypes that American politicians refer to, including the threat of rationing and long delays in care. As Reid argues, there is de facto rationing in the United States, by cost and limitations imposed by access to care by Medicaid and Medicare recipients. The American system is a fragmented one, using versions of those used by Great Britain, Canada and Germany. The most

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prominent difference is that the other nations include universal coverage, a feature that is only accomplished for Americans over age 65. Reid describes American health care as ‘the most fragmented in the world.’ Among the other significant differences and potential barriers are physician compensation, the cost and availability of high technology and pharmaceutical costs.

While stressing the variability of other health care systems, the book also identifies 3 features as common to health care in all developed countries except the United States: a unified system, applicable to everyone; nonprofit financing, meaning that for-profit insurance companies can provide only supplemental and not basic health care insurance; and universal coverage.

T R Reid raises the fundamental question of health care that has not yet been answered in the United States, ‘Before you can set up a health care system, you have to know the country’s basic ethical values. The first question is: Do your people have a right to health care?’ Reid advocates for universal coverage, citing a number of health care economists as well as the example of most other developed nations as the correct approach to dealing with health care costs. Reid argues that the United States can effectively address the issues of health care costs if we are willing to accept some features of other developed nations that have worked. A similar approach was undertaken successfully by Taiwan in 1995. The Taiwan government studied health care systems in a number of other nations before adopting a hybrid approach that used features from a number of them, including universal coverage. The reasons that it was implemented successfully were a strong moral imperative for health care for all, a political environment that was conducive to reform and a strong economy that made the adoption of major change feasible. Clearly the challenge of the twenty first century in the United States is the absence of all three of those conditions.

Mark Rosenberg, MD, FAAP

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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 Fall Bulletin
August 15 articles due to Arthur Maron MD, MPA, FAAP
September 15 mailboxes

2013 Winter Bulletin - Electronic
December 2, 2012 articles due to Arthur Maron MD, MPA, FAAP
January 3, 2013 online
When I was planning for my retirement, I was concerned that I wouldn't have enough activities to keep me fully occupied and that I would become bored. Although I belong to a health club and exercise three days a week, that wasn't enough to fill my free time. One of the men with a nearby locker is the head of the docent steering committee at the Holocaust Memorial Center and I overheard a number of his conversations. After becoming curious, I asked if there might be any opportunities to volunteer at the Center. He told me that there was a training class for new docents about to start and I should come to the orientation session to see if it might interest me. After attending that session, I decided to enroll in the training program.

There were 28 prospective docents in the class and 17 ultimately became certified. The training was more rigorous than I anticipated. We each had to buy a textbook and there were assigned readings. In addition, we were given a list of recommended books and websites for research and to further our knowledge. We had 4 mandatory classes that consisted of a 1 hour question and answer session followed by a 45 minute detailed tour of one of the sections of the Center. Everyone had to observe 5 different tours given by experienced docents. Each of us was assigned a mentor who advised us and helped us polish our presentation. I, and all the others, spent hours in the Center digesting every detail of every exhibit. When our mentors felt we were ready, we asked to be examined for certification.

Like most physicians, I have faced many exams, but this one made me very anxious. We had to conduct 3 senior docents on a tour of the Holocaust Memorial Center. I was told that they would be super-critical and quite a few people did not pass on the first try. There were two tries at the exam. If you failed the first one, you had to use their critique to try to pass again. Two strikes and you were out. I was relieved when I passed on the first try, although I made three mistakes.

If a docent wants to maintain certification, there is required continuing education. The Center has multiple educational activities involving guest speakers and panel discussions. Each year we have to attend at least two of these educational activities and have to observe the tour of another docent.

This has been a very rewarding and invigorating experience. It's also very meaningful to me to help keep alive the memories of the Holocaust and to teach the lessons to be learned from that historic event. I'm doing 7-8 tours per month and I still get excited before each tour. The tours have been mostly middle school and high school students. I have guided several adult groups and some college classes. One would think it would finally become boring doing the same thing over and over, but that's not the case. Each tour is unique depending on the group that is being guided and the docents learn to adapt the tours to the characteristics of the group. One of the most interesting groups I had was a number of adults from a rehabilitation institute who had all had traumatic brain or spinal cord injuries. They were all in wheelchairs and some had communication handicaps. Adapting the tour to their needs was a very interesting challenge. When guiding a group of middle school students, the words I use and the depth of historical detail I provide is much different from when I’m guiding a college class. These kinds of challenges keep it interesting. Also, I’m stimulated to keep studying. There is a huge amount of information about the Holocaust that is available and it seems like I can never learn enough. This “second career” not only occupies my time, but provides an opportunity to continue learning new information and to keep me intellectually stimulated.

I’m writing this article in the hope that others will write similar articles detailing the things that they are doing during retirement. Many of us are involved in very interesting activities and I invite other retired section members to tell us about our experiences.

My Second Career
By Stanford Singer, MD, FAAP
Out of The Mouths of Babes . . .

While I sat in the reception area of my doctor’s office, a woman rolled an elderly man in a wheelchair into the room. As she went to the receptionist’s desk, the man sat there, alone and silent. Just as I was thinking I should make small talk with him, a little boy slipped off his mother’s lap and walked over to the wheelchair. Placing his hand on the man’s, he said, I know how you feel. My Mom makes me ride in the stroller too.

* * *

As I was nursing my baby, my cousin’s six-year-old daughter, Krissy, came into the room. Never having seen anyone breast feed before, she was intrigued and full of all kinds of questions about what I was doing. After mulling over my answers, she remarked, ‘My mom has some of those, but I don’t think she knows how to use them.

* * *

Out bicycling one day with my eight-year-old Granddaughter, Carolyn, I got a little wistful. ‘In ten years,’ I said, ‘you’ll want to be with your friends and you won’t go walking, biking, and swimming with me like you do now. Carolyn shrugged. ‘In ten years you’ll be too old to do all those things anyway.

* * *

Working as a pediatric nurse, I had the difficult assignment of giving immunization shots to children... One day, I entered the examining room to give four-year-old Lizzie her needle. ‘No, no, no!’ she screamed. ‘Lizzie,’ scolded her mother, ‘that’s not polite behavior.’ With that, the girl yelled even louder, ‘No, thank you! No, thank you!

* * *

On the way back from a Cub Scout meeting, my grandson innocently said to my son, ‘Dad, I know babies come from mommies’ tummies, but how do they get there in the first place?’ After my son hemmed and hawed awhile, my grandson finally spoke up in disgust, ‘You don’t have to make up something, Dad It’s okay if you don’t know the answer.’

* * *

Just before I was deployed to Iraq, I sat my eight-year-old son down and broke the news to him. ‘I’m going to be away for a long time,’ I told him. ‘I’m going to Iraq.’ ‘Why?’ he asked. ‘Don’t you know there’s a war going on over there?’

Forwarded by George Cohen, MD, FAAP

Have an Issue?

Join the Section on Senior Members Listserv by contacting tcoletta@aap.org

For more information or to join the section... visit our website at: www.aap.org/seniors
For most of the 20th century, retirement in America was traditionally defined in terms of one’s participation in the active work force. An individual would work full time until a certain age, and then leave employment and enjoy their full retirement. At that time, retirement planning typically focused almost exclusively on saving enough to guarantee a desired income until one’s death. More recently, many physicians find that defining retirement is not so cut and dried. Some are choosing to retire early, while others are choosing to work in a different capacity well past the traditional retirement age of 65. In addition, retirement is now often defined by activities such as travel, returning to school, volunteer work, or the pursuit of favorite hobbies or sports.

Whatever form retirement takes, health care is an integral part of the overall planning process. Retired individuals pay for health care in a number of ways. Some are able to pay cash. Others have health insurance plans provided by former employers or are covered through a spouse who is still working. For the majority of Americans age 65 and older, however, most health care is provided through the various elements of the federal government’s Medicare program.

The original Medicare program pays for many, but not all, health care services and supplies. Many retirees will also consider purchasing a “Medigap” policy, sold by private insurance companies, to help pay some of the health care costs (the “gaps”) that the original Medicare program does not cover, including co-payments, coinsurance, and deductibles.

Medigap policies provide standardized coverage and must follow federal and state laws designed to protect consumers. Each standardized Medigap policy must provide the same basic coverage with the cost being the basic difference between the same Medigap policies sold by different insurance companies.

Retirement health care planning must also take into consideration “incapacity”. Major health problems such as a stroke, a heart attack, the onset of Alzheimer’s disease or other forms of dementia, or simply becoming weak and frail from advancing age can result in the inability to care for yourself or manage your own affairs. There are two issues to consider:

• Paying for custodial care: Medicare and other types of health care insurance are designed to cover “acute” medical conditions. They do not pay for costs associated with custodial or maintenance care for an individual whose health problems require nursing home care. Rather than pay these costs out of pocket, many individuals purchase a Long-Term Care (LTC) insurance policy.

• Managing personal affairs: If an individual is no longer able to manage his or her personal affairs, someone else will need to step in and take over. In planning for this possibility, three key documents should be considered:

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1. Durable power of attorney: A written document by which one person empowers another person to act in his or her behalf, usually as it relates to management of financial affairs.

2. Living Will: This document provides guidance as to the type of medical treatment to be provided or withheld, and the general circumstances under which the directive applies.

3. Durable power of attorney for health care: Many states have laws allowing a person to appoint someone to make health care decisions for them if they become unable to do so themselves.

Planning for health care and incapacity in retirement involves answering a number of complex questions and addressing some not-so-pleasant “what if” scenarios. The guidance of trained professionals in insurance, medical benefits, as well as the counsel of an estate planning attorney, can be invaluable in designing and implementing an effective health care plan.

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**AAP Travel Office**

The Academy Travel Office is here to serve your travel needs Monday through 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 online, 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.